STRICTLY CONFIDENTIAL

External Investigation into the Case of K

Incident date: Late 2006

Investigation report date: June 2011

Authors: Mr Peter Green, Independent Investigator, Caring Solutions UK Ltd;
Dr Colin Dale, Chief Executive, Caring Solutions UK Ltd;
Dr Michael Rosenberg, Independent Investigator, Caring Solutions UK Ltd

Caring Solutions (UK) Ltd

PO Box 717 | Southport | Merseyside | PR8 9LH | UK

Tel: +44 (0)151 324 0654 | **Fax:** +44 (0)7053442975

Email: caringsolutions@o2.co.uk | **Web**: www.caringsolutionsukltd.co.uk

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The External Review Panel wishes to thank all the staff at Northamptonshire Healthcare Foundation Trust who have willingly given their time to assist in providing an understanding of the care and management of the mental health service user K. All staff who were interviewed were clearly open to sharing information and their own reflections regarding the homicide that occurred in late 2006. Their contributions have assisted greatly in the production of this report. The Panel particularly wishes to thank Des McMorrow, for arranging interviews and responding to our requests for information and documentation.

The External Review Panel extends their thanks to the co-operation and assistance provided by K, who assisted us in understanding and incorporating the service user perspective into this investigation and report.

Contents

1 Executive Summary

1.1 Introduction

1.1.1 In late 2006 a man, known to K died at K's flat as a result of multiple injuries. K was convicted on manslaughter in late 2007, having changed his plea from Not Guilty to Guilty on the opening day of the trial. He was ordered to be detained in a secure hospital without limit of time, under the Mental Health Act 1983 (Section 37/41).

1.1.2 K had been in contact with the Northamptonshire Healthcare Foundation Trust since 2005, as a prisoner, out-patient, in-patient (including detention for assessment under the Mental Health Act 1983) and community mental health service user. He had complex mental health and substance misuse needs, along with a history of offending, including violent offences and non-compliance with conditions set by the criminal justice system. He had received both custodial and non-custodial sentences. He was also subject to the Multi-Agency Public Protection Arrangements (MAPPA: for details see Appendix Four). He also had recurrent housing needs, being of homeless on occasion.

1.1.3 Following the incident the Trust established an internal serious untoward incident investigation team who produced a report on its findings in July 2008. The report generated a number of recommendations which were subsequently adopted by the Trust and incorporated into an Action Plan.

1.1.4 This report sets out the findings of the External Review Panel . The Panel reviewed the Trust's internal serious untoward incident report into the care and treatment of K. In addition the independent investigation report was further informed by interviews with key stakeholders, a review of K's health record (for which consent was provided), and a review of appropriate Trust documentation including relevant policies and procedures. Minutes of MAPPA meetings were also reviewed as part of the independent investigation process.

1.2 Purpose

1.2.1 The independent investigation was commissioned by NHS East Midlands. An independent investigation is required when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the event. The purpose is to examine all the circumstances surrounding the care and treatment provided and in each case to identify any errors or shortfalls in the quality of the service and to make recommendations for improvement as necessary.

1.2.2 The External Review Panel was required to address Terms of Reference agreed by the NHS East Midlands and key stakeholders, set out in full in Section Two of this report.

1.3 Methodology

1.3.1 The independent investigation process was informed by:

- Interview with K (perpetrator)
- Interviews with key staff:
  - Consultant Psychiatrist
  - Care Coordinator
  - Team Manager of the Probation Office responsible for supervision of K
  - Consultant Forensic Psychiatrist, current Responsible Clinician for K
  - Trust Forensic Clinical Psychologist
- A review and analysis of K's health record,
- Psychiatric and Probation Service reports to Court
- A review and analysis of the Trust's internal report and appendices (July 2008)

1.3.2 NHS East Midlands wrote to and telephoned K's mother on several occasions to inform her of the independent investigation and to invite her to meet with the Panel. She did not respond to these messages and letters. The Panel contacted the victim's parents by e-mail: their initial response was helpful, but some month's later the family had to withdraw from the process because of severe ill-health.

1.3.3 Northamptonshire Police were unwilling to authorise release of case papers relating to the index offence and prosecution, on the grounds that they did not see why this was required in an investigation into the actions of the health service and partnership working. As an alternative, the External Review Panel purchased the transcript of the sentencing proceedings, although this was not as informative. The rationale for seeking the prosecution case papers was to assist in understanding the patient and his psychopathology, which in turn assists in reviewing the care and treatment of K.

1.3.4 K signed a consent form in February 2010 which allows the External Review Panel to access his personal information, including health records, court case records and associated papers. There was an understanding that some information may become public through publication of the investigation report.

1.3.5 The Panel utilized the Root Cause Analysis approach in carrying out this investigation

1.4 Summary of main findings

1.4.1 The External Review Panel supports the findings and conclusions of the Trust's internal serious untoward incident report (June 2008). The Panel concluded the recommendations were appropriate and that the Trust had provided evidence that they have been implemented.

1.4.2 K was clearly a complex service user with a range of treatment needs many of which appeared to have lain outside the normal remit of general adult mental health services. Despite this complexity the mental health services did attempt to help K whose chaotic life-style and limited ability to rationalise his life events were his downfall. There were failings in managing his behaviour, which were not an exclusive responsibility of the Trust.

1.4.3 There was a missed opportunity for a custodial disposal of K following the assault on the member of public prior to his admission to the Trust's inpatient facility. Had this occurred he would have not have been in a position to commit the particular homicide he did.

1.4.4 There was a lack of written clarity in relation to the purpose of admission to the Trust which could be enacted upon by nursing staff and other care workers.

1.4.5 Plans that did exist were not followed through or enforced e.g., for conditions of leave or acceptable behaviours. There was poor communication between the Care Coordinator, appointed some five months into K's involvement with the Trust, and the Probation Officer in terms of joint knowledge of K's behaviour. There was a further lack of recognition of K's poor meeting of the reporting requirements of the Community Rehabilitation Order following his sentence of Actual Bodily Harm. The Care Coordinator was not aware of his behaviour when an inpatient or how he behaved in the rehabilitation facility. The current e-pex electronic single clinical record did not exist at that time and so written documentation was dispersed.

1.4.6 The poor application of the MAPPA process operating at that time and planning to meet the risk posed by K was unfortunate, as was the uncertainty as to his status relating to recall to prison, which was awaited by the MAPPA membership, despite a decision having been made within the Probation Service this would no longer happen but not clearly communicated to MAPPA or the Trust.

1.4.7 K's victim could have been any member of the public. K was clearly warned of the dangers of excessive drinking associated with his known propensity to violence stemming from this and chose to ignore it.

1.4.8 The independent investigation panel concurred that the disposal by way of a custodial sentence (with an associated tariff and indeterminate prison sentence) was the most appropriate consideration for the manslaughter of the victim. This was proposed by a Professor of Forensic Psychiatry, whereby K could have been transferred for treatment from prison to a secure mental health facility with the hope of improvement and if this proved to be ineffective he could be returned to the wider prison estate.

1.4.9 The Panel concluded that the Mental Health Act 1983 in October 2005 was appropriate: however the powers afforded were not followed through.

1.4.10 The Panel concluded that risk assessments appear to have been timely, but there appears to have been limited input directed specifically at risk reduction.

1.4.11 The Panel consider that the Trust attempted to provide care and treatment for K, which was over and above the initial referral, for assessment and advice. The Trust appears to have been motivated by a therapeutic optimism which in the event proved not to be realistic.

1.4.12 Finally the Panel were required by the Terms of Reference to identify whether there was any aspect of care and management that could have altered and prevented the events in late 2006 and concluded that:

- The Probation Trust's officers should have taken a firmer line with K and his supervision, including recall to prison. Realistic custodial recommendations to the Court following his ABH offence in 2005 could have been made by the Probation Trust.
- Had these assertive actions been taken then K would not have been resident in the community and out of control. Therefore the Panel concluded the death of K's victim was preventable.

1.4.12 The Panel also concluded that the Trust had been left to attempt to offer some voluntary control of K which was inappropriate and furthermore that the failings identified in the application of the Care Programme Approach were not material to the homicide.

1.5 Recommendations

1.5.1 If MAPPA is the chosen vehicle of the main multi-agency planning for such individuals outside that of the multi-disciplinary care team planning of the Trust's mental health services then the Panel recommends there needs to be a clearly established agreed set of activities underpinning and holding this process together which are understood and enacted by the entire clinical and care staff of the Trust.

1.5.2 It was out-with the independent investigation panel's remit to consider how this element of public protection operates today, or to test the verbal assurances from the County Constabulary and Probation Trust that this function was much improved.

1.5.3 The panel heard from individual practitioners that issues of confidentiality made the exchange of information cumbersome and untimely and that some key individuals felt overlooked in this process. There was poor communication with the Trust concerning K's criminal behaviour and in particular the detail of the violent assault for which he had been sent to prison and which he was subject to supervision on release.

1.5.4 We believe that the Board of the new Foundation Trust should undertake a thorough review of the Trust's contribution and operational support to the MAPPA function to

reassure itself that it is indeed operating at a coherent level. The Trust may wish to consider this being chaired by a non-executive Director. The following recommendation is repeated at the end of this report:

- The Trust should undertake a thorough review of policy and working relationships with the County Constabulary, Probation Trust and other major 'duty to cooperate' agencies paying particular attention to:

- The role and function of officers and staff allocated to the liaison and operational inter-agency function of Public Protection through the MAPPA process.
- The review of all existing protocols and agreements currently operated between the police, other agencies and the Trust relating to the sharing of information.
- To describe in one operational document, which can be used as staff information and development purposes, the processes adopted by the main agencies involved in MAPPA arrangements and how these services are accessed by referral.
- To ensure that senior clinical staff and managers are all aware of the elements of MAPPA's role and function which affect their practice and receive appropriate guidance of actions to be taken and this be embedded in their job description and reviewed with them.
- To agree how the flow of information will be coordinated in a timely, accurate and comprehensive manner between agencies.
- To define the Role of any appointed Care Programme Approach Care Coordinator in the MAPPA process.
- Those staff with a role to play in the MAPPA system should have this identified in their job descriptions which in turn should be subject to supervision and review

1.5.6 The Trust to devise an annual audit of the activity of its staff in these processes and to report the outcome to the Board.

2 Terms of Reference and Principles of the Investigation

2.1 Terms of Reference

To undertake a systematic review of the care and treatment provided to K by the Trust, to identify whether there was any aspect of care and management that could have altered or prevented the events of late 2006

The external Review Panel is asked to pay particular attention to the following:

- To review the quality of the health and social care provided by the Trust and whether this adhered to Trust policy and procedure, including:
  - To identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to K and establish whether deficiencies were material in the case.
  - To identify whether the risk assessments of K were timely, appropriate and followed by appropriate action;
  - To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;
  - The Mental Health Act assessment process (if appropriate)
- To examine the role of the care coordinator and the interrelationship between the various teams within the Trust with whom he had contact with and the appropriateness of their involvement or response to referrals, e.g. Crisis Team, Community Forensic Team, Support Time Recovery workers and CMHT.
- To examine the role of the various agencies involved in his care following his release from prison in 2005, including probation and their collaboration with the Trust.
- To examine the effectiveness of the MAPPA process in the management of K
- To establish whether the recommendations identified in the Trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response to these recommendations.
- To identify any learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.
- To report the findings of this investigation to East Midlands Strategic Health Authority.

