

An independent investigation into the care and treatment of Mr F by Tees, Esk and Wear Valleys NHS Foundation Trust

March 2015

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EXECUTIVE SUMMARY

In March 2014 NHS England (North) commissioned Niche Patient Safety to conduct an independent investigation into the care and treatment of Mr F and to review the events that led up to the incidents in April 2012 which ended in the deaths of two members of the public.

This case met the following criteria for the commissioning of an independent homicide investigation as set out in the NHS England Single Operating Model.¹

“When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach of specialist mental health services in the six months prior to the event.”²

The investigation was also to determine whether or not the events could have been predicted³ or prevented⁴ and to review the Trust’s post incident report and their progress in implementing the subsequent action plan.

This report was written with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis Guidance.⁵

Summary of the incidents on 23 April 2012 and 25 April 2012:

The first victim was an 81 year old man. Mr F had previously lived next door to this gentleman and had carried out some building work for him and he also reported that he occasionally borrowed money from him.⁶ On 23 April 2012, after some of the victim’s friends had become concerned about his welfare, they forced entry into his home and found him deceased. The victim had sustained significant facial and head injuries. Mr F’s DNA and an item of his clothing were found on the body.⁷

On 25 April 2012 CCTV showed Mr F meeting the second victim in the communal hallway of the property where she lived. It is unclear why Mr F was in the building or if he knew her. She sustained fatal head and neck injuries. It was reported that Mr F took a number of items from her flat.

Following a highly publicised national police hunt, Mr F was arrested on 29 April 2012. He was found guilty of both murders and received two life sentences with a minimum term of 37 years.

¹ NHS England, Delivering a Single Operating Model for Investigating Mental Health Homicides (2013), p7

² NHS England, Delivering a Single Operating Model for Investigating Mental Health Homicides (2013), p7

³ Predictability is ‘the quality of being regarded as likely to happen, as behaviour or an event’. We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. <http://dictionary.reference.com/browse/predictability>

⁴ Prevention means to ‘stop or hinder something from happening, especially by advance planning or action’ and implies ‘anticipatory counteraction’; therefore for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.

<http://dictionary.reference.com/browse/predictability>

⁵ National Patient Safety Agency (NPSA), Root Cause Analysis Guidance

⁶ Information obtained from police interview transcript with Mr F after his arrest

⁷ Information obtained from police interview transcripts

Background:

Mr F suffered from hereditary exostosis.⁸ This disease caused Mr F to experience significant pain with increasing physical disabilities and restrictive mobility issues. At the time of the incident, Mr F was registered with two primary health care services: one was managing his methadone programme, the other his physical health needs. Mr F was being prescribed Pregabalin⁹ for neuropathic pain.

Mr F's first contact with the police and juvenile judicial system was at the age of 13. At the time of his arrest, in 2012, he had a total of 33 convictions for over 78 offences.¹⁰ Mr F's victims were either female partners or males who were "*often vulnerable in some way*".¹¹ In 2010 Mr F reported to all primary and secondary health care services that he had just been released from prison for the manslaughter of an individual who he reported was a paedophile. The OAsys¹² report documented that Mr F was found guilty of GBH¹³ and was sentenced to eight years in prison.

When Mr F was released from prison he began a relationship with a woman who was identified as his main carer. On a number of occasions during 2011 and 2012 the police attended the address of this woman for repeated incidents of domestic violence. Mr F admitted to the consultant psychiatrist¹⁴ that he had assaulted her and had locked her in the house "*without justification*".¹⁵ At the same meeting, she reported that she had taken several injunctions out against Mr F but that the relationship continued. Mr F continued, sporadically, to live with her. From 2010 Mr F registered 13 different addresses with his primary care service.

Mr F's contact with secondary mental health services:

On his release from prison Mr F was being prescribed Mirtazapine¹⁶ and Citalopram.¹⁷ On 20 October 2011 Mr F attended surgery 2 reporting that he was feeling increasingly anxious and experiencing heart palpitations. At his request a referral was made to the crisis service. It was documented that Mr F was reporting that he was having increasing issues with his anger. He also voiced concerns that he might harm somebody, as he felt that his mental health was deteriorating.

⁸ Hereditary exostosis is an inherited autosomal dominant disorder where multiple bony spurs or lumps called exostoses develop

⁹ Pregabalin is used to relieve neuropathic pain (pain from damaged nerves)

¹⁰ OAsys, p9

¹¹ OAsys, p10

¹² OAsys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the National Probation Service from 2002 to measure the risks and needs of criminal offenders under their supervision

¹³ GBH: grievous bodily harm

¹⁴ Letter from consultant psychiatrist Crisis Resolution Team, 25 October 2011

¹⁵ Letter from consultant psychiatrist Crisis Resolution Team, 25 October 2011

¹⁶ Mirtazapine is an antidepressant used to treat major depressive disorder

¹⁷ Citalopram is an antidepressant drug of the selective serotonin reuptake inhibitor (SSRI) class

At a subsequent Mental State Examination, Mr F was diagnosed with a panic disorder and prescribed Sertraline.¹⁸ He was also referred to the affective disorder team. There was a recommendation that a forensic referral be undertaken once his care had been transferred. This never occurred.

Three FACE risk assessments¹⁹ were undertaken by the crisis service and affective disorder services. The following significant risks were highlighted:

*“Risk of violence to others 3 = Serious Risk
Risk related to physical condition 2 = Significant risk
High risk of relapse 2 = Significant risk.”*²⁰

Mr F was transferred to Middlesbrough’s affective disorder team on 27 October 2011, but due to staffing issues within the team, Mr F was not seen until 23 November. Mr F was then seen by a nurse consultant (12 December 2011) where he reported that he had stopped taking Sertraline. He was prescribed Buspirone Hydrochloride.²¹ Primary care notes indicate that the GP (surgery 2) continued to prescribe Buspirone Hydrochloride until 7 March 2012, at which point a prescription was issued for Sertraline (50mg). There was no explanation as to why this change occurred. In a subsequent review by a CPN, at the affective disorder outpatient clinic, this change in medication was noted and it was reported that Mr F *“was given no reason for the change but clearly stated that he was feeling better with the Buspirone.”*²² No action was taken by the CPN to seek clarification from the GP, nor was it discussed with the nurse consultant. Mr F was seen on one further occasion before the incident by the same CPN (28 March 2012) where there was no further discussion regarding his medication.²³

The findings of Niche Patient Safety independent investigation:

We identified the following issues:

Mr F was registered with two primary care services and he also presented himself on several occasions to the Walk-in Centre. Neither surgery 1 nor the Walk-in Centre were able to access surgery 2’s patient notes. Mental health services were also unaware that Mr F was registered with two primary care services and were only sending letters to surgery 2.

As the prison service does not release a prisoner’s medical notes on their release both primary care services were unaware of Mr F’s full medical history. It took some considerable time for surgery 2 to identify that they were overprescribing Pregabalin and that it was likely that Mr F was misusing this medication. No agency was considering the possible risks associated with Mr F’s long-term use of pain-relief medication in relation to potential misuse or addiction to prescribed medication. A month before the incident surgery 2

¹⁸ Sertraline is an antidepressant used to treat depression, obsessive-compulsive disorder, panic disorder and anxiety

¹⁹ FACE: Functional Analysis of Care Environments. The FACE risk profile is part of the toolkit for calculating risks for people with mental health problems, learning disabilities, substance misuse problems

²⁰ FACE assessments dated 20 October 2011 completed by crisis service

²¹ Buspirone hydrochloride is a medicine which is used in anxiety disorders

²² Case notes, 23 March 2012

²³ Case notes, 28 March 2012

changed Mr F's psychiatric medication without consultation with the prescribing clinician.

No mental health agency sought to obtain information regarding his forensic history from the police or the probation service. They were relying on information reported by Mr F. No forensic assessment was undertaken by secondary mental health services. Mental health services did not share their risk assessments and support plans with primary care services.

No action was taken by mental health clinicians who were aware of the potential risks of domestic violence either to obtain further information or to alert the police of their concerns about the safety and welfare of Mr F's partner. She was also not offered a carer's assessment.

Despite Mr F repeatedly reporting his fears of a relapse in his mental health there was no evidence of a risk or relapse management plan being identified. No agency was considering the potential psychological effect of Mr F's chronic health condition on his mental health. Additionally, despite it being known that Mr F's housing was unsuitable, it was not being identified or given adequate consideration within successive assessments by any clinicians.

We concluded that based on the evidence that we obtained during the course of this investigation, it was clear that Mr F had very complex needs which required an integrated multi-agency approach to risk assessments, information sharing and support planning. This clearly did not occur, resulting in all agencies operating in isolation and a fragmented service being provided to Mr F. His support needs and risk assessments were based on information that was reported by Mr F who, it is now evident, was an unreliable self-historian. Individual clinicians also failed to adequately respond to information regarding the potential risks to the welfare and safety of Mr F's girlfriend.

Tees, Esk and Wear Valleys (TEWV) Post Incident Investigation Report (PIR):

The PIR provided an extensive chronology and review of the involvement of secondary mental health care. The author of the PIR reported to us that they had requested access to information from other agencies, e.g. primary care notes, police and probation services, as well as Mr F and his girlfriend. They were informed by TEWV's Patient Safety Department that "*permission had not been granted to visit the patient and consent had not been given to access information from other agencies.*"²⁴ Due to personnel changes within TEWV's Patient Safety Department we were unable to verify the reasons for these decisions or what efforts were made to invite either Mr F's partner, his and the victims' families to take part in the investigative process.

The failure to have accessed Mr F's primary care notes or to interview the two GPs resulted in the following significant issues being omitted within the PIR:

- He was registered with two primary care services.
- Surgery 2 suspected that he was misusing prescribed medication.

²⁴ Email correspondence from author of the PIR

- The fact that the GP from surgery 2 changed Mr F's medication to Sertraline a month before the killings without consultation with the prescribing mental health clinician.
- The extent of Mr F's housing difficulties.
- The consistent lack of communication between the two primary health care services and community mental health services.

Additionally the failure to obtain information from either the police or the probation service regarding Mr F's significant forensic history resulted in PIR's authors basing their analysis on information provided by Mr F; who it is now evident was an unreliable self-historian who provided contradictory information to various agencies. We would also suggest that the failure to involve Mr F's partner, who was his main carer, in the PIR investigation was a significant error. Not only did it fail to meet one of the criteria outlined in the NPSA,²⁵ regarding involving families and carers, but she may have been able to provide valuable insight which would have enabled a more comprehensive picture of Mr F's life, his risks and support needs to have been developed.

Had the authors of the PIR been able to gain access to both the primary care notes and forensic information they would have being able to have developed a more comprehensive profile of Mr F. This would have enabled the identification of more accurate issues in the care that was being provided by to Mr F by both primary and secondary services. Thereby facilitating the identification of more relevant contributory factors, which would have then informed both their recommendations and TEWV's action plan.

Furthermore, given that this incident resulted in the homicide of two innocent members of the public by a TEWV's patient, who it was believed had a manslaughter conviction (although we now know that he had in fact been convicted of GBH), a significant history of domestic violence and drug addiction. We would have expected the Trust before they accepted the findings of the PIR to have directed the Head of Patient Safety and the authors of the PIR to have more proactively pursued accessing primary care notes, as well as obtaining information from the probation service and the police and also involving Mr F and his family

Predictability and preventability:

In our consideration of the predictability and preventability of these incidents, one of the questions that we have asked ourselves was whether it was reasonable to have expected agencies and individual clinicians to have taken more proactive steps to obtain a more comprehensive profile of Mr F. Additionally, based on the information that was known at the time, did they take reasonable steps to manage his risks?

Predictability:

There were repeated narratives within Mr F's secondary care notes of significant current and historical risk factors. There were documented

²⁵ NPSA National Patient Safety Agency. Involvement and support of relatives. Findings shared with the patient and relatives

accounts of him exhibiting verbal aggression and there were verbal accounts of incidents of domestic abuse. Mr F was also repeatedly reporting that he was concerned about his inability to manage his anger and that he was afraid that this would result in him returning to prison. It was also known, by some agencies, that Mr F had a significant history of using illicit drugs and was on a methadone programme. Primary care (surgery 2) became increasingly aware that Mr F was misusing prescription medication. Also, all primary and secondary care services were aware that Mr F had been incarcerated for manslaughter, for which he had received a considerable custodial sentence. Bearing in mind the definition of a predictable homicide, which is that “*the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.*”²⁶ We concluded that, even based on the partial and at times inaccurate information that was known at the time, there was enough evidence to indicate that Mr F was a vulnerable individual who had significant known risk factors. Therefore, we consider that they should have identified that there was a significant probability that he would reoffend.

What was not predictable was Mr F’s choice of victims in this double homicide. Previously his victims had been known to either himself or his associates and there were elements of either domestic violence or a revenge motive. In this case both victims appeared to have been randomly chosen by Mr F. They were both victims of frenzied assaults and the motive appears to have been robbery.

Preventability:

We concluded that it is more difficult to definitely determine whether the incident was preventable. Clearly Mr F was a serial offender who was either unwilling or unable to engage in any meaningful rehabilitation programme. The evidence indicates that there were many deficiencies and missed opportunities by both primary and secondary health care services where important information could have been sought and shared. If obtained, this information would have enabled a more accurate assessment of Mr F’s risk factors and would have alerted agencies to his potential for reoffending.

However, we would suggest that even with improved risk assessments, inter-agency communication and information sharing, given Mr F’s historical lifestyle and his lifestyle at the time he was being seen by clinicians, it is not evident if these changes would have prevented Mr F from reoffending. Therefore, we concluded that the incidents were not preventable.

Concluding comment:

We were consistently informed that clinicians felt that Mr F did not have mental health issues and that with the changes that have been introduced to community mental health services since this incident; for example, the affective disorder service’s referral criteria Mr F would no longer be eligible for ongoing secondary mental health services. This posed the question as to where and how a patient such as Mr F would access the ongoing support and

²⁶ Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116–120

treatment in the community that they clearly require. We felt that none of the clinicians that we interviewed were able to answer this question satisfactorily.

Recommendations

The independent investigation team believes there are lessons to be learnt and has made a number of recommendations.

Recommendation 1.

Both primary and secondary health care clinicians should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting suspected and known incidents of domestic violence.

Recommendation 2.

When a patient is identified as having a history of offences, the crisis and affective disorder teams must, as a matter of course, seek to obtain information from the police and probation services.

Recommendation 3.

The Trust should review its current safeguarding policies to ensure that they reflect the findings of the latest HMIC report (*Everyone's business: Improving the police response to domestic abuse*) and Cleveland Police's associated action plan (2014).

Recommendation 4.

Mental health services' risk assessments and support plans should be identifying and considering a patient's current housing situation. Where a patient is experiencing housing issues, this should be identified as both a significant risk factor and one that requires support.

Recommendation 5.

When a patient is registered with two primary health care services, there needs to be improved communication and information sharing between the practices.

Recommendation 6.

Secondary mental health care services should be aware that patients on a methadone programme in this area may be registered with two primary care services. If this is the case, they must ensure that communication is being sent to both services.

Recommendation 7.

Both primary and secondary health care services should be considering the possible psychological effects and the potential for misuse of prescribed medication in patients with chronic or ongoing physical health issues. This issue should be considered within mental health risk and care planning.

Recommendation 8.

NHS England's Regional Homicide Leads need to address the lack of information sharing by prisons' medical services.

Recommendation 9.

Primary care services should consult with the prescribing mental health clinician when they are considering changing a patient's psychiatric medication.

Recommendation 10.

The Trust and authors of PIR should make every effort to obtain access to primary care notes and interview the relevant GPs. Where the perpetrator is known to have a forensic history, they should also obtain probation service and police information.

Condolences to the families of the victims:

Niche's investigation team would like to offer their deepest sympathies to the families of both victims. It is our sincere wish that this report does not contribute further to their pain and distress.

Publication:

The outcome of this investigation will be made public. The nature and form of publication will be determined by NHS England. The decision on publication will take account of the views of the relatives and other interested parties.

