HASCAS HEALTH AND SOCIAL CARE ADVISORY SERVICE

REPORT OF THE INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF Mr TG

JUNE 2011

Contents

1. Investigation Team Preface

1.1 The Independent Investigation into the Care and Treatment of Mr TG was commissioned by the NHS East of England and the Hertfordshire Primary Care Trust in accordance with *HSG (94)27* as amended in June 2005. The Independent Investigation Panel was asked to examine a set of circumstances associated with the homicide of Mrs S. Mr TG was subsequently arrested and convicted as the perpetrator of this offence.

1.2 Mr TG received care and treatment for his mental health problems from the Hertfordshire Partnership NHS Trust (HPT) now the Hertfordshire Partnership Foundation Trust. (HPFT). Throughout this report the HPT name will be used as this was the name of the Trust throughout the time Mr TG received care and treatment from 1996 to 2005.

1.3 It has been necessary to examine the care and treatment Mr TG received since July 1996 up to August 2005 in order to fully understand all the circumstances surrounding the homicide.

1.4 The purpose of this Investigation is to learn any lessons that might help to prevent further incidents of this nature, to help the HPT and its partner agencies to improve their services and to share the lessons learned across the NHS.

1.5 Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They have done so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who granted access to facilities and individuals throughout this process. As a result the Independent Investigation Panel has been able to reach an informed position from which we have been able to formulate conclusions and set out recommendations. We are also grateful for the assistance of the Hertfordshire County Council in relation to information about the Safeguarding and Child Protection issues associated with this Investigation, although HASCAS did at first find it difficult to identify the appropriate managers to speak with.

2. Condolences to the Family of Mrs S

2.1 The Independent Investigation Panel wishes to express its condolences to the family of Mrs S It is understood that the three children of Mr and Mrs S have been adversely affected by the homicide of their mother, as has Mr S and his present wife.

2.2 The Chair of the Independent Investigation Panel met Mr S and he kindly provided additional information about his ex-wife and their three children.

2.3 It is hoped that this Independent Investigation and its recommendations will help Mr S to better understand how the homicide occurred and the reasons for it, although no direct causal link has been established.

2.4 Mr S described Mrs S as being “a caring person who was too trusting. She was a good mother and loved her children and her family. She always wanted her children and her mother to be part of her life and always put them first. Mrs S would do anything for people.”

2.5 She missed her late father and brother. She had a great passion for Arsenal Football Club and music. Mrs S worked at an estate agent’s office for many years but stopped this when her son was born.

2.6 “The way my wife was killed no one should have to go through. My kids have suffered along with myself and other people.” Mr S concluded by saying that he still loves his ex-wife for being the mother of his three children.

3. Executive Summary

Incident Description and Consequences

3.1 Mr TG had been receiving care and treatment from HPT for his mental health problems for nine years from 1996 until the date of the homicide of Mrs S on the night of 3/4 August 2005.

3.2 That night Mr TG and his partner, Mrs S were on holiday in a caravan together with Mrs S's three young sons at Walton-on-the-Naze in Essex. There had been an argument during the day on the beach and this restarted during the night. Mr TG attacked Mrs S and hit her and strangled her. He then fled from the scene in Mrs S's car leaving the three children in the caravan. The eldest son aged 11 sought help.

3.3 Mr TG gave himself up to the police at Hertford Police Station. He was later charged with the murder of Mrs S and found guilty by a jury at Basildon Crown Court on 29 March 2006. He was sentenced to life imprisonment with no leave to appeal for licence for 17 years.

3.4 The HPT carried out an internal investigation into the care and treatment of Mr TG to identify any lessons to be learned, and following this the East of England SHA commissioned this Independent Investigation.

Background to the Independent Investigation

3.5 The HASCAS Health and Social Care Advisory Service was commissioned by the NHS East of England (The East of England Strategic Health Authority) and the Hertfordshire Primary Care NHS Trust to conduct this Independent Investigation under the auspices of Department of Health Guidance HSG (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved*".

3.6 This guidance was slightly amended the following year and the particular paragraphs in the guidance relating to 'when things go wrong' further amended in 2005.

3.7 The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the service user in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

Terms of Reference *(These are included in full on Page 14)*

3.8 An independent investigation should demonstrate and promote good practice by being open and honest in addressing any shortfall in service provision to service users and carers. The Hertfordshire Partnership Trust has already carried out an internal investigation and followed this up with an action plan. Therefore any clear shortfalls should have already been addressed. The main purposes of this Independent Investigation were to review the internal investigation and examine the care and treatment received by Mr TG with the aim of increasing public confidence and promoting professional competence.

3.9 Therefore such an Investigation should establish the facts, provide an independent perspective on the events, extract areas for development to improve services and thus endeavour to prevent a similar event from occurring in the future. To enable this task to be carried out, the Independent Investigation Panel used the Terms of Reference agreed with the SHA.

The Investigation Team

3.10 The Independent Investigation was undertaken by the following Panel of professionals who are independent of the healthcare services provided by the NHS East of England, the Hertfordshire Partnership Trust and Hertfordshire Primary Care Trust.

