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INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care and treatment of Mr X

A report for NHS South East Coast

October 2010

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1. Introduction

1.1 Early on 23 August 2007 Mr X killed Mr A at Mr A's parents' home. At his trial he was found to be not fit to stand trial, by reason of his mental state, and detained in Broadmoor High Security Hospital under the Mental Health Act.

1.2 At the time of the homicide Mr X was 25 and living in a supported house run by a housing association. He was receiving mental health care from Sussex Partnership NHS Foundation Trust[1] (the trust).

Investigation methodology

1.3 The full list of interviewees is attached at appendix A. We also met Mr A's family and tried to keep them up to date with the progress of the investigation. We have reviewed all Mr X's clinical notes and have received considerable documentary information from the trust and the housing association. Mr X declined to meet us during the investigation but did review the final draft report. He then met with us and suggested a small number of factual amendments. We received full co-operation from interviewees and the trust and thank them for this.

1.4 We offered interviewees the opportunity to be accompanied and to comment on the factual accuracy of their interview transcripts or to add to them.

1.5 It is common to expect that when a mental health service user commits homicide there must have been a failure, either in the system or by one or more professionals. With hindsight, it is always possible to identify steps that could have been taken to avert the tragedy, but part of our task was to consider whether there were culpable failings in Mr X's care and treatment, which, if they had not occurred, might have led to a different outcome.

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[1] Sussex Partnership NHS Foundation Trust was established in April 2006 from the merger of three previous NHS organisations that provided mental health and related services in Sussex. The Trust became a foundation and teaching trust in August 2008.

Sussex Partnership provides services to people who are mentally ill, have serious learning disabilities or who misuse drugs or alcohol. It employs 4,800 staff, mainly nurses, doctors (all psychiatrists), psychologists, psychological therapists, occupational therapists and social workers. The partnership provides services, care and support to more than 60,000 people a year, with an annual budget of £230 million in 2009/10. Services are provided in hospitals, clinics, other community settings and in people's own homes.

Expert assessment

1.6 Mr X was closely monitored by those responsible for his care, with good record-keeping and evidence of thoughtfulness. We had therefore to evaluate the decisions made by the professionals treating him, to establish if they fell within the bounds of reasonable professional judgment or if they provided evidence of sub-standard care and treatment.

1.7 To help us in this task we contacted three professionals also working on the south coast, who we considered were used to dealing with a population similar to that of the trust and who could therefore speak from similar experience. Expert advice was given by Dr Lindsey Kemp, a consultant psychiatrist and clinical director; Nicholas Whiting, a Mental Health Act approved social worker; and Rachel Turpin, an occupational therapist who was also a care coordinator. We provided the group with a detailed 67-page chronology and a letter of instruction setting out the questions we wanted them to address. We then met them to explore the matters of professional judgment we had identified. We found this opportunity to test our thoughts and initial conclusions invaluable.

Structure of the report

1.8 We have used the terms of reference to structure this report.

1.9 Our findings from interviews and documents are sent out in standard text. Comments and explanations are in bold italics. Quotations from interviews and evidence are indented and italicised.

People and places

1.10 We list below some of the people who had significant involvement with Mr X (in alphabetical order) and we list the organisations and places where Mr X lived. These are given at this stage to help the reader follow the chronology and details of the report.

Psychiatrist 1 worked for the trust in various locum positions between September 2003 and November 2007. He was the staff-grade psychiatrist working in the recovery team and the assertive outreach team (AOT) from October 2006, and met Mr X once when he

assessed him in August 2007. He had been trained and authorised to assess whether an individual met the criteria for compulsory detention under the Mental Health Act.

Psychiatrist 2 was Mr X's consultant psychiatrist from February 2002 to the time of the homicide. He worked for the trust and its precursors for about 25 years and at the time of the homicide was working in rehabilitation, assertive outreach and recovery services within the trust. He was also trained and authorised to assess whether an individual met the criteria for detention.

Occupational Therapist 1 was Mr X's care coordinator from June 2006 to the time of the homicide. He qualified in 1999 as an occupational therapist and worked for five or six years mainly in forensic settings before joining the assertive outreach team (AOT)/recovery team in about 2002. The joint AOT/recovery team split in October 2004. Occupational Therapist 1 stayed with the recovery team after the split. He had had previous forensic experience in medium secure units, where he undertook risk assessments and care planning as part of his work. He told us that one of the key roles of an occupational therapist (OT) in those environments is community work and that OTs take a lead on risk assessment and working with risk because they work one to one with people of recognised high risk in the community. At the time of his involvement occupational therapists were not trained or authorised to assess whether an individual met the criteria for compulsory detention.

Mr X's maternal grandmother and her husband (now deceased) brought Mr X up.

Mr X's mother lives in another county approximately 80 miles away from Residential Home 3 with her husband and two young daughters, Mr X's half-sisters.

The social worker is a senior social worker from the recovery team and met Mr X once, when she visited him on 15 August 2007 at Residential Home 3. She was trained and authorised to assess whether an individual met the criteria for compulsory Mental Health Act detention.

The team leader is a senior social worker. She was the leader (formally the team coordinator) of the recovery team while it was responsible for Mr X. She had not met him but knew about him from formal weekly team meetings and informal meetings throughout

the week. She was also trained and authorised to assess whether an individual met the criteria for compulsory detention.

The following organisations were involved in providing community support to Mr X

The assertive outreach and rehabilitation team took responsibility for Mr X's care in 2002, when he was referred to Psychiatrist 2, until it was split into the assertive outreach team and the recovery team.

The recovery team was responsible for Mr X from October 2004 until the time of the homicide.

The housing association is England's largest provider of housing and support for vulnerable and socially excluded people. Mr X had tenancies in two of its properties at Residential Home 1 and Residential Home 3.

Places where Mr X lived

An NHS psychiatric hospital.

An NHS rehabilitation unit.

Residential Home 1, was a housing association property with staff on duty 24 hours a day (it has since closed).

Residential Home 2 is a residential home that has been open since the late 1990s. It supports people with enduring mental illness, mainly those with long-term needs for its services, but occasionally those expected to move on in due course. There are 23 residents of working age and above, most of them over 40. Residential Home 2 is staffed 24 hours a day, with seven to ten people on duty during the day, including a cook and a cleaner. Residents have individually tailored care plans: some people attend the MIND day centre, others visit relatives or do individual key working sessions with a member of staff, go shopping or for a coffee. There are also planned excursions and holidays. The manager told us that they had less to offer someone of Mr X's age because most of their residents were considerably older.

Residential Home 3 was the housing association house to which Mr X moved on 23 May 2007, and in which he was living when the homicide took place. No staff were based at the house and residents could expect staff visits once or twice a week, in addition to visits from the statutory services. Five men of varying ages lived at Residential Home 3, all with a diagnosis of mental illness. All had their own rooms and shared other facilities. Each was allocated a project worker from the housing association.

2. Terms of reference

The independent inquiry is commissioned by NHS South East Coast. It is commissioned in accordance with guidance published by the Department of Health in HSG (94)27 *The Discharge of Mentally Disordered People and their Continuing Care in the Community* and the updated paragraphs 33–36 issued in June 2005.

Terms of reference

1. To examine the care and treatment of Mr X, in particular:

- The history and extent of Mr X's involvement with the health and social care services.

- The suitability of Mr X's treatment, care and supervision in respect of:

    - his clinical diagnosis
    - his assessed health and social care needs
    - his assessed risk of potential harm to himself and others
    - any previous psychiatric history
    - any previous forensic history
    - the assessment of the needs of carers and Mr X's family.

- The extent to which Mr X complied with his prescribed care plans.

- The extent to which Mr X's care and treatment corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health.

- The quality of Mr X's treatment, care and supervision, in particular the extent to which his prescribed care plans were:

    - appropriate
    - effectively delivered
    - monitored by the relevant agency.

- The adequacy of the framework of operational policies and procedures applicable to the care and treatment of Mr X and whether staff complied with them.

- The competencies of staff involved in the care and treatment of Mr X and the adequacy of the supervision provided for them.

- The internal investigation completed by Sussex Partnership NHS Trust and the actions that arose from this.

- Any other matters that the investigation team considers arise out of, or are connected with, the matters above.

2. To examine the adequacy of the collaboration and communication between all the agencies involved in the care and treatment of Mr X, or in the provision of services to Mr X, including Sussex Partnership NHS Trust and relevant housing agencies and GP services.

3. To prepare a written report that includes recommendations to the strategic health authority so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.

Approach

The investigation team will conduct its work in private and be expected to take as its starting point the trust's internal investigation supplemented, as necessary, by access to source documents and interviews, as determined by the team. The team is encouraged to engage relatives of the victim, Mr X and his family and any relevant staff in the inquiry process.

The team will follow good practice in the conduct of interviews by, for example, offering the opportunity for interviewees to be accompanied and giving them the opportunity to comment on the factual accuracy of their interview transcript.

Timetable

The precise timetable will be dependent on a number of factors including the availability of Mr X's clinical records, the investigation team's own assessment of the need for

information and the number of interviews necessary. The team is asked to have completed the inquiry, or a substantial part of it, within six months of starting its work. Monthly reports on progress should be provided to NHS South East Coast.

Publication

The outcome of the inquiry will be made public. The nature and form of publication will be determined by the NHS South East Coast. The decision on publication will take account of the views of the relatives and other interested parties.

3. Executive summary and recommendations

3.1 Mr X had lived in the catchment area of the Sussex Partnership Trust since he was a child. Apart from a few days in a private hospital when he was first admitted as an inpatient, and a nine-month inpatient stay at a specialist centre in London in 2003, all his care was provided by the local NHS services. He was well known to the specialist psychiatric services, having been an inpatient for most of the time he was under their care. His first admission was in 2001 at the age of 19.

3.2 Mr X's schizophrenia is 'treatment resistant', which means that his symptoms were never fully controlled by medication. He had delusional, persecutory beliefs that damaged his ability to live independently or even, for much of the time, to deal with basic tasks such as eating, washing and changing his clothes. He was seen as vulnerable and passive, and gave no sign of being a danger to others. For most of his time in hospital he was a voluntary patient. On three occasions he was detained under the Mental Health Act because he was not able or willing to accept the care and treatment he needed.

3.3 Although Mr X's illness was treatment-resistant, it was not impervious to the effects of medication. Over the years his doctors identified that a combination of clozapine and Abilify (both oral medications) was the most effective in controlling his symptoms. Mr X's understanding of the need to take medication fluctuated.

3.4 Mr X finally left hospital in the summer of 2006 when he moved to Residential Home 2, a 24-hour staffed residential home. He made unexpectedly good progress there, such that his clinical team agreed in February 2007 that he was ready for more independent living. He and his care coordinator, Occupational Therapist 1, looked at a number of options, and in May 2007 he moved into a shared house in Residential Home 3 run by the housing association. There were no staff based at the house, but the residents were supported by visiting staff, as well as by statutory services.

3.5 This was the first time that Mr X had ever lived independently as he had been living with his grandparents when he had first been admitted to hospital. He was not a satisfactory tenant: he did not pay his rent on time, his room was squalid and untidy, and he brought undesirable people back to the house. This caused problems for his fellow residents who had to put up with noise and mess in the shared rooms of the house.

3.6 The housing association is a tolerant landlord, as it realises that its tenants may need help and support in managing independent living. Nonetheless it does expect its tenants to try to comply with the terms of their tenancies, and will seek to evict them if the situation warrants it. By the same token, although the statutory mental health services aim to support clients so that they can live as independently as possible in the community, they are well aware that when someone is not coping, admission to hospital may be necessary.

3.7 During June, July and August 2007, the housing association and the statutory services became increasingly concerned about Mr X's behaviour. The records show that there were many meetings between Mr X and his care coordinator, Occupational Therapist 1. Occupational Therapist 1 was also in contact with his mother and grandmother, who were concerned that he was not coping, and, almost certainly, was not taking his medication consistently. Occupational Therapist 1 increasingly shared their concerns.

3.8 These concerns led to Mr X being seen twice in August to decide whether there was evidence to suggest that it was necessary, in the interests of his own health and safety, or for the protection of others, that he should be compulsorily admitted to hospital for treatment.[2] He was seen on 2 August by his care coordinator, Occupational Therapist 1 and Psychiatrist 1, a psychiatrist with special training that authorised him to assess whether compulsory powers could be used. On 15 August he was seen by Occupational Therapist 1 and a senior social worker who had also been specially trained to carry out these assessments. On both occasions the specially trained professionals decided that the situation did not justify the use of compulsory powers. On 15 August Occupational Therapist 1 tried to persuade Mr X to go into hospital as a voluntary patient, but Mr X declined.

3.9 Occupational Therapist 1 saw Mr X again on 17 August, and arranged to see him again on the following Monday, 20 August, but when he went to Residential Home 3 Mr X was not there.

[2] People who have a mental illness are generally in exactly the same position with regard to treatment for their mental illness as they would be if they had a physical illness. They are entitled to accept or reject the advice of doctors, and to accept or reject medication or any other sort of treatment. Just as a person with a heart condition can reject medical advice to stop smoking, so a person with depression can reject the offer of anti-depressants and counselling. However, in the case of mental illness, there are circumstances in which an individual's right to make their own decisions about treatment can be overridden by the views of mental health professionals with specialist training. The basis for overriding the wishes of the individual is that it is necessary, in the interests of the health and safety of the individual or for the protection of other people, that the individual should be admitted to hospital.

3.10 Two days later, on 22 August, Mr X turned up at his mother's house. This was reported to Occupational Therapist 1. Subsequently Mr X's grandmother agreed to drive Mr X back to Residential Home 3 the following day, at which point he would be assessed and almost certainly detained for treatment in hospital under the Mental Health Act.

3.11 Early on 23 August 2007 Mr X crashed his stepfather's car through the back wall of the garden and into the swimming pool. He then walked along the lane linking his family's house with that of Mr A's parents and went into the house where Mr A was staying and stabbed Mr A to death.

3.12 He was arrested at the scene.

3.13 Our terms of reference do not specifically require us to determine whether the homicide was preventable or predictable but as we are invited to make recommendations to minimise risk of harm in future, we must consider the extent to which legitimate action taken at the time might have reduced the risk of harm.

3.14 In many homicide inquiries there are missed or undervalued clues about the dangerousness or volatility of the perpetrator. However it is important to recognise that sometimes there is nothing to suggest a risk of harm being done to another. In these cases there may be evidence of some minor failures in carrying out policy, and the care may not have been at the level of the best in the country but this does not mean that the homicide could have been either predicted or prevented. We have used the following guiding principles to assess whether the homicide could have been predicted or prevented:

A. We consider that the homicide would have been predictable if there had been evidence from Mr X's words, actions or behaviour that could have alerted professionals that he might become violent, even if this evidence had been un-noticed or misunderstood at the time it occurred.

B. We consider that the homicide would have been preventable if there were actions that professionals **should** have taken which they did not take. Simply establishing that there were actions that **could** have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

3.15 For the reasons that we set out in detail in the report we consider that the homicide was neither predictable nor preventable.

3.16 We have identified a number of failings and weaknesses in the actions of the statutory services during 2007. We have looked carefully to see if these failings and weaknesses might have contributed to Mr X's actions on 23 August. For the reasons given in the body of the report, we find no such link.

3.17 Shortly after the homicide the trust instigated an internal investigation, which reported in November 2007. The investigation found many failings, and was critical of the actions of individuals involved in Mr X's care. For the reasons set out in the report, we do not agree with a number of these findings and criticisms.

Findings

Finding 1 In view of the treatment-resistant nature of his illness, the medication prescribed for Mr X was appropriate as it was the only regime available to control his symptoms.

Finding 2 The failure to undertake a formal risk assessment when Mr X moved to Residential Home 3 was poor practice. However he continued to be well monitored and supported by Occupational Therapist 1, so we find no link between this failure and the homicide.

Finding 3 The proposed level of support for the move to Residential Home 3 was documented but a meeting of all concerned should have taken place and would have identified misunderstood expectations and allowed effective planning to rectify them. However it is unlikely that such a meeting would have significantly altered the level of support Mr X received, so we find no link between this failing and the homicide.

Finding 4 Mr X's family had valid concerns about his readiness to move on from Residential Home 2 but we accept that the move to Residential Home 3 was the right move at the time.

Finding 5 We find that the acceptance by Mr X's clinical team of his explanation about the incident at Residential Home 3 was a reasonable judgment based on the well documented and close engagement with him at the time and in the absence of risk indicators that he was a danger to others.

Finding 6 We do not consider that the clinical team between 11 June 2007 and the end of July 2007 missed any signs that he was likely to engage in violence against others.

Finding 7 Those responsible for delivering his care were experienced and conscientious people. Despite some areas of practice that could have been improved, they used their professional skills appropriately in trying to meet Mr X's care, treatment and supervision needs within the structure of their organisation.

Finding 8 We consider that Occupational Therapist 1 should have convened a care programme approach (CPA) meeting when it was uncertain whether Mr X's behaviour was

due to his adapting to his new home or the relapsing of his illness. Team meeting discussions are helpful but they should not be used as substitutes for CPA reviews. A review would also have been able to assess whether a greater level of support should have been offered to Mr X.

Finding 9 We consider it would have been more appropriate if Mr X had been allocated a clozapine-trained community psychiatric nurse as his care coordinator, with Occupational Therapist 1 providing regular focused occupational therapy (OT) input. Alternatively, if Occupational Therapist 1 was the allocated care coordinator, a clozapine-trained CPN should have had a formal and regular role in monitoring Mr X. Either of these arrangements would have allowed the nurse to evaluate Mr X's behaviour and ascertain how much of it was attributable to his compliance or otherwise with his prescribed medication. However we know that the team was kept well informed of Mr X's situation and other members of the team assessed Mr X in August, and we also know that Occupational Therapist 1 believed that Mr X was not complying with his medication regime, so we doubt if the involvement of such a CPN would have significantly altered the way Mr X's care was provided.

Finding 10 The involvement of Mr X's grandmother and mother with Mr X's care and treatment and with mental health professionals was positive and helpful.

Finding 11 We conclude that there was no reason for the professionals to predict that Mr X was a risk to others.

Finding 12 On the basis of the information given to us, it seems unlikely that the result of the proposed August blood test would have been obtained in time to make any difference to the management of Mr X before he committed the homicide.

Finding 13 We conclude from the evidence of the records and our interviews that detention under the Mental Health Act was considered carefully and was based on all the evidence available at the time of the assessments in August. We find no evidence to criticise the judgments of the professionals concerned.

Finding 14 We consider that nothing professionals should have done would have prevented the homicide. We have found no evidence that the care delivered to Mr X was in breach of statutory requirements or Department of Health guidance.

Finding 15 We consider that the team complied satisfactorily with the care programme approach (CPA). The care coordinator was not only conscientious and able in carrying out his duties, but clearly believed wholeheartedly in the importance of involving other professionals and the family in seeking to help Mr X.

Finding 16 We consider that the careful records the care coordinator kept show the extensive level of his involvement with his client's care, treatment and supervision. It would have been helpful, and would have done him a service, if the notes had also said more about his own views and concerns. This would not have influenced events before the homicide but would have made Occupational Therapist 1's position clearer in the subsequent internal investigation and reviews.

Finding 17 We consider that the team, and in particular Occupational Therapist 1, complied with the recovery approach in this case, being sensitive to Mr X's wishes but at the same time aware of his needs and ready to restrict his freedom if necessary. The team, and his family, were justifiably concerned about his own health and safety.

Finding 18 We consider that Mr X could not reasonably have been thought to pose more of a danger to others than any other member of society might pose.

Finding 19 We conclude that the evidence we have received does not support the trust's serious untoward incident report's assertion that Occupational Therapist 1 or others in the team lacked understanding of schizophrenia.

Finding 20 We found no evidence that the care coordinator and the team manager did not understand the duties of a care coordinator.

Finding 21 Manager 2, as the integrated team manager, had responsibility to ensure that each team was effective. We are convinced that the wide span of management responsibility and authority he had at the time would not allow him or any other manager to exercise the role effectively.

Finding 22 Despite the obvious confusion about management responsibilities for the recovery team we do not think that this had any material effect on the decisions of team

members in this case, which were based on their professional judgment rather than their understanding of managerial lines of responsibility for the team.

Finding 23 There is no evidence that the lack of a consultant presence at team meetings had any bearing on the management of this case.

Finding 24 The composition of the trust investigation panel did not comply with the trust policy.

Finding 25 The trust investigation report is easy to read and well laid out.

Finding 26 We believe that the short time available to complete the trust investigation may have caused a number of significant weaknesses within the process of the trust investigation.

Finding 27 The trust responded to this homicide with the speed and seriousness it deserved but we think that setting up what was effectively an external independent panel was not the best way of achieving the goals of understanding how the services were delivered and of learning appropriate lessons. The pressure on the panel to produce a report quickly has meant that in places the available evidence does not support the panel's conclusions. As a consequence, some staff have been the subject of criticism that appears to us to be unjustified.

Finding 28 We set out in this report a number of areas of clinical practice and management organisation that could have been improved but we find no link between these and the homicide.

Recommendations

R1 We recommend that the trust considers issuing guidance on how the particular skills of recovery team members are matched to clients when allocating care coordinators.

R2 The trust should issue guidance on what staff can do when faced with a service-user being out of area but needing help.

R3 The trust should remind staff that families and carers should be advised of their right to request a Mental Health Act assessment.

R4 The trust should issue guidance on the value of ensuring clinical records include not only factual information but also the writer's clinical view, judgments and reasons for them.

R5 The trust should review its approach to convening internal serious untoward incident panels to ensure that they have enough time to undertake a thorough investigation. External panel members should be used only in exceptional circumstances. Interviews should be recorded and transcribed.

R6 The recovery team no longer exists and all community mental health teams (CMHTs) have been redesigned as newly formed recovery teams. Consequently the trust should provide assurance to its primary care trust commissioners that the new operational policies of these teams reflect the recommendation of the internal review that the recovery team develop a common understanding of the factors that contribute to the difficulties experienced by people with schizophrenia which gives equal recognition to biological, social and psychological factors.

R7 The trust should provide assurance to its primary care trust commissioners that the new recovery teams are using HONOS or some other recognised outcome scale.

R8 The trust should provide assurance to its primary care trust commissioners of the level of psychology involvement now available in the newly formed recovery teams (previously CMHTs).

R9 The trust should ensure that the draft dual diagnosis policy is formally approved and implemented as a trust policy to ensure that draft policies are not ignored by practitioners on the grounds that they are not yet in force.

4. Summary chronology

4.1 We provide here a short chronology to help the reader quickly put into context the various sections of the report. We include a comprehensive chronology of Mr X's contacts and involvement with the NHS in appendix B. This chronology provides a fuller appreciation of the care needs and risk factors and approach to care and treatment the statutory and community services took. We recommend that the comprehensive chronology is read as background.

4.2 Mr X had a long and intense involvement with mental health services. Records show sustained efforts by many professionals to meet his needs and to help him recover enough to enjoy his young adult life. The chronology helps to put into context the decisions of staff in 2007 because it highlights that the main and almost exclusive concern about Mr X was his deterioration leading to self-neglect and that there were no indications that he was at any time a threat to anyone else.

Mr X - the person

4.3 Mr X was born in 1982. His mother was still a teenager, and his maternal grandparents brought Mr X up. Almost immediately after moving, Mr X's grandfather had a stroke and became increasingly disabled. The family was living in a fairly isolated area with few children, so they decided that Mr X should go to a local weekly boarding school. He was there between the ages of seven and 13 then went to a local college as a boarder until he was 16.

4.4 Mr X was unhappy at his prep school because he was homesick. He did well at school, achieving 10 or 11 GCSEs, but he seems not to have been happy there either, and may have been bullied. His mother and grandmother remember him as a shy, rather introverted, boy.

4.5 He wanted to live at home after his GCSEs so he left school and started A Levels at a sixth form college but dropped out by Easter 1999. His family now believes this was the start of his illness.

4.6 Mr X lived at home with his grandparents until his first hospital admission in 2001. He was interested in computer programming and did a number of distance-learning IT courses. He became isolated and his family were concerned that he was depressed.