Acknowledgement of participants:

The investigation team would like to acknowledge the contribution of the staff from Tees, Esk and Wear Valleys NHS Foundation Trust to this investigation.

Anonymity:

For the purpose of this report:

- The identities of all those who were interviewed have been anonymised.
- The individuals are identified by their professional titles.
- Services are referred to by their service type.
- The victims are referred to as victim 1 and victim 2.
- The patient is referred to as Mr F.

1. INTRODUCTION

NHS England's Single Operating Model:

- 1.1 Prior to 2013 the Health Service Guidance (94) 27 (amended in 2005) had placed responsibility on former Strategic Health Authorities to commission independent investigations into mental health homicides and serious incidents. From 2013 this function was transferred to NHS England, who assumed overarching responsibility to ensure that *“the NHS delivers better outcomes for patients within its available resources and upholds and promotes the NHS Constitution and the NHS Mandate.”*²⁷
- 1.2 In January 2014 NHS England introduced a Single Operating Model²⁸ which identified the following criteria with regard to what now prompts the commissioning of an independent homicide investigation:
*“When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach of specialist mental health services in the six months prior to the event. To examine the care and treatment of patients and establish whether or not a homicide could have been predicted or prevented and if any lessons can be learnt for the future, to reduce the chances of reoccurrence of a similar incident.”*²⁹
- 1.3 The purpose of such an investigation is to:
*“Increase public confidence in statutory mental health service providers. Another reason for undertaking independent investigations and publishing their reports is to ensure that Trusts/providers implement the reports’ recommendations and action plans.”*³⁰
- 1.4 The intention of the Single Operating Model is to ensure that:
- *“there is a uniform and consistent approach to managing independent patient safety investigations;*
 - *to develop expertise and a body of knowledge; and*
 - *to reduce the organisational risks of running multiple systems by removing local variations.”*³¹

The commissioning of the investigation:

- 1.5 In March 2013 NHS England commissioned Niche Patient Safety to undertake an independent investigation into the homicides of two persons on 23 April and 25 April 2012.

²⁷ NHS England, Single Operating Model for Investigating Mental Health Homicides, 2013, p5

²⁸ NHS England, Single Operating Model for Investigating Mental Health Homicides, 2013, p5

²⁹ NHS England, Single Operating Model for Investigating Mental Health Homicides, 2013, p5

³⁰ NHS England, Single Operating Model for Investigating Mental Health Homicides, 2013, p7

³¹ NHS England, Single Operating Model for Investigating Mental Health Homicides, 2013, p6

Purpose and scope of the investigation:

- 1.6 The purpose of this investigation is to investigate the care and treatment of Mr F; to assess the quality of the internal investigation that took place following the incident; to review the implementation of the action plan that arose out of the findings of the Trust's internal review; and to establish whether any lessons can be learnt for the future which could prevent similar incidents occurring.
- 1.7 We will also consider whether the incidents on 23 and 25 April 2012 which led to the deaths of two vulnerable members of the public were predictable³² or preventable.³³

Terms of Reference:

- 1.8 The Terms of Reference that were agreed with NHS England are located in Appendix A.

Profile of Niche and the investigation team:

- 1.9 Niche Patient Safety is a leading national patient safety and clinical risk management consultancy which has extensive experience in undertaking complex investigations following serious incidents and unexpected deaths. Niche also undertakes reviews of governance arrangements and supports organisational compliance with their regulatory frameworks across a range of health and social care providers.
- 1.10 For this investigation Niche's investigative team was led by Senior Investigator Grania Jenkins and specialist psychiatric advice was provided by Dr Ian Cumming.
- 1.11 The report has been peer reviewed by Carol Rooney, Senior Investigations Manager and Nick Moor, Niche Director.
- 1.12 For the purpose of this report the investigation team will be referred to in the first person plural and Niche Patient Safety will be referred to as Niche.

Approach and methodology utilised throughout the investigation:

- 1.13 This report was written with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis Guidance.³⁴
- 1.14 Root Cause Analysis (RCA) methodology has been utilised to both review and analyse the information obtained throughout the course of this investigation.

³² Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'. We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. <http://dictionary.reference.com/browse/predictability>

³³ Prevention means to 'stop or hinder something from happening, especially by advance planning or action' and implies 'anticipatory counteraction'; therefore, for a homicide to have been preventable, there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring <http://dictionary.reference.com/browse/predictability>

³⁴ National Patient Safety Agency (NPSA) *Root Cause Analysis Guidance*

- 1.15 RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that lead to an incident. It is an iterative³⁵ structured process that has the ultimate goal of the prevention of future adverse events by the elimination of latent errors.
- 1.16 RCA provides a systematic process for conducting an investigation, looking beyond the individuals involved and seeking to identify and understand the underlying system features and the environmental context in which an incident occurred. It assists in the identification of common risks and opportunities to improve patient safety and make recommendations about organisational and system learning. It also promotes a culture of continuous improvement and development at both organisational and individual practitioners' levels.
- 1.17 The prescribed RCA process includes data collection and a reconstruction of the event in question through record reviews and participant interviews.
- 1.18 As part of the investigation process we have utilised an RCA Fishbone diagram to assist the investigative team in identifying the influencing and multiple contributory factors which led to the incident (Fishbone is located in Appendix B).
- 1.19 Documentation reviewed:
- Mr F's primary and secondary care records;
 - the relevant Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) policies that were operating at the time and those that have been reviewed since the incident;
 - OAsys assessment;³⁶ and
 - TEWV's Internal Report and Action Plan.
- 1.20 We referred to relevant national policies and guidelines, including the relevant Department of Health (DH)³⁷ and NICE³⁸ guidelines.
- 1.21 As far as possible we have tried to eliminate or minimise hindsight or outcome bias³⁹ in our investigation. We analysed information that was available to primary and secondary care services at the time. However, where hindsight informed our judgements, we have identified this.

Interviews:

- 1.22 During the course of the investigation we undertook a series of interviews with individuals who were involved in the care of Mr F; senior managers at TEWV who have been responsible for the implementation and monitoring of the Trust's Action Plan and the chair of TEWV's Root Cause Analysis Investigation.

³⁵ Iteration is the act of repeating a process with the aim of approaching a desired goal, target or result

³⁶ OAsys: Offender Assessment System, for assessing the risks and needs of an offender, 17 November 2014

³⁷ DH (March 2008) Refocusing the Care Programme Approach Policy and Positive Practice and Code of Practice, Mental Health Act 1983 (revised)

³⁸ NICE: National Institute for Health and Care Excellence

³⁹ Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed; for example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair (NPSA 2008)

- 1.23 Interviews were managed with reference to the National Patient Safety Agency (NPSA) Investigation interview guidance⁴⁰ and the Salmon/Scott principles.⁴¹

Involvement of Mr F and the families of the victims:

- 1.24 As part of all of Niche's investigations we will seek to obtain the views of the patient and the families of both the victim and the perpetrator, not only in relation to the incident itself but also their wider thoughts regarding where improvements to services could be made in order to prevent similar incidents occurring again. Their involvement, we would suggest, is essential in order for the investigative team to be able to develop a comprehensive understanding and analysis of the incident itself and also to inform the final recommendations.
- 1.25 Mr F was invited to take part in this investigation but he declined. His medical records were released using the Caldicott Guardian principles.⁴²
- 1.26 NHS England invited the families of both victims to take part in this investigation, but they declined.
- 1.27 Both Mr F and the families of the victims will be offered the opportunity to be provided with feedback on the findings of this investigation.

2. SUMMARY OF INCIDENTS

- 2.1 The OAsys documented⁴³ that on the weekend before both homicides, Mr F's girlfriend, who was also his carer, went to Mr F's accommodation, where he held a knife to her throat, forcing her to record a statement on his mobile phone to say that he had not assaulted her.⁴⁴ Mr F then reportedly prevented her from leaving until the following morning. She then contacted the police to report the incident. It was reported that she was in a very distressed state.⁴⁵

First homicide on 23 April 2012:

- 2.2 The first victim was an 81-year-old gentleman who lived alone.
- 2.3 During his police interview Mr F reported that he had lived next door to this gentleman for approximately eight months. Mr F reported that he had previously completed some building work on his house and on occasions he borrowed money from him. Mr F reported that he would generally leave his bank cards with the victim until he had paid back the loan.
- 2.4 During his police interview Mr F reported that he had met the victim in the street sometime during the previous week. He had asked to borrow some money and also to use his landline to phone the

⁴⁰ National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: Investigation interview guidance

⁴¹ The 'Salmon Process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere

⁴² Caldicott Guardian principles: access to patient identifiable information should be on a strict need-to-know basis

⁴³ OAsys, p7

⁴⁴ This relates to the incident in February 2012

⁴⁵ OAsys, p7

Department for Work and Pensions. They then walked back to the victim's house, where Mr F alleged that the victim gave him £40 and also loaned him his mobile phone, as his landline was not working. It was agreed that he would return the phone the following day but Mr F reported that the reason that he had this gentleman's phone with him at the time of his arrest was that it had been his intention to return it when he had received his next benefit payment.

- 2.5 Mr F remained adamant that he had not returned to the victim's house.
- 2.6 On 23 April 2012 some of the victim's friends became concerned about him, as on two successive nights he failed to attend his local social club for his usual two pints of beer. They forced entry to his house and found him on the floor with a scarf over his head. It is reported that the victim sustained significant facial injuries which were caused by repeated stamping and punching.
- 2.7 CCTV footage showed Mr F attempting to use the victim's bank card at a local ATM⁴⁶ on the night of the incident and the victim's bank statements were found in his accommodation. Both Mr F's DNA and his scarf were found on the body of the victim.

Second homicide on 25 April 2012:

- 2.8 It is known that Mr F had then cycled to Whitby, which is approximately 30 miles, and then on to Scarborough, where he sold a stolen gold ring.⁴⁷
- 2.9 By 25 April 2012 Mr F had returned to the Whitby area, where he was seen in the communal hallway of a house that had been converted into a number of flats. It is unclear why Mr F was in the building but it was reported that police believed that Mr F "*talked his way*"⁴⁸ into the second victim's flat.
- 2.10 The second victim was a 50-year-old woman who was disabled and lived alone.⁴⁹
- 2.11 The second victim's throat was cut, she was stabbed 31 times and she sustained severe head injuries.
- 2.12 Mr F took a number of items of this victim's clothing, which he was captured on CCTV wearing, a St Christopher necklace and her laptop, which he was later seen trying to sell.
- 2.13 Following a highly publicised national police hunt, Mr F was arrested on 29 April 2012.
- 2.14 Mr F strenuously denied having committed these murders but at his trial he was found guilty.⁵⁰ He received two life sentences with a minimum term of 37 years.
- 2.15 The Trust's Internal Report noted that "*it is understood that the killings happened as a result of him trying to obtain money to purchase MKAT (an illicit drug).*"⁵¹ We were unable to obtain any evidence to support this statement either within the OAsys report or in the extensive media coverage of the trial.

⁴⁶ Police interview transcripts

⁴⁷ <http://www.bbc.co.uk/news/uk-england-tees-20410758>

⁴⁸ <http://www.bbc.co.uk/news/uk-england-tees-20410758>

⁴⁹ <http://www.bbc.co.uk/news/uk-england-tees-20410758>

⁵⁰ 12 November 2012

⁵¹ PIR, p2

- 2.16 The author of the Trust's report stated that this information had been obtained during the course of their interviews of various clinicians, one of whom had been with Mr F during his police interviews. As the interviews were not transcribed, we were unable to identify or verify the source of this information.
- 2.17 The OAsys noted that "*at the time of the two murders he was drinking heavily and had returned to the use of crack cocaine.*"⁵²

3. MR F'S CHILDHOOD, EDUCATION AND FAMILY BACKGROUND

During the course of our investigation it became very apparent that Mr F provided contradictory and at times false information about his life. In the following section we have documented information from what we considered to be the most reliable sources.

Family history:

- 3.1 Mr F had two siblings and he originated from the North West region of England.⁵³ He recalled that he had an "*unhappy childhood.*"⁵⁴ His father was an alcoholic who was physically abusive towards his mother.
- 3.2 Mr F also reported that at the age of 15 he and his brother had attacked their father with a pool cue in an act of "*retaliation.*"⁵⁵ His father had required hospitalisation due to the injuries that he sustained during this attack.
- 3.3 Mr F reported that he had two children: one male born in 1999 and a daughter born in 2000. Due to incidents of domestic violence and issues of drug abuse in the relationship with the mother of his children, both children were placed, under a residency order, with the maternal grandparents.
- 3.4 We were unable to ascertain information regarding any MARAC⁵⁶ or safeguarding procedures being instigated but it was documented that due to concerns about the safety of the grandparents and Mr F's children, a panic alarm had been installed at their home.⁵⁷
- 3.5 It is unclear what the contact arrangements were regarding Mr F's access to his children, as at times he reported that he had no access to them. However, we did note that on several occasions it was documented within the primary care notes that Mr F was requesting that his repeat prescriptions, of his methadone and other medications, be issued early as he was going to see his children.⁵⁸
- 3.6 In an assessment on 14 October 2008, it was documented that Mr F reported that he also had another female child who was three months old.⁵⁹ This information was not documented in any other reports.

⁵² OAsys, p16

⁵³ Information reported in OAsys report, p14

⁵⁴ OAsys, p14

⁵⁵ OAsys, p14

⁵⁶ MARAC multi-agency risk assessment conference

⁵⁷ OAsys, p14

⁵⁸ Information obtained in Middlesbrough Care Co-ordination Comprehensive Assessment, 25 October 2010, p8

⁵⁹ Information obtained in Middlesbrough Care Co-ordination Comprehensive Assessment, 25 October 2010, p8

- 3.7 Both the Trust's Internal Report and the OAsys assessment report documented that Mr F's parents died of cancer within eight weeks of each other.⁶⁰ The authors of TEWV's Internal Report reported that Mr F cited this as being one of the reasons for him committing the offence in 2000.
- 3.8 However, a referral letter from the GP (2008) to the drug and alcohol service reports that Mr F was living with his mother and that she was identified as his next of kin on another assessment.⁶¹ The OAsys assessment, however contradicts this, noting that Mr F had stayed with his uncle and his uncle's wife after he was released from prison.
- 3.9 TEWV's Internal Report stated that "*the patient has little or no contact with most of his family other than his brother and two aunts whom he believes only maintain contact with him so that they know when he 'slips up' and offends again.*"⁶² Mr F also reported that another reason that he had no family contact was because they were "*all catholic and have difficulty in accepting his index offence.*"⁶³ Again we noted that Mr F contradicts this, as during 2010, he was repeatedly reporting that his family were sending him money⁶⁴ and that he was frequently visiting them.

Education and employment:

- 3.10 The OAsys assessment noted that there was a significant discrepancy in Mr F's accounts of his educational and employment history.⁶⁵ On one occasion he reported that he had attended a secondary school and after obtaining several good GCSE results went on to obtain an NVQ Level 2 in bricklaying. He reported that he had been employed in this field for five years, until he was unable to work due to difficulties with his wrists that were related to his hereditary exostosis.⁶⁶
- 3.11 On another occasion Mr F reported that as he had not completed secondary school education due to surgery, he had been employed on various building sites and had built conservatories for his family business.
- 3.12 We noted that in a referral assessment⁶⁷ Mr F reported that he "*was not good at reading.*"⁶⁸ It is not evident if any other agency ever questioned Mr F about his literacy skills.
- 3.13 At the time of the offences, Mr F was in receipt of sickness benefits and the police were investigating his involvement in alleged fraudulent applications for pay-day loans.⁶⁹

4. FORENSIC HISTORY

⁶⁰ Information obtained in Middlesbrough Care Co-ordination Comprehensive Assessment, 25 October 2010, p8

⁶¹ Level Two Triage Assessment, 14 October 2008

⁶² TEWV PIR, p5

⁶³ TEWV PIR, p5

⁶⁴ Information obtained in Middlesbrough Care Co-ordination Comprehensive Assessment, 25 October 2010, p10

⁶⁵ OAsys, p12

⁶⁶ Hereditary exostosis: inherited autosomal dominant disorder where multiple benign (non-cancerous) bony spurs or lumps called exostoses develop

⁶⁷ 21 January 2004

⁶⁸ Durham County & Darlington Priority Service Referral, 21 January 2004

⁶⁹ OAsys, p13

The majority of the information below has been obtained from the OAsys report and was not known to either the primary or secondary health care services or to the authors of the Trust's internal investigation.