Chair and Investigation Lead

Ian Allured	HASCAS Director of Adult Mental Health

Members of the Panel

Dr Elizabeth Gethins	Consultant Forensic Psychiatrist
Sally Gooch	Independent Consultant in Nursing and Healthcare
Sue Simmons	HASCAS National Development Consultant

Advice from a Service User Perspective

Tina Coldham	HASCAS Service User National Development Consultant.

Independent Advice

Ashley Irons	Capsticks (Solicitors)

Findings

3.11 The Independent Investigation Panel carefully examined and scrutinised all the written and oral evidence it had available. Consideration was given to the main points raised during the detailed analysis of all the information and the Panel agreed that it had not identified any key causal factors nor any direct contributory factors.

The main issues identified were:

Medical Factors/Mental Health Issues

- Psychiatric Assessment;
- Diagnosis;
- Treatment Plans;
- Risk Assessment;
- Care Programme Approach.

Social Factors/Safeguarding Issues

- Adequacy of Assessment;
- Child Protection Conference June 2003;
- Domestic Violence, Child Abuse and Mental Health Services;
- Inter-Agency Information Sharing;
- The Serious Case Review;
- Partnership Working;
- Staffing.

These issues are discussed in detail in Section 12 on Pages 92 to 96.

Conclusion

3.12 There were several service issues identified and recommendations have been made so that these areas are addressed. There were clearly ways in which the care and treatment could have been improved, but given the information available to the psychiatrists who treated Mr TG, no causal factor or combination of contributory factors could be identified to explain the reasons for the murder of Mrs S.

Recommendations

3.13 Following this Independent Investigation the recommendations were drawn together with the assistance of six staff from the HPFT at a workshop held on the morning of 13 May 2010. The chair of the Independent Investigation Panel and the HASCAS National Development Consultant highlighted the areas of concern identified by the Panel, and where they wished to make recommendations. Sample recommendations were provided, and the workshop was designed to enable the HPFT to ensure that they were correct for 2010 and to describe any corrective steps or changes which had been taken since August 2005.

3.14 The HPFT staff were also asked to help word the recommendations so that they would be totally relevant to the Trust, and also able to be fully implemented. The purpose of this approach was also to ensure that the Trust had ownership of the recommendations.

3.15 The agreed set of 12 Recommendations are:

Recommendation 1

When the psychiatrist, or other member of the mental health services, wishes to review the diagnosis of a service user this should be undertaken with a review of the complete history of that service user and the treatment and care plans which have been used. Any change in plan should be fully recorded with the reasons clearly stated. In addition if there is any consideration of a specific diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) there should be consultation with one of the Trust's four specialist consultants.

Recommendation 2

The National Service Framework for Children includes a recommendation that CPA meetings (and their equivalent) should take account of children's needs and any risk of harm to them. Therefore, when a service user is the parent of a child for whom a child protection/safeguarding conference is called, and the mental health services are asked to attend the conference and to provide a report, this should be treated as a priority. A request for information should trigger a reassessment of the service user and the risks he/she may pose to children and others. The Trust should audit attendances at child protection case conferences.

Recommendation 3

In situations where a service user is usually seen alone without any family or friends and there is no corroborative information to support the 'history' or symptoms described by the service user, any opportunity to speak to another person who knows them should be used. The person may be a carer and be entitled to an assessment of their specific needs as a carer, and may also be able to provide additional information about the service user, subject to issues of consent and confidentiality.

Recommendation 4

Service users who are only being seen by the psychiatrist should be asked about their family and social circumstances so that they are viewed within an overall context. This is particularly important where the only informant is the service user and there is no other source to corroborate the history given. All mental health professionals should complete the form designed by the Lead Nurse for Safeguarding Children which records information about children with whom the service user has contact.

Recommendation 5

When a service user is being seen by only one member of the mental health services there should be a review, at least annually, to include: diagnosis, care plan and treatment plan, current risk assessment, social and family circumstances, risk to

any children in the household and consideration of their needs. This review should set out how the treatment plan is designed to assist the service user and overcome/alleviate the symptoms being experienced.

Recommendation 6

Where there is irregular attendance and a number of missed appointments by a service user to outpatient appointments it is particularly important that there is a clear plan, which has been discussed between the medical staff and at least one other member of the CMHT, for either the continuation of appointments or an alternative strategy for engagement or discharge from the service.

Recommendation 7

In situations where it is difficult to engage service users with a complex personality disorder a needs led approach may be taken. This should be preceded by an assessment of the risk that the patient may pose to others in order to be sure this treatment modality is appropriate. This may include consultation with the specialist personality disorder team.

Recommendation 8

All health professionals responsible for completing DWP forms relating to a patient's application for State Benefits, should be reminded of their legal duty only to include information that they know is true, or have good grounds for believing to be true.

Recommendation 9

The Trust should ensure that when complaints by service users are made and investigated, the process complies with the current Trust Policy and a complete record of that investigation is held corporately by the Trust and is not retained in local managers' offices.