4.7 He met an American girl on the internet and spent his savings going to the US to visit her without his family's knowledge. He was away for only a few days and when he came back he seemed distressed and frightened. His family thought then that he was in some kind of trouble. They now think this was part of his illness. He took all his belongings and his clothes into the garden and burnt them, giving no reason. He complained of hearing voices saying bad things to him, and was admitted to a private hospital in 2001. He was in NHS hospitals for most of the next five years, either as an informal patient or detained in the interests of his own health and safety.

4.8 The professionals involved in his care spoke warmly of him, seeing him as a quiet, shy, pleasant young man. Psychiatrist 2, his consultant from 2002, told us:

> *"He was very polite, very courteous, a nice person to talk to, very cooperative in anything that you suggested, no aggressive outbursts at all…He was very articulate, he had a very impressive educational background, I always considered his IQ rather high, – he may have had some deficits in social skills and so on, but certainly, on the whole, he was one of the most educated and capable patients that I had."*

4.9 The manager at Residential Home 2[3] said:

> "*I think you would find him quite a private person, quite timid in a way. There was no aggressive nature about the boy whilst he was with us. He was quite a gentle person who you could have a conversation with but it was quite difficult to engage him. I would say he definitely presented as somebody who had mental health problems. Difficulty in expressing himself at times and yes, he definitely presented as somebody with long term mental health problems who had obviously had some kind of psychotic episode."*

[3] Staffed residential home where Mr X stayed during 2004 and 2006.

Mr X - involvement with the health and social care services

2001

4.10 In September, aged 19**,** Mr X was admitted informally to a private hospital by his grandparents because he was hearing voices telling him to kill himself. He was subsequently detained under section 2[4] of the Mental Health Act and in October was transferred to an NHS mental health inpatient unit. His provisional diagnosis at that time was *"mental and behavioural disorder due to drug use – schizophrenia?"* His section 2 ended after 28 days. He was willing to remain as an informal patient, so he was allowed to do so and he remained as an informal patient until the end of December, when he was detained under section 3[5] after leaving the ward twice without permission, putting himself at risk of injury and concealing his medication.

2002

4.11 In January he was referred to the trust rehabilitation and assertive outreach team because his clinical team thought that he would require more intensive support on discharge than the community mental health team could provide.

4.12 In February he started taking clozapine, an oral medication for people with treatment-resistant schizophrenia. His clinical team considered him to be at low risk of harming himself or others.

4.13 In June he was referred to the National Psychosis Unit because of the poor result from the medication that he had been given at the psychiatric hospital, which left him with marked negative symptoms, including lack of motivation, apathy, sleepiness.

4.14 In July he was taken off his section and remained in the psychiatric hospital as an informal patient. He asked that his medication be changed because it made him drowsy. His clozapine was consequently reduced.

[4] A Mental Health Act section where and individual is compulsorily detained for assessment for up to 28 days.

[5] A Mental Health Act section where an individual is compulsorily detained for treatment for up to six months.

4.15 In August Mr X returned from staying with his grandparents. His grandmother reported he had been giggling, staying in bed all the time, not sleeping at night, saying everything had germs on it, not attending to hygiene, and *"crawling on all fours"* which she said he had not done since he was first unwell.

4.16 In September Mr X had an appointment at the National Psychosis Unit (NPU) and the consultant who reviewed him felt that he was under-medicated and should have his clozapine gradually increased. The consultant stated in her letter to Psychiatrist 2 that Mr X admitted to erratic compliance with medication. His notes show that at the end of the month, after the recommended increase in his medication, that he was interacting with his peers and more motivated.

4.17 In the beginning of October Mr X went on leave for a few days to his grandparents, having returned to the ward for clozapine blood tests.[6] He was described as thought-disordered; responding to voices and staff noted that he had a considerable number of clozapine tablets in his bedroom. His clozapine was restarted. The notes show that was still having *"inappropriate outbursts of laughter".* Over the next days he is described as being over familiar with staff, binge eating, making bizarre movements.

4.18 Towards the end of November he was transferred to an NHS rehabilitation unit. A risk assessment completed at the time showed him to be low risk. His diagnosis was confirmed as treatment resistant schizophrenia. His behaviour and presentation suggested relapse and he was suspected of having failed to take his medication during a visit to his grandparents. He was restarted on a low dose, gradually increasing, and by the end of December his notes recorded that he was quiet, isolating himself, blocking toilets with paper towels, sleepy and passive. He spent a lot of time in his bed and alone in his room. He did not wash or change his clothes without prompting and often not even then.

Comment

In this period 2001-2002 Mr X was diagnosed with a serious mental illness and began his first episodes of hospital admissions, first in a private hospital then in two local

[6] Clozapine is often helpful for patients whose illness does not respond to standard medication. However it can have dangerous side effects for some patients and patients have to have frequent blood tests to check whether these side effects are developing. If they do, the patient has to be taken off the medication straight away.

NHS units. His care was problematic and his clinical team sought advice from more colleagues at the specialist NPU.

His schizophrenia was found to be treatment-resistant, so he was a hospital inpatient for the whole year. It was also evident that his compliance with medication was erratic and that his behaviour quickly changed depending on his compliance with medication and the levels of it in his blood. The risk screening assessment showed that he was not a risk to others. He was a detained patient for the first half of the year and a voluntary patient for the second half.

2003

4.19 In February he was transferred to the National Psychosis Unit (NPU). A neuro-psychology assessment report from the NPU shows that he had specific problems with memory and attention but his average to high average pre-morbid intellectual functioning was intact. Mr X was described as "v*irtually inactive on the ward".*

4.20 Patients go to the NPU for only a limited time for expert assessment, diagnosis and treatment. Mr X was transferred back to the rehabilitation unit on 1 December. A risk assessment form on this date shows that the only current risk factors for suicide were that he had a major psychiatric diagnosis and was unemployed. There were six current risk indicators for neglect, no current indicators for aggression or violence and none for any other risk. This shows that his clinical team thought that he was compliant with medication at that time although in a statement of risk it suggests that he would be at low to moderate risk of non-compliance when on leave from the rehabilitation unit.

2004

4.21 On 10 February Mr X moved to Residential Home 1, a 24-hour staffed hostel run by a housing association.

4.22 In July he was readmitted informally to the NHS unit, the rehabilitation unit *"due to a deterioration in his mental state, has been reported as being paranoid of people where he lives at [the housing association], staff [there] have reported that he has been staying in bed all day and probably not been taking his clozapine".*

4.23 In August Mr X's maternal grandfather died. Mr X appeared to take the news well, saying *"I am not as upset as I thought I would be*". He continued to do well over the following days and showed no distress at his grandfather's death, either at the time or after the funeral.

4.24 He continued to improve and was discharged from the rehabilitation unit back to Residential Home 1 on 14 September. In October he was transferred from the care of the trust assertive outreach team to the trust rehabilitation team.

4.25 In November he was readmitted to the psychiatric hospital, informally, from Residential Home 1 following an outpatient appointment with Psychiatrist 2. His mental state had been deteriorating. He had been neglecting himself and his medication levels were poor. Also, *"[Mr X] pushed a visitor down a couple of stairs which is out of character. [Mr X] says that guy had been threatening towards himself and other residents of the house and had made comments about getting a knife or a gun. [Mr X] says he just wanted to get this man out of his house, and he didn't act in an unprovoked manner…no sign of psychotic symptoms, personal hygiene seems poor at present".* In late November he was transferred back to the rehabilitation unit and restarted on clozapine at his own request.

Comment

In this year Mr X was transferred from the NHS unit to a community residential home but deteriorated and was readmitted informally back to the NHS unit. On admission back to the NHS Unit he was assessed as at low risk of suicide and aggression and violence, moderate to high risk of neglect and moderate risk of failing to comply with his medication regime. This kind of movement between hospital and residential accommodation is not unusual, and reflects the fluctuating level of Mr X's need for support, rather than any concerns about his dangerousness. Mr X accepted the advice of his psychiatrist, so there was no need to consider if he met the criteria for compulsory detention.

2005

4.26 Mr X was placed on section 3 of the Mental Health Act at the rehabilitation unit in April in the interests of his own health because he was not co-operating with his treatment plan and not taking his medication. He described detailed persecutory delusions. This in part explains his difficulties with eating, handling money, hygiene and clothes. He would wear only new clothes because the spirits communicating with him insisted, and would eat only takeaway food because he believed the hospital food was contaminated by the spirits.

4.27 His notes recorded a gradual improvement during the rest of the year and a significant improvement in his self-care and sociability.

2006

4.28 In late January the notes record that the voices had gone: *"spirits have reduced. [Mr X] has no thoughts as to why this has happened"*. Residential Home 2 assessed him in March and he began rehabilitation work with the occupational therapist so that he could go shopping and prepare for discharge to Residential Home 2.

4.29 In July Mr X had his first visit from CPN1, a community psychiatric nurse in the recovery team. She completed a social functioning scale and had discussions with him about Residential Home 2. His care plan shows that he was granted funding and was waiting for a bed at Residential Home 2, that he was eating the unit food and going on regular leave to his grandmother's, managing his own money, engaging in a computer course. His mental state appeared stable.

4.30 In August he went on two weeks' leave to Residential Home 2. The staff there reported he was eating the food but taking it to his room and spending a lot of time there. He was attending to his personal hygiene. In September he was discharged from the rehabilitation unit by Psychiatrist 2 who said he was doing well at Residential Home 2 with no issues or complaints. He had an outpatient appointment with Psychiatrist 2 in November and another in February 2007, also attended by his care coordinator, at which it was agreed that he was ready to move on from Residential Home 2.

2007

4.31 The dates set out below are given to help the reader have in mind the significant events in this period. The details of the care are described in the following sections of the report.

4.32 In May 2007 Mr X moved from Residential Home 2 to Residential Home 3. Here he was expected to look after himself as well as take responsibility for budgeting, cleaning and cooking for himself with some limited support from his project worker from the housing association.

4.33 On August 18/20 Mr X left Residential Home 3 without notice to family or professionals.

4.34 On August 22 Mr X arrived unexpectedly at his mother's house, some 80 miles away.

4.35 On August 23 Mr X killed Mr A.

5. Suitability of Mr X's treatment care and supervision

- Clinical diagnosis
- His assessed health and social care needs
- His assessed risk of potential harm to himself and others
- Any psychiatric history
- Any forensic history

5.1 As we say in our introduction, we have structured the report around the terms of reference (ToR). The chronologies deal with the *"History and extent of Mr X's involvement with the health and social care services"*. The bullet points above deal with the next major section of the ToR.

Clinical diagnosis

5.2 Mr X was diagnosed with paranoid schizophrenia in October 2001 and this continued to be his diagnosis throughout. His clinical team recognised early on that he had treatment-resistant schizophrenia. He spent many years as an in-patient, although there was a determined attempt by his clinical team to move him into the community in 2004 when he stayed at a housing association property, Residential Home 1, which had resident staff. During his time at Residential Home 1 his compliance with medication was erratic at best, and the deterioration in his ability to manage in the community resulted in his re-admission and in Psychiatrist 2 believing that he should not be given clozapine again. However, during Mr X's time at the National Psychosis Centre at the Maudsley Hospital he was prescribed clozapine again, and Psychiatrist 2 subsequently continued with the same treatment. Clozapine with Abilify seemed to deal most effectively with Mr X's symptoms, leading to the improvements in his mental state in 2006 and 2007 that allowed him to move out of hospital.

Comment

Mr X was correctly diagnosed with paranoid schizophrenia. His illness was treatment-resistant, and responded best to a medication regime based on clozapine. Clozapine is an oral medication, not ideal for someone whose compliance cannot be relied upon. However, when it is the only medication shown to be effective for a treatment-

resistant illness, the problems with ensuring compliance cannot be allowed to prevent the prescription of the medication that works.

Finding

Finding 1 In view of the treatment-resistant nature of his illness, the medication prescribed for Mr X was appropriate as it was the only regime available to control his symptoms.

Mr X's assessed health and social care needs before the move to Residential Home 3

5.3 We now provide a more detailed examination of Mr X's care from when he was discharged from hospital in August 2006 until the homicide in August 2007. We have chosen this period because Mr X moved quite rapidly from hospital care to semi-independent living in less than a year. Nothing suggests that his treatment in hospital was anything other than highly professional and in accordance with the policy that people with severe mental illnesses should be helped to return to the community if possible.

5.4 The records show that significant efforts were made to control Mr X's symptoms and to get him back into the community. Different medication regimes were tried, he spent a period at the National Psychosis Unit at the Bethlem Royal Hospital, and his local NHS trust clinical team understood his close involvement with his family and facilitated contact with them.

Discharge from hospital

5.5 In December 2005 while still in the rehabilitation unit Mr X was assessed by Occupational Therapist 2. His report states:

> *"It is recognised that the main limiting factor in [Mr X]'s case appears to be his current psychotic presentation, without which his functional capacities would be significantly increased. It is debatable whether historically the pharmaceutical courses of treatment [Mr X] has complied with have been successful in effecting a reduction of his positive psychotic symptoms.*

In light of the above, it is expected that future progress will be very gradual and that any internalised locus of control needed for [Mr X] to overcome the obsessional components of his mental state will only be attained through a high level of support from both mental health services and his future living environment.

It is recommended therefore, that following discharge from the rehabilitation unit, at the appropriate time, [Mr X] be transferred to accommodation that would afford this high level of ongoing support".

Comment

In layman's terms, this means that the focus of treatment should be practical support to help Mr X manage in the community despite his continuing symptoms, rather than focusing on getting rid of what turned out to be intractable delusional beliefs.

5.6 In May 2006 his care coordinator made a funding application for Mr X to go to Residential Home 2. The information supplied with the application covered his risks, his identified needs and a brief history. The report stated:

"[Mr X] has been in [the rehabilitation unit] for the past year with very slow gradual improvement with a lot of intensive recovery input from the nursing team. He is ready to move on from the rehabilitation unit but is still going to require a lot of input with all aspects of care and recovery."

Move to Residential Home 2

5.7 Mr X moved to Residential Home 2 for a two-week trial in August 2006. It was successful so he stayed there and was discharged from hospital by Psychiatrist 2, his consultant. A member of staff is always present at Residential Home 2. Residents are helped, if necessary, to do their laundry and clean their rooms, but meals are cooked by staff. Residents have only to manage their personal income because the cost of their supported accommodation is paid directly to the rehabilitation unit. The manager at Residential Home 2 told us:

"In terms of levels of having staff around, available for people, then I would say that it's well staffed in that respect. Any given shift, [Mr X] would have had some kind of interaction with some member of staff, whether that would be just to check to see if he was okay or whether or not there was something in his weekly planner that would have highlighted what he might have been doing at that time, whether or not he was going out for a tea or coffee or anything…"

5.8 While Mr X was at Residential Home 2 he had moved, successfully it seemed, onto a regime of self-medication. His family said he seemed to be committed to it, checking his watch to make sure he took his pills at the right time. The manager at Residential Home 2 told us how patients moved to self-medication at Residential Home 2:

"Initially we do a daily strip with their medication. Then we build that up over a period of time. Throughout that process, a member of staff might go and approach somebody and say, 'Can I just see that you've taken your medication today?' It could happen at any time. Once somebody gets on to a weekly pack, we still initially do a kind of – we just test in and out – but then eventually, what we also do is have an expectation that they end up with these Nomad trays that they bring to us on a Sunday and we check to see what other medication is gone and just check in with them to see that they're still taking their medication – and obviously, look for any other signs of deterioration."

Successful family holiday in France

5.9 Over Christmas 2006 Mr X had a successful family holiday in France. His grandmother told us:

"I took [Mr X] to France for a week because he was well. He had the most wonderful time with my other daughter and her family who lived over there. He had a most wonderful week, so when he came back the report was that he'd had a brilliant time and he looked well and everything."

Planning to move to shared accommodation

5.10 By early 2007 his doctor, care coordinator and Residential Home 2 staff all agreed that Mr X had improved enough to move from Residential Home 2 into shared accommodation without resident staff. The manager told us:

> *"I would say, at the time, the decision to move him to less supported accommodation was right because he had achieved a huge amount. He may not have been the most engaging[7] guy, but his mental health was very stable. His sleep pattern had improved immensely. There was incredibly good feedback from the family that things had improved and, rather than stop him at that point, yes, it would be a good idea to move him on."*

5.11 His care coordinator, Occupational Therapist 1, told us:

> *"I first met him when he was at [the rehabilitation unit[…[the rehabilitation unit] and [Residential Home 2] in many ways are similar, although [Residential Home 2] is private. In [the rehabilitation unit] he couldn't talk to you…everything was bad, he had no independence, wanted no independence, he wasn't safe[8] and he was unreliable. Those were the concerns about him. Then in [Residential Home 2] everything seemed to have levelled out completely and he presented as a very different person….and those are the things you look for in this kind of work. To see someone who spends day and night in bed becoming someone who is out and about doing things and has an idea about where he is going in his life is huge."*

5.12 Mr X, accompanied by Occupational Therapist 1, kept an outpatients appointment with Psychiatrist 2 on 2 February 2007. Psychiatrist 2 told us:

> *"What I remember was that [Occupational Therapist 1] came to me with [Mr X], and [Occupational Therapist 1] told me that [Mr X] wants to move to an independent type of accommodation, and [Occupational Therapist 1] said that he agreed with that, and I said, so do I. So both of us agreed with that move – that's my recollection of the meeting…The reason was that [Mr X] was doing so fine, that*

[7] This means that it was not possible to engage with Mr X as much as with some other residents.

[8] This refers to not being able to look after himself safely.

whether we agreed or not it was more or less immaterial, because he was going to do it, and he wasn't on a section[9]*…"*

Apparent deterioration

5.13 Various schemes were considered and abandoned early in 2007, including Mr X going to live with his grandmother while looking for independent accommodation near his mother, and his moving into an ordinary shared house. In April Mr X had another holiday with his family, which did not go so well as the Christmas one. His family were concerned that he had slipped back. His grandmother said:

"My daughter invited him back again in February. We went in February and it was absolutely different, he wouldn't go out of the door. He wasn't well, and he went downhill from then. That was before he moved, and we were concerned about him being moved."

5.14 However, he seemed to recover from this. The manager at Residential Home 2 told us:

"Then it was a case of there was a little bit of a wobbly patch for him but he seemed to stabilise again, but from that point the move seemed to be generated by what was available and whether or not Mr X was going to go for it…"

5.15 Despite this temporary setback, Mr X remained keen to move on. He was not subject to the provisions of the Mental Health Act and was therefore free to make his own decisions about where he should live, particularly as Residential Home 2 and the recovery team still supported his moving on. For a period, Mr X continued to say that he could move immediately to fully independent living, and his care coordinator did not stand in his way. He told us:

"Getting your own place is a huge symbol of success, achievement, being a man and being independent and I always take that seriously. The cautious approach is to go stage by stage, but I always take it seriously when someone says to me, 'I think I can do it'…At the end of the day, if I care co-ordinate someone who says,

[9] Mr X wanted to move on, and there were no legal grounds to prevent him as he was not detained and did not meet the criteria for compulsory detention.

'I'm going to rent a private flat', I say, 'Okay. Let's think about it. What are the pros and cons? What might you struggle with? What's going to be good? What help do you need from us? What help do you need from other people?' If someone wants to do that, I can't stop them…Maybe I don't think it's the best thing for you to do, but the whole point is about encouraging independence."

New home found

5.16 Mr X tried in vain to arrange his own accommodation and asked Occupational Therapist 1 to find him somewhere suitable. Occupational Therapist 1 said the housing association would be able to offer Mr X a place where he could be more independent than at Residential Home 2 but still have some support. The housing association assessed him on 20 April 2007 and felt that he fitted their criteria for supported housing at Residential Home 3. After visiting the house, he accepted the offer of housing on 23 May, and arrangements were made for him to move on 11 June.

5.17 In contrast to the levels of care provided at Residential Home 2, residents at Residential Home 3 were expected to do everything for themselves, with limited support by housing association project workers who visited the house to see their clients but were not based there. Furthermore, Mr X was provided with far more ready cash because he had to shop for himself as well as contributing towards the cost of his accommodation. When Mr X moved from Residential Home 2 to Residential Home 3, his disposable income went up from about £20 per week to between £75 and £125 per week, much of which he was expected to give to the housing association.

5.18 The process for helping Mr X to learn to self-medicate at Residential Home 2 was clear and closely monitored for compliance but such monitoring was not available at Residential Home 3, which did not have staff on the premises at all times.

5.19 The manager at Residential Home 2 told us:

"I do not believe that they were taking a risk that wasn't a measured risk in terms that the chap needed to move on, he needed to become more independent before becoming institutionalised at such a young age and the fact that he had shown progress towards 1) being concordant with his medication, and 2) just

understanding a little bit about the fact that he needed to take those meds in order to stay well."

5.20 The manager believed that, although Mr X was ready to move on from Residential Home 2, there should have been a full risk assessment before he went to Residential Home 3. A risk assessment was completed as part of the referral process for the housing association, but we have found no evidence of any formal risk assessment and care plan being undertaken once it had been agreed that he should go to Residential Home 3.

5.21 The recovery team leader, CP, told us:

"I would expect there to have been a CPA meeting, because it is quite a significant change".

Comment

The relevant trust CPA policy for that time states that a risk assessment should be carried out:

"…at various points throughout the inpatient episode to assist with decision making and review."

This quote refers to inpatient episodes but most mental health service professionals understand the principle of undertaking a risk assessment at major points of change. If such an assessment had been undertaken, a plan to provide more support might have been put in place. However, we heard from the expert reference group that supported accommodation like Residential Home 3 is always in short supply and when it becomes available there is often insufficient time to plan an approach for fear of losing the place.

Finding

Finding 2 The failure to undertake a formal risk assessment when Mr X moved to Residential Home 3 was poor practice. However he continued to be well monitored and supported by Occupational Therapist 1, so we find no link between this failure and the homicide.

Move to Residential Home 3

5.22 There may have been a misunderstanding between the clinical team and the housing association about the level of support that Mr X would receive. The housing association thought that the recovery team would regularly help him manage his medication. The recovery team thought that the housing association would help him with his rehabilitation. Both recognised that he had never lived independently and so would need a lot of help and support with everyday tasks until he had learnt how to carry them out satisfactorily himself.

5.23 Staff from the housing association told us:

> *"There would have been extra support put in at that time when he moved, and particularly from the Community Mental Health Team, because it was such a big step for him. We would have upped our visits, particularly in the first month or so, and made sure that we saw him more often than we do the rest of the clients there… at the time it was something like about an hour a week our low to medium support, but, when somebody first moved in, we would visit them more often because of settling them in, the settling in time…*
>
> *Also we would have checked, and I would think there is some evidence of us checking with the Community Mental Health Team how much they would have been supporting him. Because of the fact that he was coming, as you quite rightly said, from [Residential Home 2], but obviously our support centres round those things you have just said:… budgeting, meaningful use of time; things that they had recommended that he was ready to move on with that support. We can't help with regard to the mental health side, but we can liaise with the Community Mental Health Team which we do if we have any problems…"*

5.24 Occupational Therapist 1 told us:

> *"My understanding was that they would see him every day during the week – someone would pop in. You would have your individual person and the manager overseeing it."*

Comment

The confusion between the care coordinator and the staff at Residential Home 3 would have been clarified if a care plan or risk assessment plan had been formulated before the move.

Finding

Finding 3 The proposed level of support for the move to Residential Home 3 was documented but a meeting of all concerned should have taken place and would have identified misunderstood expectations and allowed effective planning to rectify them. However it is unlikely that such a meeting would have significantly altered the level of support Mr X received, so we find no link between this failing and the homicide.

5.25 Even before Mr X moved to Residential Home 3, his family was concerned that he was not well enough to move. His mother told us about an occasion in May when she and her family were staying at her mother's house with Mr X:

> "*He probably stayed there for about five days. He was talking to people on the river. Mum has a house and there's a river at the back of the house and people walk down there, and he was standing out on the balcony and calling across to people…he kept taking the dog outside in the middle of the night and tying him up. It was all, oh, what is going on, and I was very worried about him. He was up all night on the computer. That was before he moved to [the housing association], and I know, because I had to phone my Mum up to give me the contact number of who I need to speak to because I'm really worried about him".*

5.26 There is no record that Mr X's mother spoke to a member of the recovery team. She believed she may have spoken to someone at Residential Home 2 who told her that Mr X's room was needed for someone else.