- 4.1 The OAsys report documented that Mr F's first contact with the police and juvenile judicial system was at the age of 13. By the time he was 18 years old he had made six court appearances where he received either convictions or conditional or absolute discharges.
- 4.2 By the time of the incident in 2012 Mr F had a total of 33 convictions for 78 offences including Robbery in 1993, Common Assaults, ABH⁷⁰ and GBH.⁷¹
- 4.3 In 2000 Mr F is reported to have stated that he had been in 25 different prisons.⁷²
- 4.4 The OAsys report documented that historically Mr F's victims have been either female partners or males who were "*often vulnerable in some way.*"⁷³ It noted that during Mr F's relationship with the mother of his children there were incidents of domestic violence, but it is unclear if there were any convictions related to these incidents. But given that a panic alarm had been installed, we concluded that it did indicate that there had been both police involvement and concerns regarding the safety of those living in the house.
- 4.5 Between 24 and 27 February 2003 Mr F and a co-accused assaulted a male in his home. The incident was captured on a home video machine and showed the victim being tied up and assaulted. Mr F was seen stabbing the victim three times in the lower back area. Mr F repeatedly reported that he had carried out the assault because he had been informed by his co-accused that the victim was a paedophile. The OAsys report noted that this reason was not supported by the co-accused.
- 4.6 Mr F was repeatedly reporting that the victim died and that he had been convicted of manslaughter. However, the OAsys documented that in fact the victim discharged himself from hospital against medical advice and that he subsequently died. It also confirms that Mr F had not been convicted of manslaughter but had been found guilty of GBH with Intent and was sentenced to eight years' imprisonment.
- 4.7 Additionally the Trust's Internal Report documented that Mr F reported that he had "*attacked another prisoner and broke his jaw and that he had also attempted to escape, both of which resulted in an extension of his sentence from 8 to 11 years.*"⁷⁴ Again, the OAsys report contradicts this account, documenting that Mr F was released on Licence⁷⁵ and whilst staying with his aunt and uncle he had begun a relationship with their cleaner. Following an altercation between Mr F and the cleaner's son, he then attacked both the mother and her daughter, causing considerable physical injuries. He then held them both against their will until the following day, refusing to allow them to

⁷⁰ ABH: actual bodily harm

⁷¹ GBH: grievous bodily harm

⁷² Middlesbrough Care Co-ordination Comprehensive Assessment (22 October 2000) completed by surgery 1, p7

⁷³ OAsys, p10

⁷⁴ TEWV's PIR, p2

⁷⁵ Release from prison on parole but subject to recall to prison if conditions of parole are violated

- seek medical help for their injuries. Mr F was arrested and subsequently found guilty of a Wounding with Intent.⁷⁶ He was sentenced to a further custodial sentence of 22 months.
- 4.8 Both the Trust's Internal Report and the OAsys assessment noted that after Mr F was released from prison in April 2011 he began a relationship with a woman who was later identified as his main carer. On a number of occasions during 2011 and 2012 the police attended the address of this woman for repeated incidents of domestic violence involving Mr F.
- 4.9 Mr F admitted to the consultant psychiatrist⁷⁷ that he had assaulted and on several occasions locked this woman in the house "*without justification.*"⁷⁸ At the same meeting this woman reported that she had taken out several injunctions against Mr F. At least one of these injunctions she reported that she had later withdrawn and the relationship continued.
- 4.10 In a letter⁷⁹ from the from the crisis resolution team's consultant psychiatrist to the GP (surgery 2) he expressed his concern regarding the safety and well-being of Mr F's girlfriend. He reported that he had advised her to "*look very carefully*"⁸⁰ at her decision to move back in. He provided her with contact details of support organisations. The consultant recorded his intention to inform the police liaison officer of his concerns regarding the safety of this woman. There was no evidence that this occurred.
- 4.11 On 16 March 2012 Mr F was arrested and charged with Assault after he detained his girlfriend against her will at his accommodation. This case was pending at the time of Mr F's arrest for the double homicide.

Arising Issues, Comments and Analysis:

- 4.12 During the course of our investigation what was very evident was the lack of knowledge by any of the agencies involved regarding the extent of Mr F's forensic history. They all relied on information that Mr F was self-reporting.
- 4.13 There were repeated disclosures by Mr F that he had been found guilty of manslaughter. There were also repeated narratives, within both the primary and the secondary health care notes, where he was reporting historical and current incidents of violence and aggression towards others, especially towards the woman with whom he was in a relationship. It was also known that he was a polydrug user and that he had a diagnosis of anxiety and panic disorder. Mr F was also repeatedly reporting his concerns that he was unable to control his anger. However, none of this prompted either a forensic assessment or clinicians seeking to ascertain further information from either the probation service or the police.

⁷⁶ 3 June 2009

⁷⁷ Letter from consultant psychiatrist, Crisis Resolution Team, 25 October 2011

⁷⁸ Letter from consultant psychiatrist, Crisis Resolution Team, 25 October 2011

⁷⁹ 25 October 2011

⁸⁰ Letter from consultant psychiatrist, Crisis Resolution Team, 25 October 2011

- 4.14 One experienced clinician reported to us that although he often liaised with other services, such as the police and probation, he had assessed that in Mr F's case it was "*not relevant*."⁸¹
- 4.15 We would suggest that despite it being identified that Mr F had a significant number of risk indicators, there were a number of missed opportunities where inter-agency information could have been sought. One example is when the probation service telephoned⁸² the affective disorder team to report their concerns that Mr F's physical condition was having a significant effect on his psychological health.
- 4.16 We concurred with the conclusion of the Trust's Internal Report that despite the fact that partnership working is explicit within the Trust's Care Programme Approach Policy, this was not reflected in the practice of all the individual clinicians who were involved in supporting Mr F.
- 4.17 The other area that was of considerable concern to us was the lack of action being taken by various individuals who were aware that Mr F's girlfriend was at significant and immediate risk of domestic violence. It was also assessed in his initial Mental State Examination and reported to the GP (surgery 2) that Mr F had only partial insight into the consequences of his actions. But also that he had reported that "*he was afraid that one day he might go so far that he would end up back in prison*."⁸³
- 4.18 Yet despite this being clearly documented and communicated⁸⁴ all clinicians consistently failed to take the appropriate action to protect her. She was never seen without the presence of Mr F and apart from providing her with advice and contact numbers, no further action was taken. This we would suggest was a significant failure on the part of all those who were aware of the risk that she was facing.
- 4.19 The Trust's Internal Report correctly identified that this lack of action was a contributory factor and the associated action plan noted that "*we will review our engagement with [the] Safeguarding Team and MAPPAs to ensure the appropriate contact is made*."⁸⁵ The monitoring measure for this was identified as being an auditing of case files and contacts with MAPPAs at a team level.⁸⁶ However, we felt that there should also have been a recommendation with the report that there needed to be training provided in order to improve the competencies and knowledge base of clinicians regarding the identification and management of suspected and known cases of domestic violence.
- 4.20 We would also recommend that the Trust should review their current safeguarding policies, particularly in relation to inter-agency information sharing, in order to ensure that it adequately reflects the findings of the most recent HMIC⁸⁷ report (*Everyone's business: Improving the police response to domestic abuse*⁸⁸) and Cleveland Police's associated action plan (2014).

⁸¹ Trust's Internal Report, p31

⁸² Telephone call to the Affective Disorder Team from probation service, 6 March 2012

⁸³ Letter from consultant psychiatrist to surgery 1, 25 October 2011

⁸⁴ Letter from consultant psychiatrist to surgery 1, 25 October 2011

⁸⁵ Trust's Internal Report, p50

⁸⁶ MAPPAs: Multi-Agency Public Protection Arrangements

⁸⁷ HMIC: Her Majesty's Inspectorate of Constabulary for England and Wales

⁸⁸ HMIC: *Everyone's business: Improving the police response to domestic abuse*, 2014

<http://refuge.org.uk/publicinquiry>.

Recommendation 1.

Both primary and secondary health care clinicians should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting suspected and known incidents of domestic violence.

Recommendation 2.

When a patient is identified as having a history of offences, the crisis and affective disorder teams must, as a matter of course, seek to obtain information from the police and probation service.

Recommendation 3.

The Trust should review its current safeguarding policies to ensure that they reflect the findings of the latest HMIC report (*Everyone's business: Improving the police response to domestic abuse*) and Cleveland Police's associated action plan (2014).

5. HOUSING

- 5.1 Whilst we were developing the chronology of significant events in Mr F's life, we noted that after he had been discharged from prison in 2010, he had 13 different addresses.
- 5.2 As far back as 2010 it was being noted that Mr F's housing situation was being described as "*unsettled*"⁸⁹ and that he was experiencing difficulty securing suitable and affordable housing.⁹⁰
- 5.3 It was documented in successive FACE Risk Assessments⁹¹ that Mr F had "*no fixed appropriate accommodation*" but this was not considered as a significant risk factor to either his physical or his mental health.
- 5.4 On one occasion it was also noted that he had to move in with his ex-partner as his accommodation "*was not fit for habitation.*"⁹² Although there was an injunction against him with regard to a particular incident of domestic violence.
- 5.5 Although Mr F's housing situation was identified within the Mental Health Cluster Tool⁹³ it was only considered as a moderate problem. In the care plan, dated 9 January 2011, it noted that Mr F needed support to locate suitable accommodation to meet his physical needs. The plan identified that his care coordinator would provide practical and emotional support in this area. However as Mr F was not on a CPA⁹⁴ he was not allocated a care coordinator nor was he given any support to secure suitable accommodation.

⁸⁹ Middlesbrough Care Co-ordination Comprehensive Assessment (22 October 2000) completed by surgery 1, p7

⁹⁰ Middlesbrough Care Co-ordination Comprehensive Assessment (22 October 2000) completed by surgery 1, p7

⁹¹ FACE: Functional Analysis of Care Environments. The FACE risk profile is part of the toolkit for calculating risks for people with mental health problems, learning disabilities, and substance misuse problems, young and older people. Dates of FACE assessments: 20 October 2011, 27 October 2011, 23 November 2012

⁹² Affective Disorder Team's case notes, 23 November 2012, p8

⁹³ 27 November 2011

⁹⁴ CPA Community care planning is the national framework for the delivery of care in specialist mental health services across multi disciplines and partnership organisations

5.6 The only agency that appeared to be actively supporting Mr F to obtain accessible and affordable housing was a not-for-profit organisation, DISC.⁹⁵ It is not clear how Mr F accessed this service but in 2011 they had supported Mr F to secure alternative accommodation. They were also providing him with ongoing floating support⁹⁶ at the time of the incident in 2012.

Arising Issues, Comments and Analysis:

5.7 Within the documentation that was available to us, there was little evidence of any ongoing liaison or communication between his floating support and primary and secondary care agencies.

5.8 We were concerned to note that apart from DISC, no other agency was adequately identifying or responding to Mr F's inadequate housing or considering the significant effects of Mr F's lack of suitable and secure accommodation on his mental and physical health.

5.9 The correlation between inadequate housing, unstable tenancies, homelessness and mental health is well recognised. It is reported that people who are homeless have 40–50 times higher rates of mental health problems than the general population and that they are one of the most disadvantaged and excluded groups in our society.⁹⁷

5.10 Securing and maintaining appropriate housing is identified within the Department of Health's strategy 'No health without mental health.'⁹⁸ It concludes that inadequate housing and homelessness is a particular issue for people with mental ill-health. The strategy notes that "*poor housing conditions and unstable tenancies can exacerbate mental health problems while periods of illness can in turn lead to tenancy breakdown.*"⁹⁹ Research¹⁰⁰ also indicates that individuals who have inadequate housing or experience homelessness often fail to receive the appropriate care and treatment for their mental health conditions for a number of reasons:

- "*poor collaboration and gaps in provision between housing and health services;*
- *failure to join up health, social care and housing support services, and disagreements between agencies over financial and clinical responsibility; and*
- *failure to recognise behavioural and conduct problems such as self-harm, self-neglect, tenancy issues such as substance misuse and anti-social behaviour.*"¹⁰¹

⁹⁵ DISC housing support works with a variety of vulnerable people including people with mental health problems, offenders, drug and alcohol misusers, and young people leaving care, young single mothers, those with other social exclusion issues and gypsies and travellers. <http://www.disc-vol.org.uk>

⁹⁶ Floating support services supporting vulnerable tenants (includes those who are homeless or live in poor quality, temporary accommodation or sofa surfing) into independent tenancies. The support is removed (floats off) when no longer needed and tenant remains in their accommodation

⁹⁷ Department of Health. "No health without mental health: a cross-government mental health outcomes strategy for people of all ages". February 2011 <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

⁹⁸ Department of Health. "No health without mental health: a cross-government mental health outcomes strategy for people of all ages". February 2011 <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

⁹⁹ National Housing Federation <http://www.housing.org.uk/policy/health-care-and-housing/mental-health/>

¹⁰⁰ St Mungo's, "Down and Out?" mental health and street homeless, 2009

¹⁰¹ St Mungo's, "Down and Out?" Mental health and street homeless, 2009

- 5.11 In the case of Mr F, it is evident that his poor housing and homeless status was not being identified or given adequate consideration within successive assessments by clinicians. Nor was he being provided with adequate support to obtain accommodation that met his needs.

Recommendation 4.

Mental health services' risk assessments and support plans should be identifying and considering a patient's current housing situation. Where a patient is experiencing housing issues, this should be identified as both a significant risk factor and one that requires support.

6. PHYSICAL HEALTH AND DRUG MISUSE

During the course of this investigation, it became apparent to us that there were significant connections between Mr F's physical health issues and his misuse of both prescribed medication and illegal drugs. Therefore, this section will look at both these areas together.