Recommendation 10

The Strategic Health Authority should ensure that Independent Investigations following a homicide are conducted promptly. The SHA should ensure where there is also a Serious Case Review being conducted by the Local Safeguarding Children Board, that there is good liaison and joint planning between these reviews, particularly at the stage of drawing up Terms of Reference, to maximise learning and to minimise duplication.

The SHA should endeavour to ensure that there is full information sharing between the reviews insofar as this is compatible with data sharing legislation. Thought should also be given to careful liaison between the two reviews in relation to the involvement of children, parents and other family members and to the timing of publication of the two reports.

Recommendation 11

NHS organisations should be alert to the inherent risks of a long period with a shortage of senior medical staff, or a rapid turnover of such staff. In such circumstances the Human Resources Strategy should ensure that the caseload in psychiatric outpatients is reviewed to make certain that all cases have an appropriate care plan which is being fully implemented, and to address any gaps that the review identifies.

Recommendation 12

When a homicide occurs there will necessarily be an Independent Investigation. The HPFT should ensure that the clinical records and all relevant documents are held securely, including the records which comprise the archive of the Internal Investigation undertaken by the Trust until the Independent Investigation is complete.

4. Background and Context to the Investigation (Purpose of Report)

4.1 The HASCAS Health and Social Care Advisory Service was commissioned by NHS East of England to conduct this Independent Investigation under the auspices of Department of Health Guidance HSG(94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

4.2 This guidance was slightly amended the following year and the particular paragraphs in the guidance relating to 'when things go wrong' further amended in 2005. Now the criteria for conducting such an investigation include: -

i) When a person who has been under the care, i.e. has committed a homicide subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

4.3 The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the service user in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Mental Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

4.4 The role of the Independent Investigation Panel is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and

associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge.

4.5 The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services and the interest of the wider public.

5. Terms of Reference

An independent investigation should demonstrate and promote good practice by being open and honest in addressing any shortfall in service provision to service users and carers. The Hertfordshire Partnership Trust has already carried out an internal investigation and followed this up with an action plan. Therefore any clear shortfalls should have already been addressed. The main purposes of this Independent Investigation were to review the internal investigation and examine the care and treatment received by Mr TG with the aim of increasing public confidence and promoting professional competence.

Therefore such an investigation should establish the facts, provide an independent perspective on the events, extract areas for development to improve services and thus endeavour to prevent a similar event from occurring. To enable this task to be carried out, the Independent Investigation Panel will use the following Terms of Reference

"A. To examine the mental health care received by Mr TG in the context of his life history and social and family circumstances, in order to obtain a better understanding of, in particular:

i. The extent to which Mr TG's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC (90)23, and local operational policies.

ii The extent to which his prescribed care plans were:

a) effectively drawn up

b) delivered and complied with by Mr TG

iii The appropriateness and quality of any assessment, care, treatment plan and supervision having regard to his past history and current living arrangements, to include:

- medication;
- staff responses to service user and carer concerns;
- involvement of Mr TG and his family in his care plan;
- range of treatments /interventions considered;
- social care interventions;
- reliability of case notes and other documentation.

iv His assessed risk of potential harm to himself and others, compiling a comprehensive chronology of events leading up to the homicide on 3/8/05, to include specifically:

- risk of Mr TG harming others or himself;
- training of clinical staff in risk assessment;
- systems and procedures in place at the time of Mr TG's contact with services;
- staff's knowledge and skills in relation to safeguarding children arrangements and their understanding of policy in this area;
- staff's application of the safeguarding children policy and their knowledge in this case.

B. To consider the effectiveness of interagency working, including communication between the mental health service and other agencies with particular reference to the sharing of information for the purpose of safeguarding children.

C. To review the internal investigation into the care of Mr TG undertaken by Hertfordshire Partnership Foundation Trust and any action plans that may

have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal investigation, and assess the effectiveness of their implementation.

D. To comment on the care and support offered to the victim's and perpetrator's families at the time of the incident and during the internal investigation.

E. To involve as appropriate (and in accordance with their wishes) the family of the victim and the family of the perpetrator.

F. To consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence.

G. To prepare an independent report for NHS East of England, and any other relevant bodies.

H. To use the concepts and principles of *root cause analysis* as appropriate, for the purpose of enabling lessons to be learnt rather than the apportionment of blame or liability.

I. To ensure that any action plan and recommendations take full account of the progress that the Hertfordshire Partnership NHS Foundation Trust has made since the completion of the internal investigation report.

6. Investigation Methodology

6.1 The NHS East of England and the Hertfordshire Primary Care Trust commissioned this Independent Investigation under the Terms of Reference set out in Section 6 of this report. The Investigation was led by a project manager from the HASCAS, Health and Social Care Advisory Service. A meeting to discuss the procedure to be followed was held between the NHS East of England and HASCAS on 07 April 2009.