Comment

Mr X was legally competent to make his own decisions and he had decided he was ready to move on from Residential Home 2, a view with which Residential Home 2 and his clinical team agreed. His care coordinator seems to have shown considerable skill

in supporting Mr X's wish for independence while at the same time steering him towards a placement that would help him achieve his goal.

A review of the records and evidence from witnesses suggests that his treatment, care and supervision before his move to Residential Home 3 were appropriate for his assessed health and social care needs, though as we say elsewhere, a care planning meeting and a risk assessment and management plan should have been done.

Finding

Finding 4 Mr X's family had valid concerns about his readiness to move on from Residential Home 2 but we accept that the move to Residential Home 3 was the right move at the time.

Mr X's assessed risk of harm to himself and others in June and July after moving to Residential Home 3

5.27 Housing association staff told us they found Mr X a nice, polite and pleasant young man, and the team leader, the recovery team leader said:

> *"He wasn't somebody who was seen as somebody who was a risk to others and there was no history, no forensic history, a colleague of mine who worked with him on the assertive outreach team before he was transferred to us – absolutely nothing. Nothing to indicate the impending doom, as it were. There was nothing really."*

Comment

This is the background against which to judge the actions between 11 June and 21 August 2007. We include quite lengthy quotes from records or interviews in this section because it is important to gain as accurate as possible an understanding of Mr X's presentation and behaviour. We consider this will help provide a fair evaluation of the actions or lack of action of professionals in the weeks leading up to the homicide.

5.28 Straight after his move to Residential Home 3 on 11 June, Mr X seemed much as usual, or even a little more withdrawn. Occupational Therapist 1 made a note in Mr X's clinical records that he had phoned Mr X to ask him to register with a local GP so that his medication could be dispensed locally. He subsequently noted that Mr X had not been out of the house to the nearby supermarket, despite having exact directions and being able to see it from Residential Home 3. Occupational Therapist 1 recorded in the clinical notes:

> *"This does not reflect that he is ill, more that he does experience extreme passivity. Nothing of note for mental ill health. Sat and chatted with [Mr X] for longest time. He told me about his sister."*

Comment

This passivity must have changed abruptly because he managed to travel independently to his mother's home shortly afterwards.

5.29 His mother told us about his visit to her[10] within ten days of his move:

> *"On Thursday, 21 June he arrived here unexpectedly and his hygiene was particularly poor. On Friday, 22 June – so that would have been the following day – he said he was going to walk to get some cigarettes and could he take the dog, which is unheard of. He doesn't go out anywhere, he doesn't walk anywhere. What can you do? So off he goes from here with the dog….*
>
> *He ended up phoning me from a callbox and said he'd been in a spot of bother; he was in the local town, not to worry…'Don't worry, I'll be fine, I'll be back later', and put the phone down, that type of thing…I called the police and I said to them, 'My son's in town, he's just phoned me from a callbox. He's a paranoid schizophrenic and I'm really concerned about him, and what do I do and can you help me?' The lady said, 'I'm not supposed to do this but I'll tell you where he phoned from.' I asked her what I could do, and she said, 'The only thing you can do is take him to the A&E.'…He was on a bench in the middle of town opposite the Kentucky with the dog, with a pack of some form of alcohol, I don't know what type, but he was sitting there drinking, with a grin on his face, a bit animated. My*

[10] Mr X's mother's home is approximately 80 miles from Residential Home 3.

husband went to try and get him to come home and he wouldn't come home… Then I went to get him to come home, probably half-an-hour or an hour later. He seemed quite harmless, quite fine, just sitting there drinking beer. He said to me, 'I want to go to the pub.' I said, 'You can't go to the pub, [Mr X] you're not clean, you can't go out like that. You need to come home and have a shower and a shave.' Anyway, he wouldn't listen to me…I called the number of [the rehabilitation unit], which was one of the clinics he lived in, and explained the situation. They said there wasn't anything they could do…"

5.30 On 2 July Occupational Therapist 1 recorded a phone call from Residential Home 2 who had had contact from Mr X's mother to say that he had spent the weekend there and had been out drinking with new friends, and that the family were concerned that he had not been taking his medication. He then spoke to Mr X's mother, who said she had concerns over his drinking. Later the same day he met with Mr X who was reluctant to discuss his *"private matters",* and did not consider that his drinking was a concern. Occupational Therapist 1 noted that Mr X was reluctant to engage in conversation but concluded that nothing of particular note concerned him at that stage.

Deterioration or recovering

5.31 On 25 July Occupational Therapist 1 had a phone call from Mr X's grandmother, expressing her concerns about him:

"Somewhat speeded up and distracted, she reports going out with friends and drinking a lot. Early warning signs? Not taking meds. Although she reports he sets his alarm to remind self to take Clozapine. Saw [Mr X] today…[Mr X] is more animated in himself, somewhat distracted and excitable. He talked about making new friends and has two groups of people he met in the pub. Is showing a healthy interest in women. He appears well if somewhat unkempt. Talked about being free and able to live more now. No indication of drug use and denies this…"

5.32 Occupational Therapist 1 told us:

"[Mr X] was having a whale of a time. It was as if he'd been released from a cage. He had loads of mates, he was interested in women, which was certainly something that I'd been unaware of with him being hospitalised for a long time,

he could come and go as he wanted, he drank a bit and he seemed really happy. That was the plus side. He was still seeing his folks, going up to [his mother's house] and doing all of that. He was doing something on the computer and he was really into that and doing an online course. There were big pluses there in terms of his experience of the move."

5.33 However, by 27 July the housing association staff were becoming concerned. Occupational Therapist 1 went to see Mr X with his housing association project worker who reported that Mr X was £500 overdrawn, three weeks behind with his rent and that someone in the house had been throwing food. Occupational Therapist 1 noted that everyone denied responsibility, but it was Mr X's food. Occupational Therapist 1 records:

"*There are indications that [Mr X] is either not well or that his drinking and clozapine is affecting his mental state. He appears somewhat excited, very unkempt and vague with some minimising of events. Unreliable. Doesn't appear to be experiencing any psychotic symptoms although these are usually hard to see. He reports that he is well and happy. Describes how he is out with his friends and drinking at weekends. Sees no signs of illness in himself…"*

5.34 Occupational Therapist 1 told us:

"There were food fights, stuff getting broken and it was really tricky. If you were 16 or 17 and living in [this town] with nothing else to do and bumped into [Mr X], he had 'target' written all over him. He was in his mid-twenties, but he'd been ill for the best part of 10 years, so in many ways he was 13 or 14. Local teenagers had latched onto him – '[Mr X]'s house is party house, [Mr X]'s got money for fags, [Mr X] can buy us alcohol'. He was targeted quite severely and in many ways he was happy to have people who liked him and wanted to be around him. That's something a lot of our folks struggle with and there was suddenly a group of people who were all over him, for him maybe in a good way. There were a number of incidents in the house of curry being thrown around, stuff being broken and all of that."

5.35 On 30 July Occupational Therapist 1 recorded that he had received a call from the housing association's manager:

"*She was called out by another house mate who reported that [Mr X] had threatened him with a knife after returning home drunk on Friday, 27th following an argument. [Mr X] reports that this did not happen, that he had been carrying the knife, which was in the lounge because they had been slicing up a cake, back to the kitchen and that there was no confrontation. [Mr X] reports that he had been out drinking with friends some had come back for 40 minutes. [Mr X]'s report of any incident with another housemate is vague and disjointed. [Mr X] had a black eye and a gash over his right eye. He describes being attacked by some local teenagers whilst out on (?) Saturday night. He has not cleaned or attended to the wound despite prompting and lots of encouragement. His interactions are vague and illusive. His reports are disjointed, he is unwashed and unkempt.*

[Mr X] assures me he has taken meds as prescribed. He has had a blood test, (attending GP above) and phoned me this morning to remind me that his Clozopine is due. He has been ++ reluctant to show me meds boxes but he did so today and Citalopram and Alibify seem correct. His Clozapine seems to have run out a day too soon. I have now organised to give him one week at a time to monitor this. Also will request a trough level with next blood test[11]*. [Mr X] is not calm and stable. He is appreciating his freedom – the friends he has made are 17-18 which reflects his own life stage and puts his actions in context somewhat.*

I will see [Mr X] on Mondays for meds and Fridays until this appears to calm."

5.36 We asked Occupational Therapist 1 what he thought of the situation at this point. He told us:

"We all scratched our heads because it was a nightmare situation. Some of it was relapsing, clearly more so as time went on, some of it was freedom for him, inconsiderateness and being caught up in something he had no control over. I had a lot of contact with the [housing association] project worker and we used to despair a lot because when you talked to [Mr X] he was down the line and presented incredibly well. Then the next day something else would have

[11] Mr X was having regular blood tests to check if the clozapine was putting his physical heath at risk but these did not provide information about his compliance with the medication. Another test, called a trough test, was needed for this.

happened, his bed would have broken or this or that would have happened. This guy was not well, but how not well was he?"

5.37 We asked him about the knife incident. He said:

"The best story I got about this was that [Mr X] had had a bit of a party with some of his friends quite late one evening and other people in the house were a bit annoyed about it. I wasn't there, but I was told that [Mr X] was tidying up – I don't know whether that was in the night or in the morning – and was walking from the front room, through the house to the kitchen with a knife in his hand when he had an argument with one of the other people in the house who was saying, 'You're really noisy. Your friends are a nightmare' etc. That's all the fact that I know. [The housing association] told me that the other person was prone to exaggeration. In that context that person didn't say, 'I feel scared. I can't live here any more. [Mr X] was going to stab me'. None of that was said to me, so my impression of what happened was [Mr X] walking from room to room with a knife, the other guy fairly justifiably saying, 'Can you stop being such a nightmare', they had a bit of an argument and no one told me that the other person was threatened. It was an argument where one of the people – [Mr X] – had a knife in his hand. That was my understanding.

Q. Did you talk to [Mr X] about it?

A. Yes and he swore on his life, he said, 'Look, I didn't threaten anyone with a knife. I really didn't. He had a go at me', because [Mr X] is that foppish teenager type and he was convinced in his own mind that it was something and nothing. 'Yes, I had a knife in my hand, but, no, I wasn't using it as a weapon'."

5.38 The recovery team leader told us that Occupational Therapist 1 had discussed this incident with other members of the team and that the collective view was that it was too unclear to justify a response, particularly as the housing association was not asking that any action be taken.

Comment

It is important to assess this knife incident from the perspective of what was known about Mr X at the time and not with hindsight. There was no evidence of physical risk to others from Mr X, so his explanation was accepted.

Finding

Finding 5 The acceptance by Mr X's clinical team of his explanation about the incident at Residential Home 3 was a reasonable judgment based on the well documented and close engagement with him at the time and in the absence of risk indicators that he was a danger to others.

5.39 CP also confirmed that Occupational Therapist 1 was discussing Mr X regularly at meetings:

> "*From what I can remember, without looking in the minutes in front of me, [Mr X]'s mental health was fluctuating, definitely, he would have been in the amber zone some of these weeks and then, I can remember one time when [Occupational Therapist 1] came and spoke about him and he was then being compliant with his medication, but these are the sorts of clients we work with; they can change daily and that level of risk is what we are used to working with – people who don't take their medication sometimes and responding to that. As far as I can remember it fluctuated quite a bit. Clearly there were reasons for concern and [Occupational Therapist 1] did step up his visits as far as I can recall, I am sure he did. He did what I would expect.*"

Comment

Mr X's clinical notes were removed after the homicide, so witnesses had to rely on their memories of two years earlier when they spoke to us. We have reviewed the minutes of the weekly recovery team meetings and provide extracts from those minutes in the table below[12]*. It is clear from these minutes that Mr X was discussed*

[12] The Red/Amber in column one relate to the risk category that the team allocated to cases. There is also a green risk category for clients who are causing no concern.

regularly between 24 July and 21 August and the notes appear to indicate this was done in reasonable depth.

24 July 2007 **Amber Zone**	'Very speeding up' Mobile phone-not active. Complained he had run out of medication last week – then discovered he had medication left. Occupational Therapist 1 to visit pharmacy and obtain 1 weeks' worth of Clozaril (10mgs Abilify). Occupational Therapist 1 to check situation and will feed back to Psychiatrist 1. Drinking alcohol, out a lot.
31 July 2007 **Amber Zone**	Not well. Vague. Incidents around him including accusation of threats with a knife. (Police not called). Overspending (£500 o/d). Attacked in street. *[Following this meeting on 2 August Psychiatrist 1 assessed Mr X at the request of Occupational Therapist 1 and did not consider that he should be formally assessed for a compulsory MHA admission].*
7 August 2007 **Red Zone**	Seen on Monday. Mr X seems quite well. Although has some strange mannerisms. Team discussed possibility of Mr X maybe taking drugs. Also had increased appetite. Psychiatrist 1 suggested it may be an idea to assess him. Also stated that AOT have some drug testing devices – Occupational Therapist 1 to check out. He was attacked recently. Also, Mr X has now received ×2 written warnings in a week. The housing association have offered him a room at [another location] but he turned it down. If he has ×2 more warnings then he will be asked to leave. The project worker, support worker at the housing association did a room check the other day. He stated Mr X's bed was broken. Occupational Therapist 1 to see Mr X tomorrow. Assessment to be done before the weekend if possible. **Note at end of minute** Psychiatrist 1 will be on leave w/c 13 August. If anything is urgent, let him know by Friday this week. Psychiatrist 1 will speak with Psychiatrist 2 re Mr X.
14 August 2007 **Amber Zone**	Taking Clozapine as prescribed. Has fallen in with the wrong crowd – they see him as a 'soft touch'. Room was burgled last week. The person who broke in was arrested. Mr X does not seem troubled by this. Telephone has been ripped out. Stayed with his Nan last weekend. The project worker (support worker) says situation is getting worse. Door hanging off its hinges. Bed is broken. Occupational Therapist 1 to keep an eye on him. **[***Following this meeting Mr X was seen by the MHA approved social worker who also didn't consider that Mr X should be formally assessed*

	for a compulsory MHA admission]
21 August 2007 Red zone	Reports received from neighbours which vary as follows: 1) Mr X and his friends were sitting on chairs in the street drinking 2) Mr X and his friends were in the back garden drinking and urinating everywhere 3) Mr X was seen begging in the town centre. On Sunday Mr X's Nan's house was burgled. A spare set of keys have gone missing. Epilim has been stopped – Psychiatrist 2 says he doesn't need to take it. Mr X states he is taking his medication. Drinking heavily, suspicion of Cannabis use, erratic behaviour. Mr X called his Nan on Sunday. Occupational Therapist 1 has reported him to the police as a vulnerable adult. Last seen on Friday by Occupational Therapist 1. Last spoke to his Nan on Sunday. Will report as a missing person tomorrow if he doesn't turn up. No evidence that he had been to his flat. Occupational Therapist 1 is currently liaising with [a police officer].

Family's concerns

5.40 The team leader recalled that Occupational Therapist 1 would frequently refer to Mr X's grandmother, who he recognised as important for Mr X and with whom he spent a lot of time. The family acknowledged frequent discussions between them and Occupational Therapist 1 about what was happening, but in the early weeks of Mr X's time at Residential Home 3 his family evidently felt that Occupational Therapist 1 did not agree with them about the nature and extent of Mr X's difficulties. His mother told us she spoke to Occupational Therapist 1 a few days after Mr X visited her at home at the end of June:

> "*I explained to him all about [Mr X], and I was concerned about [Mr X]'s drinking. I told him about [Mr X] just disappearing with the dog. I have to be honest, he wasn't overly concerned. He said to me that the change in [Mr X] is quite natural with the change in the circumstances of his housing, and I distinctly remember he repeated this to me on numerous occasions when I was going mad down the phone at him about [Mr X]. And that it's quite normal for somebody to change, and he's suddenly got his freedom and he hasn't had any freedom for so long. I've written down here that I expressed my concerns that he shouldn't be living where he's living, and that he's not well enough and he should be in a hospital. He said to me he was going to have a brief meeting with him during the course of that week,*

but he wasn't overly concerned. I do remember him saying to me that you can't force him to take his medication, he's a grown man."

5.41 The family continued to express concern about Mr X's situation, saying he should be back in hospital. They were aware that Occupational Therapist 1 was concerned that his new friends were exploiting him. His grandmother told us:

"*[Mr X] was spending money excessively. It was almost like he was drawing out money. He had quite a lot of money in his account because where he'd been ill for so long and he was getting benefits, and they do get quite a good benefit, so he had about £1000 or £2000, and I think it was spent in a week or two.* [*Occupational Therapist 1] implied that these young men were using [Mr X] and taking advantage of him, and he was probably buying friendship, if you can call it that…[Occupational Therapist 1] was telling me a lot and I was telling him my concerns…as time went on [Occupational Therapist 1] realised that [Mr X] wasn't well."*

Housing association staff's concerns

5.42 The housing association staff had their own response to the developing situation. The first sign that things were not as they should be was when Mr X started "*making a real mess of his room which up until that point he had kept pretty tidy".* They were worried that Mr X was breaking down, that he was doing himself harm and that he was causing concern to the other residents, both by his behaviour and by the company he was keeping. Mr X's project worker kept Occupational Therapist 1 informed of events.

Comment

We have not been able to speak to Mr X's project worker but the housing association staff who we interviewed told us that they thought he had been disappointed that more support was not being offered to Mr X by the recovery team, which would have been the responsibility of Occupational Therapist 1 to organise.

5.43 The housing association had its own methods of dealing with difficulties caused by residents. Mr X had a shorthold tenancy, so could not simply be told to leave. However, he was sent letters warning that an application would be made to the court to evict him

unless he complied with the terms of his tenancy. Their impression was that these warnings had an effect and that there was some improvement in Mr X's attitude and behaviour before he left Residential Home 3. The housing association told us that they wanted their residents to succeed:

> *"[Mr X] coped quite well to begin with. Essentially you are providing a residential service with a little bit of support. We are a landlord, basically. A landlord with support…and we have a good success rate. The people go through our service, they move on, they become independent, and obviously that is what we hoped for for [Mr X], and when we assessed him he seemed to have every ambition and intention to go through that process."*

5.44 However the staff were also firm about boundaries and safety. They would have continued to press the recovery team to do something if Mr X had not maintained his signs of improvement and would have considered eviction if this had not resulted in Mr X being properly supported or re-admitted to hospital.

5.45 They also told us that the other residents knew that they should call the police if they were worried for their own safety. This was not a warning that had been given specifically to Mr X but was information given to all residents as a matter of course. The police were aware of the house's function and of the vulnerability of the residents, and would respond quickly to any reports of trouble.

Comment

The seven weeks between the 11 June and the end of July were an eventful time in Mr X's life. He suddenly had more freedom and more disposable cash than ever, and after a slow start he seemed to take full advantage of his opportunities. In view of his lack of experience of ordinary life, it is perhaps not surprising that he made some bad decisions. He was drinking and spending time with local teenagers who seemed to be taking advantage of him, and he told his care coordinator that he was enjoying himself. It seems clear now that he was not being consistent in taking his medication but we have not spoken to him so do not know why. He had been taking his medication regularly at Residential Home 2 but it is not clear how soon after moving to Residential Home 3 that he first stopped taking his medication or started to take it erratically.

Mr X had a clearly documented **"relapse signature":** *he would become withdrawn, suspicious, refuse to eat food other than takeaways, become frightened of nameless others and become passive. His behaviour during June and July did not fit this pattern.*

This created a conundrum for his clinical team, and in particular for his care coordinator. The aim was to keep his symptoms under control so that he could live successfully in the community. As long as he was managing to live in the community, however shakily, his team hoped that his compliance was sufficient to prevent a relapse that would require re-admission. His wild behaviour in the community could not all be attributed to relapsing illness, particularly as it did not follow the pattern of his relapse signature, as had happened when he was non-compliant at Residential Home 1 in 2004. By contrast, at Residential Home 3 in 2007 Mr X became sociable, albeit with undesirable companions and in a disinhibited way.

It is clear that Occupational Therapist 1 was monitoring the situation closely, working with the housing association and his client to try and maintain him in the community, and regularly discussing matters with the team and with Mr X's family. In this regard, it is important to remember the occupational therapist's report of December 2005, quoted at paragraph 5.5, which said that the professionals should give Mr X practical support to manage in the community, rather than putting too much effort into the apparently hopeless task of getting rid of all his symptoms.

Mr X's family thought at first that Occupational Therapist 1 did not share their concerns, but they later felt that he did and that he was equally worried about the situation.

We note that housing association staff felt that the recovery team was not sufficiently responsive to their concerns. It is not clear if this sense of a lack of responsiveness was generated in July, when Occupational Therapist 1 seemed hopeful about Mr X's situation, or in August, when he was doing all he could to get Mr X into hospital.

Mr X was seen as vulnerable and possibly at risk of harming himself if he became unwell. There was no evidence that he might show violence to others except the

ambiguous incident of the knife discussed earlier and for which different accounts were given. We note that the knife incident did not result in the police being called, nor did the other instances of anti-social behaviour by Mr X and his new friends.

Finding

Finding 6 We do not consider that the clinical team between 11 June 2007 and the end of July 2007 missed any signs that he was likely to engage in violence against others.

Any psychiatric history

5.46 Mr X had little psychiatric history before his admission to the psychiatric hospital in October 2001 and nothing of any significance before his admission to the private hospital in September 2001.

Any forensic history

5.47 He had no criminal convictions but was known both to the clinical team and to the police as a cannabis user for a number of years. Once again this had not led to his behaving in a way that was dangerous to himself or others, so it was reasonable for his care coordinator to assume that his use of drugs and alcohol in 2007 was not a warning sign for detention.

Summary conclusion- suitability of Mr X's treatment care and supervision

5.48 His first contact with specialist NHS services was in October 2001. From early 2002 he was under the care of Psychiatrist 2, who took great pains to find suitable treatment for the symptoms of his illness, so that he could move on to an independent and successful life in the community within the constraints created by his illness.

5.49 Psychiatrist 2 worked in the recovery and assertive outreach team in 2001. When the team split into the recovery team and the assertive outreach team in 2004, Mr X was allocated to the recovery team, with Occupational Therapist 1 as his care coordinator until Mr X's arrest.

5.50 Psychiatrist 2 believes that Mr X should have remained with the assertive outreach team when the recovery and assertive outreach team split:

> *"For a patient to be transferred from assertive outreach into rehab, we needed discussions, and doing it with careful thought and consideration. Because the move from assertive outreach to rehab meant that the community input would drop tremendously, and I wasn't happy with that, because my ethos of doing assertive outreach and rehab was that when a patient gets better, we can't just transfer the patient to another area and call it rehab. If a patient has a very severe history of psychosis, he should remain within the assertive outreach services…if my advice was sought at the time, I would never have agreed for [Mr X] to be transferred to the rehab service to start with."*

5.51 Psychiatrist 2 also had concerns about the suitability of Occupational Therapist 1 as a care coordinator for someone on clozapine:

> *"…right from the outset, I objected to the idea of an occupational therapist like [Occupational Therapist 1] looking after patients on clozapine. I put it to [Manager 1 (service manager)] that, look, clozapine therapy is not actually for somebody like]Occupational Therapist 1] – [Occupational Therapist] 1 is a brilliant senior occupational therapist, he doesn't know anything about clozapine. Why do you give somebody like – I didn't mention [Mr X], but I objected to the principle of giving the care coordinator responsibility of any patient on clozapine to somebody like [Occupational Therapist 1]. Not only that, I said that patients on clozapine should be looked after by senior nurses who are trained in how to look after patients on clozapine. So I suggested that they should attend courses, and they should get all the knowledge about clozapine, how to look after this patient, because clozapine is not like any other medication."*

5.52 Psychiatrist 2 told us that the decisions about allocation of patients to the different teams when the recovery and assertive outreach team split was a management decision, made without consulting him.