2.2 Principles of the Investigation

2.2.1 **Approach** The investigation will not duplicate the earlier internal investigations; this work is being commissioned to build upon the internal investigations. Should the reviewers identify a serious cause for concern, this should be notified to the SHA and the trust immediately.

2.2.2 **Publication** The outcome of the review will be made public. East Midlands Strategic Health Authority will determine the nature and form of publication. The decision on publication will take into account the view of the chair of the investigation panel, relatives and other interested parties.

2.2.3 **Data Protection** The completed investigation reports contain details of the clinical care and treatment the service user received and is therefore subject to the Data Protection Act and if made public could also breach the Human Rights Act. It is the responsibility of NHS East Midlands to ensure that there is a balance within the report that would protect the rights of those individuals involved in the incident whilst also discharging its duty to publish what is deemed to be in the public interest.

2.2.4 **Support to Victims, Perpetrator, Families and Carers** When an incident leading to death or serious harm occurs, the needs of those affected need to be of primary concern to the Foundation Trust, Strategic Health Authority and the independent investigation panel. This should be reflected through the principals of the NPSA guidance, which are:

- the principle of acknowledgement,
- principles of truthfulness, timeliness and clarity of communication,
- the principle of apology.

2.2.5 The families of the victims and perpetrator within this process were contacted and in this case where reasonable were offered a meeting with the independent investigation panel. In general families wish to:

- know what happened?
- know why it happened?
- know how it happened?
- know what can be done to stop it from happening to anyone else?; and,
- tell their account of events.

2.2.6 It is important that the debate on the matters of public concern which arise from this case are grounded on an accurate and full account of the facts which have hitherto been denied to the public. It would be unfair to the public for the debate to be concluded without knowledge of the facts.

2.2.7 **Procedure** All inquiries have to consider what procedure is appropriate for the particular issues to be considered. The objectives must be to conduct an inquiry which as far as is practicable:

- investigates the matters within the terms of reference thoroughly;
- ensures objectivity;
- ensures all the relevant information is considered;
- is fair to those who are under scrutiny;
- recognises the position and interests of all those concerned with the events which led to the inquiry.

2.2.8 **Principles** The independent investigation panel believes that at the core of any mental health service delivered to people with a mental disorder there must be four principles:

- clarity in current diagnosis, objectives, needs, changing the diagnosis, needs and risk assessment and the strategies to clarify and deal with them;
- coordination of the delivery of service, sharing of information and action;
- checking on the outcome of service provision by regular review;
- changes in the diagnosis needs and risk assessments, and service provision in light of the review.

3 Methodology

3.1 Data Collection and analysis

3.1.1 Consent was sought from and given by K to access relevant health and criminal justice records prior to these being seen by any member of the Panel. Information about the scope of investigation, its Terms of Reference and procedures, and information about the panel members was sent to relatives of K, the victim's parents, and staff who were invited to interview. In addition, each member of staff was sent a list of the areas the panel wished to discuss and how the panel intended to proceed with witnesses. Interviews were recorded and a transcript sent to the interviewees who were encouraged to amend, clarify or add to the points contained.

3.1.2 All staff invited to be interviewed by the panel did so voluntarily and were open and helpful in their contribution to this independent investigation.

3.1.3 The parents of the victim were contacted.

3.1.4 The mother of K was written to and telephoned by the NHS East Midlands on several occasions in order to inform her of the impending independent investigation offering her the opportunity to meet with the panel. No response to correspondence or telephone messages was forthcoming.

3.1.5 Four key staff involved in K's assessments, care, treatment and supervision were interviewed, along with the Probation Trust's Team Manager, who supported the supervising Probation Officer of K and K himself were interviewed. (Details in Appendix One)

3.1.6 The documentation viewed was significant in volume (details in Appendix One) and the panel in producing this report has gleaned from it that which it considered to be important to the key questions we had to resolve in our own minds.

3.1.7 The key questions were: does K have a treatable mental illness or disability of mind and if so where would these needs be best met? If the issue of treatability was an issue, then should he have been more appropriately dealt with by way of a custodial sentence prior to the homicide when convicted for assault? Finally, could his actions have been prevented?

3.1.8 A number of key documents were reviewed (details in Appendix One). These included health records; the internal investigation report; psychiatric and probation service reports to the courts and relevant MAPPA minutes.

3.1.9 Root Cause Analysis Root Cause Analysis seeks to identify the origin of a problem. It uses a specific set of steps to find the primary cause of the incident or problem to determine what happened; determine why it happened and what to do to reduce the

likelihood that it will happen again. RCA assumes that systems and events are interrelated. Basic types of causes are:

- **Human causes** – People did something wrong, or did not do something that was needed.
- **Organizational causes** – A system, process, or policy that people use to make decisions or do their work is faulty.

3.1.10 Root Cause Analysis helps discover specific actions that contributed to the incident under scrutiny. This often means that RCA reveals more than one root cause and helps identify what is the real reason the problem occurred.

3.1.11 The Panel utilised this approach in analysing the documentation and information from interviews. The Panel did not consider that, in this case, such fundamental underlying factors could be identified.

3.1.12 Consent Following contact with K's current Responsible Clinician a consent form was signed by K on the 2nd of February 2010 and was witnessed by his named nurse. The consent gives access to a schedule of documents including health records, including court case records and associated papers. There was an understanding that the information may become public through publication of the investigation report.

3.1.13 Cooperation with the Independent Investigation Staff of NFHT and the Probation Trust were helpful and responded to all requests for information which was within their gift to do so, or directed us to those who could help. The process for accessing information from MAPPA and the police proved to be protracted. Both the Probation Trust and the police were concerned that their staff were not to be re-interviewed in relation to matters unconnected to the mental health processes as these had been addressed by their own internal reviews. In addition, MAPPA minutes were not to be disclosed and any reference was to be a generalization and not specific. Eventually, relevant MAPPA minutes were received. Although the CPS would have been willing to provide the prosecution case papers, the police service declined to authorize disclosure. Consequently, the Panel purchased the transcript of sentencing proceedings for K. The rationale for seeking access to the prosecution case papers was to assist in understanding the patient and his psychopathology, which in turn assists in reviewing the care and treatment of K. This information also helps establish a base-line of the index offence and greatly aids or confirms the overview of the patient and their psychopathology. It also helps to clarify facts for victim's relatives,: the transcript, whilst helpful, was not as informative.

3.1.14 The panel was disappointed by the response of the police which, in part, helped frame the main recommendation and builds on one of the key recommendations made in the internal review report.

3.2 External Review Panel

3.2.1 The Panel consisted of three senior and experienced mental health professions, Dr Colin Dale, Mr Peter Green and Dr Michael Rosenberg. (Details in Appendix Two)

3.2.2 The Panel was advised by Dr Tony Fowles, a former Chair of the Lancashire Probation Board, on matters concerning the criminal justice services.

3.2.3 All three members of the External Review Panel and the criminal justice advisor are independent of any of the organisations involved with the homicide and have had no involvement in any of the previous investigations.

3.2.4 This Level 3 (independent) investigation was commissioned by NHS East Midlands from Caring Solutions UK Ltd. The investigation commenced in December 2009 and is expected to be completed in July 2011.

4 Introduction

4.1 Summary of the Incident

4.1.1 Prior to the homicide, K had recently been allocated a flat and he reported that he had been trying to keep the location a secret from acquaintances whom, he felt, would be a negative influence and impede his attempts to move away from his previous unsettled way of life. Unfortunately, many people quickly found out where he was living and turned up at his flat uninvited. Two of these acquaintances were present the night of the homicide – one becoming the victim.

4.1.2 On the night of the homicide, K and the others had been drinking heavily at his flat. K later acknowledged that he had had an argument with the victim and had punched him in the face. K was unable to explain the severity of the victim's injuries, suggesting that these were accidental. After this argument, K reported that and his 'friend' pulled the victim onto a duvet in a bedroom and that he had been snoring. In the morning K and his friend returned from a walk and on returning they concluded that the victim was dead. They called paramedics that evening who concluded that the victim had been dead for some time. The forensic pathologist attributed his death to multiple injuries leading to internal bleeding which ultimately led to his death.

4.1.3 During a psychiatric interview whilst on remand K reported that he repeatedly punched the victim but did not intend to kill him. He had not wanted to associate with the victim, nor have him visit his flat and felt he was bullied and humiliated by him in social situations. K was pleased to have a flat of his own and reported that he became enraged when, during this drunken fight, the victim was trying to break up K's newly acquired furniture.

4.1.4 K was subject of four psychiatric assessments between his being taken into police custody and court appearance. (An assessment of fitness to be interviewed and to stand trial, by the NFHT consultant who had treated him; two reports to the Court, one from a Consultant Forensic Psychiatrist, and the second by a Consultant in Developmental Psychiatry; and a report requested by the latter, from a Professor and Consultant Forensic Psychiatrist.) All mental health professionals agreed that K was not suffering from mental illness sufficient to impact on his behaviour at the time of the homicide. There was however some agreement on a diagnosis of dissocial personality disorder.

4.1.5 There was a recommendation in the final report, that an indeterminate custodial sentence, for public protection, might be appropriate, with the option of transfer to a secure psychiatric hospital for assessment of suitability for treatment. In the event, K was sentenced to a hospital order, without limit of time, under Sections 37/41 of the Mental Health Act 1983. He remains in a specialist secure psychiatric hospital where he continues to present behavioural challenges to the mental health professionals

attempting to treat and manage him. When he was interviewed he remained on the admission ward and appeared to be making little progress.

4.2 Background and Context – K's Early History

4.2.1 Events and behaviour in K's childhood were identified as pointing to the possibility of Asperger's Syndrome. He was disadvantaged at home by parental difficulties, including domestic abuse. He was placed in local authority care, and placed in and expelled from several 'special schools' presenting with aggressive behaviours. His work history reveals serious difficulty in holding down jobs. He commenced drinking and misuse of illegal drugs in his teenage years. His early years included spells in custody, living with friends and on the streets, and taking intravenous drugs.

4.3 Background and Context: K's Criminal Offending History

4.3.1 K had 15 previous convictions for 22 offences these included property offences, offences against the person (including instances of violent behaviour), drug offences and a number of occasions where he was in breach of conditions imposed by the courts. He received a range of non-custodial and custodial sentences, which did not deter him from further offending.

4.3.2 On the occasion of his first contact with NHFT services he was serving a custodial sentence in a Young Offenders' Institution (YOI) following conviction for wounding.

5 Chronology of Events

5.1 There follows a detailed chronology of events from the commencement of K's involvement with NFHT in April 2005 until the homicide in late 2007. Key events in this chronology are:

- **11 April 2005** First contact with K – visited by a member of the Criminal Justice Team of NHFT when he was serving a custodial sentence in a YOI (Young Offender's Institution); referred to Link Worker Scheme
- **19 May 2005** Discharged from YOI, homeless
- **20 May – 11 October 2005** Received support from a variety of agencies and teams (Probation Service, NHFT, voluntary sector)
- **26 Sept. 2005** Arrested and charged with Robbery
- **11 Oct 2005** Admitted to general mental health bed with suspected drug-induced psychosis; 2 days spent on PICU (Psychiatric Intensive Care Unit); 21 days detained under the Mental Health Act 1983, Section 2.
- **12 Dec 2005** Transferred to mental health rehabilitation facility, Halfway House.
- **24 Feb 2006** Discharged from Halfway House, following serious aggressive behavior and having been removed by the police. No fixed abode.
- **10 March 2006** Allocated temporary accommodation
- **9 May 2006** Pleaded Not Guilty to Robbery but Guilty to Actual Bodily Harm (ABH). Bailed pending pre-sentence reports.
- **1 Sept 2006** Sentenced to Community Rehabilitation Order (CRO) with conditions.
- **Late 2006** The homicide took place. K was convicted of manslaughter and sentenced to a Hospital Order without restriction of time. K remains in a specialist secure unit, making little progress.