6.2 Mr TG refused to give permission for the Independent Investigation Panel to access his medical and other records. The NHS East of England wrote to him on two occasions and the chair of the Independent Investigation Panel wrote once. The sequence of the letters was:

- 6 October 2008 (Consultant 5) the NHS East of England wrote to Mr TG asking for his consent and enclosing the requisite papers for signature;
- 9 October 2008 Mr TG wrote to Consultant 5 declining to give permission and asking for more information about the Investigation;
- 21 October 2008 SB wrote to Mr TG providing the requested information and no reply was received;
- 09 April 2009 the Panel Chair wrote to Mr TG requesting his consent and no response was received;
- 27 May 2009 the Panel Chair wrote to the Caldecott Guardian at HFPT requesting that Mr TG's consent to the release of his records be dispensed with on the grounds of the matter being in the public interest. This permission was granted;
- 21 December 2009 the Panel Chair wrote to Mr TG explaining that his consent had been dispensed with and asking if he would be willing to meet some of the panel to give his views on the care and treatment he had received;

- 28 December 2009 Mr TG wrote to the Chair of the Panel accepting a visit from some members of the Panel. He was seen on 19 February 2010.

6.3 All documentation received by the Independent Investigation Panel was indexed and paginated. A timeline of critical events was compiled and is contained within this report. (A detailed timeline of medical issues is also included on Page 36).

6.4 All witnesses were written to four weeks in advance of their interviews detailing the Terms of Reference of the Investigation, the areas that the Independent Investigation Panel would be questioning them about and the operational process and timescale of the work. All witnesses to the Investigation were invited to attend an informal meeting on 16 December 2009 to meet the Chair/Investigation Project Lead and another Panel Member. During this meeting the process was explained and a question and answer session conducted.

6.5 Evidence was received from 13 individual witnesses orally over a period of four days during January to March 2010. Table 1 lists the witnesses interviewed during the Independent Investigation.

Table 1 : Witnesses Interviewed by Investigation Team

Date	Witness	Interviewers
12/01/2010	Consultant 5 (HPFT)	Ian Allured, Elizabeth Gethins, Sally Gooch and Sue Simmons
	Team Manager 2 (HPFT)	Ian Allured, Elizabeth Gethins, Sally Gooch and Sue Simmons
	Consultant 1 (HPFT)	Ian Allured, Elizabeth Gethins, Sally Gooch and Sue Simmons
	Manager 1 and Manager 2 (HPFT)	Ian Allured, Elizabeth Gethins, Sally Gooch and Sue Simmons
	Manager 3 (HPFT)and LA Manager 1 (HCC)	Ian Allured, Elizabeth Gethins, Sally Gooch and Sue Simmons
13/01/2010	GP 1 (GP)	Ian Allured, Elizabeth Gethins, Sally Gooch and Sue Simmons
17/02/2010	CMHT Manager 1 (exHPFT)	Ian Allured, Elizabeth Gethins, Sally Gooch and Sue Simmons
24/03/2010	LA Manager 2 and LA Manager 3 (HCC)	Ian Allured, Sally Gooch and Sue Simmons

	Manager 4 (HCC and HPCT)	Ian Allured, Sally Gooch and Sue Simmons
	Manager 5 and Manager 6 (HPFT)	Ian Allured, Sally Gooch and Sue Simmons

(In addition Mr TG was interviewed on 19 February 2010 by the panel Chair and the HASCAS Associate and Mr S (the victim's ex-husband) was interviewed by the Panel Chair on 24 April 2010. A hand written account was made of both these interviews.

6.6 All the interviews with the full Panel were recorded and a transcript prepared. The transcript was then forwarded to each individual in order for it to be checked for accuracy and also for any additional information to be added to it. It is the amended versions that have been used as evidence in this Independent Investigation.

6.7 The Independent Investigation Panel was not able to interview all of the individuals involved in the care and treatment of Mr. TG as some had retired and some locum medical staff could not be traced. Two medical staff were traced after the Independent Investigation had taken place and were seen by the Chair of the Panel and helpful additions to the Report were made. The Chair was grateful to Consultant 3 and Consultant 4 for their contribution to the Independent Investigation.

Root Cause Analysis

6.8 The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

6.9 The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of a contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents happening in the same way again. It must, however, be noted that

where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

6.10 RCA is a four-stage process. This process is as follows:

1. **Data Collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see the detailed medical timeline on Page 33). From these two timelines causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Independent Investigation Panel utilised the approach where all the facts were discussed and their effect assessed to determine whether they were directly responsible for the homicide or if they played a contributory role.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

6.11 When conducting the RCA the Independent Investigation Panel avoided generalisations and sought to use findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

Salmon Compliant Procedures

6.12 The Independent Investigation Panel adopted Salmon compliant procedures during the course of their work. This process is set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign;

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's Final Report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

11. In addition witnesses to the Panel were offered the opportunity to read records relating to their involvement with Mr TG prior to their interview.