5.53 We asked our expert reference group whether an occupational therapist, however skilful, was the right person to care co-ordinate someone on clozapine. The agreed notes of our meeting state:

"The group were of the opinion that historically it has been considered better for someone who is taking clozapine medication to be care coordinated by a community psychiatric nurse because of their understanding of the impact of the medication and the possible side effects.

We were told that this position is now changing with the introduction of clozapine clinics where patients are reviewed and care coordinators are part of that review process.

We were advised that what is important in team working is that the professional disciplines from which team members are drawn should be used as a resource for the whole team. For example if an occupational therapist is care coordinating a patient they should have a right (and a duty) to seek advice and support from other disciplines within the team so that multi-disciplinary work is not lost through a rigid approach to the allocation of care coordinators to different patients."

Comment

Occupational Therapist 1 is a skilled and experienced occupational therapist and we have no doubt of his commitment to Mr X and to the principles of the recovery philosophy he followed in his work with Mr X.

Psychiatrist 2 believed that Mr X should have continued under the care of the assertive outreach team when it split from the recovery team. However, in view of his history of non-compliance with medication, the resistant nature of his illness, the fact that he was on clozapine and the fact that compliance was so crucial to the prevention of relapse, his care coordinator should have been someone trained in the management of community patients prescribed with clozapine – probably a doctor or nurse.

Team members told us that the main duty of each member of the recovery team was to act as a care coordinator. We understand that members of the team were allocated as care coordinators without any significant attempt to match the skills of the professional with the most significant need of the patient.

Despite not having an experienced nurse allocated to Mr X, his care was regularly discussed at team meetings. Experienced CPNs attended these meetings and therefore suitable support was available. Psychiatrist 1 was present at five of the six meetings. It may be, therefore, that decisions about Mr X's care and treatment would not have differed significantly even if a CPN had been care coordinator.

Findings

Finding 7 Those responsible for delivering his care were experienced and conscientious people. Despite some areas of practice that could have been improved, they used their professional skills appropriately in trying to meet Mr X's care, treatment and supervision needs within the structure of their organisation.

Finding 8 We consider that Occupational Therapist 1 should have convened a care programme approach (CPA) meeting when it was uncertain whether Mr X's behaviour was due to his adapting to his new home or the relapsing of his illness. Team meeting discussions are helpful but they should not be used as substitutes for CPA reviews. A review would also have been able to assess whether a greater level of support should have been offered to Mr X.

Finding 9 We consider it would have been more appropriate if Mr X had been allocated a clozapine-trained community psychiatric nurse as his care coordinator, with Occupational Therapist 1 providing regular focused occupational therapy (OT) input. Alternatively, if Occupational Therapist 1 was the allocated care coordinator, a clozapine-trained CPN should have had a formal and regular role in monitoring Mr X. Either of these arrangements would have allowed the nurse to evaluate Mr X's behaviour and ascertain how much of it was attributable to his compliance or otherwise with his prescribed medication. However we know that the team was kept well informed of Mr X's situation and other members of the team assessed Mr X in August, and we also know that Occupational Therapist 1 believed that Mr X was not complying with his medication regime, so we doubt if the involvement of such a CPN would have significantly altered the way Mr X's care was provided.

Recommendation

R1 We recommend that the trust considers issuing guidance on how the particular skills of recovery team members are matched to clients when allocating care coordinators.

The assessments of the needs of carers and Mr X's family

5.54 The only non-professional carers involved with Mr X were his mother and grandmother. Until the day before the homicide, neither requested any support from the recovery team in their care of Mr X when he was with them, though they were involved in contributing their views and concerns about Mr X's care to his clinical team. The notes show, and we were told by the professionals, that Mr X's grandmother was seen as his principal carer, although his mother's involvement and concern for him were acknowledged. His grandmother in particular found the care coordinator responsive to her concerns.

5.55 Throughout his illness, Mr X was supported emotionally, financially and practically by his extended family and in particular by his grandmother, who brought him up and still lived nearby. Mr X often spent weekends with his mother, stepfather and half-sister(s) at their home and saw his grandmother during the week at her home. However, from the time of his first admission to hospital in 2001, Mr X lived either in hospital or in supported accommodation, and was never in the full-time care of any member of his family.

5.56 Those treating Mr X encouraged this close family support. The family worked closely with the professionals and seemed to appreciate the care he was receiving, even if they sometimes felt more could have been done. In particular his grandmother got on well with Psychiatrist 2 and Occupational Therapist 1.

5.57 His family encouraged him to pursue his interests in computer programming, took him on holiday with them and included him in everyday family activities as well as celebrations such as Christmas. Mr X's ability to engage with his family varied with the extent to which his symptoms were controlled, but his family never wavered in their commitment to him.

5.58 Because of this family support, Mr X was less dependent on professionals for his day-to-day activities than would otherwise have been the case. However, he accepted Occupational Therapist 1's advice about accommodation, and seemed to respond to subsequent advice about his behaviour.

Comment

We found Mr X's mother and grandmother much as they come across in Mr X's notes: supportive of Mr X, realistic about his limitations and abilities and (generally) appreciative of the efforts of the professionals to help him. They were also fully aware of the devastating consequences of his actions on Mr A and his family.

Finding

Finding 10 The involvement of Mr X's grandmother and mother with Mr X's care and treatment and with mental health professionals was positive and helpful.

6. The extent to which Mr X complied with his prescribed care plans

6.1 Mr X's care plans included elements other than compliance with medication but only this one area gave any real cause for concern. It had always been an issue. His mother and grandmother said he had always wanted to stop taking his medication when he felt a bit better and the Residential Home 2 manager explained how common this was:

> *"I certainly think that with the reduced supervision going on there and with the temptation of all the money and probably with some people nearer his own age, all of those things contributed to him stopping taking his medication. It is incredibly common, certainly with younger people, to have a few admissions before they actually really get the idea that they might need medication for the rest of their lives. It's a tough one for anyone."*

6.2 While he was living at Residential Home 3 Mr X tried to conceal the fact that he was not taking his medication but it seems that no-one was deceived or at least not for long. By the end of July Occupational Therapist 1 believed he was non-compliant:

> *"At one stage we found untaken medication; there was enough for at least two days' doses and with Clozaril that's a huge problem for us…because when people stop taking Clozaril, the effect can be very quick. It leaves the body very quickly so you can get a psychotic reaction within a few days. A lot of medications build up their effect over a period and also lose their effect over a period, whereas with Clozaril there is a rebound psychosis, which is a huge worry. I wanted to get him into hospital because here was a guy who during the working hours was fine. Even when you said, 'Look, [Mr X], you've got to tidy your room up', he'd say 'All right, Mum, I will', and he would do it like a teenager and all that. But I've worked with people who are actively psychotic and you know it because you get that sense from them…if you have a chat with somebody in the street for a few minutes, that's fine, they can bluff it, but the amount of time we were all spending with [Mr X], if he was hiding something he was doing it incredibly well. He looked 'weller' than most of the people I worked with.*
>
> *Q. What did you think might happen if he became psychotic? What was your worry?*

A. The biggest risk in his profile was vulnerability. There had been a couple of incidents. He was in a chip shop with some of his new mates and he'd been really lecherous over someone else's girlfriend, so he'd got punched. My fear was that as he broke down he would be in very vulnerable situations because he would be drinking as well and probably smoking cannabis. My real fear was that he would disappear, wander off, get beaten up or be found on the beach or something because extreme vulnerability was what his risk profile indicated."

6.3 In reviewing the final draft report Mr X told us that his recollection was that he had been punched in an incident but it wasn't in a chip shop and not as a result of being "*lecherous over someone else's girlfriend".*

Comment

An adult who is capable of making his own decisions and who is not subject to the provisions of the Mental Health Act cannot be forced to take medication. Neither is a failure to take prescribed medication for a mental illness justification for admitting someone to hospital against his or her will. However, if someone with treatment-resistant schizophrenia stops taking their medication, this should lead to an assessment as to whether the criteria for compulsory admission are met.

6.4 Occupational Therapist 1 told us that by the time Psychiatrist 1, staff-grade psychiatrist, saw Mr X, on 2 August, he felt sure he was not taking his medication consistently. He told us:

"I would have loved to get [Mr X] into hospital because that would have solved all the problems. I'm the guy on the front line; every day I come in and think 'What's the message today? What's happened now?'"

6.5 Mr X had a routine outpatient's appointment with Psychiatrist 2, his consultant, on Wednesday 1 August, which he failed to keep. Psychiatrist 2 was not able to offer him another appointment that week so in response to Occupational Therapist 1's request for an urgent assessment, the recovery team staff-grade doctor, Psychiatrist 1 agreed to make a domiciliary visit with Occupational Therapist 1 on 2 August.

Comment

From this time on, it is clear that decisions about Mr X's care and treatment were being made in the context of what action was possible under the Mental Health Act, as described in the next section.

7. The extent to which Mr X's care and treatment corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health

7.1 The trust SUI report makes two key statements in the executive summary:

> *"An opportunity was available to detain [Mr X] under a section of the Mental Health Act and the review team were satisfied from the evidence available that detention would have been possible and appropriate. The team could not understand why a Mental Health Act assessment was not completed."*

> *"Finally the review team concluded that [the] level of violence displayed in this tragic incident could not have been predicted but it may have been prevented if effective action had been taken to intervene when [Mr X]'s mental health began to deteriorate."*

7.2 We have dealt in part in earlier sections with the second of these quotes but we address it here specifically in relation to the events in the few days before the homicide. We also deal in this section with the question of whether Mr X should have been subject to a formal MHA assessment and whether the decisions of staff at the time in the context of what they knew were reasonable.

7.3 As explained in the executive summary we have used the following as our working definition to assess whether the homicide was predictable or preventable:

- We consider that the homicide would have been predictable if there had been evidence from Mr X's words, actions or behaviour that could have alerted professionals that he might become violent, even if this evidence had been un-noticed or misunderstood at the time it occurred.

- We consider that the homicide would have been preventable if there were actions that professionals **should** have taken which they did not take. Simply establishing that there were actions that **could** have been taken would not provide evidence of preventability: there are always things that could have been done to prevent any tragedy. For example the tragedy would have been prevented if Mr X had been compulsorily admitted to hospital, but unless the professionals had the evidence to

justify detention, the possibility of its having been prevented on this basis is only theoretical.

Predictable

7.4 We set out in the history of Mr X's contact with services at the beginning of this report the ways in which Mr X's illness manifested itself. This shows that his levels of aggression or threatening behaviour were low. Generally he was passive, quiet, polite, and reserved. When he was under-medicated he became giggly and disinhibited, but this did not develop into unmanageable behaviour, nor was it ever thought that he was any risk to others.

7.5 In a different context, two incidents might have been seen as suggesting risk to others; the occasion in November 2004 when Mr X pushed a visitor who was drunk and threatening down stairs, and the occasion in July 2007 when one of his housemates complained that he had threatened him with a knife. In the first case this behaviour by Mr X seems to have been seen by his clinical team as part of the evidence of his inability to cope with his placement, rather than as an aggressive impulse arising from his illness or personality. In the second case Mr X provided a plausible explanation for having a knife in his hand. This, together with the fact that his housemate did not feel threatened enough to call the police, seems to have reassured the professionals that this was not a matter that needed further exploration or action.

7.6 Even when Mr X was struggling to cope at Residential Home 3 and when he left there to go to his mother's home the concern was always for his own health and safety, not for the protection of others.

Comment

In the overall context of Mr X's well-documented history, this view of the risks Mr X posed seems reasonable. He had been closely monitored as an inpatient for several years with no hint of danger or risk to others. Two minor incidents when he lived in the community were ambiguous, and could easily be seen as part of the rough and tumble of ordinary life. In the absence of any other reason to believe that Mr X might pose a danger to others, the response of the professionals to these two incidents was

reasonable, as was their continuing belief that the only risk Mr X posed was to himself. We go so far as to say that to believe otherwise would have been strange.

Finding

Finding 11 We conclude that there was no reason for the professionals to predict that Mr X was a risk to others.

Preventable

7.7 The trust SUI panel considered that Mr X should have been sectioned in August, and that if he had been, the homicide would not have occurred. We agree that if Mr X had been sectioned he probably would not have killed his victim and perhaps would never have become violent, so we have considered carefully whether the professionals should have sectioned Mr X. We therefore look in detail at the assessments made between 1 August and the time immediately preceding the homicide.

1 to 19 August 2007

7.8 By the beginning of August, everyone (except perhaps Mr X) knew that Mr X was in real difficulty: he was breaching the terms of his tenancy; non-compliant with his medication, living in squalor, in debt, drinking, and at risk of harm from his new friends. Occupational Therapist 1 believed that it was in his interests to be admitted to hospital to be stabilised, but Mr X would not agree. Occupational Therapist 1, as an occupational therapist, was not trained or qualified to assess whether the criteria for compulsory admission under the Mental Health Act had been reached. To advise him whether Mr X might meet the criteria for compulsory admission, Occupational Therapist 1 asked Psychiatrist 1, who was qualified to make this judgment, to assess him. Psychiatrist 1 had not met Mr X but was involved in the weekly team meetings when he was discussed and had given advice about Mr X in those meetings. He had also looked in detail at his notes. He told us:

> "*The first time I came to know [Mr X] was during a discussion with [Psychiatrist 2] and myself in clinical supervision about the success that he had had in treatment with [Mr X] on a particular pharmacological combination treatment…I was doing some background work on the feasibility of a research paper on this Clozapine and*

Abilify combination that needed me to look at patients' past histories and treatment…I had the good fortune of having reviewed [Mr X]'s clinical notes way before this and just looked at how the treatment combination actually improved his case…I wouldn't want to put my hand on my heart and say I looked at his risk assessment, I may have glanced at his risk assessment but I did definitely have a good, detailed look at his clinical presentation and the changes that he had experienced with this combination treatment."

7.9 Psychiatrist 1 told us what he remembered about Occupational Therapist 1's concerns:

"I got the sense from [Occupational Therapist 1] that he was concerned that [Mr X] was vulnerable…because he had generally kind of lived quite a protected life, I mean through his illness, and so his behaviour at the time was very out of character. I know that [Mr X] had been in a scuffle, and he had been punched…that he may be mixing in with the wrong crowd and he was not streetwise at all…If I remember correctly, I think [Occupational Therapist 1] was concerned about [Mr X] taking his medication or not taking it, because they may have found some tablets…and he had missed his appointment…"

7.10 We asked Psychiatrist 1 about his perception at this point of Occupational Therapist 1's understanding of the importance of Mr X's compliance with medication. He told us:

"I don't think he realised how quickly people could relapse, how severe the relapse could be…I think he realised how important it was for patients to continue taking their treatment.

I would say from my impressions, I don't think he realised how quickly and some of the early signs that may alert you or cause you to be suspicious…because there are many patients in the community that suddenly stop the treatment; they stop the clozapine, it is common. In the team that we worked in it was common practice, and people who you had become concerned about you wouldn't necessarily – depending on the situation you would keep an eye –but you didn't necessarily rush in there or put them into hospital…often the risk assessment is what underpins our

reactions and informs our management plan very much, and so Mr X's risk was so low – negligible, really."

7.11 Psychiatrist 1 describes in the clinical notes how Mr X appeared and what he said. He concludes:

"[Mr X]'s presentation very different to how he is. Relapsing, more outgoing, drinking, involved with people who have notorious reputations and some actions jeopardising tenancy. Limited insight into how he is.

1. *[Occupational Therapist 1] to keep an eye*
2. *Clozopine trough level in 1/52"*

7.12 We asked Psychiatrist 1 what he meant by "*[Occupational Therapist 1] to keep an eye*". He told us:

"We had a discussion about the change; to keep an eye on the behaviours. You know, there were on-going out of character behaviours, and also on medication; …if some of these signs and symptoms were on-going, then with someone like [Mr X], we needed to have a plan of what to do…"

7.13 We asked if Psychiatrist 1 had impressed upon Mr X the need to take all his medication because the combination had proved most successful in controlling his symptoms. He told us:

"*Yes. I don't think he was able to take it on board, though. I remember sitting in his front lounge having met him for the first time and it was a difficult interview, consultation for me to try and follow and understand what he was trying to say because his thoughts were so vague and he was so circumstantial. Also communicating with him, I wasn't sure – I mean I had impressed upon him – but how much of that he took on board I couldn't judge."*

7.14 We asked him why he had not thought that Mr X should be required to accept treatment. He said:

"*There are so many patients like [Mr X], you know, that we see…we always try to follow the least restrictive option in managing our patients, and the team like the Recovery Team is geared towards supporting patients in the community and so we are able to muster up a lot more resources and see people on a daily basis to a point where it becomes either too risky or unsafe or we are unable to manage patients in the community and then let them into hospital. So the team was able to offer them the monitoring that [Mr X] needed to what is I think is accepted as a standard…this can grumble on and grumble on or it can resolve itself…You know it could be that someone like [Mr X] who wasn't taking his medication he suddenly starts taking his medication and things get better within three or four days…"*

7.15 We asked him if he and Occupational Therapist 1 had discussed the possibility that Mr X was going through a delayed adolescence. He said they had:

"I think he meant it in the sense that [Mr X] was maybe finding himself; an opportunity to not find himself but he was well and going out and so on. As much as that was a reasonable and legitimate explanation, this was someone that had a schizophrenic illness and so there were other things that one needed to consider and be alerted to. That was what [Occupational Therapist 1] and I discussed…

I discussed with [Occupational Therapist 1] the plan that [Mr X]'s medication needed to be checked, and between that meeting and our team meeting a couple of visits would be reasonable. And then of course to keep [Psychiatrist 2] informed who was the responsible clinician but was responsible for [Mr X]'s care and treatment in the community."

Mental Health Act Assessments during August

7.16 Occupational Therapist 1 told us that if Psychiatrist 1 had thought Mr X was detainable it would have triggered a formal Mental Health Act assessment, with two doctors and a social worker.

7.17 On 2 August Psychiatrist 1 did not think Mr X met the criteria for detention. He told us:

"…there are two options for admission to hospital. One is a voluntary admission which [Mr X] wouldn't want, and then there is an assessment under the Mental Health Act, and at the time on that particular day I made the judgment that [Mr X] didn't fulfil the criteria of being detained in hospital, and so we needed to do the best we could…there were a couple of things that we had agreed on and that were also in place. One was that [Mr X] was regularly reviewed or regularly discussed at our weekly meeting, so his progress like as if he was in hospital which would happen at the ward round; that discussion happened on a weekly basis."

Medication blood level tests during August

7.18 Psychiatrist 1 recommended that a "*trough*" level test should be done within seven days. This test establishes the level of clozapine in the blood and is therefore a test of the patient's compliance with medication. In fact, although Occupational Therapist 1 made arrangements for this test, the appointment was made for 22 August. He was booked in for an earlier appointment but failed to attend.

7.19 We asked Occupational Therapist 1 why he had not pursued the trough level test more vigorously. He told us that he already believed Mr X was not taking his medication reliably so the trough level would make no difference to his management of Mr X's care.

"If I'd found out the next day that his trough levels were really low, that wouldn't have told me anything I didn't know. I tried to organise it with his local GP…I organised an appointment that he didn't go to…"

7.20 Psychiatrist 1 told us:

"If the level comes back low of course we would have wanted to come into hospital, offered him a voluntary admission or have detained him if there were sufficient grounds for detention under the Mental Health Act, or at least have him assessed under the Mental Health Act."

7.21 Psychiatrist 1 told us that the results of trough level tests took two to three weeks to arrive.

Comment

Psychiatrist 1 saw Mr X on Thursday 2 August and said that a trough level test should be made within a week. This would have to be arranged with Mr X's GP, and would not have happened before Monday 5 August. If the blood had been taken on that day and the results had taken only two weeks to come back, they would not have been received until 20 August (19 was a Sunday), by which time Mr X had already left Residential Home 3, much to the concern of his care coordinator.

We have not been able to talk to Mr X about the extent of his non-compliance, but we note that the last time he saw Occupational Therapist 1 before going to his mother's it had been agreed that he would have a trough level test taken the following week. It seems to us quite plausible that one of the reasons Mr X left Residential Home 3 when he did was to avoid the consequences of having a trough level test or telling Occupational Therapist 1 that he was not going to take the test. This non-compliance was obviously self-destructive, although presumably Mr X did not have the insight to recognise this. However, it cannot be categorised as showing a wilful disregard for the safety of others because there is no evidence that Mr X had any reason to believe that he was capable of the violence he later showed.

Finding

Finding 12 On the basis of the information given to us, it seems unlikely that the result of the proposed August blood test would have been obtained in time to make any difference to the management of Mr X before he committed the homicide.

Relapse or catching up on missed social opportunities

7.22 After Psychiatrist 1's visit, Occupational Therapist 1 complied with the requirement to watch what was happening by visiting more frequently. His next visit was on 6 August (four days later) and his notes record that he saw Mr X with his housing association project worker:

> *"Overnight there was a social gathering at the flat. There was food on the walls…on the floor and on the road outside. These are the only definite facts. [Mr X] vaguely acknowledges some responsibility for something as he was involved in a*

food fight at some stage. But was very vague about what he did, who the other people were. It's clear that these things are not important for [Mr X] and he is able to laugh at it. This will result in his second formal warning from [the housing association].

Attempted to convince [Mr X] of the seriousness of events in the house and the possibility that he will be evicted and therefore voluntarily homeless. Three events that happened in the house within a week plus him being attacked in the street. He appears mentally well and reminds me that he has run out of meds every Monday. It appears that this is at least partially a kind of 'catch up' in terms of life stages since [Mr X] has been ill and in hospital settings for many years, missing his late teen/early 20s development.

<u>Plan</u> – to see two/three times a week including dropping off new Clozapine and collecting empty blister pack. Attempt to help [Mr X] reflect on his situation, his actions and his vulnerability. Monitor signs of illness/relapse/non compliance. Liaise with [the housing association] and his Nan. See next 8th August."

7.23 Occupational Therapist 1 explained to us his thinking about the relationship between Mr X's illness and his behaviour:

"*If we see people purely in terms of medical aspects we are not doing them a service and we are on a slippery slope to dehumanising them and symptomising people. I would have been a fool if I hadn't recognised that he was a guy who got ill when he was about 16…and has been out of the real world for many years. When he comes back into the real world with money in his pocket and freedom, nine out of 10 people would see that as an opportunity or catch up. 'I've been away from all of this for years and I want to do something about it'. Looking at [Mr X] as a complex, rich human being, that's a part of it. He has a diagnosis of treatment-resistant schizophrenia, so that's a part of him as well. Those two overlap and drawing a line between the two of them is very difficult. If I had been overly focused on the psychosocial stuff I don't imagine I would have got a doctor and social worker to come and see if he was sectionable. I remember talking to the social worker about this: "Who is this guy? What's he all about?"*

7.24 The social worker told us:

> "*I had a thorough discussion with [Occupational Therapist 1]; that here was a young man who from the age of about 19 had been in hospital and in institutionalised settings, he had then come out into the community in a minimally supported environment; yes, of course he is going to go out and drink and associate with people that maybe he should not have. I think that is normal behaviour for a young man who has been deprived of being able to do that because he has been detained in hospital or whatever, and there probably were some left-over delays, because he had had this illness for a significant number of years going back to his late teens*."

7.25 She went on to say that Occupational Therapist 1 was clear that this was only part of the explanation and that he fully understood the need for Mr X to take medication.

Comment

Occupational Therapist 1 was an experienced occupational therapist who had worked with patients in forensic settings, giving him a good understanding of the need to continue taking medication during rehabilitation.

7.26 On 8 August Occupational Therapist 1 records:

> *"[Mr X] not answering on my arrival, have called all his contact numbers without response. Will continue to attempt to contact him. Have made team aware of concerns and preparing joint visit with ASW[13]."*

7.27 On 9 August Occupational Therapist 1 records:

> *"Contact with [the housing association]. I have seen [Mr X] at home with the project worker [housing association project worker]. [Mr X]'s mental health continues to appear intact with no signs of active illness.*

[13] ASW is an Approved Social Worker trained and authorised to assess whether an individual meets the criteria for Mental Health Act compulsory detention.

There are some signs of distraction and inappropriate laughing as well as ongoing vagueness and lack of awareness. No indicators that would warrant an MHA assessment. He assures me that he is taking his Clozapine and he shows me the blister packs with the appropriate amount used."