Physical health:

- 6.1 The primary care notes indicate that Mr F was diagnosed at birth with hereditary exostosis.¹⁰²
- 6.2 Mr F reported that he had undergone over 22 surgical procedures,¹⁰³ which we are presuming were for the removal of the exostoses.¹⁰⁴ However, there was no medical documentation available to us to support this account.
- 6.3 After Mr F was released from prison, he was initially briefly registered with surgery 1 (4 April 2011). The GP reported that he had been notified by the prison facility, in the form of a brief fax, that the management for Mr F's exostosis was Pregabalin.¹⁰⁵ This was being prescribed to manage Mr F's ongoing neuropathic pain. The GP from surgery 1 documented that based on this limited information he felt that it was "*reasonable*"¹⁰⁶ to continue to prescribe Pregabalin whilst he tried to obtain more information about hereditary exostosis.
- 6.4 Mr F then registered with another primary care service (surgery 2) for his physical health needs whilst surgery 1 continued to manage his ongoing methadone reduction programme.¹⁰⁷
- 6.5 In November 2011 Mr F was referred by surgery 2 to a consultant orthopaedic surgeon, as he had a significant swelling and deformity of his foot (hallux valgus). On examination the orthopaedic surgeon

¹⁰² Hereditary exostosis is an inherited autosomal dominant disorder where multiple benign (non-cancerous) bony spurs or lumps called exostoses develop

¹⁰³ Information within GP report to the Department for Work and Pensions (DWP), 28 September 2011

¹⁰⁴ Exostosis is the formation of new bone on the surface of a bone because of excess calcium forming

¹⁰⁵ Pregabalin: used to relieve neuropathic pain

¹⁰⁶ GP notes, p8

¹⁰⁷ Surgery 1 are the sole providers for substance and opiate misuse in Middlesbrough

- noted that Mr F had “*lumps everywhere all over his chest.*”¹⁰⁸ X-rays reported that he had severe hallux valgus deformity, which was due to a congenital abnormality in the bones in his foot. The consultant advised Mr F that surgical intervention was not an option without significant risk to his foot and even in the unlikely event of the surgery being successful he would still be experiencing severe pain. On 29 March 2012 Mr F was referred to the Bone Tumour Unit to investigate a possible chondrosarcoma.¹⁰⁹ Tests indicated a negative result.
- 6.6 Mr F was also referred (3 February 2012) to the gastroenterology department due to significant weight loss. A subsequent CT scan reported that there were “*a few lung nodules of uncertain significance.*”¹¹⁰ It was also reported that there was “*fairly marked faecal loading*”¹¹¹ which was thought to be a side effect of Mr F’s continued use of opiate analgesics. It was suggested that his medication be changed to Targinact¹¹² which has fewer GI¹¹³ side effects. This did not occur. Mr F was also referred to the Dietetic and Nutrition Service but he failed to attend his assessment appointment and was subsequently discharged from the service.
- 6.7 By 2011 it was being documented¹¹⁴ that Mr F’s symptoms were progressively affecting his mobility and that he required increasing personal care support.¹¹⁵
- 6.8 With regard to Mr F’s mobility issues, it was reported that a visiting CPN¹¹⁶ from the affective disorder team had observed Mr F walking along a street near his home unaided, which had led him to question the level of disability that Mr F was reporting that he was experiencing.¹¹⁷

Drug and alcohol use:

- 6.9 On 17 April 2003 the GP, at the time, referred Mr F to the substance misuse team. He reported that Mr F had just been released from prison and that he had been using ecstasy “*in large quantities and has been drinking alcohol up to 24 units per day.*”¹¹⁸ The referral letter also noted that Mr F had a history of substance abuse since the age of 13 (1996) when he started using Temazepam and abusing lighter fuel.
- 6.10 The referral letter stated “*I am not sure exactly how motivated he is to break his drug habit.*”¹¹⁹ Mr F failed to attend his assessment appointment and was discharged from the service.
- 6.11 After Mr F was released from prison in 2008 he reported that he had been taking illegal drugs “*on and off*”¹²⁰ from 2000 and also that he

¹⁰⁸ Letter from consultant orthopaedic surgeon to GP, 10 November 2011

¹⁰⁹ Chondrosarcoma is a malignant tumour

¹¹⁰ Letter from consultant gastroenterologist from hospital 1 to GP, 20 April 2012

¹¹¹ Letter from consultant gastroenterologist from hospital 1 to GP, 20 April 2012

¹¹² Targinact oxycodone plus the opioid antagonist naloxone

¹¹³ GI: gastro-intestinal tract

¹¹⁴ Surgery 2’s reports to Department for Work and Pensions (DWP)

¹¹⁵ Department for Work and Pensions report from GP, 28 August 2011

¹¹⁶ CPN; Community Psychiatric Nurse

¹¹⁷ Interview with CPN Affective Disorder team

¹¹⁸ Letter from GP to Drug and Alcohol Team, 17 April 2003

¹¹⁹ Letter from GP to Drug and Alcohol Team, 17 April 2003

¹²⁰ Middlesbrough Care Co-ordination Comprehensive Assessment (22 October 2010) completed by surgery 1, p4

- “had developed a significant Subutex dependency”*¹²¹ whilst in prison and had engaged in a drug rehabilitation programme.¹²²
- 6.12 An assessment undertaken in 2010 documented that he was an IV¹²³ heroin user as well as taking crack cocaine and smoking cannabis.¹²⁴
- 6.13 This assessment also documented that Mr F was reporting that he was attending AA¹²⁵ meetings and receiving support from a community alcohol service to manage his drinking. As he had stopped drinking he reported that he did not require support. We noted that there was no further reference made with regard to either assessing or supporting Mr F to manage his alcohol consumption.
- 6.14 On registering at surgery 1 a Care Co-ordination Initial Care Plan¹²⁶ was undertaken by Crime Reduction Initiatives (CRI).¹²⁷ The assessment identified the following goals with Mr F:
- *“to access treatment for his heroin use;*
 - *to attend appointments;*
 - *to take medication as prescribed; and*
 - *to try and smoke heroin instead of IV.”*¹²⁸
- 6.15 After this initial assessment at surgery 1 there is no evidence of any further risk assessments or care plans.
- 6.16 From November 2010 until the incidents in April 2012 Mr F was being seen on a regular basis by a number of key workers at surgery 1 for regular drug testing, prescribing and monitoring of his methadone and subsequently a Subutex¹²⁹ maintenance and reduction programme.¹³⁰ Once established on his methadone programme, Mr F was obtaining his prescriptions on a weekly basis from the pharmacy without incident.
- 6.17 Records indicated that mouth swabs, taken on 8 November 2011 and 10 January 2012, were negative for opiates, indicating that he was not using additional drugs. However, we found that the OAsys report was of the opinion that much of Mr F’s criminal activities centred on attempting to obtain money in order to fund his ongoing drug use.¹³¹

Arising Issues, Comments and Analysis:

- 6.18 Hereditary exostosis disease is reported to be a complex disease with multiple symptoms, such as pain, numbness from nerve compression, vascular compromise, inequality of limb length and irritation of tendons and muscles. Mr F was regularly reporting that he was experiencing many of these symptoms.

¹²¹ Subutex medication prescribed for the treatment of opiate dependence

¹²² Affective Disorder team’s case notes, 23 November 2011, p8

¹²³ IV: intravenous injection

¹²⁴ Middlesbrough Care Co-ordination Comprehensive Assessment (22 October 2010) completed by surgery 1, p3

¹²⁵ AA: Alcoholics Anonymous

¹²⁶ Middlesbrough Care Co-ordination Initial Care Plan, 25 October 2010, p12

¹²⁷ CRI were at the time commissioned to provide some aspects of the drug and alcohol treatment, including the initial assessment of patients

¹²⁸ Care Coordination Plan (2010), p12

¹²⁹ Subutex was at the time the licensed brand name for buprenorphine

¹³⁰ It was reported by surgery 1 clinicians that methadone is a pure opiate agonist, i.e. replaces the opiate.

Buprenorphine is partial agonist/partial antagonist, i.e. partially antagonises opiates

¹³¹ OAsys, p13

- 6.19 Surgery 2 was treating the biomedical¹³² aspects of Mr F's medical care, and, when required, referrals were being made to secondary health care services. It was reported to us that in this area surgery 1 manages all patients on a methadone programme and that patients can also register with another primary health care service for their other health care. However, on two occasions¹³³ the GP from surgery 1 increased Mr F's Buprenorphine¹³⁴ medication in response to him reporting that he was in increasing pain. Surgery 1 did not directly notify surgery 2 that they had increased the dosage in response to Mr F reporting increased neuropathic pain.
- 6.20 On several occasions in April 2011 Mr F presented himself to the Walk-in Centre to obtain additional prescriptions of Pregabalin. As the GPs at the centre did not have access to his primary care notes, they were not alerted to the fact that Mr F had already obtained a prescription of Pregabalin from surgery 2 several days prior to presenting himself.
- 6.21 It was reported to us that both primary care services were using the same patient electronic record system but at the time surgery 1 were unable to access surgery 2's notes. It was reported¹³⁵ that also at this time surgery 1 routinely wrote to the primary care service of patients whom they were prescribing methadone programmes to request information regarding the patient's medical status and current medication. The only letter that we noted from surgery 1 to surgery 2 was on 30 January 2012, which requested information regarding Mr F's diagnosis and treatment plan, but at the time of the incident surgery 2 had not responded.
- 6.22 We also noted that correspondence from secondary mental health services was only being sent to surgery 2. Letters were uploaded to the patient record system, but as surgery 1 did not, at the time, have access to these notes, they reported they had been unaware of Mr F's mental health issues, forensic history or the treatment and support he was receiving.
- 6.23 Surgery 2 reported that they had begun to identify that Mr F's lifestyle was chaotic and that he was only engaging with them when he needed medication or was in an acute medical crisis. So in order to monitor both his medical condition and his use of medication, they were only prescribing a limited amount of medication. However, in our review of Mr F's primary care notes, we noted that there were numerous occasions (refer to chronology) where Mr F was reporting that his medication had been lost or stolen or that he was going away and therefore required early prescriptions of Pregabalin and at times Zopiclone.¹³⁶
- 6.24 Additionally, we also identified several occasions when Mr F presented himself to the Walk-in Centre, where he obtained further prescriptions for Pregabalin. For example, during April 2011 Mr F went to the Walk-

¹³² Biomedical model constitutes the freedom from disease, pain or defect, thus making the normal human condition 'healthy'. The model focuses on the physical processes, such as the pathology and the physiology of a disease. It does not take into account the role of social factors or individual subjectivity. Biomedical model focuses on purely biological factors and excludes psychological, environmental and social influences

¹³³ 2 March 2012 increased Buprenorphine to 8mg and 29 March 2012 to 10mg

¹³⁴ Buprenorphine is an opioid medication used to treat opioid addiction

¹³⁵ Interview with surgery 1 clinicians

¹³⁶ Zopiclone tablets are sleeping pills

in Centre on two occasions, where he obtained prescriptions for Pregabalin. He also presented himself twice during this same month to the GP from surgery 2, where he obtained further prescriptions for Pregabalin.

- 6.25 Although letters were sent by the Walk-in Centre to surgery 2, we noted that this was not identified as an issue until October 2011. At this point they had challenged Mr F and informed him that they would no longer accept his accounts of lost or stolen medication and that *“if he was coming back with similar request we will take him off the list.”*¹³⁷
- 6.26 After this point there was evidence of more appropriate prescribing, although we did identify occasions when Mr F was requesting and was being dispensed early prescriptions of Pregabalin (see chronology).
- 6.27 The potential risks associated with long-term use of prescribed pain relief are well recognised, for example the development of drug tolerance and the need for escalating doses, hyperalgesia,¹³⁸ and addiction.¹³⁹ The National Institute of Drug Abuse notes that although it can be challenging,
*“the monitoring of patients for signs of abuse is crucial ... Early or frequent requests for prescription pain medication refills, for example, could represent illness progression, the development of drug tolerance, or the emergence of a drug problem.”*¹⁴⁰
- 6.28 We were also interested to note that in a recent NHS England publication (2015)¹⁴¹ regarding the prescribing of both Pregabalin and Gabapentin; it advises that due to their analgesic effects they do have potential benefits in the management of a number of disabling long-term conditions, including neuropathic pain. However, it warns that prescribers should be aware of the potential for dependency or misuse. It also reports that Pregabalin is associated with significant *“euphoric effects”* and that *“there is a growing illegal market.”*¹⁴² It advises that:
*“prescribing for patients with a known or suspected propensity to misuse, divert or become dependent on these drugs may place these people at greater risks from their use. Prescribers must make a careful assessment to balance the potential benefits against the risks.”*¹⁴³
- 6.29 Surgery 1 reported that although at the time Mr F was registered they did have risk and care planning assessments in place, they recognised that they had not been used for Mr F.

¹³⁷ Primary care notes, surgery 2, 13 October 2011

¹³⁸ Hyperalgesia is an increased sensitivity to pain

¹³⁹ <http://www.drugabuse.gov/publications/research-reports/prescription-drugs/chronic-pain-treatment-addiction>

¹⁴⁰ <http://www.drugabuse.gov/publications/research-reports/prescription-drugs/chronic-pain-treatment-addiction>

¹⁴¹ NHS England Guidance, *“Pregabalin and gabapentin: advice for prescribers on the risk of misuse”*, 11 December 2014

¹⁴² <https://www.gov.uk/government/publications/pregabalin-and-gabapentin-advice-for-prescribers-on-the-risk-of-misuse>

¹⁴³ NHS England Guidance, *“Pregabalin and gabapentin: advice for prescribers on the risk of misuse”*, 11 December 2014, p3

<https://www.gov.uk/government/publications/pregabalin-and-gabapentin-advice-for-prescribers-on-the-risk-of-misuse>

¹⁴³ NHS England Guidance, *“Pregabalin and gabapentin: advice for prescribers on the risk of misuse”*, 11 December 2014, p1 and 5

<https://www.gov.uk/government/publications/pregabalin-and-gabapentin-advice-for-prescribers-on-the-risk-of-misuse>

- 6.30 They also reported¹⁴⁴ that they are currently required to use a risk assessment process that their commissioner, Public Health, has provided. However, there are no accompanying guidelines or training provided; therefore, decisions regarding levels of risk are based on subjective opinions. It was agreed that this was not satisfactory and that the practice is currently trying to resolve this issue.
- 6.31 Whilst considering this arrangement we referred to the Department of Health Dual Diagnosis Practice Implementation Guide (2002). This guidance suggests that with patients such as Mr F, who have both drug addiction and mental health issues, their *“use of substances often exacerbates problems with their mental state, finances, legal issues and poor engagement with services. Their needs are high and treatment outcomes are poor.”*¹⁴⁵ It goes on to suggest that *“rather than seeing people with dual diagnosis as having two main problems, it may be more useful to acknowledge that they have complex needs ... and often have difficulty accessing appropriate services due to their complex presentations.”*¹⁴⁶ The guidance goes on to advocate that the care for such patients should be *“mainstreamed and provided primarily by mental health services.”*¹⁴⁷ Their rationale is that mental health services are better placed to offer the intensity of input, such as crisis management, assertive outreach and more intense monitoring. This guidance, however, does not exclude a role for substance misuse services. Such services should continue to provide advice, support and, if appropriate, joint work to assist the mental health service in providing care for patients with a dual diagnosis.
- 6.32 With regard to the effects of Mr F’s physical illness on both his well-being and mental health, from the evidence available we concluded that there appeared to be minimal consideration being given by either primary or secondary health care services to the possible social, emotional, economic and cultural effects that such a chronic condition may have had on him.
- 6.33 We noted that on 6 March 2012 the Probation Service did contact mental health services to report that in their opinion, the deterioration in Mr F’s physical condition was having a significant effect on his psychological health. However, there was no evidence that this issue was being considered by either the crisis or the affective disorder teams.
- 6.34 The Royal College of Psychiatrists (2013) noted that many people with physical disabilities and long-term conditions have complex needs and require, often simultaneously, support to access health and social care services. They go on to state:
*“Evidence is clear, however, that these services can be fragmented, and those who need to rely on them often find that they are hard to access and that there are inadequate links between them.”*¹⁴⁸

¹⁴⁴ Interview with surgery 2 clinicians

¹⁴⁵ Closing the Gap, p4

¹⁴⁶ Department of Health Dual Diagnosis Practice Implementation Guide (2002)

¹⁴⁷ Department of Health Dual Diagnosis Practice Implementation Guide (2002)

¹⁴⁸ Mental Health Foundation, *“Crossing Boundaries: Mental Health Foundation’s Inquiry into integrated health care for people with mental health problems”*, p31

<http://www.mentalhealth.org.uk/content/assets/PDF/publications/crossing-boundaries.pdf?view=Standard>

They suggest that there is a need for greater integrated care for such patients, with improved links between physical and mental health services.¹⁴⁹

- 6.35 One of the conclusions of the Trust's Internal Report was that "*it would appear that his mental health and potential risks were diluted in favour of his physical needs.*"¹⁵⁰ We disagree with this opinion, as based on the evidence that we obtained, we concluded that there was in fact a consistent lack of consideration given by all agencies, including the authors of the PIR, to the effects on either Mr F's physical health or his mental health of having such a chronic and painful condition. The potential risks associated with Mr F's long-term use of pain-relief medication were similarly not recognised.
- 6.36 We were interested in the fact that the prison medical services records are a "*closed system*"¹⁵¹ (i.e. not disclosed) and that they only provide primary health care with a brief summary of medication when a prisoner is released. Clearly this can result in there being significant gaps in a vulnerable patient's medical history. Clinicians from surgery 1 reported that this was not "*a new issue*"¹⁵² and that it was one that "*had been debated for a long, long time.*"¹⁵³ They agreed that this was a far-from-satisfactory situation, as it made it problematic to provide seamless care to the patient because they had to rely on the patient self-reporting, which could often be an unreliable source of information.
- 6.37 We also noted that on several occasions Mr F expressed considerable insight into his previous violence and his fear that his impulsivity would cause him to be violent again. We would suggest that it was perhaps possible that Mr F's polydrug misuse¹⁵⁴ was a way that he was attempting to manage, by self-medicating, his unprovoked emotional outbursts and paranoid feelings. Again this was not considered as a possibility by any agency.