7. Information and Evidence Gathered (Documents)

7.1 The Independent Investigation Panel examined all the clinical files. These comprised the following files about the involvement of health and social care services with Mr TG from 1996 to 2005:

- Untoward Incident/Accident Form dated 26 August 2005;
- Adverse Incident 72 hour Report dated 20 September 2005;
- Internal Investigation Report dated and signed July 2007;
- HPFT Action Plan from the Internal Investigation dated October 2007;
- Learning from Adverse Events Policy Document;
- Reporting and Managing Adverse Events Procedure and Investigation of Incidents, Complaints and Claims Procedure dated May 2007;
- Briefing on Managing Risks Associated with Child Protection dated September 2008;
- Clinical Risk Assessment and Management for Individual Service Users dated September 2002 (and reviewed in January 2004);
- Clinical Risk Assessment and Management for Individual Service Users dated October 2005;
- Integrated Care Programme Approach and Care Management Policy dated October 2004;
- Guidelines for Sharing Information and Involvement in the Legal Process of Child Protection Policy dated 2005;
- Guidelines for Sharing Information and Involvement in the Legal Process of Child Protection Policy dated July 2007;
- Casenotes;
- Medical Records;
- GP Records;
- Clinical Notes from HPT;
- Clinical Notes from East and North Hertfordshire Trust – Part 1;

- Clinical Notes from East and North Hertfordshire Trust – Part 2;
- Statements by Staff and others to the police;
- The Executive Summary of the Hertfordshire Local Safeguarding Children Board Serious Case Review Re Case A15;
- Section 47 Enquiries and Complex Needs (Core) Assessment – Child Protection Procedures (September 2002);
- Child Protection Enquiries – Hertfordshire Safeguarding Children Board Child Protection Procedures March 2007 (HSCB 4559);
- Hertfordshire Partnership NHS Foundation Trust Action Plan for Adverse Events SUI l1573 (TG) 01/10/2007;
- Department of Health Schedule 3 : Quality Requirements and Nationally Specified Events (For Primary Care Trust commissioning and monitoring).

8. Profile of Mental Health Services (Past and Present)

8.1 Hertfordshire Partnership NHS Trust became Hertfordshire Partnership NHS Foundation Trust (HPFT) in 2007. The Trust serves a local population of around one million people across Hertfordshire and provides a range of secure, rehabilitation and specialist services in Hertfordshire, Norfolk and North Essex.

8.2 Services are provided on 78 sites across Hertfordshire with care focused on four main service groups: community services, specialist services, acute and rehabilitation services and learning disabilities and forensic services.

8.3 HPFT combines the provision of health and social care for the county of Hertfordshire. The Trust divides their services into teams and Mr TG received his mental health services from the Community Mental Health Team at Cygnet House, Ware in South East Hertfordshire.

2004

8.4 In 2004 the Trust employed 2900 staff and had an expected income of £160 million. In 2001 the Trust had become a partnership organisation with Hertfordshire County Council Adult Care Services providing health and social care for people with mental health problems. The Trust had seconded Council staff to provide integrated Mental Health Services for adult service users within community teams.

8.5 At the time of the incident and during 2004 the Trust was divided into three service directorates, which were:

- Mental Health. The Adult Mental Health section of the Directorate being further divided into Adult and Older People's Mental Health Services;
- Learning Disabilities;
- Child and Adolescent Mental Health.

8.6 The Adult Mental Health service comprised integrated health and social care for both their Inpatient and Community Services:

Inpatient Services

8.7 HPFT Inpatient Services were located on a variety of sites across the county including the Queen Elizabeth the Second Hospital (QE11) at Welwyn Hertfordshire and Lister Hospital at Stevenage Hertfordshire.

8.8 The Trust had no Psychiatric Intensive Care Beds (PICU) on these hospital sites providing acute inpatient care.

Community Services

8.9 The Community Services were divided into the following teams:

- Community Mental Health Teams (CMHT) providing health and social care to people with mental health problems being treated in the community.
- Crisis Intervention and Home Treatment Teams providing emergency care to people with mental health problems facing a crisis, and giving intensive support in the community for a short period as required.
- Assertive Outreach Teams providing intensive support to people with mental health problems who find it difficult to engage with services and require considerable help to remain living independently in the community.

8.10 Mr TG was under the care of the CMHT at Cygnet House, Ware, Hertfordshire and was seen as an outpatient over a period of nine years.

Specialist Services

8.11 Psychiatric Intensive Care beds and Low Secure beds were available in different locations for the geographical areas covered by the Trust, some being purchased on a contractual basis. East and North Hertfordshire teams used the PICU and Low Secure beds available at the Orchard Unit run by the Bedfordshire and Luton Trust in Luton.

9. Chronology of Events

9.1 There is a detailed Medical Timeline starting on Page 35.

Childhood

9.2 Mr TG was born on **30 May 1972** in Hertford and lived there until he was three with his parents. Mr TG then spent much of his life in foster care with a series of foster parents. He was reported to have suffered parental neglect, but continued to have intermittent contact with his mother and step-father. In foster care he lived mainly in the Hertfordshire area but did have short periods in Lancashire and Kent. Mr TG said that he did not suffer abuse once in foster care, but he hated school and left school with very few qualifications.