7.28 On 13 August:

"*Finally caught up with [Mr X] today and delivered one week's Clozapine. [Mr X] has been sleeping downstairs due to state of room. Broken bed. Broken door. Extreme untidiness, mostly food, fire extinguisher discharged. Spent time with [Mr X] alone attempting to help him reflect on the likely consequences of his actions. He appears to appreciate this but it is unclear. I advised him to…clear his room…he is complying with agreement for no visitors…[Mr X] assures me that he will start on this before my next visit on 15th August."*

Second opinion sought from approved social worker

7.29 On 15 August Occupational Therapist 1 recorded that he received a phone call from the housing association project worker, reporting that unused clozapine had been found in Mr X's room. He visited with Mental Health Act approved social worker, the social worker, at 4.10pm to assess whether a MHA assessment was warranted and to provide a second opinion about what was happening. They spent an hour with Mr X and then met his grandmother. Mr X acknowledged the unused clozapine but said it was spare from before. Staff from the housing association were present and gave Mr X an ultimatum about the state of his room and the need to clean it. Housing association staff helped him start. The records state:

"[Mr X] verbally acknowledged the need to complete this and has accepted the challenge – in part to 'show you that I am well'. Assures us that he is taking medication apart from Epilim, which he states was described as optional by his psychiatrist…discussed the situation fully with [Mr X]. I explained that I believe he is taking only his Clozapine regularly. I believe he is drinking heavily…and some cannabis…suggested a stay in the rehabilitation unit to break this cycle which he declined. [The social worker] agreed that there were not enough symptoms to warrant MHA assessment. To see again 18 August. Liaised with Nan who believes

that [Mr X] needs to be in hospital and explains the bizarre behaviour – avoiding eye contact, being overly interested in women, giggling inappropriately."

7.30 Occupational Therapist 1 described the purpose of this meeting between Mr X and the social worker to us:

"Her visit was about whether a Mental Health Act assessment was something we could do, but also it was a professional second opinion of him…I said, '[Occupational Therapist 1] can you come and see my guy? I've got real worries about him', she said, 'Okay. Let's do it on Wednesday'…The really odd thing with this case is that when you would see [Mr X] during the day, he was pretty well the same as he had been three to six months before. He was presenting really well and that was difficult…In terms of how he interacted with us, I was struggling to say, 'Look, that's a symptom of relapse'. [Mr X] has ideas about things. He will talk about destiny and things like that, but we all have that. That's not big enough for me to point as being indicators…"

7.31 Occupational Therapist 1 told us that Mr X was not displaying his typical relapse pattern of staying in his room, eating only takeaways and being suspicious, although his lack of personal hygiene fitted his relapse signature, and said:

"From the patient's perspective, if I say, 'I'm going to get my social worker to come and have a chat with you to see if there's anything we can do', that seems more humane than saying, 'Here are some doctors and forms and they are going to do something to you'. If there had been a Mental Health Act assessment, fair enough, but to get someone to see him who is specially trained in Mental Health Act assessments seems a great first step to me…The odd thing about him presenting was that whoever saw him during the day, even for an hour, he was fine. He's a bit distractible, but you couldn't say, 'Look at all the symptoms here'. It was what happened during the evening and overnight. If he had been in the rehabilitation unit, for example, you would instantly have had a view of him overnight…I got [Psychiatrist 1] out because I wanted him in hospital. I make no bones about that and that feeling went on for two weeks until I said, 'the social worker, can you help me? Can you get this guy to hospital?'."

7.32 The social worker told us about the information she had before the visit:

"I had never met [Mr X], up until the date that I went out to see him with the care coordinator, which was around 15 August. But obviously, as part of the Recovery Team process, [Mr X] was discussed over a number of weeks at the Recovery Team meeting. I think one of the ways that we worked very well in the Recovery Team is that we each knew a little bit about everybody who was part of that service. So I knew a little bit about [Mr X] before I actually went out to see him…

I understood that [Mr X] was a young man who had spent the majority of his adult years in institutional care, he had moved out to less supported accommodation and was struggling a little bit, which is very normal for somebody who has moved from a very institutional setting to a less supported setting, that there were concerns around his mental health, about his compliance with treatment…The anxieties were around risks in terms of his mental health deteriorating because he was not complying with his medication – or there was an idea that he was not complying – also that he was getting involved with the wrong crowd, and that was an anxiety, and that obviously his grandmother was concerned about that…

I think [Psychiatrist 1] went out on the 2nd and felt that [Mr X] was not detainable. And then, the following week at the team meeting, because there were further concerns we had another discussion about maybe doing another Mental Health Act assessment. So I think I said I would be available on the 13th because I was on call that day…"

7.33 She also told us about the content of the conversation she had with Mr X:

"We talked about whether he was taking his medication. I asked him about whether he had been taking illegal substances. We talked about his room had ended up in such a state. I asked him about whether he was having any unusual experiences, any thoughts or feelings he could not explain, whether he felt he might want to hurt himself, or there were risks to others around him. I think the main emphasis was on his room and why it had got into such a state. But his reasoning was very plausible…I think he said he had had some friends round who would trash the place, young men, boys, whatever. I think there was some mention that his room had been burgled and tipped upside down. To be honest I

cannot really recall the fine details of the conversation…I was trying to ascertain where he was in terms of his mental health…"

7.34 She told us about how she had assessed his mental state:

"…often you find when you are assessing someone's mental health that if they are relapsing, they can be coherent for a certain amount of time but it is generally not very long. They can have a perfectly reasonable conversation, but you mention something and it triggers something and then the conversation takes a turn and they are then displaying open and active symptoms. But I think I was probably there for about 45-50 minutes with [Mr X], and at no time did I think, 'This man is relapsing significantly enough to warrant detention in hospital'. It was clear that he needed some support, and he was offered an informal admission, which he did not want to take…In my mind, he was not detainable. It would have been unlawful to detain him because he did not satisfy the criteria for detention. With the relapsing patient, if I had had clear evidence that this set of circumstances would have led to a full-blown relapse, I could have detained him, but I did not have that evidence."

7.35 In respect of his compliance with medication she told us:

"We did not have conclusive proof either way, whether he was or he was not, and he was convincing when he said, 'I am taking my medication'. Short of saying, 'Actually, you're telling lies', it is very difficult, because you want to work collaboratively with a person. If they suspect you, they do not trust you or whatever, that makes that whole working relationship more difficult…My judgment, I believe, at that time and in those set of circumstances, was a sound clinical judgment…I guess with someone like [Mr X] who is potentially at risk of relapsing, having a bit of time out in somewhere like the rehabilitation unit – which is an acute unit, but more of a rehabilitation unit, to get him back on track with his other medications and to really check out whether he was compliant…would have been ideal. But you cannot make someone go to hospital if they do not want to and they are not detainable under the law…"

7.36 Mr X's mother and grandmother remember the social worker's assessment on 15 August:

> *"Mother: By that time [Occupational Therapist 1] was in agreement with me and Mum that [Mr X] was not well, he should not be out on the streets and he wanted him sectioned.*
>
> *Grandmother: Four people interviewed [Mr X] on 15 August. I went over and I was trying to get him to come home, and he was going to come home. I went to get him and [Occupational Therapist 1] arrived with these other people and he said, 'You can't take [Mr X], he's going to be assessed.' Four of them went with [Mr X] into that room and I sat outside in the car for an hour…[Mr X] didn't come home with me that time, I don't think, so I went back the next day with a load of cleaning things, hoping that [Mr X] would let me help him clean the room, and he said no. He took all the cleaning stuff and I never saw [Mr X] again until 22 August, he disappeared…*
>
> *Mother: We were [Mr X]'s family, and I appreciate that sometimes family can't be very nice so you can't always trust what they're saying, but [Occupational Therapist 1] was also saying at this point what we were saying, and his opinion wasn't taken into account, I don't believe. He said, 'I'm really sorry but [Mr X] put up a really good case and there's nothing we can do.'*
>
> *Grandmother: And he said, 'I can't force [Mr X] to take his medication'.*
>
> *Mother: But there was nothing [Occupational Therapist 1] could do.*
>
> *Grandmother: But we were relaying our frustrations on [Occupational Therapist 1] because he was the only person we could really talk to…I don't blame [Occupational Therapist 1] at all for anything; I know he tried."*

7.37 Occupational Therapist 1 told us how he felt after the second assessment:

> *"As a care coordinator you think, 'Here's a guy who's not very well. What are the things I need to do?' Typically two people need to see him, one is a social worker with ASW powers and one is a psychiatrist. Having had both those people see him,*

the information I received from them was that he was not ill enough to section. That puts you in a terrible position; you know that they guy is not well and that he's on that descent, but when you meet him he's holding it all together. He's clear and sensible and presents very well. He understands, looks you in the eye and takes in what you say.

I sat there with [a project manager] from [the housing association] and we talked to him for ages. I was seeing him every other day and talking to someone on the days I wasn't seeing him and everything seemed to happen between five in the evening and nine in the morning. But when I came to work and sit with him, no one could tell me that he's sectionable and the two people whose job it is to think about that have said that he's not."

7.38 For a reason we have not been able to discover, Psychiatrist 2 was not asked to assess Mr X at this stage. He and Psychiatrist 1 both recall that when they discussed Mr X after Psychiatrist 1's visit to him, Psychiatrist 2 said a formal Mental Health Act assessment should be carried out and that he should be one of the assessing doctors because he was responsible for Mr X. Psychiatrist 1 recalls this conversation on 9 or 10 August because it was just before he went on holiday on 13 August. Occupational Therapist 1 was not aware that Psychiatrist 2 had asked Psychiatrist 1 to arrange for him to assess Mr X.

Comment

We have been unable to discover what happened to the plan that there should be a formal MHA assessment. Psychiatrist 2 made clear to us that he should have been consulted before any decision not to proceed with a formal assessment and it may be that it was simply overtaken by events. The weekly team meeting notes indicate that the arrangements to have Psychiatrist 2 involved in a Mental Health Act assessment were discussed in the week after Psychiatrist 1 had carried out his assessment and assigned to Psychiatrist 1 to arrange.

7.39 Psychiatrist 2 told us:

"Whether I could have found any symptoms or not, I would have suggested to place him on a section if I knew that he wasn't taking his Clozapine…If a patient is

on Clozapine and has stopped taking Clozapine, all clinicians know that you get the rebound psychosis, and that symptom alone, when withdrawal happens, would qualify a patient to be detained. So I would have detained [Mr X] if I had come across him without being able to detect any psychotic symptoms, because I would have detected that he hasn't been taking this medication, and I could have justified that detention, because I knew that based on his history, how many months it took for him to get better, I knew that he was a difficult patient and if he relapses, it would be detrimental, so I would have stopped that if I had come across him. So it wasn't a question of whether I could detect psychotic symptoms or not. For me, to be disorganised or dishevelled, or being a victim of violence, and so on – all these things would have been more than enough for me to detain him."

Comment

We do not doubt Psychiatrist 2's sincerity but we cannot be sure that Mr X would have been sectioned if Psychiatrist 2 had assessed him that week, either on 13 August or later. A patient can be detained for treatment only if two doctors and an approved social worker agree. We know that the social worker, an experienced approved social worker, did not consider that Mr X reached the threshold for detention on 15 August and even if Psychiatrist 2 had supported detention, the other doctor and the social worker might not have done so.

The extensive quotes above and some notes taken at the time, show that Occupational Therapist 1 was visiting regularly to assess the situation with Mr X or to respond to particular events. The records show that he actively took steps to gather advice from colleagues to help him understand what was happening and to determine whether Mr X should be the subject of a formal MHA assessment.

Two professionals who were approved to undertake MHA assessments saw Mr X. Both Psychiatrist 1 and the social worker were familiar with Mr X's difficulties before their assessments. They both concluded that when they saw him he did not meet the criteria for compulsory detention in hospital.

Expert reference panel view

7.40 We asked our expert panel to consider whether Mr X should have been sectioned. The team first considered Psychiatrist 1's visit on 2 August. They were aware that Psychiatrist 1 was a staff-grade psychiatrist, trained and authorised to assess whether someone met the criteria for detention and a member of the recovery team familiar with Mr X's case from team discussions. He also reviewed Mr X's notes in detail before visiting him with Occupational Therapist 1.

7.41 Our expert reference group made the following points:

- Arranging a pre-MHA assessment was a reasonable approach on the first occasion. Occupational Therapist 1 could have requested a formal MHA assessment on the second occasion. Alternatively, he could have asked Psychiatrist 1 to do a second visit.

- It is not uncommon to have a decision as to whether someone should be formally assessed stretch over a number of weeks as the patient's situation develops.

- Professionals undertaking a formal MHA assessment would have had difficulty in justifying detention simply on the grounds that they thought Mr X was not taking his medication.

- Arranging a formal MHA assessment would have been a legitimate step for Occupational Therapist 1 to take. However, what he did was within the bounds of a reasonable professional judgment, particularly as neither Psychiatrist 1 nor the approved social worker believed Mr X met the criteria for detention. It is also clear from the chronology that Occupational Therapist 1 had put in place carefully thought-out strategies and responded to changing circumstances in a timely and appropriate way. Therefore, the decision not to request a formal MHA assessment should not attract criticism of Occupational Therapist 1. Furthermore, the opinions of the doctor and social worker, that Mr X was not detainable, were within the range of reasonable professional judgments that could have been made by them.

Comment

During the time Mr X was at Residential Home 3 the thinking of those involved in his care and treatment show the ambiguities and complexities that existed in his care. It seems that everyone believed that Mr X was not taking his medication regularly and that this was a problem because erratic compliance could put his physical as well as mental health at risk.

By August Occupational Therapist 1 agreed with Mr X's family that he should be admitted to hospital, and tried unsuccessfully to persuade him to go in as a voluntary patient when he met him with the social worker on 15 August. He also arranged for informal assessments from suitably qualified professionals to establish whether compulsory powers could be used. Mr X was not considered to meet the statutory criteria for detention by those who assessed him and who were approved and experienced in undertaking those assessments.

Finding

Finding 13 We conclude from the evidence of the records and our interviews that detention under the Mental Health Act was considered carefully and was based on all the evidence available at the time of the assessments in August. We find no evidence to criticise the judgments of the professionals concerned.

Possible action by professionals between 17-22 August 2007

This section is a continuation of section 7. We have started it on a new page as it is an important part of the chronology as it deals with the immediate events leading up to the homicide of Mr A.

7.42 On 17 August Occupational Therapist 1 saw Mr X for the last time and noted:

> *"Saw [Mr X] at home with [the housing association] support worker. [Mr X] has cleaned his room, removed all the rubbish…agreed to getting the carpet steam-cleaned at his expense. [The housing association] are satisfied at his efforts and have agreed to work together to clean the rest of the house. [Mr X] reports to taking his meds. When looking in the room found his Clozopine blisters taking correctly up to lunch Friday but no sign of the Abilify or Citalopram. Agreed to trough level and Cloz. bloods on Monday."*

Comment

At this point, it seemed that all the effort and concern that had been put into Mr X's care and treatment was at last showing results; he had cleaned his room; he had averted the threat of eviction and he had agreed to have a blood trough level test the following Monday.

7.43 We do not know where Mr X was from 18 to 21 August, but we know he was not at Residential Home 3 or with his family.

7.44 On 20 August Occupational Therapist 1 went to Residential Home 3 as previously agreed to deliver Mr X's medication for that week. The clinical notes record that Mr X was not in and Occupational Therapist 1 arranged for his CPN colleague to visit later. She went twice without success.

7.45 The records note that Mr X spoke to housing association staff, who had had reports of a group of teenagers drinking and being rowdy in the garden and on the street; abusive language from members of this group (not from Mr X); Mr X being seen begging in the town. Mr X told us that he had never begged.

7.46 Occupational Therapist 1 contacted the police on 20 August and registered Mr X as a vulnerable person who he believed was being taken advantage of and because of his vulnerability/developmental delay was unaware or unwilling to stop this.

7.47 The note for 20 August ends:

> *"Call from [Mr X]'s Nan to report that her house had been ransacked. TV, jewellery, credit card, alcohol had been taken. No evidence of a break in. She is aware that a set of her keys has been missing for more than a week. [Mr X] contacted her while she was away yesterday 19 August. This would give [Mr X] the knowledge that the house was empty. She intends to report this to the police. [Mr X] is out of contact. To be discussed at team meeting tomorrow."*

7.48 Occupational Therapist 1 told us*:*

> "*With the last two weeks of wondering how ill he was, how much of what was happening was illness and how vulnerable he was and what would happen to him, for him to disappear and to be pretty sure that he wasn't taking his medication anyway – and because he was not there on the Monday it was clear he wasn't taking it – I was pretty scared for him. Registering him as a vulnerable person seemed the most appropriate thing to do, because the less medication he took, the more vulnerable he would become…*
>
> *Q. You were very concerned about [Mr X] and his vulnerability. What did you make of this call from his Nan about the ransacking? Did you assume that was him?*
>
> *A. It's a pretty good chance it's going to be [Mr X]. You don't assume anything. You don't say, 'that's got to be [Mr X]', but the fact there was no break in, the keys had gone missing and he knew she wasn't there does point to him."*

Comment

Kitchen knives were taken during the burglary, but no mention of this is made in Occupational Therapist 1's note of his conversation with Mr X's grandmother. We asked him if there had been any such mention. He said there had not.

We asked Mr X's grandmother about this and she agreed that she probably had not referred to the knives because at the time she told Occupational Therapist 1 of the burglary she had not had time to check what had been stolen.

7.49 Psychiatrist 1 commented on Occupational Therapist 1's response to this situation:

> "*It should have worried him, and it did worry him. I remember that week [Occupational Therapist 1] was very concerned, so it did worry him because with Clozapine if the patient goes 48 hours without having had their medication, the risk of relapse is very significant and the rate of relapse is very rapid. Also you have to restart the medication and re-titrate it from the beginning; you can't just go back on the same dose, unlike many of the other medications which has implications of course for how you set up the treatment plan."*

7.50 A team meeting took place on 21 August. The notes of that meeting are quoted above after paragraph 5.39 and show that Occupational Therapist 1 made a comprehensive report of the situation and what action he was taking.

Mr X arrives at his mother's home

7.51 On 22 August, Occupational Therapist 1 notes:

> *"[Mr X]'s mother contacted me to tell me that [Mr X] has arrived at her home…She reports that he is 'not well but not really ill as he has been before'…*
>
> *Spoke with [Mr X]. He has agreed that he will return to [Residential Home 3] tomorrow and come to [the psychiatric hospital] for admission as a voluntary patient. I will meet with him tomorrow at 11am. My belief is that he will not actually come voluntarily to the ward. I have been in contact with SS Adults Help Desk to organise an MHA assessment if this is required. [Mr X] has had no Clozapine since last dose on 19 August. T/C with manager of [the housing association]. He has not paid rent since moving to current address."*

7.52 We asked Occupational Therapist 1 about his reaction to the phone call from Mr X's mother:

"I was relieved. With [Mr X]'s pattern of behaviour he could have gone anywhere. As I said, all my concerns were about him just disappearing. The fact that he went to his mother's was so reassuring and may even have indicated that if he was not doing very well and knew it he would go somewhere safe, somewhere he trusts people and they are on his side, like his mum's where his sister is, who he has a great relationship with. That was a reassuring incident that he wasn't running away from everything…

For him to get there on his own…shows a certain level of holding it together and being able. Whether he jumped the train and didn't buy a ticket, I don't know, but the fact that he got there was good as was the fact that his mother said that while he was not right, he was not as bad as she'd seen him. His mum knows [Mr X] way better than I do, so that was a useful thing to hear from her. Again, talking to him on the phone, he was this well presented, able, articulate man saying, 'yes'."

7.53 We asked Occupational Therapist 1 what he had done in response to the news:

"It's difficult to know exactly when I was thinking at the time. My sense that he was with his mum and that if he was with them, maybe they would bring him down and be part of that…I knew his Nan quite well because she was his main carer. I met his mum years ago when he was at the Maudsley. I've met her since, but I didn't have such an understanding with her…She had seen him at his worst, seen him get better and was now seeing him at this stage. Realistically all of us in the mental health profession know the limits of our own knowledge. His mum will know him in complex detail that I couldn't hope to achieve and if she was saying, 'He's okay. He's not great, but he's not awful.' I'm sure I said to her, 'Here's my number. Please contact me if anything changes.'"

7.54 He told us he had phoned his local social services adult helpdesk and said:

"'Here's my situation. I've got someone who's stopped taking his med and is probably not very well. I'm really worried about him and I don't know where to go

with this. If he's up in [another area] or wherever, what can I do?' I had that conversation"

7.55 We asked him if he had made contact with the mental health services in that county. He told us:

"*I wish I could remember more about this, because I wonder whether I had a conversation in terms of saying 'If you've got any concerns, call the police'. If the police picked someone up down here, CMHT would have a liaison person to go to the cells and assess him, whether they knew him or not. That would be the same for A&E or wherever.*

The only concerns we had were about his vulnerability, not his risk to anybody else. There's never been anything that's changed the view at that time there was no way of knowing he was a threat to anybody else…He was with a bunch of supportive people, who he trusts and who know him inside and out. They have been with him throughout every stage of this illness and that is such a relief in terms of him being somewhere safe. The risks that he was presenting were much more controlled in the environment he was in there than they had been over the last few weeks. For his mum to say he was not as ill as she had seen him, he wasn't right, but he wasn't as ill as she had seen him, was also reassuring. I can't remember the detail of how I thought he was going to get home. This was two years ago, but I have the sense that his Nan would bring him back, because she drove him around a lot."

7.56 We asked other members of the team about their recollections of 22 August and what steps they would have taken. The team leader told us:

"I recollect…that his mother said that he wasn't as bad. This is from [Occupational Therapist 1] to me or to the team in general…[Occupational Therapist 1] seemed to have a handle on what he needed to do."

Q. Was the impression that you had when [Occupational Therapist 1] was reporting, he was with his mum, was it one of continued anxiety or relief?

A. A bit of both, because in one way if someone is with another person and particularly a relative, there is some relief that they are upright and standing. But no, your anxiety wouldn't lessen because you would know that they are not being treated; they are not receiving their medication. That is presumably why [Occupational Therapist 1] spoke to her and said 'He needs to come back'. He had offered him admission as well somewhere in all of this.

7.57 We asked for her views on the possibility of asking for an assessment from the services in that area and on whether Occupational Therapist 1 should have done so. She told us:

"Having spoken to [Mr X]'s mother he would be quite hopeful that his mum – his grandma was a very protective factor, or barometer – she would ring [Occupational Therapist 1] quite regularly with information about [Mr X]. [Occupational Therapist 1]'s overwhelming feeling would be 'They are going to make sure that he comes back'…If it was the situation where a client from this area was in Reading, then I would hope and expect that people would ring the social care team there…Just to alert them and say that you had spoken to their mum, or whatever and you had spoken to the patient and obviously tried to persuade them to come back. But, given that this is a young guy who hasn't been medicated for several days, that would probably [be] *a bit belt and braces, but it wouldn't be out of order…Not put them on alert, alert them to the fact that one of our patients was in their area…I wouldn't expect people to do it routinely every time, even given what happened. It is simply that [Occupational Therapist 1] knew where he was and I don't at all think that he made an error in not contacting a duty team."*

7.58 Psychiatrist 2 told us:

"I would have phoned the police in [the county] if I knew that, and I would have said, I have this patient, and I'm concerned about his safety – that's the least I could have done. Probably, if you contact the mental health services, they are not terribly interested in the problems of their neighbouring areas, or further away areas, so probably they are right about that, but I would have phoned the police, because in any situation that I had any doubts, I would phone the police. I would say, I have this patient, I'm concerned about his safety, and this is his description

– you may come across him at 2 o'clock in the morning, could you just look for him?"

Comment

On the basis of Occupational Therapist 1's report of his conversation with Mr X and his mother, the plan proposed was reasonable and sensible. Mr X was undoubtedly ill and would probably get more ill before he got better because he had no medication. On the other hand, the professionals did not think he was at risk of harming himself or anyone else. He was vulnerable but he was in the safe and capable hands of his loving and experienced family, who seemed to have the situation under control. There was no reason to think that he would not have been persuaded to return next day to Residential Home 3, where plans for his assessment and almost certain admission to hospital were in place.