Recommendation 5.

When a patient is registered with two primary health care services, there needs to be improved communication and information sharing between the practices.

Recommendation 6.

Secondary mental health care services should be aware that patients on a methadone programme in this area may be registered with two primary care services. If this is the case, they must ensure that communication is being sent to both services.

Recommendation 7.

Both primary and secondary health care services should be

¹⁴⁹ Mental Health Foundation, "*Crossing Boundaries: Mental Health Foundation's Inquiry into integrated health care for people with mental health problems*", p15

<http://www.mentalhealth.org.uk/content/assets/PDF/publications/crossing-boundaries.pdf?view=Standard>

¹⁵⁰ Trust's Internal Report, p38

¹⁵¹ Interview with surgery 1, p6

¹⁵² Interview with surgery 1, p6

¹⁵³ Interview with surgery 1, p6

¹⁵⁴ Polydrug use occurs when two or more drugs are used at the same time or on the same occasion

considering the possible psychological effects and the potential for misuse of prescribed medication in patients with chronic or ongoing physical health issues. This issue should be considered within the patient's mental health risk and care planning.

Recommendation 8.

NHS England's Regional Homicide Leads need to address the lack of information sharing by prisons' medical services.

7. MR F'S PSYCHIATRIC HISTORY AND SECONDARY MENTAL HEALTH SERVICES INVOLVEMENT:

Psychiatric history:

- 7.1 The first documented information regarding Mr F's mental health that we were able to obtain was in 2003, when a GP diagnosed him with minor depression.
- 7.2 There was no evidence of any medication being prescribed until 2010, when Mr F reported that whilst in prison he had been prescribed the antidepressants Mirtazapine¹⁵⁵ and Citalopram.¹⁵⁶ As we have already noted, as Mr F's prison medical records are not available, there was no information as to why he was being prescribed this medication or what his mental health issues were whilst he was incarcerated.
- 7.3 There is very little information available regarding Mr F's mental health history, but we noted that, in an assessment undertaken in 2010¹⁵⁷, Mr F did report that, whilst he had been intoxicated, he had jumped in front of a taxi in 1996 and had tried to commit suicide by hanging in 2006.¹⁵⁸ We could not find any evidence of this information within any of the three FACE risk assessments that were undertaken by the crisis and affective disorder services.¹⁵⁹
- 7.4 On 3 June 2011 Mr F reported to his GP (surgery 2) that he was having "*anger issues since reduction of Methadone*"¹⁶⁰ and that he had stopped taking his antidepressants as "*he did not want to become addicted.*"¹⁶¹
- 7.5 The GP referred Mr F to the IAPT service.¹⁶² This referral noted that Mr F's drug addiction was historical and that his main issue was that he had lost both parents within eight days of each other. Also, although he had "*a good relationship with his partner ... he was concerned about sometimes being angry and shouting for minor things.*"¹⁶³ The GP reported that "*there was no risk now in my opinion*"

¹⁵⁵ Mirtazapine is an antidepressant used to treat major depressive disorder

¹⁵⁶ Citalopram is an antidepressant drug of the selective serotonin reuptake inhibitor (SSRI) class

¹⁵⁷ Middlesbrough Care Co-ordination Comprehensive Assessment, 22 October 2000. Completed by Surgery 1, p6

¹⁵⁸ Tees, Esk and Wear Valleys Level Two Triage Assessment, 14 October 2008

¹⁵⁹ Middlesbrough crisis service: seven days a week, 24 hours a day. Function is to offer an assessment of those people in need of urgent care and treatment around their mental disorder or some emotional distress. Affective Disorder Team's function to assess and provide support to patients with mood disorders, anxiety and personality disorders

¹⁶⁰ Primary care notes, 3 June 2010

¹⁶¹ Primary care notes, 3 June 2010

¹⁶² IAPT: Improving Access to Psychological Service

¹⁶³ Referral letter from GP (surgery 2) to IAPT, 22 June 2011

- of Mr F “*being aggressive or being impolite*”¹⁶⁴ and that he did not pose a risk to himself or others.
- 7.6 Mr F failed to attend two assessment appointments with the IAPT service and was discharged from the service.
- 7.7 On 30 June 2011 the GP (surgery 2) sent an urgent referral to the crisis team requesting an assessment of Mr F. After Mr F failed to attend several appointments, he was discharged from the service.
- 7.8 In a DWP assessment (28 September 2011), the GP¹⁶⁵ documented that Mr F’s ongoing pain and disabilities, caused by his multiple exostoses, were causing his depression, anxiety, stress and “*affecting his insight.*”¹⁶⁶
- 7.9 On 20 October 2011 Mr F attended surgery 2 reporting that he was feeling increasingly anxious, experiencing heart palpitations and requested sleeping pills. At Mr F’s request, a second referral was made to the crisis service, who visited Mr F at his home to carry out an initial assessment.¹⁶⁷
- 7.10 Mr F continued to report to both his primary and secondary health care services that he was having increasing issues with his anger and was concerned that his mental health was deteriorating. Mr F was also voicing his concerns that he might harm somebody as he had previously done when he had felt this level of anger.

Risk assessments:

- 7.11 A Multi-Agency Risk Assessment (25 October 2010) that was completed by CRI¹⁶⁸ as part of Mr F’s initial assessment at surgery 1 assessed that he was a high risk to sex offenders but was “*a low risk to staff as, apart from the GBH, he had no history of offending behaviour. It was also assessed that there was no identified risk to children and that he had two children who he had occasional contact with.*”¹⁶⁹ We noted that this assessment was not available to the secondary mental health services or to surgery 2.
- 7.12 The initial assessment¹⁷⁰ undertaken by the crisis service noted the following issues:
*“That patient is worried that his anger that has caused him to be extremely violent in the past and a fear that his impulsivity would cause him to be violent;
 Reports of feeling paranoid about people and thoughts to harm them but has not acted upon it since his release from prison; and
 Breakdown of his relationship with his partner as a result of his behaviour.”*¹⁷¹

¹⁶⁴ Referral letter from GP (surgery 2) to IAPT, 22 June 2011

¹⁶⁵ Surgery 2

¹⁶⁶ DWP report, 28 September 2011

¹⁶⁷ Initial assessment visit by Crisis Service, 21 October 2011

¹⁶⁸ Crime Reduction Initiatives (CRI) is a social care and health charity working with individuals, families and communities across England and Wales that are affected by drugs, alcohol, crime, homelessness, domestic abuse and antisocial behaviour

¹⁶⁹ Multi-Agency Risk Assessment, 25 October 2010, p13

¹⁷⁰ 20 October 2011

¹⁷¹ Trust’s Post Incident Report, p7

- 7.13 Three FACE risk assessments were undertaken by the crisis service and affective disorder services. The following significant risks were consistently highlighted:
*“Risk of violence to others 3 = Serious Risk
 Risk related to physical condition 2 = Significant risk
 High risk of relapse 2 = Significant risk.”*¹⁷²
- 7.14 There was no evidence of a Risk/Relapse Management plan being undertaken despite Mr F repeatedly reporting his fears of a relapse in his mental health.

Mental State Examination undertaken by the crisis service’s consultant psychiatrist:

- 7.15 Mr F was seen by the crisis team’s consultant psychiatrist on 24 October 2011, where it was assessed that although Mr F was not presenting with psychotic symptoms, he did have some *“overvalued ideas about how people were watching him, following him and a persistent anxiety.”*¹⁷³ It was also noted that Mr F only had partial insight but was aware of the consequences of his actions. It was reported that Mr F *“was afraid that one day he might go so far that he would end up back in prison.”*¹⁷⁴
- 7.16 Mr F was diagnosed with a panic disorder and prescribed Sertraline¹⁷⁵ and he was to be referred to the affective disorder team. There was also a recommendation that a forensic referral be undertaken once his care had been transferred. We found no evidence that the forensic assessment was completed.
- 7.17 Mr F’s notes indicate that he was discussed in the affective disorder team’s multidisciplinary meeting on 28 October 2011, although there were no notes available from this meeting. He was placed on a CPA level of Standard Care from this date. Reportedly, due to staffing issues within the affective disorder team, Mr F was not seen until 23 November 2011.
- 7.18 Mr F was reviewed by a nurse consultant (12 December 2011) who documented that Mr F reported that he had stopped taking Sertraline. He was prescribed Buspirone Hydrochloride,¹⁷⁶ initially 5mgs tds increasing to 10mg tds after three days, and a 14-day supply of Zopiclone 7.5mg.

Care planning:

- 7.19 We were only able to locate one care plan,¹⁷⁷ within Mr F’s secondary care notes, which identified that he required support regarding his housing, monitoring of his medication and his mental health. It

¹⁷² FACE assessments dated 20 October 2011 completed by crisis service

¹⁷³ Letter from Crisis Resolution Team Consultant Psychiatrist to GP (surgery 1), 25 October 2011

¹⁷⁴ Letter from Crisis Resolution Team Consultant Psychiatrist to GP (surgery 1), 25 October 2011

¹⁷⁵ Sertraline is an antidepressant used to treat depression, obsessive-compulsive disorder, panic disorder and anxiety

¹⁷⁶ Buspirone Hydrochloride treatment of anxiety disorders; short-term relief of anxiety symptoms

¹⁷⁷ Care plan dated 13 March 2012

identified that support in these areas would be provided by his allocated care coordinator. There is no evidence that Mr F was ever allocated a care coordinator.

Carer's Assessment:

- 7.20 We noted that Mr F's partner was in receipt of Carer's Benefit.
- 7.21 Despite it being recorded on numerous occasions that she was Mr F's primary carer, there was no evidence that she was offered a carer's assessment.

Arising Issues, Comments and Analysis:

- 7.22 We noted that none of the three FACE risk assessments¹⁷⁸ considered the effects of either Mr F's historical or current drug abuse issues on his ongoing mental health issues.
- 7.23 Neither was there evidence of any liaison with surgery 1 to obtain further information regarding treatment planning. Both primary and secondary services reported that they had relied purely on information provided by Mr F regarding his historic and current drug misuse and that nothing triggered any particular concern that would have prompted them to seek further information.
- 7.24 This lack of inter-agency communication was also apparent with regard to obtaining information relating to Mr F's forensic history. Apart from a brief note that stated that he had spent 11 years in prison for manslaughter, which we now know to be inaccurate, there was the consistent lack of information regarding Mr F's extensive forensic history.
- 7.25 Mr F and his carer both reported that there were current issues of domestic violence¹⁷⁹ within their relationship and that he was buying drugs to manage his anxiety.¹⁸⁰ There is no evidence that this triggered any of the clinicians to ascertain further information or undertake a more comprehensive risk assessment. Indeed, even when the affective disorder team received a call¹⁸¹ from the probation service, they did not use this opportunity to obtain information regarding Mr F's current situation or to clarify probation service's involvement.
- 7.26 In our review of the primary care notes we noted that the GP (surgery 2) continued to prescribe Buspirone Hydrochloride until 7 March 2012, at which point a prescription was issued for Sertraline (50mg). There was no explanation as to why this change occurred.
- 7.27 In a subsequent review by a CPN, at the affective disorder outpatient clinic, this change in medication was noted and Mr F reported that "*he was given no reason for the change but clearly stated that he was feeling better with the Buspirone.*"¹⁸² No action was taken by the CPN to seek clarification from the GP, nor was it discussed with the

¹⁷⁸ FACE assessments dated 20 October 2011, 27 October 2011 completed by Crisis Service. 9 January 2012 completed by Affective Disorder Service

¹⁷⁹ Case notes summary, 12 December 2011

¹⁸⁰ Case notes summary, 12 December 2011

¹⁸¹ 6 March 2012

¹⁸² Case notes, 23 March 2012

- prescribing nurse consultant. Mr F was seen by the same CPN on one further occasion before the incident (28 March 2012), where we noted that there was no further discussion regarding his medication.¹⁸³
- 7.28 It was reported¹⁸⁴ to us that it was not an uncommon event for GPs to change medication or dosages without consulting the prescribing clinician from secondary mental health services. We were informed that, as there can be some delays in GPs acting on notification of a change in a patient's medications, the affective disorder team now issue prescriptions and will also monitor a patient until their symptoms have stabilised. At this point the patient's primary health care service takes over the prescribing. This process was not in place at the time Mr F was a patient.
- 7.29 It was also reported that GPs do get invited to their patient's CPA meeting but rarely attend, although they are sent copies of CPA meeting notes.
- 7.30 Mr F's initial assessment by the affective disorder team was incomplete six months after the initial referral. This was in breach of the policy operating at the time, which stated that "*a full and comprehensive CPA assessment, FACE risk assessment and mental health clustering tool will be completed within 28 days.*"¹⁸⁵
- 7.31 It was acknowledged by all those interviewed from both the crisis and affective disorder teams that at the time there were significant deficiencies within both services that have now been addressed. These changes will be discussed further in section 8.
- 7.32 During the interviews with the clinicians who were involved with Mr F we noted that all were of the opinion that if he was referred to the current affective disorder service, it was unlikely he would be accepted. In their opinion "*he wasn't mentally ill to a degree that would have warranted specialist mental health services.*"¹⁸⁶ It was felt that he would not now have reached their threshold for treatment (see section 8), although he would still have been able to access the crisis service.
- 7.33 All the mental health clinicians that we interviewed who were involved in the treatment of Mr F reported that they had been aware that he was being treated for opiate withdrawal from surgery 1, which was the sole provider of methadone treatment in the area. None of them were aware that Mr F was also registered with a second primary care service (surgery 2). However, they all failed to notice that their correspondence was in fact being addressed to surgery 2.
- 7.34 The failure to offer a carer's assessment to Mr F's partner was clearly an error on the part of all services. Not only did it fail to support her in what was known to be an abusive situation, but practitioners failed to both identify and support her needs as a carer. They also failed to comply with national¹⁸⁷ and local carers' strategies that were in place at the time.

Recommendation 9.

¹⁸³ Case notes, 28 March 2012

¹⁸⁴ Interview with nurse consultant from the affective disorder team

¹⁸⁵ Affective disorder team's Operational Policy

¹⁸⁶ Interview with affective disorder and crisis team manager

¹⁸⁷ Department of Health, "*Recognised, valued and supported: next steps for the carers strategy*" 2010, and Carers Trust's, "*The Triangle of Care (TOC)*", 2010

Primary care services should consult with the prescribing mental health clinician when they are considering changing a patient's psychiatric medication.

8. TEWV'S POST INCIDENT REVIEW (PIR)

As part of NHS England's Terms of Reference for this investigation we were asked to:

“Review the Trust’s internal investigation and assess the adequacy of its findings, recommendations and action plan.”