9.3 He undertook some further training as a car mechanic but has never held a job for more than a few days.

9.4 When Mr TG was 17 he started a relationship with his first long-term partner and they had two children in 1989 and 1995.

Forensic History

9.5 Mr TG first went to prison aged 18 in 1990 followed by a series of short jail terms for affray, burglary, car theft and assault, between 1997 and 1999. His last spell in prison ended in July 1999. During periods in prison Mr TG suffered numerous medical and psychiatric complaints.

First contacts with mental health services 1996 – 1999

9.6 Mr TG was referred to the mental health services in Hertfordshire in July 1996 and had his first appointment for assessment with Consultant 1, a consultant psychiatrist, on 12 August 1996. He was described as extremely complex with problems on all Axes I-V including:

Axis I Panic disorder with agoraphobia, recurrent brief depression now in remission and minor depression.

Axis II Borderline personality disorder.

Axis III Migraine, undiagnosed headaches

Axis IV Recent imprisonment, pending court case

Axis V Marked impairment in function.[i]

9.7 On **14 October 1996** Consultant 1's SHO wrote a letter which referred to bouts of violent temper, arguments with his wife and 'smashing up the place'. This letter also referred to Mr TG having spent four months in prison during the year due to violent behaviour.[ii]

9.8 Consultant 1 wrote to Mr TG's GP on **21 October 1997** saying he had seen Mr TG in outpatients, and making reference to interpersonal conflict with his wife, and that serious charges against him had been dropped.[iii]

9.9 Contact with Consultant 1 during this period was sporadic and interrupted by one or more periods in prison.

Second period of contact with mental health service November 2000-June 2002

9.10 During this period Mr TG was living in Hatfield at several different addresses.

9.11 On **19 November 2000** Mr TG referred himself to Accident and Emergency saying that he 'couldn't handle things', complaining of poor sleep, poor appetite and concentration, low energy, and hearing voices. A lengthy history was taken by the psychiatric SHO. Mr TG told the doctor that he had been seen by the mental health service three years earlier before going to prison. The SHO's plan was for him not to be admitted but for him to be seen in outpatients as soon as possible.[iv]

9.12 In the early hours of the following day (**20 November**) Mr TG re-presented at A&E with superficial self-inflicted cuts. Again he was examined and the outpatient plan was explained to him.[v]

9.13 On **9 January 2001** Mr TG had his first appointment at the Community Mental Health Centre (CMHC) with Staff Grade 1, Consultant 1's staff grade psychiatrist. Staff Grade 1 diagnosed obsessive compulsive disorder with panic, borderline personality disorder, antisocial personality disorder and depressive disorder, but made no reference to his two attendances at A&E in Nov 2000. Staff Grade 1 also recorded that Mr TG lived with his wife and children.[vi]

9.14 Mr TG did not attend his next outpatient appointment.

9.15 In **April 2000** Mr TG's GP received a letter from a solicitor saying that Mr TG's wife had applied to the Court to order him to vacate their house, and a few days later (**18 April**) Mr TG was taken to A&E by police officers following a 'suicide attempt' on a bridge over the motorway. He was accompanied by a friend. He had also cut himself. Mr TG told staff that he was upset as he was breaking up with his wife and losing his child, and was about to be evicted. He was assessed as a low suicide risk and a high risk of 'acting out'. The plan was for him not to be admitted, but for the assessing SHO to discuss him with Consultant 1 the following day.[vii]

9.16 On **22 May 2001** Mr TG attended Consultant 1's outpatient clinic and was seen by Staff Grade 1. He reported feeling better than before but still feeling paranoid, with poor concentration and motivation. He did not attend the next two appointments.[viii]

9.17 On **31 October 2001** Mr TG presented at A&E with superficial lacerations and was seen by the on-call psychiatric SHO. Mr TG had self harmed and explained that he was going through a messy divorce and had a court case pending. The plan was to send him home with reassurance and bring forward his outpatient appointment. This SHO completed an assessment and management of risk form at the time of this attendance at A&E. The SHO recorded risk to self (overdose and self harm) and to others (injury to another which resulted in prison) and said that he should not be seen by a lone worker, and definitely not a lone female. In the SHO's judgement Mr TG should have been on Enhanced CPA.[ix]

9.18 Mr TG was next reviewed in Consultant 1's outpatient clinic by Staff Grade 1 on **10 December 2001**. He reported mood swings and continuing paranoia. He had split up with his wife in April and had a new girlfriend. He said that he had no social worker or CPN and would like to talk to someone. The plan was for him to continue medication (chlorpromazine, setraline and oxazepam) and to be seen in two months.