5.2 The following contains a more detailed chronology of events and indicates the evidence from which this information was drawn. The overall picture provided by the events described is that K's presentation was of intermittent and disabling periods of deterioration in his mental health due to excessive consumption of alcohol and poly drug abuse, including aggression and violence. This was interspersed by periods when he appeared to be making some progress, when not under the influence of legal or illicit substances.

Date	Event	Source
2005		
11 April	1st contact K and NFHT. K seen at HMP YOI by member of Criminal Justice Team (CJT). K assessed as not having overt psychotic/mood disorder symptoms and not active mental health treatment. Primary problems identified as substance misuse and accommodation problems. (K banned from local Night Shelter for life because of previous violence towards staff). CJT referred K to Link Worker Scheme (LWS: details in App. 6) with support from CAN (details in App. Five). Noted that K would be released on licence with supervision by Probation Officer (PO) for 8 months after release.	Clinical notes; LWS notes
18 April	Referral to LWS. LWS agreed K was suitable for their service.	LWS notes LWS notes
29 April	LWS – initial contact in YOI to assess needs prior to release. K's main area of concern was accommodation. LWS referred K to CAN homeless team requesting support.	
11 May	LWS & CJT discussion of K Agreed he needed to address alcohol issues. Agreed he was not appropriate for referral to Community Mental Health Team (CMHT) or Personality Disorders Service. Psychotherapy considered a possibility if K engaged with services on release.	LWS notes
19 May	K released from HM YOI. K was of no fixed abode on release.	Criminal Justice records
20 May	Meeting about K's housing needs MAPPA (Multi-agency Public Protection Arrangements) Manager informed meeting K had a diagnosis of Asperger's Syndrome.	LWS notes
12 July	MAPPA meeting LWs attended meeting, agreement refer K to Transition and Liaison Team (TLT).	Criminal Justice records
10 August	Referral to TLT sent. K had missed several appointments with LWs to compile referral.	Clinical notes
21 July	Referral by PO to NFHT Initial Screening Assessment Team (ISA) PO noted K's history of personality difficulties and behavioural issues and was requesting a formal diagnosis by a Consultant Psychiatrist (CP) which would form a basis from which to work in regards to accommodation, support and treatment. Report from Clinical Psychologist 1, with initial advice on possible diagnoses. This identified possible diagnosis of Anti-Social Personality Disorder with Schizotypal features and alcohol problems. This referral was transferred to the out-patient service for an appointment with a CP.	Clinical notes;

25 July	GP referral to CP for assessment This included the psychology report with suggested diagnoses.	Clinical notes;
4 August	Threshold Assessment Grid (TAG) completed by LWs, indicating K should only be visited by 2 people in public, and not at all if he was drunk.	LWS notes
30 August	1st appointment with CP. K did not attend; LWs did and discussed clinical psychologist's report, difficulties of engaging K and some of his social difficulties. Further appointment made.	Clinical notes;
6 Sept.	MAPPA meeting PO reported K had been a good attender at appointments, but had a very chaotic lifestyle at present, being homeless and 'bed hopping'. Concerns were expressed regarding K reverting to misuse of drugs. It was explained that a firm diagnosis of Asperger's Syndrome would take more than one appointment. In the interim he may be allowed access to support services. Noted he was himself at risk whilst on the streets, as well as being a risk to others. Housing Dept to pursue application to MSAADA, a care home provider (details in Appendix Five), and re-engagement with CAN.	Criminal Justice records
20 Sept.	2nd Appointment with CP K did attend (albeit late, so assessment not completed). K was distracted, did not like his accommodation, was drinking to give him courage. He was stressed and anxious, found it difficult to get along with people and was in arrears with his rent. Provision diagnosis of Attention Deficit Hyperactive Disorder (ADHD), Personality Disorder and substance misuse. Further appointment made in 3 week's time with K agreeing to address his substance misuse problems through CAN, continue to see his PO and LWs would try to link him with services. Following the meeting, LWs informed by CAN that no suitable housing options were available. K's mother rang LWs to express concern he was not getting the support he needed and was advised to put her concerns in writing to the CP.	Clinical notes;
21 Sept.	K reported to have punched a stranger in the face. The victim noted K appeared drunk. K was arrested.	Pre-sentencing report regarding offence of Actual Bodily Harm.
26 Sept.	LWs advised K had been arrested and charged with Robbery (later corrected to Actual Bodily Harm – ABH) and was released on bail.	LWS notes
11 Oct.	Third appointment with CP K attended late but was seen. Prior to his arrival LWs discussed concerns (from his mother and PO) regarding his volatility, that he seemed to be hallucinating and feeling paranoid. Suspected drug-induced psychosis. K arrived and was very agitated, with pressure of speech	Clinical notes

	and seeming confused. He was willing to be admitted as an in-patient for 72 hrs for observation and assessment. CP and LWs were prepared to detain K for assessment under the Mental Health Act, 1983 (MHA)if K changed his mind.	
11 Oct, 23.00 hrs.	Admitted to in-patient ward Staff unclear as to reason for admission. A full physical examination was completed, no obvious psychotic features were noted and he denied any suicidal feelings. There did not appear to have been any risk assessment prior to his admission.	Clinical notes
12 Oct.	Reviewed by Senior House Officer (SHO) K presented as quite thought disordered, was swearing and was unable to give any detailed information. The CP reviewed him later that day, K wished to sort his life out. PO telephone call and police checks confirmed significant forensic history. Ward to inform PO when discharge was scheduled.	Clinical notes
13 & 14 Oct.	NHFT Risk Assessment Indicator demonstrated assessed risks of suicide, neglect and violence to self and others. It was noted that he had a well documented history of violence and aggression, exacerbated by poly drug abuse. K had a low tolerance threshold and easily moves to hostile behaviour if demands are not met or he feels threatened by others. There was evidence of undiagnosed mental illness. Noted K was difficult to assess, being uncooperative. K remained volatile in mood and staff continued to suspect he had access to illicit substances. The plan derived from this assessment was to admit K for assessment of mental state, refer to CAN/NDAS for support in respect of his drug use, to psychology department for psychological assessment and to request a full Multi-Disciplinary meeting prior to discharge to clarify diagnosis, including any mental illness, and follow-care. K seen by Complex Needs Worker (CNW) from Drugs and Alcohol Service (DAS) Ward staff suspected use of illicit substance, behaviour erratic at times. Later in day, K's behaviour was variable, sometimes settled and sometimes restless. Deteriorated over the day. CP advised staff to adopt clear communication and be fairly flexible, recording how he responded to this approach. Nursing staff felt that a firm approach with fixed boundaries would be more appropriate. K allowed out for 4 hours to	Clinical notes

	collect some belongings. 2nd appointment with CNW K given some options for support to help him manage drug and alcohol abuse. He rejected offer to attend groups at NDAS and agreed to self-refer to CAN. No further appointments to be made with CNW.	
14 Oct.	The 72-hr review, the CPA documentation and the risk assessment was completed. K agreed to stay informally, for a care and treatment plan to be developed. Recommendations included: • A full multi-disciplinary meeting, including liaison with probation • Come to a clear diagnosis • Agree appropriate treatment and medication • Continue support from other agencies, including involvement of CAN/NDAS • Referral to psychology services for further assessment • Introduction to Occupational Therapy and encourage low level activity • Continue to re-inforce the 'zero tolerance' policy.	Clinical notes
15 Oct.	K requested a telephone conversation with his father, who did not wish to speak to him. K became very angry and threatening. His mood fluctuated, between calm/rational and angry/paranoid.	Clinical notes
16 Oct.	Female co-client reported K had illicit drugs and was pressuring her to take some. A search later gave no sign of drugs.	Clinical notes;
17 Oct.	Ward round by CP Reported that K had been presenting difficulties on the ward, regarding drugs and behaviour. Ward plan continued as above, with the proviso that detention under the MHA would be considered if K was unwilling to stay. Ward staff to complete risk assessment and check forensic history.	Clinical notes;
18 Oct.	K went out with his girlfriend, returning cheerful.	Clinical notes
19 Oct.	K reported feeling depressed, wanting to move away from his previous way of life. Settled after talking to staff.	Clinical notes
20 Oct.	Discussion with Forensic Community Psychiatric Nurse (CPN) Agreed a screening assessment would be appropriate. K was on leave overnight, he had been to exceeding agreed leave hours, but had informed the ward he would be late back. Urine sample to be taken on his return, to be informed of need to comply with leave times; he would be referred to the Transition and Liaison Team (TLT) for further assistance in coming to a diagnosis.	Clinical notes;

	K telephones key nurse to say he wanted to stay overnight, he was informed he should return then ended the call.	
21 Oct.	Discussion with TLT (forwarding referral to the ward) and telephone conversation with PO (to meet with CP following week with information from K's HM YOI stay. Noted that K seemed to be having problems with his memory.	Clinical notes
21 Oct 18.00 hrs	K returned to the ward, have exceeded his leave. Request for Diazepam refused	Clinical notes;
24 Oct	CP Ward round K restless and agitated, admitted have taken illicit drugs. Team agreed that for a proper assessment could not be carried out whilst he was an informal patient, so he should be considered for MHA Section 2 detention for assessment. An open ward was not appropriate due to his high level of risk and volatility. Threatening and abusive to staff that evening.	Clinical notes;
25 Oct.	K presented as chaotic and agitated. Requested medication for side effects of medication he was not taking. MHA assessment: K placed on Section 2 of MHA and transferred to closed ward, on grounds that he was not compliant with care plan, spending unauthorised periods off the ward and bringing back street drugs. On arrival on the closed ward he was abusive and threatening towards staff, staff found illicit drugs in his property.	Clinical notes
27 Oct.	Ward round on closed ward. K had presented as pleasant and agreed to comply with treatment plan. Granted escorted ground leave. Remained under MHA. Later K ws involved in altercation, staff intervened and diffused the situation. K transferred back to open ward	Clinical notes
30 Oct.	Police visited ward, requesting DNA sample from K He agreed to co-operate. Unclear from the records what had triggered this request.	Clinical notes
31 Oct.	Ward round K reported as being demanding at times and especially loud at night. Care plan for K included: • Referral to psychology service • Referral to TLT for assessment	Clinical notes;