- 8.1 Following this incident TEWV commissioned a Level 2 investigation.¹⁸⁸
- 8.2 We undertook a benchmarking exercise of TEWV's Post Incident Review (PIR) report by utilising the National Patient Safety Agency's RCA Investigation Evaluation Checklist.¹⁸⁹ We also interviewed the independent chair of the PIR panel.
- 8.3 We found that the PIR provided an extensive chronology and review of the involvement of secondary mental health care.
- 8.4 The author of the PIR reported to us that they had requested access to information from other agencies, e.g. primary care notes, police and probation services, as well as Mr F and his partner. They were informed by TEWV's Patient Safety Department that *“permission had not been granted to visit the patient and consent had not been given to access information from other agencies.”*¹⁹⁰ Due to personnel changes within TEWV's Patient Safety Department we were unable to verify the reasons for these decisions or what efforts were made to invite either Mr F's partner, his and the victims' families to take part in the investigative process. Thereby the PIR failed to meet the following requirements for a Level 2 investigation:
- *“involvement and support of relatives; and*
 - *findings shared with the patient and relatives.”*¹⁹¹
- 8.5 The failure to have accessed Mr F's primary care notes and interview the two GPs resulted in the following significant issues being omitted:
- He was registered with two primary care services.
 - Surgery 2 suspected that he was misusing prescribed medication.
 - The fact that the GP from surgery 2 changed Mr F's medication to Sertraline a month before the killings without consultation with the prescribing mental health clinician.
 - The extent of Mr F's housing difficulties.

¹⁸⁸ Level 2 – normal Root Cause Analysis review based on Root Cause Analysis Guidance (NPSA)

¹⁸⁹ NPSA, Root Cause Analysis Guidance

¹⁹⁰ Email correspondence from author of the PIR

¹⁹¹ National Patient Safety Agency (NPSA)

- The consistent lack of communication between the two primary health care services and community mental health services.
- 8.6 Additionally the failure to obtain information from either the police or the probation service regarding Mr F's significant forensic history resulted in PIR's authors basing their analysis on information provided by Mr F, who it is now evident was an unreliable self-historian who provided contradictory information to various agencies.
- 8.7 We would suggest that the failure to involve Mr F's partner, who was his main carer, in the PIR investigation was a significant error. Not only did it fail to meet one of the criteria outlined in the NPSA, regarding involving families and carers, but she may have been able to provide valuable insight. Thus enabling a more comprehensive picture of Mr F's life, his risks and support needs to have been developed.
- 8.8 The PIR did correctly highlight that there was an insufficient response by secondary mental health services to the reported incidents of domestic violence. However it failed to highlight the fact that no agency provided Mr F's partner with a carer's assessment.
- 8.9 The authors of the PIR also appropriately questioned why Mr F was not placed on a CPA as he fulfilled three of the five criteria: he had a significant history of violence, a dual diagnosis (substance misuse) and unsettled accommodation.
- 8.10 Had the authors of the PIR been able to access both Mr F's primary care notes and Mr F's forensic history, they would have been able to have developed a more comprehensive profile of Mr F. Thus enabling them to have highlighted considerably more deficiencies in the care that was being provided to Mr F. This would have facilitated the identification of more accurate contributory factors, which would then have informed both their recommendations and the Trust's action plan.
- 8.11 Furthermore, given that this incident resulted in the homicide of two innocent members of the public by a TEWV's patient, who it was believed had a manslaughter conviction (although we now know that he had in fact been convicted of GBH), and a significant history of domestic violence and drug addiction. We would have expected the Trust to have directed the Head of Patient Safety and the authors of the PIR to have more proactively pursued accessing primary care notes, as well as obtaining information from the probation service and the police and also involved Mr F and his and the victims' families before they accepted the findings of the PIR.

Recommendation 10.

The Trust and authors of PIR should make every effort to obtain access to primary care notes and interview the relevant GPs. Where the perpetrator is known to have a forensic history, they should also obtain probation service and police information.

9. TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST AND THE IMPLEMENTATION OF THE PIR'S ACTION PLAN:

Profile of TEWV:

- 9.1 TEWV provides a range of mental health, learning disability and eating disorder services for the 1.6 million people living in County Durham, the Tees Valley, Scarborough, Whitby, Ryedale, Harrogate, Hambleton and Richmondshire. TEWV currently employs over 6,000 staff over c.180 sites. The services are spread over a wide geographical area of around 3,600 square miles, which includes coastal, rural and industrial areas.¹⁹²
- 9.2 TEWV has a Clinical Assurance Framework in place. This consists of the Quality and Assurance Committee (QuAC), which is a subcommittee of the Board of Directors, who oversee the clinical governance systems and processes and the Trust-wide governance infrastructure. The QuAC reports to the Board of Directors monthly and provides assurance on the quality of services by monitoring regulatory compliance, services and clinical outcomes. Within each of the Trust's four localities there is a Locality Management and Governance Board (LMGB), which receives monthly assurance on the quality of services from the Directorate Quality Assurance Groups (QuAGs). QuAGs are in place for each of the localities' functional service directorates.
- 9.3 The Directorate QuAGs receive monthly information reports on a range of quality metrics and indicators, including patient safety, safeguarding and patients' experience. The monthly reports include trend analysis of incidents and complaints and the progress of action plans that have arisen from PIRs.
- 9.4 Since this incident the Trust has also introduced a process that is known as Rapid Process Improvement Workshops; these are weekly events facilitated by trained teams who work with the operational and clinical team from each service.
- 9.5 Prior to the workshop the team scrutinise all aspects of the service, including reviewing serious incidents and complaints, in order to develop a comprehensive understanding of the issues that a particular team may be facing.
- 9.6 In addition, every month the Trust has "*report-out of quality improvement events*."¹⁹³ We were informed that currently every Head of Service and Band 7 levels are in the process of being trained to be Workshop Leads.

Progress on implementation of TEWV's Action Plan:

- 9.7 We noted that all the PIR's identified contributory factors have been incorporated into statements of intent and had a named responsible lead person attached to each action.
- 9.8 All actions had a clear and measurable process identified to monitor progress to the point of implementation, for example team meeting minutes, supervision and case and service audits.
- 9.9 The action plan also noted where there was a need for an extension to the initial time frame for completion. A revised date was identified.

¹⁹² Information taken from TEWV website <http://www.tewv.nhs.uk/About-the-Trust/>

¹⁹³ Interview with Locality Manager

- 9.10 We were provided with considerable evidence of communication between senior managers and team leaders that demonstrates where evidence was being triangulated and monitored to the point of completion.
- 9.11 All actions were completed in 2014.
- 9.12 We also reviewed LMGB and QuACs' monitoring processes of the PIR's action plans.

Developments of the crisis and affective disorder services since the incident:

- 9.13 It was reported to us that since this incident there have been some significant changes to both of these services, particularly in relation to the referral, assessment and care pathways. Resulting in there being a significant change in the eligibility for acceptance and treatment in the affective disorder service. However, the crisis service remains available to all.
- 9.14 There is now a joint service manager in place who oversees both services and support staff often operates across both teams.
- 9.15 We were told¹⁹⁴ that the transition between the crisis and affective disorder teams are now more integrated and that patients are being assessed and transferred within a seven day target.
- 9.16 The psychiatrist from the affective disorder team reported that there are regular multidisciplinary Formulation Meetings that enable both her and the multidisciplinary team to have a greater awareness of all the patients.
- 9.17 There are also daily meetings where staff can discuss particular patients. Several clinicians reported that these meetings also serve as an ongoing supervision structure for the more complex patients whom they are managing.
- 9.18 We were informed that advice is regularly sought from both the forensic and drug and alcohol services, which will now inform a patient's risk assessments and management plans. Where a patient scores a 3 on the FACE risk assessment for violence to others, this would now automatically trigger a forensic assessment.¹⁹⁵
- 9.19 It was reported¹⁹⁶ that there is now greater integration and communication between the inpatient and community services; for example, they operate a shared diary where team minutes and the wards' daily report-outs are documented.
- 9.20 The affective disorder service now undertakes a four week assessment process, and each patient has achievable aims with clear timescales identified in their support plans. Where possible, the point of discharge from the service is identified at the point of admission.
- 9.21 It should be noted that it was not part of the Terms of Reference for this case to interview patients from this service in order to obtain their experiences of the changes in the service delivery. We would suggest that this would be a useful exercise to undertake in order to evaluate the impact of the changes on both their care and their support.

¹⁹⁴ Interview with manager of crisis service and affective disorder service

¹⁹⁵ Interview with affective disorder and crisis and locality manager

¹⁹⁶ Interview with affective disorder and crisis and locality manager

10. PREDICTABILITY AND PREVENTABILITY:

Throughout the course of this investigation we have been mindful of the requirement, within NHS England's Terms of Reference, to consider if the incidents which resulted in the killing of two members of the public were either predictable or preventable. As we have previously acknowledged a significant amount of information regarding Mr F's criminal background has only come to light during the course of this investigative process. It was not available to either services that were supporting Mr F or obtained by the PIR's authors.

In our consideration of the predictability and preventability of these incidents one of the questions that we have asked ourselves was if it was reasonable to have expected agencies and individual clinicians to have taken more proactive steps to obtain a more comprehensive profile of Mr F. Also, based on the information that they did ascertain, largely through Mr F's self-reporting, did they take reasonable steps to manage the known risk?

We would suggest that in this case, the benefit of hindsight that we have obtained through the course of our investigation is very important. As it has not only highlighted significant deficiencies within the PIR but it has also identified repeated failures on the part of both primary and secondary health care services to obtain essential information regarding Mr F's potential risk and support needs. It also highlighted a consistent lack of information sharing and inter-agency communication. We have concluded that both of these were fundamental and significant contributory factors.

Predictability:

- 10.1 There were repeated narratives within Mr F's secondary care notes of significant current and historical risk factors. There were documented accounts of him exhibiting verbal aggression and reports of domestic abuse reported by both by both Mr F and his girlfriend. Secondary mental health care services were also aware of the police's involvement and that despite several injunctions having been taken out against Mr F he remained in contact was the victim of the abuse.
- 10.2 Secondary mental health services were aware that Mr F had been incarcerated for manslaughter and that he had received a considerable custodial sentence.
- 10.3 Mr F was repeatedly reporting that he was concerned about his inability to manage his anger and that he was afraid that this would result in him returning to prison.
- 10.4 It was also known, by some agencies, that Mr F had a significant history of using illicit drugs and was on a methadone programme. Surgery 2 also became increasingly aware that Mr F was misusing prescription medication.
- 10.5 Bearing in mind the definition of a homicide that is judged to have been predictable where "*the probability of violence, at that time, was*

*high enough to warrant action by professionals to try to avert it.*¹⁹⁷ We concluded that, even based on the partial and at times inaccurate information that was known at the time by secondary mental health services, there was significant evidence to indicate that Mr F had extremely high risk factors and few protective factors. Therefore it should have been assessed that there was a significant probability that he would reoffend.

- 10.6 We conclude that all involved agencies failed to identify this risk or take steps to obtain further information that could have informed their assessments and clinical judgements.
- 10.7 What was not predictable was Mr F's choice of victims in this double homicide. Previously his victims had been known to either himself or his associates and there were elements of either domestic violence or a revenge motive. In this case both victims appeared to have been randomly chosen by Mr F and it appears that the motive in both cases was robbery.

Preventability:

- 10.8 It is more difficult to definitely conclude whether the incident was preventable. Clearly Mr F was a serial offender who was either unwilling or unable to engage in any meaningful rehabilitation programme. The evidence indicates that there were many deficiencies and missed opportunities by both primary and secondary health care services where important information could have been sought and shared. This information would have enabled a more accurate assessment of Mr F's risk factors and may have alerted agencies to his potential for reoffending.
- 10.9 We concluded that even with improved assessments etc., given Mr F's historical risk as well as his lifestyle at the time it is not evident if these changes would have prevented Mr F reoffending. Therefore, we concluded that the incidents were probably not preventable.

11. CONCLUDING COMMENT

We concluded that based on the evidence that we obtained during the course of this investigation, it was clear that Mr F had very complex needs which required an integrated multi-agency approach to risk assessments, information sharing and support planning. This clearly did not occur, resulting in all agencies and services operating in isolation. Mr F's support needs and risk assessments were based on information that was reported by him and it is now clearly evident that he was consistently an unreliable self-historian.

Finally, we were informed that Mr F did not have mental health issues and that he would now not be eligible for ongoing secondary mental health services. This posed the question as to where and how a patient such as Mr F would access ongoing support and treatment in the

¹⁹⁷ Munro E, Rungay J, "Role of risk assessment in reducing homicides by people with mental illness". The British Journal of Psychiatry (2000), 176: 116–120

community. We felt that none of the clinicians that were interviewed were able to satisfactorily answer this question.

12. RECOMMENDATIONS

Recommendation 1.

Both primary and secondary health care clinicians should undertake domestic violence training in order to improve both their understanding of and their responsibilities for reporting suspected and known incidents of domestic violence.

Recommendation 2.

When a patient is identified as having a history of offences, the crisis and affective disorder teams must, as a matter of course, seek to obtain information from the police and probation services.

Recommendation 3.

The Trust should review its current safeguarding policies to ensure that they reflect the findings of the latest HMIC report (*Everyone's business: Improving the police response to domestic abuse*) and Cleveland Police's associated action plan (2014).

Recommendation 4.

Mental health services' risk assessments and support plans should be identifying and considering a patient's current housing situation. Where a patient is experiencing housing issues, this should be identified as both a significant risk factor and one that requires support.

Recommendation 5.

When a patient is registered with two primary health care services, there needs to be improved communication and information sharing between the practices.

Recommendation 6.

Secondary mental health care services should be aware that patients on a methadone programme in this area may be registered with two primary care services. If this is the case, they must ensure that communication is being sent to both services.

Recommendation 7.

Both primary and secondary health care services should be considering the possible psychological effects and the potential for misuse of prescribed medication in patients with chronic or ongoing physical health issues. This issue should be considered within mental health risk and care planning.

Recommendation 8.

NHS England's Regional Homicide Leads need to address the lack of information sharing by prisons' medical services.

Recommendation 9.

Primary care services should consult with the prescribing mental health clinician when they are considering changing a patient's psychiatric medication.

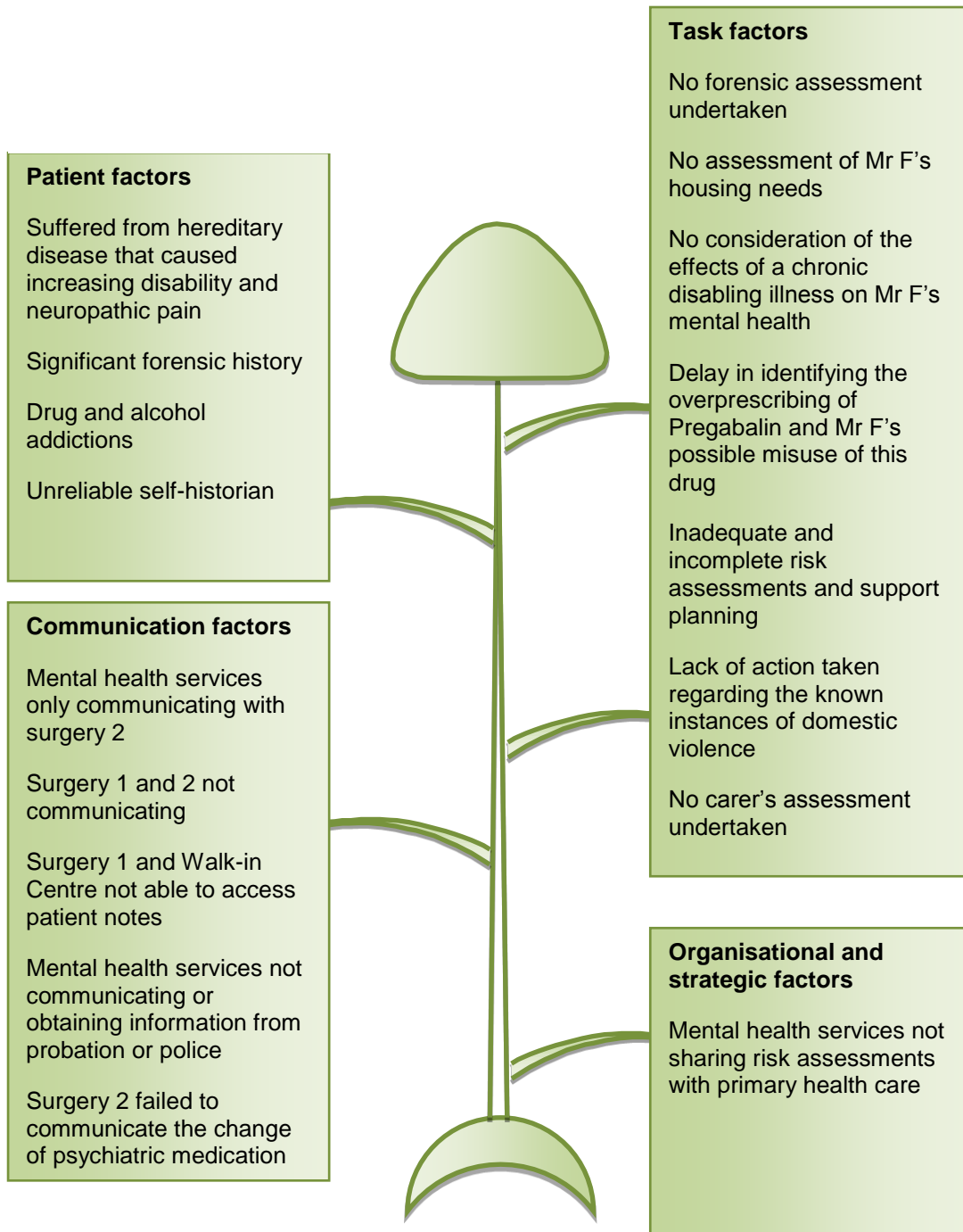
Recommendation 10.