7.59 Mr X's family, being on the spot, have a different perspective on the events of the day. His mother told us:

"I was taking my daughter to school on Wednesday, 22 August and [Mr X] was walking down the road. He was filthy dirty, which isn't unusual but he was extremely filthy dirty. I shouted [Mr X] out of the window, He looked at me and sort of smiled, and then I turned the car round and he'd gone. I pulled over to the pub, I was running everywhere – I thought he'd run off, I just didn't know where he'd gone. Anyway, by the time I got back here he was here."

7.60 She explained that she was worried and anxious by her son turning up in this way. She had spoken to her mother and to Occupational Therapist 1 since he had gone missing, knew he had had no medication for several days and believed that he had played a part in the burglary at her mother's house. She had her two young daughters with her and did not know what to do for the best. She told us she rang Occupational Therapist 1 asking for help and said she and he had a number of conversations that day. He explained to her that he could do nothing quickly to get her son back to Residential Home 3, but that if the family could bring him back, he would arrange for her son to be assessed immediately, with a view to detaining him in hospital. She said that Occupational Therapist 1 spoke to her son on the phone and Mr X agreed to return to Residential Home 3. Mr X's mother then

rang her mother, who said she would drive up straight away to take Mr X back to Residential Home 3.

Comment

At this point Mr X had done nothing to justify calling the police. He was out of the local area so the professionals treating him had no authority to assess and section him. They could have asked the local services to do so, but as things stood there seemed no reason to do so. He was in the care of his supportive family, who had always dealt competently with the problems caused by his illness. The situation was unusual but it still seemed to centre on Mr X's needs, rather than risk to anyone else. The plan for his grandmother to drive him home, if it had worked, would undoubtedly have been the quickest solution to the problem.

7.61 His grandmother arrived in the afternoon and recalled that her grandson was agitated:

> *He didn't want us to speak to him at all. If we spoke to him he was rather curt in his answer. I could see he was still unwell, extremely dirty. He looked as if he'd been sleeping in fields, he was really dirty. Then he started talking that he wanted to go out to meet someone. Initially he wouldn't take off his coat – he had a great big loose jacket on and he wouldn't take that off. He said about going out, and I spoke to him about going back to [Residential Home 3]. First of all he said yes, he was going to go back to [Residential Home 3]. I brought some clean clothes up with me because [his mother] had said he was dirty. I said, 'You can't go out like that. How about you having a nice bath and putting some nice clean clothes on?' Which he did…It took us about two hours to encourage him to go up, but he did, so he was upstairs for a good hour or two and then he came down. Then I vaguely remember he wasn't going out. He was very indecisive about going out and not going out, and at the end of the night he said he wasn't going out, but he was sitting on that couch fidgeting.*
>
> *When we understood that we had to get him back, it was our responsibility, and I think he [Occupational Therapist 1] would meet [Mr X] in the morning, we then had second thoughts about taking [Mr X], if we could get him back, to [Residential Home 3]. I thought perhaps if I take him back this evening he may disappear…He*

was running away from the situation; he didn't want to go back into hospital. This is my feeling…I thought the best thing to do was take him in the morning. So that's what we agreed and that was fine."

7.62 Mr X's mother and grandmother told us about their thoughts and feelings that afternoon and evening. They were worried that Mr X's difficulties seemed to be escalating. They believed that he had been involved in the burglary at his grandmother's house but also believed that he had not been alone because a car would have been needed to take away the stolen goods and Mr X neither had a car nor knew how to drive. They feared that he had fallen into bad company and that in his vulnerability he was being exploited. Mr X's mother felt that he was out of sympathy with them and that he might try to steal from his mother's house. His mother was not certain that he could be persuaded to return to [Residential Home 3] but his grandmother was confident that she would be able to reason with him and get him to comply, as had always happened in the past.

7.63 They told us that they were worried about Mr X but they were not frightened of him. His mother pointed out that she would have left the house if she had felt that she or her children were at risk. Instead she took the portable valuables to her bedroom before she went to bed.

7.64 Mr X's mother and grandmother both recall that by this time they were aware that knives had been taken during the burglary of Mr X's grandmother's house. However, it did not occur to them that Mr X might be armed with these knives. He had no history, as far as they knew, of being violent, threatening or dangerous. They believed that someone else had been involved in the burglary and had probably instigated it. Insofar as they thought about the stolen property, they assumed that someone else had it. It was not until the car that Mr X crashed was searched on 23 August that Mr X's grandmother's knives were found and Mr X's family realised that he had had them with him all the time.

Comment

If Mr X's family had told Occupational Therapist 1 that they believed Mr X was carrying knives and was dangerous, Occupational Therapist 1 would have been greatly at fault for failing to respond accordingly. However, we accept that the family did not believe this or suggest it to Occupational Therapist 1. Our acceptance is based both on what we have been told and on the surrounding evidence:

- *Occupational Therapist 1 was an experienced professional, with a background of working with forensic patients. He would have known what to do if he had reason to believe Mr X was dangerous, and his conduct up until that point suggests that he would have responded promptly and effectively.*

- *Mr X's family were (and are) supportive of him, but not to the extent of putting themselves, and particularly Mr X's little sisters, at risk. Their behaviour, letting Mr X play with his sisters, encouraging him to have a bath, leaving him downstairs when they went to bed, was not consistent with believing that he might be armed and dangerous.*

Expert reference group advice

7.65 We asked the expert group to give a view on what the recovery team did or did not do after Mr X turned up at his mother's house the day before the homicide. The following paragraphs are a summary of the issues on which we sought advice from the expert group.

7.66 When Mr X turned up at his mother's home she phoned Occupational Therapist 1 because she was worried about him and wanted the team to do something. Occupational Therapist 1's notes state that Mr X's mother told Occupational Therapist 1 that Mr X was not well but not as bad as he had been. Mr X's mother recalls that she was explicit in letting Occupational Therapist 1 know how worried she was. They agree that Occupational Therapist 1 advised Mr X's mother that there was little he could do until Mr X could be brought back to the area where Occupational Therapist 1 was based. Occupational Therapist 1 also spoke with Mr X who agreed he would come back the next day with his grandmother who was driving up to collect him.

7.67 Members of the recovery team told us that Occupational Therapist 1's actions were appropriate to the circumstances at the time, bearing in mind that Mr X's risk was perceived to be vulnerability, not dangerousness, and his family were thought to be well able to keep him safe.

7.68 We know that Occupational Therapist 1 contacted the social services adult help desk in his local area to seek advice because Mr X was out of area and was likely to need a formal MHA assessment when his family brought him back next day.

7.69 We sought advice on whether Occupational Therapist 1's suggestion to Mr X's family that they return him the next day was appropriate or whether he should have taken more assertive action in either:

- making arrangements for Mr X to be returned to his home area and assessed or
- contacting the local social services either to alert them or to arrange for them to make an assessment.

7.70 The expert group thought that Occupational Therapist 1 could have:

- notified the local mental health services that Mr X was in its area
- told the family that they could request a MHA assessment from the local mental health services team.

7.71 Despite these possible actions, in the group's opinion:

- Mr X was a low risk patient
- his mother had indicated that he was not as bad as on other occasions when she had seen him
- Occupational Therapist 1 had put a plan in place with which the family appeared to agree.

7.72 The group agreed with the recovery team members to whom we spoke that the purpose of contacting the local mental health services would mainly be to tell them that Mr X was in their area, in case problems arose requiring local action. They thought that even if this contact had taken place the local services were unlikely to have taken any action, such as arranging an assessment, because there would have seemed no need.

7.73 The group pointed out that practical options open to the recovery team were limited. They would have no right to collect Mr X against his will unless he were sectioned. He was out of their area so they would not have the authority to section him, nor would the mental health services or police in his mother's area have been authorised to insist on his returning to the area where he had been receiving treatment. If Occupational Therapist 1 or the family had felt the situation was out of control, they might have been able to persuade the local services that he should be assessed to see if he should be

compulsorily admitted to a local hospital, from which, in due course, he could have been transferred back. It is also possible that some arrangement could have been made with services in his mother's area to co-ordinate a MHA assessment followed by a return to where he had been receiving treatment, but this would have taken time. Neither of these options could sensibly have been the first choice of action when it was reasonably believed that Mr X's grandmother would succeed in returning him the following day.

7.74 The group felt that the local services could have been notified but also that the plan Occupational Therapist 1 agreed with Mr X and his family was within the bounds of reasonable professional judgment.

7.75 We sought advice from the trust about whether guidance exists for staff on what they are authorised to do if one of their clients is in another area and needs professional mental health support. Such guidance does not exist.

Recommendation

R2 The trust should issue guidance on what staff can do when faced with a service-user being out of area but needing help.

Family requesting a MHA assessment

7.76 The expert group also told us that Occupational Therapist 1 could have told the family that they were able to request a MHA act assessment from local services if they felt it necessary. This was not done. However, even if the family knew that they had the right to request a MHA assessment we have had to assess whether, it is likely that they would have done so in the circumstances.

Comment

We have discussed this with both Mr X's mother and his grandmother and consider that it is unlikely that the family would have requested such an assessment, for the reasons given above. They had been told he was to be assessed for a section by staff who knew him well the next day after returning to the local area. We also consider that any such request for an assessment would only have been actioned if Mr X had refused to go back with his grandmother on the following day.

Recommendation

R3 The trust should remind staff that families and carers should be advised of their right to request a Mental Health Act assessment.

Comment

With hindsight, there was evidence to justify sectioning Mr X during August. However, sectioning is a last resort, and even if evidence could justify overruling an individual's wishes, this has to be balanced against the possible disadvantages of sectioning, such as loss of confidence in the patient, and damage to the relationship between him and those treating him. The context of the judgments being made was that Mr X had not been assessed as a danger to others and that the evidence indicated his vulnerability was the main concern.

Despite the fact that Occupational Therapist 1 could have advised the family to request a MHA assessment from the local area staff, we accept the opinions of our expert group that Occupational Therapist 1's decisions were reasonable and within the acceptable limits of professional judgment.

Finding

Finding 14 We consider that nothing professionals should have done would have prevented the homicide. We have found no evidence that the care delivered to Mr X was in breach of statutory requirements or Department of Health guidance.

8. The quality of Mr X's treatment, care and supervision

8.1 In this section we assess Mr X's care and treatment against the requirements of the care programme approach and the trust's policy of compliance with the recovery approach, in particular the extent to which his prescribed care plans were:

- appropriate
- effectively delivered
- monitored by the relevant agency.

Policy background

8.2 At the time of the homicide in August 2007 Sussex Partnership NHS Foundation Trust, which had recently been formed from the amalgamation of three trusts, had not amended the CPA policies from each of the predecessor trusts. Therefore the care being delivered to Mr X was delivered in line with the previous *"West Sussex Locality CPA Policy and Practice Guidance for Effective Care Co-ordination"* (West Sussex CPA policy).

8.3 The West Sussex CPA policy is a 41-page document covering all essential requirements of the CPA set out by the Department of Health; it is comprehensive and reflects the multi-agency nature of mental health work. We highlight in the following paragraphs three aspects of the policy that are relevant to the approach to care the recovery team took.

Carer assessment

8.4 *The policy on page* six states that:

> *"…all individuals who provide regular and substantial (see glossary under care) care for a person on CPA should:*
>
> - *Have a written assessment of their caring, physical and mental health needs… repeated on at least an annual basis.*
> - *Have their own written care plan… which is given and implemented in discussion with them."*

8.5 The definition of regular and substantial set out in the glossary states:

> *"Substantial care is when the care provided is essential for the service user's safety, basic life needs and quality of life."*
>
> *"Regular care includes care needs which may vary over time but which have a significant impact for the carer at specific times."*

8.6 We found no record of a carer's assessment. It is clear that Mr X's grandmother or his mother provided regular support to him but it is unlikely that the support could be described as substantial (within the definition above). Despite the lack of a carer's assessment the family, in particular Mr X's grandmother, were closely involved in decisions about his care.

Care coordinator and team work

8.7 The policy on page 12 sets out the care coordinator's responsibilities. In the introductory paragraph it states:

> *"The role of the Care Coordinator combines the person's professional skill and co-ordination of care. It is not intended that the care coordinator carries out all the tasks nor that they should carry out none. The mix will depend on the person's professional skills and the need to engage other people in completing necessary tasks. It is the duty of team members and others to support the coordinator in apportioning different activities."*

8.8 The definition above states that the care coordinator is not expected to be skilled in every aspect of a service-user's needs but should call upon others as required. In this case, Occupational Therapist 1 may not have had the necessary experience to look after someone being treated with clozapine. A person in this position might be expected to call in other colleagues as required.

8.9 Our review of the recovery team operational policy shows that this aspect of multi-professional working was not covered in the policy. Occupational Therapist 1 told us:

"As a specialist team I guess there was a hope that rather than everyone working individually, you would be able to bounce off each other, MDT it and work in that way, but that never really happened."

Also:

"I never felt that the team worked well as an MDT. Everyone tended to work in isolation and have close, sustained, long-term relationships with their clients. The joint working only tended to happen when people were on leave and then people would step into the gap."

8.10 Despite these views from Occupational Therapist 1, the records and our interviews indicate that Occupational Therapist 1 called upon others for advice. In particular, he asked for advice on whether Mr X's deterioration was sufficient to request a formal MHA assessment.

Care Plans

Care plans dated 2 January 2007 and 16 August 2007

8.11 The January care plan identified realistic goals and how to work towards them and gave details of contingency and crisis plans. The August plan described what had been happening since Mr X moved to Residential Home 3 and described a plan of close observation and trying to persuade him to have a brief hospital admission. Both plans were detailed and individual but the copies on file were not signed either by Occupational Therapist 1 or Mr X.

8.12 Mr X had an outpatient appointment with Psychiatrist 2 and Occupational Therapist 1 on 1 February 2007, with another appointment six months later on 1 August. He failed to keep this appointment, so Psychiatrist 1 and Occupational Therapist 1 made a domiciliary visit on 2 August.

Risk Assessment

8.13 The CPA policy on page 21 deals with risk assessment and management. It is a short and concise part of the policy but covers all essential elements. It states clearly that:

"The best assessments have little value unless effective management plans are developed and implemented. Assessment should never be viewed as a substitute for effective risk management planning."

8.14 Our review of the medical records shows that risk assessment and risk management planning took place satisfactorily in this case. Risk assessments took place on 4 October 2001, 21 February 2002[14], 2 December 2003, 11 July 2004, 18 October 2004, 8 May 2006 and 13 August 2007. They are in a standard form but have been completed differently and show clear evidence of being the product of careful thought, rather than mere box ticking.

8.15 Occupational Therapist 1 completed a risk assessment when he made the referral to the housing association in March 2007. This was supplemented by a risk assessment carried out by housing association staff on 20 April 2007, apparently in discussion with Mr X. These risk assessments were thorough and individualised.

The expert reference group were asked by us about compliance with the care programme approach throughout 2007

8.16 The group thought that Occupational Therapist 1 and the recovery team used and applied the requirements of the CPA approach to care appropriately.

8.17 One issue in respect of CPA was the transition from the Residential Home 2 staffed home to the Residential Home 3, which was supported accommodation with no resident staff.

8.18 The staff at Residential Home 2 had been preparing Mr X for a move. The decision for him to move was taken in January but he did not do so until the end of May. In the interim he considered moving in with his grandmother with Occupational Therapist 1's help. He had also viewed possible accommodation, including a flat where he would live on his own. Mr X came to the view that none of these options was suitable. The place in Residential Home 3 became available and Mr X accepted that it was more suitable.

[14] Between February 2002 and December 2003 Mr X was an inpatient at the Maudsley Hospital.

8.19 There is no recorded full CPA in anticipation of this move. Although such a meeting would have been justified, the expert group felt that is not unusual for meetings not to be called in these circumstances, as a full CPA meeting can take a while to organise and the need to move quickly when accommodation becomes available militates against delay. In this case there was already:

- a good risk assessment in place
- a clear record of his relapse indicators
- a detailed plan in place in preparation for his move.

8.20 The group thought the important issues when moving someone on from staffed to supported living were the preparation and support available. They were concerned about how quick the transition from Residential Home 2 to Residential Home 3 had been, though they acknowledged that Mr X did not meet the criteria for detention and so was entitled to move if he wanted to. The group confirmed that in such circumstances professionals should focus on helping the individual to make good decisions and as far as possible put the appropriate levels of support in place to maximise the prospect of those decisions having a good outcome.

8.21 The group thought the team could have considered putting in some support worker time to add to the support time Residential Home 3 was providing but thought that the level of support Occupational Therapist 1 was providing was high.

8.22 The group told us that a CPA meeting and input from a support worker could have been useful but nonetheless the move to Residential Home 3 was arranged with reasonable care and though more support might have helped Mr X settle more easily into the house, particularly in the early weeks, the support offered to Mr X was appropriate to his needs.

Comment

The move to Residential Home 3 was a significant step in the rehabilitation of Mr X and with hindsight it is clear that he would have gained by having more support worker time. Despite this, Occupational Therapist 1 was in regular contact with him.

Finding

Finding 15 We consider that the team complied satisfactorily with the care programme approach (CPA). The care coordinator was not only conscientious and able in carrying out his duties, but clearly believed wholeheartedly in the importance of involving other professionals and the family in seeking to help Mr X.

Recovery philosophy

8.23 During 2006 the new trust issued a short document to all staff setting out its vision and values. It states:

> *"We will promote recovery and independence, through our own services and by working with other partner organisations."*

8.24 The recovery team operational policy sets out its *"Guiding Vision Statement"* on page three:

> *"The pathway to recovery is a process, defined by an individual, whereby quality in his/her life is claimed or reclaimed, by that individual empowering themselves to take control of their own life and reach their own self-defined goals. The role of the Recovery Team is to assist in that process."*

8.25 We were told in interview that the recovery team were set up to work with clients to further their independence. Mr X had spent most of his young adult years in hospital and so what professionals did to help him to move out of hospital into staffed housing and from there to supported lodgings was within the purposes that the team was created for. The issue of risk had to be taken into account but the medical records show no indication that he was a risk to anyone other than himself and his main risk was deterioration back to his earlier self-neglecting stage.

8.26 We asked the team leader about Mr X and recovery:

> *"Our focus was very much on recovery, at the service user's own pace, within their own limits. I think [Mr X] had a real desire to move on to more independent living, for a young man like that to be resigned to a life of institutional care is not*

really a life, and our job as a Recovery Team was to support him to do that…the majority of our service users had a high level of complex need. That is the nature of the service that we provided".

Comment

When examining the details of any particular case, it is always possible to find minor errors and failures to comply with good practice. We identify some in this report. We are not convinced that the particular failure to arrange an earlier blood level trough test or organise a MHA assessment involving Psychiatrist 2 on or after 13 August would have made any significant difference to Mr X's management.

Occupational Therapist 1's notes are detailed in the factual information they contain but would have been more useful to us and others looking at Mr X's care, treatment and management if they had contained more of Occupational Therapist 1's thinking about what was going on, what he would have liked to do and what he could do. One of the important purposes of written records is to allow someone coming fresh to the situation to understand what happened and why. The thoughts and concerns of the professionals involved are as important in this regard as the thoughts and actions of the service-user.

Recommendation

R4 The trust should issue guidance on the value of ensuring clinical records include not only factual information but also the writer's clinical view, judgments and reasons for them.

Finding

Finding 16 We consider that the careful records the care coordinator kept show the extensive level of his involvement with his client's care, treatment and supervision. It would have been helpful, and would have done him a service, if the notes had also said more about his own views and concerns. This would not have influenced events before the homicide but would have made Occupational Therapist 1's position clearer in the subsequent internal investigation and reviews.

Finding 17 We consider that the team, and in particular Occupational Therapist 1, complied with the recovery approach in this case, being sensitive to Mr X's wishes but at the same time aware of his needs and ready to restrict his freedom if necessary. The team, and his family, were justifiably concerned about his own health and safety.

Finding 18 We consider that Mr X could not reasonably have been thought to pose more of a danger to others than any other member of society might pose.

The quality of Mr X's treatment, care and supervision, in particular the extent to which his prescribed Care Plans were appropriate, effectively delivered and monitored by the relevant agency

Community recovery team

Operational policy

8.27 This policy is undated but we understand that it was in force in August 2007. It sets out:

- the criteria for referral to the team
- the range of work that will be undertaken and discharge arrangements
- other key activities of the team.

8.28 The policy does not cover:

- how individual practitioners or care coordinators were to be allocated to individual clients
- the function of team meetings
- how the multi professional expertise of individuals was to be accessed in accordance with the CPA policy.

8.29 The recovery team was formed out of a split from the assertive outreach team and rehabilitation team in 2004. In the summer of 2009 the recovery team was disbanded and the clients transferred to a number of different community mental health teams (CMHT). All CMHTs have now been reformed as recovery teams with specialist areas of expertise.

8.30 We were told in interview that these changes were not a result of the events covered in this investigation but of the trust focusing services on the recovery model. The trust supplied us with documents to help us understand the wider organisational context of services. One of the documents written by the medical director states:

> *"This was followed by an extensive restructuring of services around a care group as opposed to locality structure."*

The recovery team

8.31 The trust serious untoward incident (SUI) report contains criticism of the skills, experience and knowledge of the team. We identify below four areas we believe we needed to explore in more detail:

> *"The review team recommend that the recovery team needs to develop a common conceptual understanding of the factors that can contribute to the difficulties people with schizophrenia experience, which gives equal recognition to biological, social and psychological factors rather than a single cause."*

> *"The review team were also concerned that the care coordinators' responsibilities, which are comprehensively described in the trust's Care Programme Approach Policy, were not understood by the care coordinator or the manager of the recovery team…"*

> *"It was also apparent that management arrangements were complex and unclear and the review team recommended that these were clarified.."*

> *"The clinical supervision policy had not been implemented within the recovery team and the care coordinator who would clearly have benefitted from a rigorously applied policy reported that clinical supervision was erratic and that he had no current individual development plan."*

8.32 These conclusions from the trust internal SUI report amount to the panel's view of serious and fundamental weaknesses in the operational working of the recovery team. If these conclusions are valid they would justify the conclusion of the trust panel that while this homicide was not predictable:

> *"…it may have been prevented if effective action had been taken to intervene when [Mr X]'s mental health began to deteriorate."*

8.33 Consequently we have examined the working of the team in some detail. We have done this from the perspective of what they did and evidence from interviews. The following quote is from the trust SUI report:

Understanding schizophrenia

> *"The review team recommend that the recovery team needs to develop a common conceptual understanding of the factors that can contribute to the difficulties people with schizophrenia experience, which gives equal recognition to biological, social and psychological factors rather than a single cause."*

8.34 Occupational Therapist 1 told us:

> *"All the members of that team had been working with people who had schizophrenia for years."*

8.35 We asked Manager 1, the service manager, whether he thought the team understood schizophrenia. He told us:

> *"There were some very experienced people in that team and, if you asked them – personally, if I asked them at that time – I would have picked up that they were experienced clinicians and I would have been very surprised if they did not have that basic understanding of what schizophrenia was."*

8.36 We asked Psychiatrist 1 how competent he thought the team was:

> *"There were competent clinicians in the team. All the members of the team had significant experience in treating people with a severe enduring mental illness."*

8.37 We asked the team leader the team coordinator whether she had any concerns about the team's understanding of schizophrenia:

> *"No, not at all. I supervised the majority of the team myself. I didn't supervise [Occupational Therapist 1], but the people I supervised equally then supervised support workers, etc. So it would have become very clear to me if people I was supervising and working with actively every day with a number of clients with schizophrenia didn't understand the concept of the illness. That would have become clear throughout supervision."*

8.38 Manager 2, the integrated team manager, told us:

"I found them to be a very experienced team, a very close team, very, very supportive of each other, who had, I thought, quite useful and quite meaningful clinical discussions about the clients. There were certainly some psychological input that was missing, but the team seemed to be able to cope very well in being able to examine cases, even in that absence. I found them to be a very capable team in that respect and I have no concerns about their clinical knowledge or ability."