	• Weekly urine drug test • Daily unescorted leave to the village, condition that he returned on time and avoided alcohol and illicit drugs. Leave to be reviewed if K breaches conditions • Continue with medication regime. Later that day returned from leave; pleasant but appeared to be intoxicated. To be assessed by Forensic Team as well as TLT.	
1 Nov.	MAPPA meeting Concerns expressed regarding liaison issues.	Criminal justice records
7 Nov.	K having leave, returning 30 mins late, concern he was taking illicit drugs, awaiting results of urine test. K appeared agitated most of the time, with poor concentration and focus.	
8 Nov.	K went on leave with another patient, both returned smelling of alcohol. Leave to be reviewed. Restricted to ward.	Clinical notes
9 Nov.	Assessment by Clinical Psychologist, TLT and Forensic CPN. When assessment complete, psychologist to liaise with Forensic Clinical Psychologist regarding risk.	Clinical notes
10 Nov.	Ward round with CP CP noted K showed better concentration, medication appeared to be working. Plan to: • Referral to CMHT • Unescorted leave up to 4 hours • Increase in medication • Urine samples continued.	
10 – 14 Nov.	Clinical record notes several occasions when K appeared to be intoxicated on return to the ward but did not present major management difficulties.	Clinical notes
14 Nov.	Ward round K reported to have been pushing the boundaries and seeking increased leave periods: continued concern he was taking drugs and alcohol. K discharged early from Section 2. K was happy with this. Plan to send urine sample for analysis; no medication to be given if K had been drinking.	Clinical notes;
22 Nov.	Ward round Care plan: • Seek feedback from Forensic Team – would they take over K's care? If not, refer to CMHT • Seek feedback from TLT • No change in medication	Clinical notes;

	• Referral to rehabilitation unit/halfway house.	
24 Nov.	Ward round Agreed K ready to move to Halfway House. Care Plan: • Refer to CNW regarding drinking issues • CP help regarding housing application • TLT to complete assessment • Reduce medication • Referral to CMHT and Halfway House Discussion with Forensic CPN Forensic Team not going to take K onto their caseload. TLT to see K again.	Clinical notes
25 Nov.	Referral written to CMHT and Halfway House; K gave permission for TLT to contact his mother.	Clinical notes
28 Nov.	Noted that K was expressing suicidal ideas. K due to attend police station on 1st Dec. regarding delayed charge bail. LW would attend with him. Psychologist to be asked to assess K and prepare report for Court regarding risk.	Clinical notes
29 Nov.	MAPPA meeting PO reported she would prepare paperwork for K to be recalled from licence and would ask Court to delay proceedings pending Forensic Psychologist's report.	Criminal Justice records
1 Dec.	Ward round K had attended police station and missed appointment with the Halfway House. Had been coming back drunk from leave. Reported paranoid ideas.	Clinical notes;
6 Dec.	Ward round K more settled and able to manage his temper; His involvement with the TLT continued. K felt he had benefitted from his stay in hospital. He had 3 months left on his licence; PO to seek support from CAN with his alcohol difficulties; CJT were exploring accommodation options and would continue their support. TLT and psychologist would continue work on diagnosis.	Clinical notes;
12 Dec.	Transfer to Halfway House Staff felt he became agitated when challenged on anything.	Clinical notes;
13 Dec.	K became physically and verbally aggressive when checked by staff. He was later noted to be socialising with other clients.	Clinical notes
15 Dec.	K spend most of the evening off the unit; he rang to say he was staying with a relative; he had been sighted, drunk; he was asked to return but failed to do so.	Clinical notes
16 Dec.	A fellow patient reported that K had been making a nuisance of himself at her flat and it was suspected that he had acquired a key. It is not clear from thenotes how this came about. PO was informed, and	Clinical notes

	arranged an appointment to see him the following week. K returned to the unit at 20.45 hrs, said that he had been mugged. He eventually confirmed that he had been at female patient's flat but would not expand on this.	
20 Dec.	LW accompanied K to police station regarding delayed charge bail. He was charged with Robbery, to appear at Magistrates Court in two week's time. He was also accompanied to inform his PO.	Clinical notes
29 Dec.	K appeared agitated, told staff he was feeling paranoid. He went to the office for medication and became argumentative regarding when he should be taking it. He became verbally threatening and the situation was successfully diffused by staff.	Clinical notes
31 Dec.	K went out to the local shop and returned with his arm scratched and bleeding. He caused damage to items on the unit, police were called and attended the scene. K had left the unit before they arrived. Later he contacted his mother with threats to kill her and himself. She had not known him like this before. He returned to the unit drunk.	Clinical notes
2006		
6 Jan	Clinical psychologist from TLT reported. Diagnosis was ADHA, Tourette's Syndrome, Asperger's Syndrome and Schizotypal Personality Disorder. This Team planned to support him with day services.	
1 Feb.	MAPPA meeting. TLT reported K's diagnosis as PO was preparing recall paperwork; discussion around accommodation issues, but it was understood K could stay in Halfway House until after the Court case.	LWS notes
9 Feb.	K returned to the unit late in the evening, appearing to be intoxicated and had scratches and bruises to his hands and elbows. He denied having been in a fight and said the injuries were self-inflicted as a way of controlling urges to hit out at others.	Clinical notes
20 Feb.	Staff were contacted: K was in police custody, having been arrested for drunk and drug offences. He was to be detained overnight and assessed the following morning.	Clinical notes
21 Feb.	LW attended Magistrates Court. He was given a conditional discharge for a public order offence, and returned to Halfway House. K was informed his behaviour was unacceptable. PO and CP informed of latest events. Multi-disciplinary meeting was arranged for beginning of March. PO would look at recalling K from licence, because he had had many chances.	LWS notes

24 Feb.	K involved in fight with fellow resident had made threats to kill. Later he threatened staff twice, whilst smelling strongly of alcohol. Police were called, and K was removed to police cells. Police assessing if they have enough information for a charge of assault. PO intending to complete recall papers in case a he is charged. Tel call to CP to discuss management in relation to K. CP agreed K should be discharged to the Night Shelter (staff appear to have been unaware of his ban). He was advised to seek assistance for housing, given 7 days medication. LWs and PO were informed and a message left for the TLT.	Criminal justice records; Clinical notes
1 March	A multi-disciplinary CPA review was held.	
2 March	Letter to GP regarding CPA Discharge Review. K was advised to abstain from illicit drugs and alcohol for 3-4 weeks so that medication could be initiated. Ritalin was to be prescribed as a trial to assess his response: however this was concluded early because K continued to take alcohol cannot be taken at the same time: he was never prescribed a therapeutic does, which CP anticipated might have therapeutic effects.	Clinical notes; Interview
6 March	K seen by student social worker. He was homeless after an argument with his mother. He self-reported he was not taking any alcohol or drugs, but was finding difficult to maintain this whilst mixing with people who were taking them regularly. Referral form completed and given to MSAADA and given voucher for soup kitchen.	Clinical notes
10 March	K was given keys to temporary (3 months), part furnished flat. CMHT agreed to visit daily for first week.	Clinical notes
29 March	Out-patients appointment Seen by CP; K keen to start medication so could move forward. Pleasant at interview. K to be given further appointments with CP and Care Coordination (Principal Social Worker) as and when required. CMHT, TLT and CJTY to continue support.	
3 April	Care Coordinator rang NAS. Funding would need to be agreed for support service and they requested a referral and risk assessment.	Clinical notes
18 April	Appointment with student social worker To discuss impending Court case and possible outcomes. K could not remember any assault but was ill at the time, but had some recollection of a commotion. He would be pleading Not Guilty. Forensic Psychologist would be recommending a hospital order rather than a prison sentence.	Clinical notes

25 April	Forensic Clinical Psychology report concluded that • K posed a high risk of committing future violent acts, though risk reduction treatment might assist • It was not possible to say that who might be at risk or the likely gravity of any further violence • K had been unresponsive to imprisonment • K would benefit from a hospital order under the MHA • A non-specialist hospital would be unlikely to manage a reduction in the risk of future violence	
26 April	Out patient appointment with CP K did not attend. Care Coordinator contacted K and he attended later that day, with bruises and cuts to his face and hands. He was low in mood. The possibility of a prison sentence for the Robbery charge was discussed.	Clinical notes
9 May	K informed he was 'high priority' for accommodation, they were awaiting a copy of the care package from the CMHT Court Case K pleaded Not Guilty to Robbery but Guilty to the lesser charge of ABH, on the advice of his barrister. Sentencing adjourned for reports.	LWS notes
24 May	MAPPA meeting K no longer on licence from previous sentence. (This is taken from LW notes, but there is no record of a MAPPA meeting and no minutes)	LWS notes
1 June	Risk Indicator Completed	Clinical notes;
19 June	CP completes pre-sentencing report for the Court - CP opinion is that K's mental health problems do not warrant detention under the MHA.	Clinical notes;
12 July	LW accompanies K to Court for sentencing. Court awaiting pre-sentence report from PO so case adjourned for 4 weeks. In addition, funded care package required if Community Rehabilitation Order (CRO) was to be considered. Case conference to be called to look at other sources of funding if required. Given conflicting recommendations of the two reports (CRO or hospital order) there was some discussion of requesting a third report but there is no evidence this happened.	Clinical notes; LWS notes
28 July	Out-patient appointment K reported to be settled, was concerned about possible prison sentence. Plan K to start medication and that the monitoring and support would continue.	Clinical notes;
2 August	LW visited K at his flat, which was untidy. K had cuts and bruises to his face. Letter from Crown Court regarding outstanding fines. PO called, she would request a further adjournment to complete her report.	LWS notes

3 August	Funding request for care package had been turned down and was being re-assessed. K received an eviction notice for non-payment of rent	Criminal Justice records Clinical notes
9 August	Revised care package funding request accepted.	Clinical notes
14 August	PO informed that following sentencing LW support would cease.	LWS notes
30 August	PO pre-sentencing report scores K as 'High' risk of reconviction. National Autistic Society (NAS) worker informed funding for care package had been agreed; she agreed to attend court to support K.	LWS notes
1 Sept.	K given 3 year CRO, with conditions of residence and he engages with the care package. PO attended Court hearing, CMHT and NAS were not represented.	Clinical notes; LWS notes
4 Sept.	PO advised K he did not need to attend forthcoming appointment.	LWS notes
5 Sept.	LW and Care Coordinator conversation – LW feels K not fully aware of consequences of breaching conditions of CRO, and that care package should be put in place as soon as possible. K was going away for the week-end and stated that PO had agreed. No record to corroborate this. LW stressed need for him to meet CMHT to get his care package up and running. K to attend court on 14th September regarding outstanding fines	Clinical notes
12 Sept.	K failed to attend meeting with NAS and Care Coordinator: they went to his flat and eventually he let them in. He was told they would commence care package the following seek.	Criminal Justice records
19 Sept	K failed to attend appointment with his PO	Criminal Justice records
3 Oct	Details of NAS appointments for two weeks sent to Care Coordinator. K had missed last two appointments.	Clinical notes
4 Oct	K did not attend out-patient appointment, he had also missed previous appointment. Care Coordinator tried to contact him without success.	Clinical notes
5 Oct	K failed to attend appointment with PO	Criminal Justicenotes
11 Oct	LW visited K at his flat. K reported he was doing well and engaging with services in line with CRO. LW advised K they would cease their input now.	LWS notes
13 Oct	K seen by duty worker, he had no money and no electricity. Loan of £10 provided, K was taken to get card for electricity. K was agitated and abusive in first shop and was escorted to another where cards	Clinical notes

	were purchased. He calmed down slightly.	
19 Oct	K informed that Salvation Army were able to provide some furniture for his flat. K visited Care Coordinator, he was very angry as benefits had not been paid. As his medical certificate had run out.	Clinical notes
25 Oct.	K visited Care Coordinators office with NAS support staff as arranged. K became angry when questioned about PO appointment – he had not attended. K was noted to be staying with 'a friend'	Clinical notes
25 Oct	K attended office with new address details. Risk assessment not reviewed.	Criminal Justice records
1 Nov	Support Team Recovery Worker visited K at his flat to sort out his heating. Another service user present at the flat who threatened CMHT worker who left.	Clinical notes
Late 2006	Duty ASW telephoned to say K was one of two men arrested on suspicion of murder; the victim was at that time unidentified. Forensic Medical Examiner assesses K as fit to be interviewed after taking the day's medication. Appeared very distressed but no sign of mental illness.	Clinical notes

6. Findings - Contributory Factors

6.1 The findings of this investigation are presented under the headings of the Terms of Reference. The overall objective of the investigation was to undertake a systematic review of the care and treatment provided to K by the Trust, to identify whether there was any aspect of care and management that could have altered or prevented the events of late 2006. The investigation addressed the following specific points:

6.2 Review of the quality of the health and social care provided by the Trust and whether this adhered to Trust policy and procedure, including:

6.2.1 Identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to K and establish whether deficiencies were material in the case.