The Trust and authors of PIR should make every effort to obtain access to primary care notes and interview the relevant GPs. Where the perpetrator is known to have a forensic history, they should also obtain probation service and police information.

**APPENDIX A
Terms of Reference**

- *“Review the trust’s internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- *Review the progress that the trust has made in implementing the action plan.*
- *Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user’s first contact with services to the time of their offence.*
- *Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.*
- *Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.*
- *Examine the effectiveness of the service user’s care plan including the involvement of the service user and the family.*
- *Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.*
- *Review and assess compliance with local policies, national guidance and relevant statutory obligations.*
- *Consider if this incident was either predictable or preventable.*
- *Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.*
- *Assist NHS England in undertaking a brief post investigation evaluation.”*

APPENDIX B The Fishbone Analysis



APPENDIX C Chronology

Based on information obtained from primary and secondary health care notes, OAsys report and police interview

Date	Source	Event	Details	Comments
29 April 1976	Primary care notes	Hospital n/k	Excision of exostosis on both femora and tibia (both legs)	Exostosis: formation of new bone on the surface of a bone, because of excess calcium forming Excision: removal by cutting
25 July 1990	Primary care notes	Hospital n/k	Cartilage cap exostosis proximal end, left fibula	
13 January 2003	Primary care notes	Appointment	Diagnosed with minor depression NOS	NOS: not otherwise specified
17 April 2003	Primary care notes	Letter from GP to Drug and Alcohol Team	Mr F referred by GP to Drug and Alcohol Team. Noted that he had been released from prison three weeks before and had been using ecstasy " <i>in large quantities and has been drinking alcohol up to 24 units per day.</i> " Noted that he was living with his mother. Noted that he had a history of substance abuse since 1996 (temazepam and abusing lighter fuel).	Age 20
2006	Tees, Esk and Wear Valleys	Level Two-Triage Assessment	Mr F attempted to commit suicide by hanging whilst intoxicated.	
13 October 2008	Tees, Esk and Wear Valleys	Level Two-Triage Assessment	Mr F was released from prison.	
14 October 2008	Primary care notes	Appointment	GP referred Mr F to counsellor. Level Two Triage Assessment.	
27 October 2008	County Durham Drug & Alcohol Action Team	Level One Assessment	Noted that Mr F was using Diazepam.	

3 November 2008	County Durham Drug & Alcohol Action Team	Client records	Mr F cancelled appointment, stating that he did not want to engage with the service.	
25 October 2010	Primary care notes	Appointment (surgery 1)	Referred by organisation 1. Mr F reported that he had been released from prison six to seven weeks earlier after serving eight years for "GBH against known sex offender", was on licence for 12 weeks, was currently using IV heroin daily (£20 plus) along with occasional cannabis use. Noted Mr F suffered from depression currently related to his accommodation (probation hostel). Due to pain related to his Multiple Exostosis Syndrome was being prescribed Dihydrocodeine and antidepressant Mirtazapine. Checked needle sites and provided harm minimisation advice. Mr F refused consent for surgery to share information with probation service or hostel. Middlesbrough Care Co-ordination Comprehensive Assessment completed. Noted that 14 years earlier, when Mr F was he had jumped in front of a taxi. Multi-agency risk assessment completed.	Surgery 1: specialist GP service and substance misuse service Organisation 1: harm minimisation service and needle exchange Mirtazapine: noradrenergic and specific serotonergic antidepressant (NaSSA) Dihydrocodeine: opiate/opioid medicine
29 October 2010	Primary care notes	Appointment (surgery 1)	Assessment: refused to start treatment as there was no clinical evidence of opiate use. Mr F was very "unhappy and advised that if he went back to hostel without a scrip he would go back to prison". Mr F asked to speak to manager but was advised that they were not available. Mr F became aggressive and caused damage to wall; he was asked to leave premises. Due to assessed risk, they contacted probation hostel to advise that they were not dispensing a prescription.	OMT: opioid maintenance treatment
2 November 2010	Primary care notes	Appointment (surgery 1)	Mr F tested positive for opiates and methadone treatment (1mg/ml oral solutions) commenced. Plan to maintain methadone until stable, then to be transferred to Buprenorphine.	

			Noted that he could not be prescribed Subutex until he stopped Dihydrocodeine (was on 240mg at that time). Mr F reported that he had last used heroin eight to nine days previously.	Buprenorphine (Subutex): approved for the treatment of opiate dependence. Contains buprenorphine hydrochloride. Reduces the symptoms of opiate dependence.
2 November 2010	Primary care notes	Surgery 1	CRI Care Co-ordination and DIP Assessment review	CRI: social care and health charity working with individuals, families and communities across England and Wales who are affected by drugs and alcohol DIP assessment: criminal justice and treatment agencies working together with other related partners, to provide a tailored solution for substance misusers who commit crime to fund their drug use
10 November 2010	Primary care notes	Appointment (surgery 1)	Review: Mr F reported that he had not been using heroin but was using cannabis. Advised Mr F of risk of overdosing if he used heroin. Surgery 2 GP: supervising reduction in Dihydrocodeine and prescribed Pregabalin for pain.	Pregabalin: used to relieve neuropathic pain (pain from damaged nerves)
15 November 2010	Primary care notes	Surgery 1	Surgery notified that Mr F had been recalled to prison.	
1 April 2011	Primary care notes	Surgery 1	Probation hostel contacted surgery to advice that Mr F had been released and required methadone prescription. Methadone 1mg/ml oral solution was prescribed. Noted that he had served ten years for wounding with intent.	
4 April 2011	Primary care notes	Appointment Surgery 1	Assessment: noted no probation involvement. Mr F reported that he had been recalled to prison due to " <i>unsuitable behaviour</i> " and his original sentence had been extended for two years due to " <i>distributive behaviour.</i> " Noted that he had applied for social housing and also requested a place at an alternative hostel.	

5 April 2011	Primary care notes	Walk-in Centre	Noted that Mr F had attended Walk-in Centre where he was prescribed Citalopram 20mg, Mirtazapine 30mg and Pregabalin (all seven day prescriptions).	NB Walk-in Centre cannot access patient notes
6 April 2011	Primary care notes	Surgery 1	Change of address noted	Second move to probation hostel
11 April 2011	Primary care notes	Appointment Surgery 1	Seen by GP: Mr F reported that he had been assaulted and was experiencing significant pain in the back of his head. Noted that he also reported that he had undergone "20 operations". O/E it was observed that he had numerous scars from operations to remove bone growth. Probation hostel reported that he was "not adjusting to being out of prison". Mr F was issued a prescription for Pregabalin 150mg 56 caps (twice daily), Diclofenac 150mg 56 caps. Seen by health professional (Access Role) methadone review. Noted that Mr F reported that he was not using heroin.	O/E: on examination Pregabalin: 28-day supply
14 April 2011	Primary care notes	Walk-in Centre	Mr F had been seen at Walk-in Centre, which dispensed a prescription for Mirtazapine 15mg x 14 tabs, Pregabalin 150mg x 21 caps and Citalopram 10mg x 14 tabs. Mr F registered with surgery 2.	NB: repeat medication being dispensed was not identified as an issue. Change of address third move. Pregabalin eight-day supply.
17 April 2011	Primary care notes	Appointment Surgery 2	Noted change of address. Mr F seen by GP. He reported that he was going away to see his family and that his "wife had beaten him yesterday." Repeat prescriptions issued: Citalopram 10mg 7 tabs. Mirtazapine 15mg 7 tabs. Pregabalin 150mg 42 caps.	Change of address fourth move. Pregabalin: 21-day supply.
18 April 2011	Primary care notes	Surgery 2	Noted change of address.	Change of address fifth move.
19 April 2011	Primary care notes	Appointment surgery 2	Mr F reported that his girlfriend had stolen his medication. Prescription dispensed for Pregabalin 150mg 21 caps. Temazepam 10mg 2 tabs.	Pregabalin: seven-day supply

21 April 2011	Primary care notes	Appointment surgery 1	Noted: Mr F phoned to say that he was " <i>around corner as fellow patient has an injunction against him</i> " so he could not attend appointment. Agreed to leave a " <i>tide over</i> " methadone prescription at reception.	
23 April 2011	Primary care notes	Appointment surgery 2	Mr F reported that he had been arrested and handcuffed and that his right wrist was " <i>hot and inflamed</i> ". Also requested a prescription for Pregabalin as going to Blackpool to visit his family. Prescription: Pregabalin 150mg 27 caps.	Mr F's children living in Blackpool with maternal grandmother Pregabalin: nine-day supply
26 April 2011	Primary care notes	Appointment surgery 2	Prescription: Citalopram 10mg (28 tabs). Mirtazapine 15mg (28 tbs). Pregabalin 150mg (56 caps). Noted that Mr F apologised for his behaviour on 23 April 2011.	Pregabalin: 28-day supply
5 May 2011	Primary care notes	Appointment surgery 1	Methadone review: Mr F reported that he was " <i>doing really well in new relationship</i> ". Reported that he had not used heroin but continued to smoke cannabis. Wanted to reduce methadone to 20mls and then change to Buprenorphine. Methadone reduced to 27.0ml.	Methadone reduction
11 May 2011	Primary care notes	Appointment surgery 2	Mr F reported that he had moved	Sixth move
15 May 2011	Primary care notes	Appointment surgery 2	Mr F presented with swelling on right sixth rib. Requested a referral to orthopaedics for shaving and excision. Also noted had right hallux valgus deformity. Prescription: Mirtazapine 15mg 28 tbs, Pregabalin 150mg 56 caps. Written referral to orthopaedic service hospital 1.	Hallux valgus: bunion Pregabalin 28-day supply
20 May 2011	Primary care notes	Appointment surgery 2	Noted that Mr F had been advised to increase Pregabalin to Qds. Noted that " <i>pt unhappy about the amount of time he has to come down here so I've put Pregabalin on Rpt for an extra month</i> ".	NB Not clear who advised as not documented in primary care notes Qds: four times daily Pt: patient Rpt: repeat
23 May 2011	Primary care notes	Surgery 1	Mr F informed surgery of change of address	Seventh move
3 June 2011	Primary care notes	Surgery 2	Noted that Mr F was having " <i>anger issues since reduction of Methadone</i> ." Mr F reported that he had stopped taking Mirtazapine and Citalopram as " <i>he doesn't want to become addicted</i> ." GP referred Mr F to IAPT service.	IAPT: Improving Access to Psychological Therapies

8 June 2011	Primary care notes	Surgery 2	Mr F informed surgery of change of address.	Eighth move
13 June 2011	Primary care notes	Surgery 1	Methadone reduction review: reduced to 22.0ml.	
21 June 2011	Primary care notes	Surgery 2	Repeat prescription: Pregabalin 150mg 112 caps, Zopiclone 7.5mg.	Zopiclone: non-benzodiazepine hypnotic agent used in the treatment of insomnia NB first time prescribed so unclear how it was on repeat prescription. Pregabalin: 28-day supply.
30 June 2011	Primary care notes	Surgery 2	Mr F reported that he had injured his hand in an " <i>alleged break in where he lived.</i> " Advised Mr F to go to A&E for X-ray. Noted that Mr F had not made appointment with orthopaedics. Surgery staff made appointment via Choose and Book system. GP referred Mr F to crisis service.	
4 July 2011	Primary care notes	Surgery 1	Methadone review: Mr F reported that he had not been taking any street drugs.	
5 July 2011	Primary care notes	Surgery 1	Mr F notified surgery of change of address.	Ninth move.
18 July 2011	Primary care notes	Surgery 2	Mr F reported that he had an orthopaedic appointment. Prescription: Pregabalin 150mg 112 caps.	Pregabalin 28-day supply
19 July 2011	Primary care notes	Surgery 1	Methadone review: noted last dose 7 a.m. the previous day. Mr F agreed to transfer to Buprenorphine 6mgs. Collection alternate days, noted that he was " <i>aware that trust of collection is dependent on appropriate use.</i> " To review in eight days.	
22 July 2011	Primary care notes	Surgery 2	Access Team contacted surgery to report that Mr F DNA'd his appointment. Confirmed last known address for Mr F.	DNA'd: did not attend
27 July 2011	Primary care notes	Appointment Surgery 1	Mr F DNA'd appointment for Care Plan review. Dispensed seven-day prescription for Buprenorphine. Sent letter to Mr F.	
28 July 2011	Primary care notes	Surgery 1	Documented that Mr F's medical records had been sent to solicitor.	Reason not known

2 August 2011	Primary care notes	Appointment Surgery 1	Mr F DNA'd appointment.	
3 August 2011	Primary care notes	Appointment Surgery 1	Subutex review: noted Mr F reported that transfer to Buprenorphine was initially difficult but improved after five days. OMT taken. Mr F reported that he had not been taking any other illegal drugs. <i>"Discussed separating emotions from one another as opposed to bottling them with end result being anger"</i> .	
8 August 2011	Primary care notes	Surgery 1	Mr F DNA'd CMHC appointment	
12 August 2011	Primary care notes	Surgery 2	Mr F DNA'd appointment	
26 August 2011	Primary care notes	Surgery 2	Mr F presented with chest infection and new eruptions of exostosis. Referred for X-ray for chest and foot. Chest X-ray reported to be clear.	
30 August 2011	Primary care notes	Surgery 1	Buprenorphine reduction review: noted that Mr F was <i>"aiming to keep his own addiction and issues separate to those of partner"</i> . Wanted to begin reduction of Buprenorphine, agreed 0.4mg.	
4 September 2011	Primary care notes	Surgery 2	Mr F presented with significant weight loss. Full blood screen taken (reported on 5 September 2011 all within normal range. No further action).	
5 September 2011	Primary care notes	Surgery 2	Requested further chest X-ray, as previous X-ray report had not commented on Mr F's multiple exostosis.	
7 September 2011	Primary care notes	Surgery 2	X-ray reported no fractures or rib deformities.	
8 September 2011	Primary care notes	Surgery 2	Referral sent to orthopaedics	
21 September 2011	Primary care notes	Surgery 2	Noted that Mr F was going to Blackpool for ten days and requested a prescription of Pregabalin: dispensed Pregabalin 150mg (112 caps).	Pregabalin: 28-day supply
27 September 2011	Primary care notes	Surgery 1	Noted that Mr F requested to stay on current dose of Buprenorphine, as he was <i>"having a difficult time with relationship, had some issues with feeling tempted."</i> To be reviewed in four weeks.	