8.39 Psychiatrist 3, consultant who was appointed to the team in 2008, told us:

"Generally these were people with complex problems on complex medication regimes who needed intensive support in the community to manage. Certainly a number of members of the staff were quite effective at using CBT techniques and a lot of social support. I was surprised by Recommendation 2 where it says:

'equal recognition to biological, social and psychological factors'

because, unless that had changed, when I was in the team there was quite a lot of recognition of the social factors. I didn't think the level of psychological work with people was different from what you would find in many of the CMHTs I've worked with before."

Q. When you arrived, how many of the team members were still around who had been there when [Mr X] was being cared for?

A. I don't know, but I think most people.

Q. So there was still a major consistency within the team.

A. Yes. As far as I am aware…"

Comment

The team consisted of a range of clinicians who had worked with people with schizophrenia for a long time and knew the patient group well. The SUI report records:

> **"The review team were particularly concerned about the notion of 'developmental delay' explaining the behaviour of [Mr X]. From the evidence presented to the team, they were of the view that the patient was experiencing a relapse of his schizophrenia illness."**

We quote earlier (in paragraph 7.23) Occupational Therapist 1's response to us about what he meant about developmental delay. It is clear that Occupational Therapist 1 took a holistic approach to his assessment of Mr X. He recognised that he had treatment-resistant schizophrenia but also that his improved symptoms and the freedom arising from his leaving institutional care had to be taken into account. The fact that Occupational Therapist 1 discussed the management of Mr X in team meetings and sought advice from Psychiatrist 1 and the social worker (ASW social worker) indicates that he was not ignoring the biological and psychological aspect of Mr X's illness.

Finding

Finding 19 We conclude that the evidence we have received does not support the trust's serious untoward incident report's assertion that Occupational Therapist 1 or others in the team lacked understanding of schizophrenia.

8.40 The trust SUI report comments on the work of the care coordinator's role:

> *"The review team were also concerned that the care coordinators' responsibilities, which are comprehensively described in the trust's Care Programme Approach Policy, were not understood by the care coordinator or the manager of the recovery team…"*

8.41 We asked Occupational Therapist 1:

"When you became a care coordinator, did you have any training as a care coordinator? Did the team have any training as care coordinators?"

He replied:

"That was the role that was assumed with the post, but I did have training in care co-ordination. It was run by service users."

Comment

All the professional staff were care coordinators and Occupational Therapist 1 had been in this role for six years. The evidence indicates that Occupational Therapist 1 managed Mr X's care through:

- *regular contact with Mr X*
- *regular CPA reviews*
- *liaison with and seeking advice from other professionals and support staff at Residential Home 2 and Residential Home 3*
- *frequent contact with Mr X's family and*
- *comprehensive and contemporaneous record keeping.*

All these actions are core to the role of care coordinator.

Finding

Finding 20 We found no evidence that the care coordinator and the team manager did not understand the duties of a care coordinator.

8.42 The trust SUI report comments on team management:

"It was also apparent that management arrangements were complex and unclear and the review team recommended that these were clarified…"

8.43 The team and senior management structure was as follows:

- the team coordinator/leader, reporting to:

- Manager 2: integrated team manager reporting to:
- Manager 1, service manager for recovery services.

8.44 Manager 2 told us he had responsibility for seven teams covering two towns in the area. These teams consisted of rehabilitation units, assertive outreach teams and recovery teams in both towns. He said he took over the area where Mr X was living at the beginning of 2007. Before that Manager 1 had covered that area and knew the recovery team well.

8.45 Manager 2 told us his responsibilities were:

> *"Day-to-day operational management, so HR issues, recruitment and I would regularly meet with the managers of each of the teams, I would address operational issues on a day-to-day basis, I would work with the team, for example if there was a vulnerable adult alert, if there were SUIs, if there crises, if there were difficulties and problems. I was the point of contact between the teams and Manager 1, who was the service manager."*

Finding

Finding 21 Manager 2, as the integrated team manager, had responsibility to ensure that each team was effective. We are convinced that the wide span of management responsibility and authority he had at the time would not allow him or any other manager to exercise the role effectively.

8.46 Manager 1, service manager had two offices 21 miles apart, one of which he shared with the team leader. He had previously been the team leader's manager but Manager 2 had since taken over that role.

8.47 We asked Manager 1 about his involvement with the recovery team:

> *"I did make a point, with all the teams, of knowing them. [The team leader] and I used to meet informally. I didn't provide her supervision because [Manager 2] was doing that, but I used to meet her informally. We'd have discussions about the team in general and anything that she wanted me to take to [Manager 2]. If [Manager 2] was on leave, I would obviously do that. I had a good working relationship with [the team leader]."*

8.48 We asked if he had any involvement with patient issues:

"Yes, if you like. It wasn't direct clinical time with the clients, but if there were any issues and I was around at the time, that I could help out with or that people would come to me to discuss, then of course I would do that. I would make a point of doing that anyway, to ensure that the teams were okay."

8.49 We asked him if he became involved in professional issues:

"Yes. The remit that my staff had and have is that I consider myself to be fairly approachable and accessible if there is some issue that needs to be discussed. It may be that their direct line manager is not around or that their direct supervisor is not around, or that the clinical lead is not around and then of course I would be happy for them to come to me. Yes."

8.50 Manager 2 told us:

"Certainly in the [area where Mr X lived] more particularly, I was relying on [Manager 1] as my line manager, quite a lot and very much working with him in that area, simply because of the fact at that time [Manager 1] tended to be based here the majority of the time, whereas my office was in [another town]. The intention was that Manager 1 was going to base himself more in [that town] as well, but the reality is that he was based here."

"…in reality I can see that there may well have been confusion in the teams as to who they were reporting to. Some of that was due to the fact that obviously [Manager 1] was based here quite a lot. Whilst they should have been coming to me, they saw him sat across the office; they would often go to him."

Comment

Manager 1 was the previous line manager of the team but had taken a more senior position and Manager 2 had been appointed as the line manager for the recovery team leader. Manager 1 had an office in the recovery team base. Manager 2 was based in another town 21 miles away. This arrangement inevitably confused the team's understanding of who was the next level line manager. To have the previous

line manager (now in a more senior position) of the team located in the same office as the team manager was organisationally unwise.

Finding

Finding 22 Despite the obvious confusion about management responsibilities for the recovery team we do not think that this had any material effect on the decisions of team members in this case, which were based on their professional judgment rather than their understanding of managerial lines of responsibility for the team.

8.51 The SUI report deals with clinical supervision and states:

> *"The clinical supervision policy had not been implemented within the recovery team and the care coordinator who would clearly have benefited from a rigorously applied policy reported that clinical supervision was erratic and that he had no current individual development plan."*

8.52 The SUI report also states that the panel found few records of supervision for the period of December 2006 to the incident in August 2007.

8.53 We asked Occupational Therapist 1 about his experience of supervision:

> *"In theory it was monthly, but it probably drifted to on average every six weeks. It's what I was used to. Generally my working experience has been that I would get monthly OT supervision and then have access to team coordinators, team leaders and team managers to pick up anything else on a more informal basis. That's what I've always had in my career."*

8.54 He told us he had regular supervision but found some aspects of it difficult:

> *"[Occupational Therapist 3] was my main supervisor for a long time, who I really struggled with. I didn't feel that she was open to the kind of clinical discussions that I would expect of someone of her banding."*

8.55 Occupational Therapist 1 told us that he attended regularly, despite not finding supervision satisfactory.

8.56 Manager 2 was asked about his role in monitoring supervision he told us that this was one aspect of his role and that he *"…felt comfortable at the time that everybody was receiving due clinical supervision in an appropriate and timely manner".*

Comment

Supervision could undoubtedly have been improved - a finding common in many reviews of services. The SUI panel stated:

> **"…the care coordinator would have benefited from a rigorously applied policy…"**

This implies that some aspect of the exercise of his role required close supervision. We have found nothing to show that his practice required such rigour.

8.57 The trust SUI report makes a recommendation that:

> *"…a consultant psychiatrist should be actively involved in the recovery team."*

8.58 Psychiatrist 2 was the consultant psychiatrist responsible for Mr X and the recovery team. He was also the consultant psychiatrist involved in the assertive outreach team. The rehabilitation and assertive outreach team was split to form the assertive outreach and recovery teams in 2004. Psychiatrist 2 decided to attend the assertive outreach team meetings and Psychiatrist 1 who was a staff-grade psychiatrist, reporting to and supervised by Psychiatrist 2, would attend the recovery team meetings.

8.59 The minutes of the recovery team meetings already quoted show that Psychiatrist 1 attended regularly. Psychiatrist 1 described the split of responsibilities:

> *"Within the Recovery Team, both [Psychiatrist 2] and I saw patients and were involved in the clinical care and management. We had our own caseload for community patients. The service at the time was split into Assertive Outreach and Rehab & Recovery, so [Mr X]'s care had been under the umbrella of the Recovery Team and [Psychiatrist 2] was the responsible consultant for both teams. I was the staff grade for both teams and we worked across them in an integrated way*

although the teams were separated in terms of their functions and also in terms of the day-to-day management."

"I would tend to raise things with him when I was particularly concerned and felt his input as a consultant was necessary, or even just to make him aware of some things that were brewing that he needed to be aware of. And of course [Psychiatrist 2] would then get involved, be that by liaising or making the appropriate contacts."

8.60 Occupational Therapist 1 told us that he rarely saw Psychiatrist 2 but that if he wanted him to see one of his patients this was easily arranged and that he was always available to give advice.

8.61 Psychiatrist 2 told us that Manager 1, who was the service manager when the two teams were formed, suggested which team meeting he would attend and which Psychiatrist 1 would attend. He also told us that he had two weekly outpatient appointments and a ward round at the psychiatric hospital when he would regularly meet members of the team who had patients they wanted him to see.

Comment

Psychiatrist 2 was a well-respected clinician, readily accessible to staff who wanted him to see their patients or get advice. The team meeting lacked the leadership of a consultant. The presence of a consultant is desirable but we found little evidence of it significantly affecting the way the team was working at that time.

Finding

Finding 23 There is no evidence that the lack of a consultant presence at team meetings had any bearing on the management of this case.

9. Process of the SUI investigation and the trust action plan

9.1 After the homicide the trust set up an investigation as part of the serious untoward incident policy in force at that time. That policy is comprehensive and provides appropriate advice on categorising and handling various types of incidents.

9.2 The SUI panel report states that:

> *"In following this policy and having regard to a document issued by the NHS South East Coast concerning an independent investigation process following a serious mental health adverse event, the Trust commissioned a review of the care and treatment it offered to the patient."*

9.3 The trust convened a panel which had three independent members and an associate director from another locality in the trust. It was chaired by a retired mental health chief executive and included a consultant psychiatrist and a mental health nurse.

9.4 The trust policy states in appendix two:

> *"The most severe incidents (Red Incidents with a score of 20 to 25) may subsequently warrant an internal inquiry (a more formal process involving an independent chair and other staff not involved directly in the incident) or an external inquiry (a large scale review of events by an independent panel, mandatory in certain circumstances such as homicides by patients in contact with specialist services)."*

Comment

The trust policy allows for the appointment of an independent chair but the appointment of three external independent members created a hybrid panel covering a local investigation and an independent panel. We understand this was in response to the seriousness of the incident and in that regard we commend the trust. We believe the composition of the panel had the unintended consequence of requiring a panel mostly of external members to undertake an investigation within a short time more suited to an internal investigation whose investigators are already familiar with the workings of the service.

Findings

Finding 24 The composition of the trust investigation panel did not comply with the trust policy.

Finding 25 The trust investigation report is easy to read and well laid out.

9.5 The trust panel state in their introduction that they were working to a short timetable. The timetable for completing an internal report in accordance with the trust policy is 35 days from the date of incident. The incident occurred on 21 August 2007 and 35 days from then was 25 September. The panel began interviewing relevant staff during the week beginning 24 September 2007 but the whole panel did not meet until 1 October and only then formally agreed terms of reference. We know that drafts were being circulated earlier. The final trust report is dated November 2007.

Comment

A 35-day headline to complete a thorough internal trust investigation is a stretching but achievable target if the panel members are all trust employees. This target is much more difficult if the panel consists of external members, some of whom must secure release from their employer. The time pressure is made evident in that the panel started interviewing witnesses prior to meeting together to:

- *scope the investigation*
- *identify the key aspects that needed to be examined*
- *identify who needed to be interviewed*
- *undertake a root cause analysis of the evidence, or to use some other analysis process.*

Finding

Finding 26 We believe that the short time available to complete the trust investigation may have caused a number of significant weaknesses within the process of the trust investigation.

9.6 The panel report without appendices is 20 pages and provides a brief analysis of most of the issues that needed to be examined. We asked for notes or transcripts of the evidence taken by the panel but were told by the trust that the notes were not available and no transcripts were taken. In a number of places the brevity of the report means that there is little or no evidence within the report to show how the panel arrived at its conclusions.

9.7 We comment elsewhere on the conclusions and recommendations of the report.

Comment

The trust should ensure that it examines the impact on the investigation process and outcome of appointing external panel members. Timeframes for completion of an investigation are important but unless statutorily demanded they must be balanced with the need to ensure that the panel can complete a thorough investigation.

An external independent investigation may not be commissioned for months or even years after an incident, so it is also important that written or taped records of internal investigation interviews are made and kept. This makes the task of an external panel easier by ensuring that the thoughts and recollections of staff close to the time of incident are available. It also allows external investigators to understand how the internal investigators reached their conclusions.

Finding

Finding 27 The trust responded to this homicide with the speed and seriousness it deserved but we think that setting up what was effectively an external independent panel was not the best way of achieving the goals of understanding how the services were delivered and of learning appropriate lessons. The pressure on the panel to produce a report quickly has meant that in places the available evidence does not support the panel's conclusions. As a consequence, some staff have been the subject of criticism that appears to us to be unjustified.

Recommendation

R5 The trust should review its approach to convening internal serious untoward incident panels to ensure that they have enough time to undertake a thorough investigation. External panel members should be used only in exceptional circumstances. Interviews should be recorded and transcribed.

Finding

Finding 28 We set out in this report a number of areas of clinical practice and management organisation that could have been improved but we find no link between these and the homicide.

Implementation of the trust action plan

9.8 The trust investigation report contained 12 recommendations and we comment below on them and the progress in implementing them.

> *1 "That the Trust reviews the implementation of National Institute of Clinical Excellence guidance on the treatment of Schizophrenia."*

Comment

The trust action plan shows this recommendation as complete and that the guidance is being used in clinical work.

> *2 "That the Recovery Team develop a common understanding of the factors that contribute to the difficulties experienced by people with schizophrenia which gives equal recognition to biological, social and psychological factors."*

Comment

The trust action plan shows this as complete.

Recommendation

R6 The recovery team no longer exists and all community mental health teams (CMHTs) have been redesigned as newly formed recovery teams. Consequently the trust should provide assurance to its primary care trust commissioners that the new operational policies of these teams reflect the recommendation of the internal review that the recovery team develop a common understanding of the factors that contribute to the difficulties experienced by people with schizophrenia which gives equal recognition to biological, social and psychological factors.

> *3 "That the Trust devises and implements an action plan to ensure its commitment to involve fully users and carers is realised and that the action plan addresses the need to comply with local policy on carer assessment."*

Comment

The trust action plan shows this as complete. A carers' charter is in place, carers' packs have been developed and carers' assessments are being reported on as part of the performance assessment framework.

> *4 "That an outcome tool is used e.g. HONOS[15], to monitor the effectiveness of the recovery team."*

Comment

The trust action plan shows this as complete.

Recommendation

R7 The trust should provide assurance to its primary care trust commissioners that the new recovery teams are using HONOS or some other recognised outcome scale.

> *5 "That the Trust ensure that all staff familiarise themselves with the Trust's Care Programme Approach Policy and Practice Guidance."*

[15] Health of the Nations Outcome Scale.

Comment

The trust action plan shows this as complete. A new CPA policy has been published and all staff have seen and have access to the new CPA policy. Also eCPA was implemented in December 2008[16]*.*

> *6 "The management arrangements for the Recovery team should be clarified and made known to all relevant staff."*

Comment

The trust action plan shows this as complete. The integrated team manager has had his direct reports reduced and his and the service manager's role clarified.

> *7 "That a consultant psychiatrist should be actively involved in the recovery team."*

Comment

The trust action plan shows this as complete. A substantive consultant was appointed.

> *8 "That the vacant psychology post in the recovery team should be filled at the earliest opportunity."*

Comment

The trust action plan shows this as complete. The recovery team was to be merged into the new CMHT structure so an internal locum was recruited.

[16] eCPA is a electronic version of CPA allowing staff to complete the records on the trust computer system so that staff across the trust can have access to the information.

Recommendation

R8 The trust should provide assurance to its primary care trust commissioners of the level of psychology involvement now available in the newly formed recovery teams (previously CMHTs).

> *9 "That a revised operational policy is devised for the recovery team which recognises national policy in the delivery of mental health services."*

Comment

The trust action plan shows this as complete.

> *10 "That the Trust should ensure full compliance with the clinical supervision policy."*

Comment

The trust action plan shows this as complete.

> *11 "That the Protection of Vulnerable Adults Policy should be brought to the attention of all staff within the trust."*

Comment

The trust action plan shows this as complete. The trust states that the policy is **"…readily available and accessible and a process in place to ensure all staff have read the policy and are working with it".** *A monthly report is also submitted on all safeguarding vulnerable adults' activity.*

> *12 "That the draft policy on the management of dual diagnosis should be finalised, ratified and implemented."*

Comment

The trust action plan shows this as complete. The completion column of the action plan states:

> **"The draft policy is acknowledged as a working document and has been circulated to all service areas."**

It is difficult to see how this action can be marked as complete when the policy is still in draft.

Recommendation

R9 The trust should ensure that the draft dual diagnosis policy is formally approved and implemented as a trust policy to ensure that draft policies are not ignored by practitioners on the grounds that they are not yet in force.

Summary comment

Our conclusions differ from those of the trust panel. We consider the evidence does not support some of their conclusions. Nevertheless, we commend the commitment the trust has shown in addressing the recommendations of the panel. Despite our differing conclusions, we think that the trust's actions will contribute to a more effective service.

Appendix A

List of interviewees

- Chief executive, Sussex Partnership NHS Trust
- Chief operating officer
- Clinical outcomes project manager
- CPN2 – community psychiatric nurse
- CPN3 – community psychiatric nurse, recovery team
- Consultant clinical psychologist
- Deputy service director for recovery services
- Executive director of nursing
- Executive locality director, Sussex Partnership NHS Trust
- Executive medical director, Sussex Partnership NHS Trust
- Integrated team manager 1
- Integrated team manager 2
- Interim head of recovery
- Interim service manager, West Sussex Mental Health
- Manager of the housing association
- Occupational Therapist 1 – Mr X's care coordinator
- Psychiatrist 1 - psychiatrist/staff grade doctor
- Psychiatrist 2 - consultant psychiatrist
- Psychiatrist 3 – consultant psychiatrist
- Project worker, housing association
- Senior social worker, recovery team
- Service director for learning disabilities and substance misuse
- Service manager for recovery services
- Service director for working age mental health
- Strategic director of social care and partnerships
- The team leader - senior social work practitioner
- Mr X's mother
- Mr X's maternal grandmother
- Mr A's family

Appendix B

Comprehensive chronology

We have included here a comprehensive chronology of Mr X's contacts and involvement with the NHS. This young man had a long and intense involvement with mental health services. The records show sustained efforts made by many professionals to meet his needs and to help him recover sufficiently to enjoy his young adult life. The chronology is also important to put into context the decisions made by staff in 2007 because what is clear from this chronology is that the main and almost exclusive concern about Mr X was his deterioration leading to self neglect and that there were no indications that he was at any time a threat to anyone else.

2001

September He was admitted informally to a private hospital by his grandparents, aged 19 because he was hearing voices telling him to kill himself. He was placed on section 2[17] of the Mental Health Act.

October He was transferred on section 2 to a local NHS psychiatric hospital. On his admission he was identified as having persecutory delusions (the police were after him). His provisional diagnosis at that time was *"mental and behavioural disorder due to drug use – schizophrenia?".* His section 2 lapsed and he remained as an informal patient.

December He absconded from the ward on the day of his great-grandmother's funeral which he was not attending, and made his way to the railway station where he was found by the police sitting on the edge of the platform. He was returned to the ward but absconded again and was found walking along the dual carriageway trying to get home. Mr X's explanation was that he was hearing voices and laughter in his head. He was placed on section 3[18] because he had absconded and was concealing medication so he was putting himself at risk of injury and was not giving reliable consent to remain on the ward informally.

[17] A section where and individual is compulsorily admitted for assessment.
[18] A section where and individual is compulsorily admitted for treatment.

Comment

During the three and a half months since his initial admission, he was diagnosed with paranoid schizophrenia, and the main concern of staff was to keep him safe and prevent his deterioration. Some of the time he was sectioned, and some of the time he was a voluntary patient.

2002

January He was referred to the rehabilitation and assertive outreach team because it was thought that he would require more intensive support on discharge than could be provided by the community mental health team.

February He starts taking clozapine. His risk assessment showed suicide low, neglect medium, aggression and violence low. He was also noted as trying to hide his clozapine in his hand.

June He was referred to the National Psychosis Unit because of the poor result from the medication that he had been given at the psychiatric hospital, which left him with very marked negative symptoms. He remained on section 3 because it was felt that he would not remain in hospital as an informal patient.

July He was taken off his section and remained in the psychiatric hospital as an informal patient. Throughout this period of detention Mr X is described as polite and pleasant, compliant with medication, engaging superficially, giggling inappropriately (apparently in response to hallucinations) and sleeping a lot. He shows negative symptoms and does not want to engage with the various plans that are made for him. He goes out on leave with his grandparents and his mother and that always seems to go well and he is always back on time. He asked that his medication be changed because it made him drowsy. His clozapine was consequently reduced.

August Mr X returned from leave. His grandmother reported he had been giggling, staying in bed all the time, not sleeping at night, thought everything had germs on it, not attending to hygiene, and *"crawling on all fours"* which she said he had not done since he was first unwell. He had also been crying and she thought he might have been hitting himself as his cheek was very red. During August many of the nursing notes showed that Mr

X was compliant with medication but there was a lot of *"inappropriate"* giggling and laughing. His behaviour was causing concern as he was staying in his room a lot, he was sleeping fully clothed on top of his bed or putting all his bedclothes on the floor and sleeping on them there. He was also not eating properly.

September Mr X had an appointment at the National Psychosis Unit and the consultant felt that he was under-medicated and should have his clozapine gradually increased. The consultant stated in her letter to Psychiatrist 2 that Mr X admitted to erratic compliance with medication as *"none of them affects me".* The consultant concluded in her letter that she thought that the tests showed that Mr X had been taking his clozapine fairly regularly but that he was on too low a dose and she recommended nearly doubling the dose, and putting him on section if necessary to do this. She described him as *"extremely unwell".* It was noted at the end of the month, after the recommended increase in his medication that he was being interactive with his peers, and more motivated.

Beginning of October Mr X went on leave for a few days to his grandparents having returned to the ward for clozapine blood tests. After he came back from leave, there is a note to say that he had not slept all night and he was laughing continuously and inappropriately *"insist he has taken all his medication whilst on leave".* He was described as thought disordered, responding to voices and it was noted by staff that he had a considerable amount of clozapine tablets in his bedroom. His clozapine was restarted. The notes show that he is still having *"inappropriate outbursts of laughter".* Over the next days he is described as being over familiar with staff, binge eating, making bizarre movements. He denied having stopped taking his medication while he was on leave. After a few days his inappropriate laughter appeared to have gone and he was more settled, but over the following weeks he reverted to being isolated and unmotivated. He complained of the medication making him drowsy.

End of November he was transferred to an NHS rehabilitation unit. A risk screening assessment was completed. Under the heading of 'aggression/ violence' the form records the 'No' box was ticked for:

- previous incidents of violence
- previous use of weapons
- known person trigger factors
- expressing intent to harm others

- paranoid delusions about others
- violent command hallucinations
- signs of anger and frustration
- sexually inappropriate behaviour
- preoccupation with violent fantasy
- admissions to secure settings
- denial of previous dangerous acts.