6.2.1.1 CPA documentation was appropriately completed in detail when K was admitted as an in-patient on 11th October 2005. This documentation records plans for K' future care, namely:

- To request a full multi-disciplinary meeting (team plan notes to liaise with probation)
- To obtain a clear working diagnosis
- To look at provision of suitable appropriate treatment and medication
- To continue the support of other service available to K at this time
- To arrange involvement of CAN/NDAS in his care
- To refer to psychology services for further assessment.
- Team action plan also notes to introduce to OT and encourage low key OT activity
- To continue to reinforce zero tolerance policy.

6.2.1.2 A multi-disciplinary CPA discharge review took place (2 March 2006) just after he was discharged from the Halfway House after being removed be the police. This review, attended by K's CP, PO, Care Coordinator (Principal Social Worker), K's aunt, CJT and key worker from Halfway House, was to review his care plan.

6.2.1.3 These meetings were appropriate and timely.

6.2.1.4 It is of concern to the External Review Panel was that K was first admitted to the inpatient care of the Trust with clearly complex needs in October 2005 but was not allocated a CMHT Care Coordinator until some five months later. Soon after admission, when he was subject to the Care Programme Approach, a Care Coordinator should have been appointed, rather than relying on the treating Consultant Psychiatrist. The

appointed Care Coordinator would then have been in a position to have been involved from the start and establish the pulling together of all the strands of his various assessments and care needs including the preparation and coordination of reports to the court from the Trust.

6.2.1.5 The independent investigation panel was perplexed as to why an Enhanced CPA Care Coordinator for K was not nominated at the inpatient stage. K had known complex assessments, was also receiving input for both assessment and support from a number of services within NFHT, in addition to his supervision on licence by his PO. The delay in appointing a Care Coordinator, carried out some five months later is incomprehensible.

6.2.1.6 The Principal Social Worker was allocated K's case as his Care Coordinator. In interview she reported that this took place with little discussion and little information about his history, including the serious nature of his 'Wounding ' offence nor the details of the assault to which he admitted Guilty to ABH. She was also not aware of his behaviour and non-compliance as an in-patient or how he behaved in the Halfway House.

6.2.1.7 The Panel concluded that these deficiencies in the implementation of the CPA, in particular the failure to appoint a Care Coordinator much sooner in the care and treatment of K were not material factors in the homicide.

6.2.2 To identify whether the risk assessments of K were timely, appropriate and followed by appropriate action.

6.2.2.1 A number of risk assessments were completed in relation to K.

6.2.2.2 Threshold Assessment Grid. This was carried out on 4th August by the Link Workers to provide guidance on risks to themselves when visiting K. It concluded that he should not be seen by a one worker alone, should only be seen in a public place, and should not be seen at all when intoxicated. When the CMHT and Care Coordinator took on his case, they were not aware of this recommendation.

6.2.2.3 The NHFT Risk Assessment Indicator demonstrated assessed risks of suicide, neglect and violence to self and others. It was noted that he had a well documented history of violence and aggression, exacerbated by poly drug abuse. K had a low tolerance threshold and easily moves to hostile behaviour if demands are not met or he feels threatened by others. There was evidence of undiagnosed mental illness. The purpose of the admission on 11th October was to observe and monitor K, in order to clarify his diagnosis and develop appropriate care and treatment plans. The plan included referral to CAN/NDAS for support in respect of his drug use, to psychology department for psychological assessment and to request a full Multi-Disciplinary meeting prior to discharge to clarify diagnosis, including any mental illness, and follow-care. Although recommending admission to hospital, this assessment is dated 13th October, which is after the admission which it recommends. In any event, the ward staff should have been

made aware of a purpose of the admission, particularly as K arrived at the ward very late at night. Unfortunately K declined input from the Drug and Alcohol Service thereby reducing the value of this plan. His decision does not appear to have been challenged.

6.2.2.4 The CPA documentation completed on his admission to an inpatient ward in October 2005 recorded that, given his unpredictable nature and his propensity for violence that staff should visit him in pairs and in safe environments only. In addition, it was noted that, once back in the community, he would pose a significant danger to others unless an appropriate treatment plan is instigated and he is to be monitored closely whilst living in the community.

6.2.2.5 A second Risk Screening Assessment was completed by the ward based clinical leader on December 4th 2005. In particular it noted that he was hypersensitive to perceived slights. He quickly became abusive, hostile and threatening if his needs were not me or he felt threatened by others. This was exacerbated by substance misuse. However, it was noted that as the admission progressed he did engage more with staff although could still be verbally aggressive. This suggested that K was showing some slight signs of progress whilst an in-patient – a conclusion with which his CP agreed.

6.2.2.6 The Forensic Clinical Psychologist (FCP) was asked to prepare a risk assessment by K's PO to inform her pre-sentencing report to the Court in relation to his ABH offence. This HCR-20 assessment was completed despite the difficulties posed by K's inattention, lack of concentration and focus at interview. The report concluded, amongst other things, that:

- K posed a high risk of committing future violent acts, though risk reduction treatment might assist
- It was not possible to say that who might be at risk or the likely gravity of any further violence
- K had been unresponsive to imprisonment
- K would benefit from a hospital order under the MHA
- A non-specialist hospital would be unlikely to manage a reduction in the risk of future violence

6.2.2.7 There remains a difference of opinion as to the appropriateness of this assessment. The FCP was criticised in the internal report for having carried out this assessment without proper training in its use. He requested an interview with the External Review Panel , at which he produced evidence to the effect that formal training was not necessary for an experienced clinician such as himself. The Independent Forensic Psychiatrist on the internal panel felt that the use of this tool to generate a risk score for an individual is not especially helpful. He argued that it would be better used to create a detailed narrative about the risk factors, identify the interventions that can be used to manage those risks and then create risks scenarios. NFHT concurred with his view that a multi-disciplinary approach would have been more appropriate, There was a concern that the

Psychologist appeared to be working independently of the team in this instance and was not communicating his assessment findings with the Community Forensic Team. The internal review team also did not consider it appropriate for a psychologist to be making a recommendation for a Hospital Order at all.

6.2.2.8 The independent investigation panel concluded that this Psychologist conducted his assessment under difficult conditions considering K's presentation when seen. The Psychologist gave his opinion and advice to the Probation Officer to give her options to put before the Court for consideration. The Community Forensic Team, which was in its infancy, had concluded , through the CPN, that K was not deemed suitable for their services and the Link Worker had informed the Psychologist that this was the case and he therefore did not consult with them.

6.2.2.9 K's victim could have been any member of the public. K was clearly warned of the dangers of excessive drinking associated with his known associated violence stemming from this and chose to ignore it.

6.2.2.10 All risk assessments appear to have been timely, but there appears to have been limited input specifically directed at risk reduction. For example, K's continued access to illicit substances whilst an in-patient and whilst detained under the MHA 1983, despite this being a known risk factor in his aggressive behaviour. Similarly, there appears to have been no challenge of his decision do turn down support from the DAS groups which he was offered.

*6.*2.3 To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;

6.2.3.1 The independent investigation panel believes that, by the time of discharge from the Halfway House on 24th Feb, the request by both GP and PO for a diagnosis and psychological and risk assessments had been achieved. K's response to care and treatment in the short term were disappointing and the Panel felt there was evidence that it would continue to be so in the future. The Panel felt the outcome to this date indicated that further valiant efforts by the Trust would do little to change K's behaviour or outlook. The panel felt K's management was, at this stage, in need of a response from the criminal justice system's processes and procedures. The Panel concurred with the Care Coordinator, that the CMHT was not an 'appropriate means of monitoring people with a forensic history'. Within this context, Link Workers, who were not professionally qualified mental health care workers, appear to have carried a certain amount of responsibility for his management such as trying to ensuring he attended appointments.

6.2.3.2 Prior to clarification regarding diagnosis K's treatment and care was hindered by the lack of a clear diagnosis or diagnoses and their complexity. There were provisional diagnoses of: development disorders (ADHD, Asperger's Syndrome, Tourette's Syndrome); multiple substance abuse, including alcohol, and drug-induced psychosis; of personality disorders

(Dissocial Personality, Anti-social Personality with Schizotypal features). The External Review Panel considers that too much attention was paid to the confirming the developmental disorders with insufficient focus on the personality difficulties and substance misuse.

6.2.3.3 The Consultant Psychiatrist reported to the court that K was engaging reasonably well with a multi-professional assessment of his complex needs and had shown a good level of compliance with his care plans. This was not an accurate reflection of the situation. In interview, CP felt that some small steps had been made, with improved behaviour on some occasions, but in reality the underlying substance misuse, personality difficulties, and resorting to aggression when faced with any challenge or adversity remained key features of his presentation.

6.2.3.4 The Independent Investigation Panel agreed with the internal review report observation that, had K stayed longer on the PICU, this would have facilitated clarification of diagnosis and risk management. In turn this may have changed the management plan with respect to the involvement of the Community Forensic Team, MAPPA and probation service. Section 2 of the Mental Health Act 1983 enabled up to 28 days to assess him whilst detained. Unfortunately this opportunity was not taken - returning him to lesser observation and granting leave did little to aid the assessment process although it did confirm his chaotic drug and alcohol dependent outlook.

6.2.3.5 There was evidence of disagreement when K was an in-patient, in that nursing staff wished to impose firmer boundaries, with the Consultant Psychiatrist taking the view that K needed some flexibility to encourage him to engage with mental health services. There is no evidence that this disagreement was resolved. In the event, K largely abused the flexibility that was offered; and when attempts were made to be firmer, setting and maintaining clear boundaries, services struggled to manage his aggressive reactions

6.2.3.6 The Consultant Psychiatrist's therapeutic optimism should have been tempered with the knowledge of K's disruptive behaviour in the community – but he did not have the full information on this. K's abnormality of mind, namely psychopathic disorder, should have been the focus of planning the management of risk rather than the identified developmental disorders.

6.2.3.7 K was clearly a complex service user with a range of treatment needs many of which appeared to have lain outside the normal remit of general adult mental health services. Despite this complexity, the mental health services did attempt to help K whose chaotic life-style and limited ability to rationalise his life events were his downfall. There were failings in managing his behaviour, which were not an exclusive responsibility of this one service. It is probable that such a serious adverse event would have occurred in time and the only possibility of avoiding this was for him to have been detained via a custodial sentence with a transfer direction to a secure hospital in order for long term continuing treatment with the hope of improvement.

6.2.3.8 There was a lack of written clarity in relation as to the purpose of acceptance to the Trust's services which could be enacted upon by nursing staff and other care workers. Plans that were made were not followed through or enforced e.g., conditions of leave or acceptable behaviours on the ward.