10 October 2011	Primary care notes	Surgery 2	Mr F notified surgery of a change of address. Seen by GP: Mr F requested an early prescription of Pregabalin as he had lost his medication. GP dispensed a prescription of Pregabalin 150mg (112 caps) but told Mr F that it was his responsibility to keep his medication safe.	Tenth move Pregabalin: 28-day supply
13 October 2011	Primary care notes	Surgery 2	Mr F requested another prescription for Pregabalin as he reported that his " <i>carer kicked him out of the house and would not give him his medication.</i> " GP noted " <i>? same story lost meds.</i> " GP 1 came into the consultation to discuss his repeated lost prescriptions/medication. GP 1 informed Mr F that the surgery would no longer issue replacement prescriptions and " <i>if he is coming back with similar request we will take him off the list</i> ". Mr F was placed on weekly prescriptions for a month. Prescription issued for Pregabalin 150mg (28 caps).	GP takes action re Pregabalin
20 October 2011	Primary care notes	Surgery 2	Telephone encounter: Mr F reported that he was " <i>feeling anxious, wants more medication and referral to psychiatry.</i> " Noted " <i>no self-harm thoughts.</i> " Appointment: Mr F reported that he was feeling low after his carer, who was his partner, left him. Experiencing palpitations, " <i>no interest in life wants to kill himself.</i> " Noted poor eye contact. Diagnosis: anxiety and depression. Referral made to crisis team who would see him at 18:45. Mr F requested sleeping pills and was prescribed Zopiclone 7.5mg % tbs.	
21 October 2011	Crisis team case notes	Support session	Seen by crisis team. MDT meeting agreed to undertake a medical review of Mr F. Noted that Mr F had a forensic history. No details or consideration of forensic referral.	MDT: multi-disciplinary meeting

22 October 2011	Crisis team case notes	Support session	Seen by crisis team. Letter from crisis team's Consultant Psychiatrist to GP following a Mental State Examination. Documented that Mr F admitted assaulting his girlfriend/partner. Police liaison officer was to be alerted. Crisis team to continue supporting Mr F.	
24 October 2011	Crisis team case notes	MDT meeting	Mr F to be referred to affective disorder team for further assessment and risk management, medical review and forensic assessment. Noted that the affective disorder team were unable to accept Mr F due to staffing situation.	Forensic assessment did not occur
25 October 2011	Primary care Crisis team case notes	Surgery 2 Support session	Noted that Mr F DNA'd orthopaedic appointment. Crisis team provided telephone support session. Mr F reported that he was experiencing increased panic attacks and insomnia and that he intended to buy some Zopiclone "off the streets."	
26 October 2011	Crisis team case notes	Support session	Telephone support.	
27 October 2011	Crisis team case notes	MDT and assessments	Mr F's care transferred to affective disorder team. FACE Risk Assessment and Mental Health Cluster Tool completed.	
28 October 2011	Primary care notes	Surgery 2	Mr F requested sleeping pills, GP prescribed Zopiclone 7.5mg, 5 tabs. GP noted that he had informed Mr F that they may not prescribe any further sleeping pills.	Sertraline: antidepressant used to treat depression, obsessive-compulsive disorder, panic disorder and anxiety
30 October 2011	Primary care notes	Surgery 2	Mr F's partner came to see GP to report that Mr F was coughing blood, rectal bleeding and losing weight. Noted that partner "very upset". GP telephoned Mr F who agreed to be examined in hospital. GP arranged ambulance transport. Prescription dispensed: Pregabalin 150mg (56 tabs) 1 x 2 daily. Pregabalin 300mg caps (28 caps 1x daily).	Pregabalin: return to monthly prescriptions

31 October 2011	Primary care notes	Surgery 2	09:50 Hospital 1 bed manager phoned surgery 2 to inform that Mr F had DNA'd the previous day. 10:00: Mr F's partner phoned to say that Mr F had agreed to go to hospital. 18:53: GP telephoned Mr F who reported that he went to hospital but left against medical advice. Agreed to come to surgery. 19:24: Mr F was seen by GP and agreed to go to hospital.	
2 November 2011	Primary care notes	Surgery 1	DNA'd appointment	
5 November 2011	Primary care notes	Surgery 1	Buprenorphine review: Mr F reported that he had not taken any illegal drugs. OMT taken. Mr F also reported that he had moved out of the accommodation where his partner also lived and that police had advised him not to make any contact with her.	11 th move
8 November 2011	Primary care notes	Surgery 1	Courtesy telephone call from pharmacist: reported that the police had come to collect Mr F's medication as he was in custody	
10 November 2011	Primary care noted	Hospital 2 letter to GP	Mr F attended appointment with orthopaedic surgeon. Consultant advised that it was not possible to correct Mr F's hallux valgus without risk to his foot. Also noted that even if the operation was successful, he would remain in considerable pain.	
11 November 2011	Hospital 1 notes	A&E admission	Arrived by ambulance from the probation hostel with a sprained ankle. Given tetanus booster.	
13 November 2011	Primary care notes	Surgery 2	Mr F reported that Sertraline was not helping him so he had stopped taking it. He also reported he was becoming more anxious and that he had been requesting medication to help him sleep from mental health services. GP rang crisis services. GP prescribed Zopiclone 7.5mg (5 tabs).	

14 November 2011	Hospital 1 notes Affective disorder case notes	A&E admission	Arrived by ambulance to A&E with abdominal pain and blood in stools. Also documented that he was experiencing increased panic attacks, dizziness and palpitations. IV Buscopan given. Noted that Mr F was complaining that " <i>they were not giving him enough analgesia and that it is starting 'to wind him up and states that he has a problem with anti-social behaviour.'</i> " Mr F's partner/carer contacted affective disorder team requesting additional support.	Buscopan: antispasmodic medication which specifically relieves abdominal discomfort and pain due to cramps and spasms
15 November 2011	Primary care notes	Surgery 2	Mr F reported that he had been discharged from hospital the previous day after being admitted for six episodes of haematemesis and three of melena. Diagnosis: depressive disorder.	Haematemesis: vomiting of blood Melena refers to the black, "tarry" faeces that are associated with upper gastrointestinal bleeding
18 November 2011	Primary care notes	Surgery 2	Seen by affective disorder team: GP discussed with Mr F the addictiveness of Zopiclone. Agreed to prescribe lower dose of 3.76 (10 tabs).	
22 November 2011	Primary care notes	Surgery 1	Buprenorphine review.	
23 November 2011	Affective disorder team	Mental Health Cluster Tool	Assessment by Nurse consultant: noted that Mr F's housing was " <i>unsettled.</i> " Assessed Mr F's drinking and drug taking as 0 (no problem), CPA standard level. Medication Review: diagnosed with Panic Disorder. Again noted history of domestic violence.	Noted conviction and offences and disability sections were not completed
28 November 2011	Primary care notes	Surgery 2	Referral to community-based dietetics service by GP.	
1 December 2011	Primary care and hospital 1 notes	Surgery 2	Mr F presented with lower abdominal pain, reporting change in bowel habit with rectal bleeding 4/52; loss of appetite and weight loss. GP to make urgent referral to gastroenterology department hospital 1. Mr F presented himself at A&E with acute abdominal pains. He refused analgesic.	
6 December 2011	Primary care notes	Surgery 1	Buprenorphine review.	

8 December 2011	Primary care notes	Surgery 2	Perscribed Omeprazole 20mg and Ensure yoghurt liquid	Omeprazole: used to treat gastroesophageal reflux disease (GERD) and other conditions caused by excess stomach acid
12 December 2011	Hospital 1 notes	A&E	Police brought Mr F to A&E. Presented with tenderness over the lateral and medial malleolus (soft tissue inflammation injury, right ankle). Noted in Discharge Summary that Mr F requested pain relief stating " <i>that if we didn't give pain killers in the department he wouldn't get anything</i> ".	
13 December 2011	Primary care notes	Surgery 2	Entry diagnosis panic disorder (new episode)	
20 December 2011	Primary care notes	Surgery 1	Telephone encounter: Mr F reported that he was not going to attend appointment as he was " <i>in bed with pleurisy</i> ." Requested a " <i>tide over prescription</i> " of Buprenorphine.	Pleurisy: condition that results from the swelling of the linings of the lungs and chest
23 December 2011	Primary care notes	Surgery 2	Mr F presented with a chest infection and also requested a repeat prescription. Prescription: Amoxicillin 500mg, Buspirone 10mg (30 tbs), Zopiclone 7.5mg (14 tabs). Referred to physiotherapy.	Buspirone: used to treat symptoms of anxiety
27 December 2011	Primary care notes	Surgery 2	Mr F DNA'd his appointment	
29 December 2011	Primary care notes	Surgery 1 & 2	Home visit as Mr F was unwell. Arranged a " <i>tide over collection</i> " prescription. Buprenorphine, Doxycycline 100mg.	Doxycycline: antibiotic used to treat bacterial infections
3 January 2012	Primary care notes	Organisation 2	Referral from South Tees Physiotherapy: discharged from care treatment completed. Update regarding physiotherapy treatment: on waiting list.	
9 January 2012	Primary care Affective disorder notes	Secondary care 1 Affective Disorder	Seen by physiotherapist: given walking stick and instruction on safe use. Affective Disorder FACE Risk Assessment.	
10 January 2012	Primary care notes	Surgery 1	Buprenorphine review. Noted that Mr F wanted an increased dose of 0.8mg. Noted that Mr F reported that his GP " <i>was aware of the situation</i> " – this would be reviewed in 14 days " <i>due to complication of case/medical situation</i> ."	

11 January 2012	Primary care notes	Surgery 1	Health professional documented that he had completed an incident report regarding an accusation that Mr F made against him the previous day	No information available in primary care notes
12 January 2012	Primary care notes	Surgery 1	Mr F notified a change of address	12 th move
17 January 2012	Primary care notes	Surgery 1	Regarding the incident on 10 January 2012, Mr F informed the surgery that he " <i>wanted the matter closed</i> "	
20 January 2012	Hospital 1 notes	Hospital 1	Colonoscopy procedure	
21 January 2012	Primary care notes	Surgery 2	Prescriptions dispensed: Pregabalin 150mg and 300mg (56 caps and 28), Zopiclone 7.5mg (14 tabs). Colonoscopy results: no demonstrable abnormality in chest, abdomen or pelvis to explain weight loss. Awaiting a referral under " <i>the two week rule</i> ".	The two-week rule (TWR): introduced to ensure that all patients with a suspected cancer see a hospital specialist within 14 days of an urgent GP referral
24 January 2012	Primary care notes	Surgery 1	Buprenorphine review.	
25 January 2012	Affective disorder team notes	Support session	Mr F attended support session but left before the session ended.	
30 January 2012	Primary care notes	Surgery 2	Mr F asked for a copy of a previous letter relating to a housing application. Receptionist noted that she explained to him that " <i>we are extremely busy in admin and it is not always possible to do things straight away.</i> " GP made referral, using the two-week rule referral process, to gastroenterologist (via Choose and Book).	
3 February 2012	Primary care notes	Surgery 2	Seen by gastroenterologist; referred for a CT scan to exclude a malignancy. Referral made to Dietetic and Nutrition Service. Subsequently Dietetic and Nutrition Service referred Mr F to CMHT's hospital dietitian (hospital 2).	
8 February 2012	Affective disorder team notes	Dietetic assessment	Entry that referral has been received and that Mr F will be offered an appointment when one becomes available.	Mr F was not seen by dietitian

9 February 2012	Affective disorder team notes	Telephone call	Housing support worker contacted Affective Disorder Team to report that Mr F had locked his partner/carer in the house, accusing her of stealing money from him. Police removed Mr F from the property and he was rehoused. Requested that Affective Disorder Team develop a support/care plan to manage Mr F's physical disabilities. Noted that Mr F was unable to provide himself with personal care. Affective disorder team instructed support worker to contact Social Services Occupational Health Therapist (OT). OT informed affective disorder team that they needed to provide OT support to Mr F as he was their patient.	
10 February 2012	Primary care notes	Surgery 2	Noted that Mr F was having a CT of his head (referred by gastroenterologist). Again discussed addictive effects of Zopiclone. Prescribed Zopiclone 7.5mg 14 tabs and Pregabalin 150mg (56 caps twice daily), 300mg (28 caps 1x daily).	
17 February 2012	Affective Disorder notes	Mr F arrested	Mr F was arrested for assault. Victim his partner/carer. Affective disorder team attended interview as his Appropriate Adult. Mr F made a counter allegation of assault.	
18 February 2012	Hospital 1 and primary care notes	A&E	Police brought Mr F to A&E as he had two "rusty" nails in his back	
21 February 2012	Primary care notes	Surgery 1	Noted that Mr F was attending court	
24 February 2012	Primary care notes	Surgery 1	Notified by prison that Mr F was possibly being released and to notify them of his last administration of Buprenorphine	Mr F in prison re assault charge
24 February 2012	Primary care notes	Surgery 2	Noted that Mr F had been released from prison and required repeat prescription. Prescribed: Pregabalin 150mg (56 tabs) and 300mg (28 caps), Zopiclone 7.5mg (14 tabs).	
29 February 2012	Primary care notes	Surgery 2	Noted that Mr F and GP had a "long chat about what's going on." Discussed changing Buspirone to Sertraline. No change made.	
1 March 2012	Primary care notes	Surgery 2	Mr F informed surgery of a change of address.	13 th move

2 March 2012	Primary care notes	Surgery 1	Buprenorphine and clinical care plan review. Noted that Mr F reported that he was in a lot of pain with various different ailments and requested an increase to 8mg of Buprenorphine.	
7 March 2012	Primary care notes	Surgery 2	Mr F agreed to Sertraline 50mg. Noted that " <i>when things start to settle</i> " Mr F's use of Zopiclone would be reviewed. Prescription given for Zopiclone 7.5mg (14 tabs).	
12 March 2012	Hospital 1 notes. Affective Disorder case notes	A&E admission. Support Session	Mr F presented in A&E with rectal (PR) bleeding. Home visit by affective disorder team: Mr F was not at property but was later seen walking unaided.	
13 March 2012	Affective Disorder case notes	Care plan	Care plan developed: identified housing, monitoring of medication and mental health	
20 March 2012	Hospital 1 notes	A&E admission	Mr F presented with tender area over 3 rd metacarpal region. X-ray reported no bone injury.	
23 March 2012	Affective disorder case notes	Review	Review in clinic: risk assessment and support plan updated	
27 March 2012	Affective disorder case notes	Home visit	Mr F did not answer his door but later phoned the team to say that he had been in	
28 March 2012	Primary care Affective disorder case notes	Surgery 2	GP referred Mr F to Bone Tumour Unit at hospital 1 " <i>to rule out Chondrosarcoma.</i> " Home visited by affective disorder team.	Chondrosarcoma : type of sarcoma that affects the bones and joints. NB this is the last time he was seen by the affective disorder team.
29 March 2012	Primary care notes	Surgery 1	Telephone encounter with GP: Mr F reported that he had lost four stone in weight and had been diagnosed with chondrosarcoma. Also informed GP that he was going to Newcastle and wanted repeat Buprenorphine prescription. Mr E informed surgery that his support worker would pick up his prescription. Increased Buprenorphine 10mg in response to Mr F reporting increased pain.	Mr F had not been diagnosed with chondrosarcoma
30 March 2012	Primary care notes	Surgery 2	Seen in oncology clinic	

3 April 2012	Primary care notes	Surgery 2	Telephone encounter: Mr F requested his prescription two days early as he was due to go into hospital in Newcastle the next day for investigations. GP noted that Mr F's bone condition had not been confirmed and that Mr F had told surgery 1 that he had already been diagnosed with chondrosarcoma.	
4 April 2012	Primary care notes	Surgery 2	Seen by another GP. Documented that Mr F denied having a drug use history of IV drug use.	
12 April 2012	Primary care notes	Surgery 1	Buprenorphine review: Mr F informed GP that he had been told that he did not have chondrosarcoma and that he had gained weight.	
18 April 2012	Primary care notes	Surgery 2	Last seen by GP: medication review.	
23 April 2012			Mr F murdered victim 1 (male) in his house	
25 April 2012			Mr F murdered victim 2 (female) in her house	

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