His diagnosis is given as treatment resistant schizophrenia.

Beginning of December Mr X had overnight leave to stay with his grandparents for one night. He phoned in to say that he had hurt his back and could not come back. There was concern expressed because he was then out of touch and not answering phone calls. His grandfather picked up medication. During a home visit Mr X was identified as stable in mental state but they were unsure about his compliance with medication and he was refusing to return to the rehabilitation unit so a visit the following day to assess him for a section was arranged.

He returned to the rehabilitation unit with his care coordinator from the assertive outreach and rehabilitation team. She said his mental state had deteriorated since the previous day and he was laughing inappropriately but said he had been taking his medication. He was also responding to auditory hallucinations, sexually disinhibited towards female staff, attempting to touch their bottoms, and was put on level 3 observations. He was given clozapine, but then became extremely drowsy to the extent that he wet his bed so a decision was made to do a trough level and then re-start him on the lowest level of clozapine because it was thought he probably had not been taking his medication while he had been at home.

Mr X remained manic, sexually inappropriate, elated (but no management problem). It seems that he set off a fire extinguisher (which he denied) on 15 December and continued to be very giggly. By the middle of the December he was described as less elated. A conversation with his grandparents took place during which his grandfather said that he had found lots of clozapine tablets hidden around their house. Mr X was described as behaving childishly, pulling out all the paper towels. A note on 19 December states he seemed to be back to normal.

End of December He is described as quiet, isolating himself, blocking toilets with paper towels, sleepy, passive. He spends a lot of time in his bed and in his room on his own. He does not wash or change his clothes without prompting and even when prompted very often does not.

2003

January - 6 February In the first half of January 2003 there is evidence of him becoming more sociable and engaged with staff and patients although there is also comments about him being tired all the time, which he put down to the clozapine. He seemed to be eating the hospital food. His clozapine was increased on 28 January but on the same day he had an amber[19] result from his blood test so he had to have another one on 30 January (page 5-265). On 31 January he stayed in bed saying *"I have been drained of blood".* He spent most of the next few days in bed, and refused to have a further blood test done on 3 February 2003.

February He had his bloods done by Psychiatrist 2 *"although he complained and was very reluctant"*.

February He refused the blood test again. Someone rang the clozapine patient monitoring service to get advice and was told that Mr X was on the border of getting a red blood result so there would need to be another test tomorrow on 6 February. On 6 February he refused. Later in the day he did agree to a blood test, which gave a green result, but clozapine was discontinued because of the problems with taking blood and the previously low white cell count.

10 – 19 February On 10 February he is reported as elated, with pressure of speech, some inappropriate sexual conversation and said that he felt great and that coming off clozapine had let his mind *"come alive again*". During this period he is described in the clinical ward record sheet as *"very elated, sexually inappropriate, more animated joining in ward activities. It was agreed that he would be assessed for section".* He was described as inappropriate in mood, childish and not polite, being offensive to a fellow resident, but no threatening behaviour.

[19] Blood tests are analysed and graded as green (satisfactory) red (undertake another test) red (requires medical review and possible intervention).

20 February He was transferred to National Psychosis Unit (NPU) at Bethlem Royal Hospital.

16 October A neuro-psychology assessment report from the NPU shows that he has specific problems with memory and attention but his average to high average pre-morbid intellectual functioning was intact. At the end of the report it says that:

> *"It is important in the early stages of rehabilitation to provide [Mr X] with the best opportunity to learn new skills through the presentation of clear and written information, through allowing [Mr X] time to process the information and through opportunities for practice. Individual work undertaken so far with [Mr X] has also suggested that this is best achieved by providing opportunities but moving forward at [Mr X]'s own pace".*

November CPA review at the NPU attended by his grandmother, grandfather, his mother, Psychiatrist 2 and his then care coordinator from the trust. Mr X is described as "v*irtually inactive on the ward".* The relapse indicators were listed simply as *"avoiding the company of others".*

28 November NPU psychologist writes to Psychiatrist 2: *"He will benefit from an environment which continues to offer opportunities to gradually expand his current activities and interests without placing undue pressure on him to change".*

Transferred back to the trust

1 December Transferred to the rehabilitation unit from NPU.

December A risk assessment form of this date shows that the only current risk factors for suicide were that he had a major psychiatric diagnosis and was unemployed. There were six current risk indicators for neglect. There were no current indicators for aggression or violence and there were no indicators of any other risk. This shows that it was thought that he was compliant with medication at that time although in a statement of risk it suggests that he would be at low to moderate risk of non-compliance when on leave from the rehabilitation unit.

December He went to visit the housing association property at Residential Home 1.

11 December He had a shopping and cooking one to one session which seemed to go well. Throughout December and January there are frequent references to his lack of personal hygiene, smelling, sleeping in his clothes, refusing to change them. He was going away on weekend leave quite successfully, seemed to be okay when he came back, was eating lots of take-aways.

2004

January to 10 February During his stay at the rehabilitation unit he was not eating the hospital food or drinking the water provided with medication but he denied having any concerns about it, simply saying that he did not like it. A note at the rehabilitation unit says that Mr X has not eaten one meal provided by the rehabilitation unit since admission. "*At first he survived on take-aways. Recently he has been eating cold tins of soup or ravioli*."

Moves to community residential home

15 January to 10 February During this time he visited Residential Home 1, an association house, he went on weekend leave to his grandparents and was due to go to the housing association directly from there, on leave and on 10 February went to Residential Home 1 on leave.

11 February A discharge summary from the NPU talks about his progress on the ward. He had a one month drug free period, during which time he showed considerable negative symptoms:

> *"In particular lack of motivation and poor self care. He also increasingly was noted to be laughing inappropriately and at times appeared to be scared, and possibly responding to auditory hallucinations."*

The overall message from the discharge summary is that they weren't able to achieve very much, except that some of his negative symptoms improved "*to a degree".*

24 February After the trial leave period he is now formally discharged from the rehabilitation unit to Residential Home 1.

5 April His care plan showed that it was agreed that staff at Residential Home 1 would watch Mr X take his medication. The early warning signs/relapse indicators were:

- any change of behaviour as Mr X continued to be quite guarded about past and present symptoms
- concern about his dietary intake which should continue to be monitored
- any strange behaviour should be reported to staff at the assertive outreach and rehabilitation team.

The nature of the service response to a crisis was that medication should be monitored closely, visits from assertive outreach and rehabilitation team can be increased, an outpatient appointment to be arranged and if Mr X appeared to be responding to auditory hallucinations then hospital admission should be considered.

25 April Care plan review showed that he had settled in well to Residential Home 1 and was happy with the accommodation. He was being watched taking evening medication but it was agreed that this would stop and Mr X would take control of his medication but continue to sign for it. Assertive outreach and rehabilitation team visits were to be reduced to twice a week.

26 May Letter from Psychiatrist 2 to GP saying that Mr X had had some difficulty and had been reported as standing in the lounge of his residential home continuously for eight hours. Staff at the housing association were keeping an eye on his medication and the situation had improved a great deal.

Readmitted back to hospital

7 -11 July Readmitted informally to the rehabilitation unit *"due to a deterioration in his mental state, has been reported as being paranoid of people where he lives at [the housing association], staff [there] have reported that he has been staying in bed all day and probably not been taking his Clozapine".* He spent the next couple of days asleep and or in bed. On 9 July he was told that he needed to eat, drink and take his medication otherwise he might be sectioned and transferred to the locked ward. He continued not to eat or drink apparently but on 11 July he said that he wanted to go back on clozapine. He ordered a take away on 11 July. Risk assessment dated 11 July showed that Mr X displayed:

- 4 out of 14 risk indicators for suicide
- 8 out of 14 for neglect
- 3 out of 14 for aggression or violence.

However, of the latter three one is misuse of drugs and or alcohol and another is previous dangerous impulsive acts, which is entirely derived from the suicide risk indicators. The third has a question mark beside it for sexually inappropriate behaviour, but the information provided about his sexually inappropriate behaviour does not suggest that it was violent or aggressive.

No other risk indicators are shown. He was assessed at low risk of suicide and aggression and violence, moderate to high risk of neglect and moderate risk of failing to comply with his medication regime.

18 August Staff were advised that Mr X's grandfather had died the previous night. Mr X appeared to take the news well, stating that *"I am not as upset as I thought I would be*". He continued to do well over the following days, and didn't seem to show any distress at his grandfather's death, either at the time or subsequently after the funeral.

1 -14 September Mr X cooked himself some breakfast independently and then went on leave to Residential Home 1 for two days. He continued to do well, playing football, cooking, being active and was discharged from the rehabilitation unit back to Residential Home 1 on 14 September.

Transfer to rehabilitation team

15-18 October 2004. Transfer of care from assertive outreach team to rehab team. Risk assessment says *"No known history of aggression or violence towards others".*

21 October Care plan: in addition to the support he was being given by the staff at the housing association, he was to have regular outpatient appointments with Psychiatrist 2, see his care coordinator at least twice a week and receive support from a support worker. There was a contingency plan that if the care coordinator wasn't available the assertive outreach team could be contacted as they would have a copy of his care plan. His relapse indicators were listed as:

- lack of attention to hygiene
- poor dietary intake
- lack of motivation spending long periods in bed
- complaints of feeling physically unwell
- command hallucinations have told him to climb out of windows and harm himself.

The nature of the service response to a crisis were listed as:

- increase visits from assertive outreach team
- medication to be monitored
- out-patient appointment to be made
- assess and consider hospital admission.

Readmitted to NHS psychiatric unit

16 November Readmitted to the psychiatric hospital, informally, from Residential Home 1 following an outpatient appointment with Psychiatrist 2. His mental state had been deteriorating. He had been neglecting himself and his medication levels were poor. Also*:*

> *"[Mr X] pushed a visitor down a couple of stairs which is out of character. [Mr X] says that guy had been threatening towards himself and other residents of the house and had made comments about getting a knife or a gun. [Mr X] says he just wanted to get this man out of his house, and he didn't act in an unprovoked manner…no sign of psychotic symptoms, personal hygiene seems poor at present."*

Transferred back to community house

26 November Transferred to the rehabilitation unit:

> *"On arrival [Mr X] presented as chaotic, requesting PRN +++ expressing his experiencing positive psychotic symptoms, hearing voices and has been guarded…no management problems…"*

November-January 2005 Psychiatrist 2 noted that he is putting Mr X back on clozapine: *"He is desperate to go back on Clozapine*". Much as before – spending a lot of time

sleeping, eating take-aways, quiet and pleasant, dirty and dishevelled, not attending to his daily living activities.

2005

February - March Mr X reported to his grandmother that he felt he could not express himself to the nurses as he is afraid he will be put on section. He would love to be able to bathe and change his clothes but finds that he can not. There is a reference to him saying that it was bearable for him to shower but when he changes his clothes the spirits would cause him immense physical pain.

Mr X was at his grandmother's and said that he could not go back to the unit. His grandmother said that he had not eaten or drunk anything for a couple of days. He said that he was brain damaged and that this was going to get worse. He refused to go back to the unit. Eventually he was persuaded to return to the rehabilitation unit because he was told that otherwise there would be a mental health act assessment to see if he should be sectioned.

April While still at the rehabilitation unit he was detained under section 3, in the interests of his own health only, because he was not co-operating with his treatment plan and in particular taking medication. Mr X is recorded as saying that he gets a burning sensation when he goes out into the garden. On the same day he said that if he showers the demons will get him. There are comments throughout these notes that quite often, he will get a take away and then throw all or most of it away sometimes without even unwrapping it.

Psychiatrist 2 notes that following an increase in clozapine Mr X is better kempt, has changed his clothes, shaved but says that there are consequences now. He can not watch television as the spirits are getting into his eyes.

May There is a note that Mr X wasn't changing his clothes because of contamination by spirits *"delusional beliefs persist"*. There appears to be improvement shown from June onwards, and there are comments about him finding it easier to keep clean, humour returning, not smelling and smiling.

Psychiatrist 2 records that Mr X says that he can't keep money on him for long because the spirits contaminate it. There is another note which records that Mr X got angry about staff

giving him £10 for his take away wanting more. There is also a note that he became verbally abusive when offered food from the barbeque and became calmer when this was taken away.

Despite the comments above most of the notes in this month record that his mood is pleasant, settled, isolative, and calm. He spends a lot of time in his room, asleep in or on his bed. He is generally described as polite and appropriate in interactions and compliant with medication.

There are many visits from his grandmother and he also goes out with her and goes out with his mother. The only clean clothes that he would wear were brand new ones, so when he was eventually persuaded to change his clothes, somebody would have to go out and buy him new clothes – for instance *"on 19th June 05 he requested some new trousers as he had been incontinent of urine during the previous night. Unfortunately, the shops were closed when a staff member tried to buy some for him".*

June His grandmother gave him some fruit but he put it in the bin saying he could not eat it. He had tried but he felt it may have been affected by spirits from the nursing office or the manager's office. That afternoon he was taken off section. He said that changing his clothes caused him to feel anxious and agitated due to spirits.

July Care plan shows Mr X's relapse indicators to be:

- lack of attention to hygiene, poor dietary intake
- lack of motivation spending long periods in bed
- lots of complaints re feeling physically unwell
- command hallucinations have told him to climb out of windows and harm himself. AORT to be contacted and informed.

The nature of the service response to a crisis is increased visits from AOT, medication to be monitored, out-patients appointment to be made, assess and consider hospital admission.

The notes show he was verbally abusive towards staff over his 10p for the phone and was confrontational in mood. The next entry in the notes says that he was pleasant on approach.

August After being offered some liquid laxative, he said that he was having problems drinking it and had *"vines"* growing out of his face. He could feel them growing. It is noted that he was watching TV for most of the evening and was happy to engage in conversation with staff. *"Good sense of humour. Discussed if he felt better he would like to be out with his mates getting drunk. Core beliefs around spirits remain".* The notes in August show a significant improvement in his self care and sociability etc. His medication had been increased.

September Mr X is reported as being a little perturbed when asked to pay for his take away with the change he has accumulated in the safe. He said he had issues with the coins. It is reported that Mr X eventually agreed to change his clothes if new clothes were bought for him in town. This was done but then he was adamant that he could not wear the new clothes as they had been brought into the nursing office and thus were contaminated by spirits and it would cause him pain to wear them. With gentle persuasion he finally changed his clothes.

November There is a mention of Mr X having his care plan varied so he gets his daily allotted money for take-aways when he orders and gets his first take-away. Initially he was in agreement, but later he expressed concern that this would cause him problems with the spirits. The next day it is noted that he was reluctant to have all his money for the day saying that the spirits would punish him. When he got back from a visit to Residential Home 1 he insisted on the balance of his money being put back in the safe until his evening take away. Mr X said that the spirits did not affect him so much at the housing association.

December Report from the housing association which shows that when he was living at Residential Home 1 he used to avoid taking his medication even when the staff were watching him taking it by palming it and then throwing it away. They then detailed his other difficulties in relation to looking after himself, laundry, self care, cooking etc. and end:

> *"The staff team feel it is not fair to [Mr X] to ask him to carry out tasks that he is not actually able to do. He is already on his final tenancy warning and it could be setting him up to fail to return to a project intended as a final step towards independent living. We feel that his best interests would be served by providing*

him with personal care until he has built up the confidence and abilities to do some things for himself again. We would be happy to take a re-referral at this stage."

Letter from the placement support manager of the trust responding to a report from the housing association saying that Mr X's care needs are in excess of those provided by them at Residential Home 1. She wanted to know whether he might be able to manage there if he was given extra help from the trust, for instance three hours of one to one support seven days a week.

Occupational Therapist 2 reported:

"When prompted, [Mr X] has alluded to staff that his ability to carry out tasks is primarily dictated by 'spirits' that [Mr X] believes inflict physical and mental distress upon him if he engages with tasks against 'their' wishes. [Mr X] has stated in the past that the 'spirits' have made him stand for long periods as opposed to sitting or lying down, as a form of punishment. On one occasion, having been encouraged by staff to venture briefly into the unit back garden, [Mr X] complained of pains radiating through his head and neck brought on by the 'spirits'…[Mr X] believes he is prohibited from eating food provided by the unit due to perceived contamination from the 'spirits'. [Mr X] also believes that his money from the nursing office is equally contaminated…Throughout this admission [Mr X] has presented as a patient with a high level of behaviourally and psychotically based controls affecting his volition to engage in most of his habits and roles, and negatively affecting his capacity to perform activities of daily living (ADLs).

These controls affecting [Mr X] have lead to a breakdown in a supported housing placement despite consistent support and input, and resulted in another year-long hospital admission for him.

During this admission some minimal progress has been observed in [Mr X]'s ability to engage with chosen habits and routines, limited by the aforementioned controls. However, little or no progress has been observed with regard to [Mr X]'s psychotic mental state.

It has remained unclear the degree to which the cause for [Mr X]'s current presentation is behaviourally based or psychotically based. However, approaches focused on the behavioural elements of [Mr X]'s presentation have proved more successful than attempts to engage [Mr X] in a discourse regarding his psychotic beliefs…From assessment and therapeutic interventions thus far, it is felt that with continued intensive support, [Mr X] has the capacity to acquire the confidence and insight needed to overcome the behavioural elements of his current presentation.

It is recognised that the main limiting factor in [Mr X]'s case, appears to be his current psychotic presentation, without which his functional capacities would be significantly increased. It is debatable whether historically, the pharmaceutical courses of treatment [Mr X] has complied with have been successful in effecting a reduction of his positive psychotic symptoms.

In light of the above, it is expected that future progress will be very gradual and that any internalised locus of control needed for [Mr X] to overcome the obsessional components of his mental state will only be attained through a high level of support from both mental health services and his future living environment.

It is recommended therefore, that following discharge from the rehabilitation unit, at the appropriate time, [Mr X] be transferred to accommodation that would afford this high level of ongoing support."

Notes state that Mr X had not returned from leave as negotiated, and phone calls to his grandmother's house were unanswered. *"[Mr X] not assessed to be at high risk when with his grandmother, thus no further action taken at this time."* He returned the next day. During December/January the nursing notes show an improvement in his sociability, ability to keep himself clean etc. and in his interest in his lap-top computer. By the beginning of January there is comment about trying to find other placements and by the end of January there is a note that finding a suitable residence is *"very difficult."*

2006

January - April In late January it is reported that the voices have gone *"spirits have reduced. [Mr X] has no thoughts as to why this has happened".* In March he is assessed by Residential Home 2. And then embarks on rehabilitation work with the occupational therapist to go shopping and preparing for discharge. In April he made an informal visit to Residential Home 2. During April and May he was going out on leave every week for two or three days to stay with his grandmother. He also seems to be showering and washing his hair every two or three days, eating take-aways and taking pride in his appearance.

Even though there were obvious signs of progress, he still seems to spend most of his time in his room using his computer and listening to the radio and he is still eating take-aways most of the time.

May During this month an individual patient funding application request was made for Mr X to go to Residential Home 2. His risks were identified as:

> "*…self neglect, poor hygiene and diet, history of drug use, history of self harm in response to auditory hallucinations, isolative, difficulty in maintaining physical health, poor concordance with prescribed medication".*

His identified needs were shown as:

> "*Slow track rehabilitation, supervision of medication, encouragement with all aspects of daily living, diet, hygiene, physical and mental well being, relapse prevention, graded exposure."*

The brief history was recorded:

> *"[Mr X] was first admitted to hospital in 2001. Since this time he has only managed to spend six months in total out of hospital. [Mr X] was unable to remain in supported housing as they felt his care needs were too high despite intensive support from the Assertive Outreach Team. [Mr X] has fixed delusional beliefs around his diet and will only eat take away food. He does not attend to his hygiene needs, requires constant prompting from the rehabilitation unit staff. [Mr X] has just started going outside on his own. This is just for short periods. He now*

is able to feel comfortable going on leave to his grandmother's. [Mr X] has been in the rehabilitation unit for the past year with very slow gradual improvement with a lot of intensive recovery input from the nursing team. He is ready to move on from the rehabilitation unit but is still going to require a lot of input with all aspects of care and recovery."

Under *'Duration of placement'*:

"It would depend on [Mr X]'s continued recovery. Due to [Mr X]'s young age hopefully he would be able to move back to supported accommodation as soon as he is ready."

A risk screening assessment shows much higher risk than previously:

- under suicide there are three positive indicators
- under neglect there are nine
- under aggression/violence there are four
- under other there are three.

However, in the summary under *'Aggression/violence'* it says "*No known history".* The risk assessment says under '*Neglect'* that he eats take-aways in response to delusional beliefs around food and that he states that when he washes or changes his clothes he experiences pain from "*spirits"*.

Funding for Residential Home 2 agreed. There is a note that he had been making sandwiches in the kitchen and eating from the patients' fridge and there are then further comments of him making sandwiches and eating unit food. He went out shopping again and said that next time he would be willing to walk from the car to the shop on his own leaving a staff member in the car, rather than being accompanied the whole way.

Following assessment Mr X was transferred from the care of the assertive outreach team to the recovery team.

June There is a long note which we summarise here. The note says that when it was time for night medication Mr X asked if the nurse would mind if he did not have his clozapine that night as he said he was having negative feelings and the clozapine was slowing his

body down and he felt that missing one dose would be enough to let him know if he would be better off without clozapine. When the nurse raised an issue about whether he was trying to sabotage his discharge or feeling anxious about it, he gave an explanation that he had fallen on to a chair and hurt his testicles while he had been staying at his Nan's and that they were still numb and he thought that the clozapine was stopping the circulation in some way. He insisted that he did not want to take clozapine that night. The nurse explained to him the risk of relapse. He insisted. The next day he said that he felt much better "*The blood is going back into my body*" and he then started taking medication again, although he continued to express concern about his testicles.

Later that month he went to see his GP about this and was given a course of antibiotics for an infection identified by testing his urine. His occupational therapist, during this trip to the GP, identified two major changes – one he was eating unit food on the unit and two he was washing clothes which meant that he did not need to buy new clothes every week. When asked why this might be, he said that the mounting financial outlay had been a significant factor and he still found it difficult to leave the unit.

Mr X attended the creative art group. He queried whether the creative art work was for analytical purposes and the OT said that it was not and he stayed for the duration of the group having originally said he would only stay for five minutes.

July Mr X had his first visit from CPN1 on the recovery team. She completed a social functioning scale and had various discussions with him about Residential Home 2. His care plan shows that he has been granted funding and is awaiting a bed to become available at Residential Home 2, that he is now eating the unit food and going on regular leave to his grandmother's, managing his own money, engaging in a computer course, mental state appears stable.

August – November In August he is on two weeks leave to Residential Home 2. At Residential Home 2 he is reported to be eating the food but taking it up to his room and spending a lot of time in his room. He was attending to his personal hygiene. In September he is discharged from the rehabilitation unit by Psychiatrist 2 on that day who said that he was doing well at Residential Home 2 with no issues or complaints. He has an outpatient appointment with Psychiatrist 2 in November.

Appendix C

Biographies

Tariq Hussain

Senior consultant Tariq is a former nurse director who brings to Verita his considerable experience of leading change management in the fields of learning disability and mental health services. Tariq has undertaken a wide range of projects for Verita which have included mental health homicide investigations and an investigation into sexual abuse by an eating disorder clinic manager. He also serves as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Prior to Tariq's appointment with Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting.

Lucy Scott-Moncrieff

Lucy qualified as a solicitor in 1978, and has worked in the fields of mental health and human rights law ever since. She is a member of the Law Society's Mental Health & Disability Committee and its Access to Justice Committee, having previously chaired both committees. In 2005 Lucy was awarded the Mental Health Legal Aid Lawyer of the Year award, and two years later her firm was short listed for the Law Society's award for Excellence in Innovation. Lucy is a director of Edge Training Limited, a company that offers training on the law to the purchasers and providers of health and social care, and a member of the QC Appointments Panel. She is also a commissioner with the Royal Mail regulator Postcomm. Lucy is on the editorial boards of the *Community care law reports* and the *Mental health law journal* and has written and broadcast regularly on legal issues over the years.