6.2.3.9 There were several references in the records to the possibility that K would be recalled to prison following his release on licence in May 2005. Failing this recall, a range of options for the disposal of K should have been included in the Consultant Psychiatrist's report to the court in respect of sentencing for the September 2005 charge for ABH. These options, for consideration by the Court, should have ranged from the Community Rehabilitation Order, to a Hospital Order in a secure setting, to a custodial sentence with the option of a transfer direction from prison for treatment and return to the prison estate if he was deemed untreatable.

6.2.3.10 The Care Coordinator reported that at the time of the Trust's involvement with K it had been difficult to collect information together from the myriad sources of paper documentation. Now that the electronic system is in operation it is much easier to find and consequently to get a clearer picture.

6.2.4 The Mental Health Act assessment process

6.2.4.1 K was detained under Section 2 of the MHA for assessment and observation in October 2005. He was an in-patient at the time of the MHA assessment process, but was not complying with his care plan. He had been taking unauthorised leave from the ward, accessing illicit drugs and alcohol, brining drugs onto the ward and giving them to other patients, and returning to the ward under the influence of a range of substances in a volatile and abusive mood.

6.2.4.2 The Panel found that the process was appropriate and timely, given the difficulties faced by the ward staff. The process was carried out correctly. Unfortunately, the service did not take advantage of their powers, continuing to allow him leave which he continued to abuse. Although he was moved to a closed ward, this was only for two days. He was discharged from the Section 2 detention after 21 days (28 days detention was permitted.) So again, a plan, in this case for assessment, observation and clarification of his diagnosis without the influence of illicit drugs and alcohol, was not followed through.

6.3 To examine the role of the care coordinator and the interrelationship between the various teams within the Trust with whom he had contact with and the appropriateness of their involvement or response to referrals, e.g. Crisis Team, Community Forensic Team, Support Team Recovery Workers and CMHT.

6.3.1 There were a number of examples where interrelationships between the various teams were not as effective as they might have been, in particular breakdowns in communication were seen.

6.3.2 Prior to his appearance in court for the assault in September 2005 the social work student had taken up the possibility of the Community Forensic Psychiatrist seeing K. He informed her he would respond if the Court, K's solicitor or Consultant Psychiatrist asked for an opinion for this particular offence and surrounding issues. This conversation was not communicated to anyone else and was not therefore considered for action.

6.3.3 Referral to the Community Forensic Team should have been made at consultant to consultant level and a discussion between them could have taken place on any proposed disposal at court, including future plans for continuing or terminating the Trust's involvement. The Forensic Clinical Psychologist could have referred the request to him to the Team for multi-disciplinary consideration.

6.4 To examine the role of the various agencies involved in his care following his release from prison in 2005, including probation and their collaboration with the Trust.

6.4.1 It is important to draw the distinction between the role of the Probation Officer and the clinical work of the Trust's staff. As the Probation Officer's role was that of demonstrating that they took, "all reasonable action" to keep risk of harm in general to a minimum and that they are expected to make restrictive interventions to achieve these purposes and that of the Trust which is required to achieve treatment in the least restrictive environment in a proportionate manner.

6.4.2 The probation officer and therefore the probation service missed the mark with the supervision of K and the Trust missed the opportunity to assess him when detained and transferred to the Intensive Care Unit thereby possibly achieving their stated aim of the assessment of K drug and alcohol free. He would not have been allowed to come and go in a way which gave him control of his behaviour when receiving inpatient care from this unit. The same behaviour occurred when at the rehabilitation facility which finally led to his discharge from it.

6.4.3 The interviews of the Probation Officer and Care Coordinator indicated that neither knew the full picture (nor did the Trust's staff in the preceding five months prior to the appointment of the Care Coordinator) of the detail of K's previous offending behaviour or when he was being voluntarily assessed and supported by the Trust. For example, there were assumptions on the part of the PO that, when K was an in-patient he would be on the ward being monitored – she was not aware that he was being given leave which he regularly abused, and was accessing alcohol and illegal substances. She was under the impression that he was responding to treatment, which is her rationale, given in interview, for not recalling K to prison from his licence. Similarly, the Care Coordinator (and other members of the mental health team) were not fully aware of the details and severity of his offences.

6.4.4 The responsibility for the management and supervision of K fell within the domain of the local Probation Service and the MAPPA arrangements at the time. The Mental Health Trust was asked to help the supervising Probation Officer establish a confirmed diagnosis and risk assessment which in turn would inform MAPPA and the courts. However, the main responsibility for the supervision of K appeared to fall to, or was taken on by, the Trust for the significant majority of the twelve plus months they provided voluntarily care and support to K.

6.4.5 The last recorded MAPPA meeting took place on the 1st of February 2006, eight months before the homicide. The record notes that the PO was preparing the recall paperwork: K was going to be recalled and she was looking at where he was to be recalled to. She then advised in the same meeting that she was intending to recommend the therapeutic route for his sentence (when he appeared in court). This contradiction is difficult to understand and was not challenged within the meeting.

6.4.6 If K had been recalled to prison, as a minimum this would have enabled more permanent housing arrangements to be established and supervision by the appropriate agencies determined with a clear plan of what would be available to support him on further release.

6.4.7 However, discussion with her manager had concluded that they would not initiate recall proceedings, on the grounds that he was making progress. This decision was not communicated to Trust staff – if it had been, there might have been an opportunity for sharing of information about the real status of his progress. Any impetus then evaporated in the MAPPA planning of this case.

6.4.8 The admission of K was not accompanied with the detail from the Probation Officer of his offending behaviour and in particular the Wounding offence for which he had received a lengthy custodial sentence prior to his admission. Without this detail the Trust could only concentrate on diagnosis issues and behaviour as it presented itself.

6.4.9 The Probation Officer should have been more assertive in her engagement with the Trust's Consultant Psychiatrist regarding attendance at Ward Rounds and other planning opportunities. Discussion concerning the approach to be taken in the pre-sentencing reports (for the ABH charge), could have involved a meeting of those concerned to discuss their differing views –considering the time taken to produce them. *(Contributory Factors, PG rpt p. 53)*

6.4.10 There was poor communication between the Care Coordinator, appointed some five months into K's involvement with the Trust and the Probation Officer in terms of joint knowledge of K's behaviour. His PO reported that it was not until she saw the NFHT internal review report that she realised how much information she did not have. His Care Coordinator, gave her opinion that the two function of care coordination and probation supervision did not gel together, and that they struggled. Given the information gaps between services within NFHT and between NFHT and the Probation Service, professionals from both agencies were over-reliant on K's own version of events which often did not reflect the perceptions of staff working with him. They were unable to cross-check K's accounts against other parties' knowledge of his history.

6.4.11 There was a further lack of recognition of K's lack of poor meeting of the reporting requirements of the Community Rehabilitation Order following his sentence of Actual Bodily Harm some six months prior to the homicide. *[Findings PG rpt p.54].* Mental health services were not supported by the Probation Service in respect of K's several breaches of the conditions of his CRO. These included: conditions of residence (loss of his accommodation at the Halfway House); failure to engage with the care package (missed appointments); failure to comply with PO supervision (missed appointments, failure to inform her he was going away for a week); and behaviour which was not in the spirit of the CRO (continued use of illicit drugs and misuse of alcohol). The mental health professionals could have expected that his behaviour would trigger a more assertive response, which could have included a referral back to the courts for re-evaluation of his disposal.

6.4.12 It was reported that, following the homicide, a 'full case review' had been held where the chronologies held in probation's records were examined in depth with the findings submitted to the regional offender manager. The resulting action plan was implemented.

6.5 To examine the effectiveness of the MAPPA process in the management of K

6.5.1 This section deals with the effectiveness of the MAPPA process from the perspective of the mental health service professionals.

6.5.2 The referral to the Probation Service and MAPPA with only a few weeks notice of release from YOI and given his complex needs was badly timed considering the length of

his sentence. There would have been a greater chance of obtaining accommodation if a referral had been made to MAPPA some six months or so earlier.

6.5.3 There was an opportunity here, in addition to holding the clinical meeting to consider the requirements of the Care Programme Approach, to hold the MAPPA meeting in the same setting and agree risk assessments, exchange information and agree any planned action. In the case of K, if the Care Programme Approach had been regular and attended by the appropriate clinicians involved then the police and probation could have been represented by the MAPPA Manager and the probation officer alone. This formula would not necessarily suit all cases but those such as K could be considered, especially when an inpatient or receiving a consistent majority input of effort from the Trust. It is a case of lateral thinking rather than being constrained by set procedures and one location. Such an approach does not have to be without agreed formats, but may put the correct people together at a more appropriate location. The Probation Officer recalled being the only person who attended for one MAPPA meeting concerning another case. It was only toward the end of MAPPA management of K that the Consultant Psychiatrist was to be invited to a meeting. After this decision in fact, no further MAPPA meetings took place so there was never an opportunity for the CP to contribute to the MAPPA process. It should be noted that MAPPA was in relatively early stages of development at this time.

6.5.4 The lack of information sharing between Care Coordinator, PO and CP, was a testament to the extreme lack of communication or understanding of the crucial nature of K's behaviour. The MAPPA coordination of his risk and offending did not facilitate such communication at this time. The Consultant Psychiatrist reported in interview that he was trying to provide a therapeutic 'still centre' in the chaos of K's life, in the hope of some more stable future and expectation that the role of the criminal justice system was draw the line on attempts to help him and impose sanctions. He did not however have all the information about K's offending behaviour and behaviour in the community, therefore he was not fully able to accurately consider the risk to the public K posed

6.5.5 The (June 2006) (pre-sentencing) report to the Crown Court (regarding the Robbery/ABH offence), by the Consultant Psychiatrist, in the opinion of the Panel offered a diluted picture of K's propensity for out of control behaviour, fuelled by drugs and alcohol, coupled with his developmental deficits and homelessness which were a potent mixture in this man's presentation and potential for violent responses. The Consultant Psychiatrist had not been fully informed of the detail of K's previous offending and low-level, although worrying, problematic behaviour in the community.

6.5.6 The Trust's staff attending the MAPPA meetings concerning K were the wrong staff. The appointment of a Care Coordinator some five months later when K had been discharged from hospital and the rehabilitation facility was incomprehensible and therefore they played no part as the gatherer of information from the multiple, differing groups of staff and acting as the conduit of such to other agencies. This led to a disjointed approach

commencing with admission and gaps in the collective knowledge of K's behaviour when not directly supervised. The Care Coordinator would have been the expected representative from the Trust at MAPPA meetings. Instead a forensic principal social worker attended from the team which had declined to become involved with K. Indeed the Forensic Community Psychiatric Nurse who had attended a discussion with the ward based clinical leader and had declined to become involved with K also attended the final MAPPA meeting.

6.5.7 Some three weeks after this last recorded MAPPA meeting K was discharged from the rehabilitation facility for the violent attack on a fellow patient and was homeless. The Probation Officer, Link Workers and the TLT were notified. This discharge and homelessness significantly changed K's risk status and, despite a short stay with his mother which ended badly, the problems of homelessness would re-stress K who descended into alcohol and drug abuse. This should have triggered another MAPPPA meeting to re-assess their plans for managing this period.