9.19 In January and February 2002 there was some correspondence between Mr TG's GP and Consultant 1 saying that Mr TG had not been collecting his prescriptions regularly and had last collected a prescription in June 2001.[x]

9.20 Mr TG did not attend his next two outpatient appointments in February and June 2002.

Mental health care at Ware Community Mental Health Centre July 2002 – July 2005

9.21 In **July 2002** Mr TG moved from Hatfield to Stanstead Abbotts. Mr TG asked his GP, to refer him to the local mental health services. Consultant 1 wrote a summary for his next consultant on 19 August 2002. He described Mr TG's psychiatric condition as multi-mode, with a definite diagnosis of borderline personality disorder, with antisocial and paranoid features. He went on to say that Mr TG was not a regular or consistent user of services but someone who dropped in and out depending on his needs, and was skilled at navigating the system. The plan had been not to admit him to inpatient care, nor to explicitly encourage or discourage engagement.[xi]

9.22 Following this, on **7 September 2002**, Mr TG's new GP, GP 1, wrote to Cygnet House, the Ware Community Mental Health Centre, asking for Mr TG to be sent an appointment to review his medication.[xii]

9.23 Mr TG then had his first appointment at Ware CMHT on **28 October 2002**. He was seen by SHO 1, SHO to, consultant 6 DHO 1 took quite a detailed history and was told by Mr TG that he was living with his partner of 13 months and their two week old baby (born on 14 October 02). Mr TG wanted to lead a settled and responsible life for the sake of the baby. His chlorpromazine medication was stopped and he was to commence citalopram. [xiii]

9.24 Mr TG was next seen in outpatients by, SHO 1, on **25 November 2002**. He complained of feeling more anxious and agitated, although his mood, appetite, sleep pattern and self esteem had improved. There were further changes to his medication, with chlorpromazine being re-started.

9.25 Mr TG did not attend his next two outpatient appointments in January and February 2003.

9.26 In 2003 Mr TG suffered frequent migraines, confirmed by a consultant neurologist.[xiv] It was noted that Mr TG had reported in 1997 that he had at some point in his earlier life suffered an intracranial haemorrhage.

9.27 On **9 April 2003** Mr TG was seen in outpatients by a locum consultant, Consultant 3, who considered a possible diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) persisting into adulthood. Consultant 3 sought further information from Mr TG's mother about his childhood, speaking to her by telephone on **24 April 2003.** She described him as 'an absolute horror as a child', only sleeping for two hours at a time, and at three he was disruptive and aggressive at nursery. He had displayed poor concentration, overactivity and restlessness.

9.28 Mr TG had an outpatient appointment on the same day as this telephone conversation but did not attend. However he attended three days later on **27 April 2003**, saying that he had got the date wrong and saw Consultant 3 then. It was reported that he was happy to start Ritalin.

9.29 The following day Consultant 3 wrote to GP 1 proposing a diagnosis of ADHD persisting into adulthood and commencing treatment with Ritalin.[xv]

9.30 On **22 May 2003** Mr TG was seen in outpatients by Consultant 2, a new locum consultant. He reported feeling much better on Ritalin, with better concentration and being more settled. He denied any depressive, manic or psychotic symptoms. His dose of Ritalin was increased. [xvi]

9.31 Mr TG did not attend his next outpatient appointment on **5 June 2003**.

9.32 On **9 June 2003** the Ware CMHT was sent an invitation from the Children, Schools and Families Department (CSF) to attend a child protection meeting in relation to Mr TG's nine month old baby, and that a report was requested. From the information on record there is no evidence that anyone from the CMHT attended the case conference. [xvii]

9.33 On **11 June 2003** GP 1, referred Mr TG to the CMHT for an anger management course.[xviii]

9.34 Following the case conference Mr TG visited Cygnet House on **1 July 2003** and was seen by the duty worker. Mr TG described the recent child protection case conference. He felt the social worker there was biased against him and was advised to seek legal advice. Mr TG said he would put in writing his complaint to the manager about release of his medical information.[xix]

9.35 On **2 July 2003** the PCT sent a fax to GP 1 about the recent child protection meeting and requested that Mr TG should be referred to take an anger management course (although this appears to have already happened). The liaison slip following the case conference confirmed that Mr TG's baby had been placed on the child protection register for emotional abuse. There is no record in the mental health service records to this case conference or its outcome. [xx]

9.36 On **3 July 2003** GP 1, wrote to the PCT's child protection named nurse, saying that Mr TG had had a one-to-one consultation for anger management classes, but that he had not enjoyed it and had asked to be referred elsewhere.[xxi]

9.37 On **27 July 2003** Mr TG told GP 1 that he had been involved in a road traffic accident and on **15 September 2003** he told him that he had been gassed with CS gas by the police.[xxii]

9.38 On **24 September 2003** the Ware CMHT manager, wrote to Mr TG in response to his complaint about information being passed to the Children, Schools and Families Department, confirming that his complaint was justified. The letter confirmed that partial information had been passed on, under Section 47 of the Children Act, but an error led to more information than necessary being supplied to CSF.[xxiii]

9.39 On **9 December 2003** Mr TG was seen in Consultant 4's outpatient clinic. Consultant 4 had been appointed to the substantive post as consultant psychiatrist at the CMHT. Mr TG reported feeling much better in relation to his anger, and his relationship with his partner had improved.[xxiv]

9.40, GP 1, wrote to the police in **January 2004** in response to their communication about Mr TG's complaint about being sprayed with CS gas and sustaining injuries. He also described a small patch of skin on his forehead which looked like a superficial burn, and some reddening of his nasal mucosa.