6.5.8 The poor application of the MAPPA process operating at that time and planning to meet the risk posed by K was unfortunate, as was the uncertainty as to his status relating to recall to prison, which was awaited by the MAPPA membership. A decision was made within the Probation Service not to institute recall proceedings, but this was not clearly communicated to MAPPA or the Trust.

6.5.9 The role of the Probation Service is inherently different from that of NHS Mental Health Services and the Trust struggled to hold K consistently in a voluntary therapeutic approach. The Probation Service and MAPPA should have taken the lead in protection of the public and were perceived to have in that expectation.

6.5.10 The failings in communication noted above also illustrate the inadequate workings of the MAPPA arrangements at this time. K was managed under Level 2 arrangements, in which there should be a permanent membership of all local agencies which have an active role to play in managing risk – it is clear that this was not the case as far as mental health professionals were concerned, in the MAPPA arrangements responsible for the management of K.

6.5.11 During the investigation number of interviewees reported that communication and co-operation with the police continues to leave room for improvement.

6.5.12 The independent investigation panel have, however, been assured by the County Constabulary and Probation Trust that the MAPPA function was much improved. It is not within the remit of this panel to consider these assurances.

6.6 To establish whether the recommendations identified in the Trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response to these recommendations.

6.6.1 The internal investigation was undertaken by the Medical Director, Director of Mental Health Services, a Consultant Psychiatrist and an independent Consultant Forensic Psychiatrist member. They found that, *"K was clearly a complex service user with a range of treatment needs many of which appeared to remain outside the normal remit of the general Adult Mental Health Service. Despite this complexity, the Mental Health Services did try to offer support and assistance to him.*

6.6.1 *There is good evidence to show that the majority of workers involved with K did their utmost to try to engage, care and support him. There were systematic failings which had detrimental effect on the care given to K. It is possible however that a serious adverse event of this nature may still have occurred even if the identified problems had been addressed."*

6.6.1 Identified failings were:

- "*There was a lack of clarity in relation to the purpose of admission.*
- *Plans were not carried through e.g. conditions of leave, PICU stay.*
- *The lack of clear engagement from the Community Forensic Team.*
- *The conflict between the reports for the 21st September offence.*
- *The lack of recognition of K's poor engagement following implementation of the Community Rehabilitation Order.*
- *The poor application of the MAPPA process and probation engagement.*
- *The Care Coordinators role and function"* (vis-a-vis the probation officer).

6.6.2 The Internal Review's Recommendations The independent investigation agrees with the 19 recommendations contained in the internal review report and considers that these were appropriate. Broadly, these recommendations were:

- *There should be handover meetings between clinicians before transferring patients between wards and units, which clearly specifies the reason for and the expected outcome of the transfer. This should be achieved through a multi-disciplinary care-planning meeting between key staff from both units prior to transfer taking place and the outcome of this recorded in the Single Clinical Record."* (Recommendation 3).
- *"The purpose of leave should be clear within the care plan and action to be taken where conditions for leave are not taken."* (Recommendation 4).

- *"The Trust should ensure that the multi-disciplinary teams (inpatient and community) are responsible for the full completion of the risk screening assessment upon admission, in order to inform the risk management record in line with the Trust's service user risk management policy."* (Recommendation5).
- *"Medical staff should be trained to use the Trust's Risk Assessment tools and e-PEC (the then recently introduced electronic integrated record system) and as part of their training this must become mandatory. All staff should be aware of the electronic systems warning indicators and ensure they are completed when a risk is identified and these should be regularly reviewed."* (Recommendations 6 and 7).
- *"All referrals to the Community Forensic Team (CFT) should be in writing, detailing expectations of the referral and include an up to date care plan, risk assessment and clinical summary….an entry in the notes should be made following any assessment made by the CFT in the Single Clinical Record. The ability to have an informal discussion and seek advice with members of the CFT should remain available"*. (Recommendation 8).

6.6.3 Recommendations 9, 10 and 11 refer to a review of the Community Forensic Team and its management, supervision and location arrangements and the usefulness of HCR-20 and similar risk assessment tools in the management of high risk patients.

6.6.4 One of the key recommendations is Number 12. This states, *"There should be clear policy guidance for Trust staff with regards to their respective roles and responsibilities whilst members of MAPPA or any other related group. The Trust should request that the overseeing strategic body for MAPPA should review the system and offer training and support to all who attend. There should be clear rules of engagement created to ensure a seamless pathway."*

6.6.5 The training of Care Coordinators in their role and core competencies was Recommendation 13 and was indicated as a future requirement in the review of CPA in 2008.

6.6.6 The remaining recommendations concerned referral routes with an acknowledgement that multiple referrals lead to confusion if not coordinated. There was recognition of the timing of the allocation of the Care Coordinator.

6.6.7 The Action Plan of the Internal Review Report The Trust provided the independent investigation panel with their coordinated response to the recommendations made in the internal review report which was signed off as completed. The following table includes signification action points, along with evidence (or otherwise) of implementation.

Action Point	**Implementation**
All requests for acute admission to hospital are to be referred to the Crisis Resolution Home Treatment Team (CRHT) to allow a multidisciplinary assessment of the needs of the service user and now provide all relevant information, both in writing and verbally to the admitting unit and doctor with entry to the Single Clinical Record. (Recommendation 1).	A quality service evaluation report dated January 2010 noted that now 95% of all patients are offered this service.
All referrals to the Community Forensic Team to be made in writing, detailing the expectations of the referral and include an up to date care plan, risk assessment and clinical summary. Informal approaches to the CFT are encouraged but no referrals are now accepted verbally. (Recommendations 8, 9, 10 and 11)	A review of the management arrangements has taken place with a management structure in place with an accompanying supervision schedule. The whole forensic service and staff from other teams attended HCR-20 training sessions in early 2009 with follow up sessions. Security Needs Assessment Profile (SNAP) training has been given which helps determine the level of security needs to inform placement decisions. In determining more roundly a patient's care, social, support and accommodation needs the Recovery Star assessment tool is also available to team members when undertaking fuller needs assessment in addition to risk assessment.
Clear policy guidance for Trust staff with regards to their respective roles and responsibilities whilst members of MAPPA or any other related group to be produced. The Trust should request that the oversseeing strategic body for MAPPA should review the system and offer training and support to all who attend. There should be clear rules of engagement created to ensure a seamless pathway. (The central Recommendation 12)	On examination of the response to this recommendation the independent investigation panel were provided with an update document in which the author states, *"I have identified a written policy* (undated and no author) *regarding MAPPA panel representation for trust staff, but I cannot identify, as yet, an electronic copy or one on the intranet."* A detailed examination of this paper was undertaken. Its status is unclear. It describes the function of MAPPA, the three categories of offender and levels of risk management. It further describes the 'duty to cooperate' on a number of key agencies including the NHS and

	Local Authorities and in particular that the Responsible Authority and the 'duty to cooperate' agencies must set out the ways in which they are to cooperate in a memorandum which they must draw up together. A list of attendees for MAPPA training in January 2010 was provided and out of 34 staff present only 3 were from the Trust with the police having 11 places, Probation 8, the Prisons 6, Housing 3 and Social Services 2. The need for staff of the Trust to receive such training needs quantifying and a programme developed for them.

6.7 Overall Conclusions

6.7.1 The victim's death was not predictable. The mix of individuals consuming large quantities of alcohol together was a potentially violent scenario coupled with K's known aggressive loss of control when intoxicated.

6.7.2 Despite a well funded care plan with specialist help from the National Autistic Society all of this could not ensure an enduring remission which further led to relapse into alcohol and drug intake. A few days of relapse into previous styles of living resulted in a scenario when he was once again in a vulnerable situation from which he could not extricate himself. Along with his difficulties in coping with his anger and stress induced by drunkenness and arguments, he responded with extreme violence.

6.7.3 This external review , into the homicide by K and the events prior to it, is dominated by the complex issues of a multiplicity of diagnoses and their authenticity, how they were responded to and the management of his offending behaviour. K was a challenge to multi-agency working and continues to be so in his current secure hospital setting by presenting similar long term behavioural challenges. The description of his disposal at the trial and the difficulties he continues to present in his current specialist secure placement (Para 4.1.5) helps demonstrate the complexities faced by the Trust's general mental health services, prior to the homicide.

7 Recommendations

7.1 If MAPPA is the chosen vehicle of the main multi-agency planning for such individuals outside that of the multi-disciplinary care team planning of the Trust's mental health services then there needs to be a clearly established agreed set of activities underpinning and holding this process together which are understood and enacted by the entire clinical and care staff of the Trust.

7.2 It was out-with the independent investigation panel's remit to consider how this element of public protection operates, although we received verbal assurances from the County Constabulary and Probation Trust that this function was much improved.

7.3 The panel heard from individual practitioners that issues of confidentiality made the exchange of information cumbersome and untimely and that some key individuals felt overlooked in this process. There was poor communication with the Trust concerning K's criminal behaviour and in particular the detail of the violent assault for which he had been sent to prison and which he was subject to supervision on release.

7.4 We believe that the Board of the new NHS Foundation Trust should undertake a thorough review of the Trust's contribution and operational support to the MAPPA function to reassure itself that it is indeed operating at a coherent level. The Trust may wish to consider this being chaired by a non-executive Director

7.5 The Trust should undertake a thorough review of policy and working relationships with the County Constabulary, Probation Trust and other major stakeholder agencies paying particular attention to:

- The role and function of officers and staff allocated to the liaison and operational inter-agency function of Public Protection through the MAPPA process.
- The review of all existing protocols and agreements currently operated between the police, other agencies and the Trust relating to the sharing of information.
- To describe in one document, which can be used as staff information and development purposes, the processes adopted by the main agencies involved in MAPPA arrangements and how these services are accessed by referral.
- To ensure that senior clinical staff and managers are all aware of the elements of MAPPA's role and function which affect their practice and receive appropriate guidance of actions to be taken.
- To agree how the flow of information will be coordinated in a timely, accurate and comprehensive manner between agencies.

- Those staff with a role to play in the MAPPA system should have this identified in their job descriptions which in turn should be subject to supervision and review

- Patients subject to MAPPA arrangements should have a clearly identified entry field on the e-pex Single Clinical Record with the relevant information to be contained within it decided upon by the Trust

7.6 The Trust should devise an annual audit of the activity of its staff in these processes and report the outcome to the Board.

July 2011

8 Appendices

Appendix One: Staff interviewed and documents reviewed

Interviews were held with the following:

- The Consultant Psychiatrist from NFHT who assessed and treated him as an inpatient and continued to offer out-patient support.
- The NFHT Care Coordinator appointed under the auspices of the Care Programme Approach.
- At his own request, one of the clinical psychologists (forensic) from NFHT who assessed K.
- K's current Responsible Clinician from NFHT was seen at K's current secure psychiatric hospital placement.
- The Probation Trust Team Manager who supervised K's Probation Officer

The following key documents were reviewed:

- 'The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation', National Patient Safety Agency, (NPSA).
- 'Review into the Care and Treatment of K', STEIS REF 2006/7579, Northamptonshire Healthcare NHS Trust, 9th July, 2008.
- 'Independent Psychiatric Report regarding K', Secure Centre for Forensic Mental Health.
- The independent psychiatric report provided to the Crown Court for sentencing produced by a Professor of Forensic Psychiatry
- The independent psychiatric report produced by a Consultant in Developmental Psychiatry.
- The evidence given to the sentencing court and the judges observations.
- The full clinical notes and correspondence held by the Trust.
- Psychology reports.
- The pre- sentencing report provided to the court by Probation and the treating Consultant Psychiatrist for K's appearance on the charge of ABH.
- The full clinical notes and correspondence held by the secure hospital currently containing K
- Correspondence between services providing different levels of security concerning the current and future placement of K post sentencing for the homicide.
- MAPPA minutes.

Appendix Two: Members of the External Review Panel

Dr. Colin Dale has been an Executive Nurse in three NHS Trusts; has worked as a professional adviser to the Royal College of Nursing (RCN), National Institute for Mental Health in England (NIME), National Patient Safety Agency (NPSA) and the Dept of Health. He has successfully worked on a large number of projects in recent years. He is currently the Vice Chairman of a NHS mental health foundation trust and has functioned as an executive Director of Nursing with three previous NHS Trusts for a period spanning 11 years. He continues to work on a freelance basis as an independent Nurse Consultant and expert witness, combining this work with research and writing. He has worked on several previous mental health inquiries.

Dr Michael Rosenberg was previously the Consultant Psychiatrist, Inpatient Triage, South Downs Health NHS Trust (a new post involving the assessment and care of newly admitted patients for the first seven days of their care episode). Between 2003 and 2006 Michael was the Chief Executive and Honorary Consultant Psychiatrist South Downs Health NHS Trust; a Trust where he had previously been the Medical Director between 1998 and 2003. Michael was responsible for the Psychiatric Intensive Care Unit at Mill View Hospital from 1999 to 2005 (a modern 10-bedded unit caring for acutely mentally ill patients, requiring short-term intensive treatment). He is approved under Section 12(2) of the Mental Health Act 1983. Michael has extensive experience of the investigation of critical incidents and advised on the management of complaints in his Trust. He was the lead director for the Trust Patients' Advisory Forum and responsible for developing the Trust Strategy for Patient and Public Involvement.

Peter Green is a qualified psychiatric social worker and general manager with significant experience as a senior executive in local government, the National Health Service, the Mental Health Act Commission and latterly independent psychiatric hospital provision and consultancy. Peter was the principal social worker at St. James's University Teaching Hospital, Leeds and has worked in all three high security hospitals, as a senior practitioner at Rampton Hospital, the head of social work services at Broadmoor Hospital and the Director of Rehabilitation and General Manager at Ashworth Hospital. He has considerable expertise in the assessment of mentally disordered offenders and evaluation of service delivery. He has aided the administration of two public inquiries.

Appendix Three: Criminal Justice Services

Background to MAPPA

Multi-Agency Public Protection Arrangements is a set of arrangements established by police, probation and the prison service (known as the Responsible Authority) to assess and manage the risk posed by sexual and violent offenders. Other agencies that co-operate in MAPPA include youth offending teams, Jobcentre Plus, local education authorities, registered social landlords, social services, strategic health authorities, NHS Trusts and electronic monitoring providers.

The principles that govern MAPPA are simple:

- Identify who may pose a risk of harm.
- Share relevant information about them.
- Assess the nature and extent of that risk.
- Find ways to manage that risk effectively, protecting victims and reducing further harm.

Central to all risk management is the need to consider the protection of previous and possible future victims. As part of any risk management strategy it may be considered necessary for information to be disclosed directly to others by the police in order to prevent harm, such as new partners, landlords, and other agencies.

A Strategic Management Board monitors and reviews how these arrangements are working in each local area. Chaired by a senior representative of the police, probation or prison service, the Board includes senior representatives of other agencies. Each Board has two members of the public appointed by the Secretary of State, to act as lay advisers in the review and monitoring of the arrangements and to help improve links with communities.

Revised guidance issued by the Home Office and National Probation Service relating to sections 325-327 of the Criminal Justice Act 2003, resulted in guidance which identified the following features of good practice crucial to the effectiveness of public protection.

- Defensible decision making in the assessment and management of risk.
- Rigorous risk assessment and the importance of the victim focus of MAPPA work.
- Robust risk management in coordinating the work of each agency and integrating work to promote the offenders' self management.

Guidance identifies three categories of offenders who are subject to the MAPPA process, and emphasizes the importance of identifying them promptly and accurately:

- Category 1 – Registered sex offenders who have been convicted or cautioned since September 1997 of certain sexual offences and are required to register personal and other relevant details with the police in order to be monitored effectively. The police have primary responsibility for identifying category 1 offenders.

- Category 2 – Violent and other sex offenders receiving a custodial sentence of 12 months or more, since April 2001, a hospital or guardianship order, or disqualification from working with children. All these offenders are subject to statutory supervision by the National Probation Service and consequently probation is responsible for identifying Category 2 offenders.
- Category 3 – Other offenders who are considered by the Responsible Authority to pose a "risk of serious harm to the public". Identification is largely determined by the judgment of the Responsible Authority, based on two considerations :

The offender must have a conviction that indicates that he is capable of causing serious harm to the public.

The Responsible Authority must reasonably consider that the offender may cause harm to the public. The responsibility of identification lies with the agency that deals initially with the offender.

Below these categories an operational structure was created to ensure offenders were managed according to their assessed risk and risk management needs. In brief the structure is:

- Level 1 (Ordinary risk management) – Where the agency responsible for the offender can manage risk without the significant involvement of other agencies – only appropriate for Category 1 and 2 offenders who are assessed as presenting low or medium risk.
- Level 2 (Local inter-agency risk management) - Where there is "active involvement" of more than one agency in risk management plans, either because of a higher level of risk, or because of the complexity of managing the offender. The essential feature of Level 2 arrangements is that their permanent membership should comprise those local agencies which have an active role to play in risk. (**K was managed under the Level 2 arrangements)**
- Level 3. Those offenders defined as the "critical few" who pose a high or very high risk. Level 3 cases can be 'referred down' to Level 2 when risk of harm deflates.

The quality of both risk assessments and the risk management plan are heavily determined by the effectiveness of information sharing arrangements. The Responsible Authority also has a clear duty to share relevant risk assessment information and that the risk identified is managed robustly. This means that the Responsible Authority must seek to ensure that strategies to address that risk are identified and plans developed, implemented and reviewed on a regular basis. Those plans must include action to monitor the behaviour and attitudes of the offender and to intervene in their life in order to control and minimise the risk of harm.

However the ability of the Responsible Authority to ensure robust management is thought to depend on a number of factors. Case specific detail such as the nature and severity of risk posed and the factors that may trigger reoffending behaviour, the attitude of the offender and

whether any statutory powers exist to modify or contain behaviour are all highly relevant in determining what risk management options are appropriate. So too is the engagement of the range of agencies that are able to make a specific contribution to the development of appropriate strategies and to directly manage elements of the risk management plan. It is believed that the strongest examples of MAPPA development reflect the ability of the Responsible Authority to engage other agencies.

The Guidance states that key to the effectiveness of Level 2 and 3 arrangements are the multi-agency representation and involvement. In determining the level of the representation and the nature of that involvement three factors must be considered. First, the representatives must have the authority to make decisions committing their agency's involvement. If decisions are deferred then the effectiveness of the multi-agency operation is weakened. Secondly, they require relevant experience of risk/needs assessment, management and the analytical and team playing skills to inform deliberations. Thirdly, the effectiveness of Level 2 and Level 3 arrangements depend in a large part upon establishing continuity. Multi-agency work is often complex and benefits greatly from the continuity of personnel and their professional engagement.

The Role of the Probation Service and supervising Probation Officer

There is a general criminal justice purpose which means that the supervisor must make the individual less likely to reoffend while also implementing diligently the sentence of the Court.

One of the defined outcomes of public protection is that practitioners can demonstrate that they took, "all reasonable action" to keep risk of harm in general to a minimum. Probation Officers are expected to make restrictive interventions to achieve these purposes. Probation's original remit was, "to advise, assist and befriend" but since 2001 this has changed to, "punish, help, change and control" within the broader National Offender Management Service. The supervising probation officer is an offender manager in the new terminology.

Recall to Prison

When an offender under supervision is charged with an offence committed whilst on license consideration must always be given to whether there has been a breach of the good behaviour condition and if so whether it is sufficiently serious to warrant recall. When considering breach action the probation area should disregard the charge, any plea and whether the offender has been remanded into custody and instead focus upon:

- The behaviour of the offender surrounding the incident that resulted in the charge being made.
- Whether the new offence is similar to the one for which the offender is on license and was originally sentenced.
- Whether the new offence indicates any rise in the level of immediacy of the risk the offender presents to others.

If having considered all available information the supervising officer considers that on balance there has been a breach of the good behaviour condition the presumption must be to request recall. The only exception is where the breach is considered to be sufficiently minor as to warrant a warning.

Appendix Four: The Care Programme Approach

One of the Terms of Reference was to consider this cornerstone of practice within mental health services.

The Care Programme Approach (CPA) was introduced in 1990 as the framework of care for people with mental health needs, originally intended to be implemented by April, 1991 and to run in parallel with the Local Authority Care Management system.

The CPA was revised and integrated with Care Management in 1999 to be used by health and social care in all settings, including inpatient care.

Two tiers of CPA were established: Standard and Enhanced.

Standard was described as being for those people whose needs could be met by one agency or professional worker.

People on Enhanced CPA have multiple needs which are more likely to be met by inter-agency co-ordination and co-operation. There is likely to be a higher element of risk and disengagement from services. A Care Plan was to be developed to address those needs. A key worker or Care Coordinator was to be appointed and regular review was to take place making changes to the plan to reflect changing need.

(A new system for conducting CPA was implemented in October, 2008 (this was not within the time frame of K) however it restated that the role of the Care Coordinator was vital.)

Appendix Five. Abbreviations and descriptions

Abbreviation	Meaning and description
CAN	Council on Addictions Northamptonshire (CAN is CAN is an independent regional agency, first established in 1972. CAN provide a range of drug, alcohol and homelessness services throughout Northamptonshire and Bedfordshire.)
CJT	Criminal Justice Team (service provided by NFHT)
CNW	Complex Needs Worker
CP	Consultant Psychiatrist
CPA	Care Programme Approach (See Appendix Five for details)
HMYOI/YOI	Her Majesty's Young Offenders' Institution/Young Offenders' Institution
ISA	Initial Screening Assessment Team, whose role was to 'triage' all referrals to identify the most appropriate pathway.
LWS	The Link Worker Scheme was a partnership between Revolving Doors Agency, Northamptonshire Healthcare Foundation Trust and a charity, P3, which offers practical and emotional support across the Criminal Justice System to people with mental health issues who have been arrested or imprisoned. The help those referred to access and engage with appropriate services, thereby trying to address their offending behaviour. There was a team of two, who were both based within the Criminal Justice Team of NHFT. The Link Workers were not qualified health care professionals. This service has now ceased.
LW	Link Worker.
MAPPA	Multi-Agency Public Protection Arrangements (See Appendix Four for details)
MSAADA	MSAADA Care Ltd, a private company which provides care homes for people with, amongst other things, drug and alcohol problems, learning difficulties and mental disorder.
NAS	National Autistic Society
NDAS	Northamptonshire Drug and Alcohol Service
NHFT	Northamptonshire Healthcare Foundation Trust
STRW	Support Team Recovery Workers
TAG	Threshold Assessment Grid (a structured risk assessment)
TLT	The Transition and Liaison Team supports secondary services in working with adults in transition between services. This includes young adults with Asperger's Syndrome, Tourette's Syndrome or Attention Deficit Hyperactivity Disorder (ADHD).