9.41 On **10 March 2004** Mr TG was seen in outpatients by Consultant 4. Mr TG reported that he was still feeling quite paranoid and was suspicious about food. There were some changes to his medication and Consultant 4 reported to his GP that Mr TG's prognosis was poor given the continued paranoia. His medication was to be Ritalin, citalopram, oxazepam, risperidone and procyclidine.[xxv]

9.42 Mr TG did not attend his next outpatient appointment on **22 March 2004**, but four days later on **26 March 2004** Consultant 4 completed a medical support form for his application for Disability Living Allowance. His diagnoses were ADHD, depression, OCD, anxiety and panic attacks, paranoia, and personality disorder.[xxvi]

9.43 Mr TG failed to attend the next two outpatient appointments in April and July 2004.

9,44 During the later months of 2004 Mr TG split up with his partner and developed a relationship with Mrs S who was a neighbour and had three children. Mr S had left the marital home.[xxvii]

9.45 GP 1wrote to Consultant 4 on **16 December 2004** asking him to send Mr TG an appointment and to take over the prescribing of Ritalin.[xxviii]

9.46 Mr TG was then seen on **1 February 2005** by Consultant 4, almost eleven months since he last attended an appointment. He continued to have paranoid delusions and suspicions about food.[xxix]

9.47 He did not attend his next two outpatient appointments in April and June 2005.

9.48 Mr TG was last seen at the CMHT on **12 July 2005**. His appointment was with Consultant 4, (Consultant, and his SHO. Mr TG reported continuing paranoia and obsessive compulsive behaviour. He was at that time prescribed ritalin, citalopram, lorazepam, risperidone, procyclidine, co-dydramol. He also requested that his DLA form was filled in and signed. This form stated that he had diagnoses of '*schizophrenia, obsessive and depressive symptoms, and ADHD, and that he was not doing any work, remains house bound, says he can't go out alone because of his paranoid ideas. Remains low in mood most of the time. Complains of checking and re-checking doors and cooker.'*[xxx]

9.49 On **3 August 2005** Mr TG committed the homicide of Mrs S. Following his arrest he told staff that he had not been taking any medication apart from the Ritalin and requested that this should continue.

9.50 He was found guilty of murder on 29 March 2006.

10. Timeline and Identification of Critical Issues

Timeline

10.1 The Independent Investigation Panel produced a Timeline in tabular format in order to plot significant data and identify the critical issues and their relationships with each other. This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns of the Investigation Panel.

10.2 The Timeline was examined by the Independent Investigation Panel and its contents considered, using Root Cause Analysis techniques.

10.3 The interviews with the members of staff and managers, and that with Mr TG and Mr S were examined at length by the Independent Investigation Panel and are quoted (anonymously) throughout the next section where the findings are described in detail.

10.4 These factors are examined under two main headings which group the findings from the overall analysis. These headings are:

Medical Factors/Mental Health Issues

- Psychiatric Assessment;
- Diagnosis;
- Treatment Plans;
- Risk Assessment;
- Care Programme Approach.

Social Factors/Safeguarding Issues

- Adequacy of Assessment;
- Child Protection Conference June 2003;

- Domestic Violence, Child Abuse and Mental Health Services;
- Inter-Agency Information Sharing;
- The Serious Case Review;
- Partnership Working;
- Staffing.

Medical Factors/Mental Health Issues

Introduction

10.5 At the time of the homicide at the centre of this Independent Investigation Mr TG was a 33 year old man who had had erratic contact with the psychiatric services for the previous nine years, initially through the Queen Elizabeth II Hospital, and then through Cygnet House in Ware. During those nine years he saw a total of nine psychiatrists at outpatient clinics (A&E attendances are not included) including two substantive consultants, two locum consultants, two staff grade doctors and three junior doctors. He received a variety of diagnoses. The Independent Investigation Panel is grateful to Consultant 1, the first consultant to see Mr TG, for his views and insights during his interview with the Investigation Panel. It was regrettable that the Trust was not able to trace any of the other mental health medical staff involved with Mr TG in time for the initial investigation panel interviews. Subsequent to the preparation of the final draft report, the Trust was able to contact Consultant 3 and Consultant 4 and we are grateful to them for their comments on the draft report. Their contribution has improved the Report significantly.

10.6 It is important to look at Mr TG's contact with the psychiatric services in overview to provide a perspective on his treatment and to further understand the complexities which this man presented. He had had a dysfunctional upbringing, significant contact with the criminal justice system, several sexual relationships (which had produced several children) and a variety of presentations to psychiatric services which included crisis presentations with deliberate self harm, a myriad of mental health "symptoms" and social concerns. Themes identified by the

Independent Investigation Panel during Mr TG's contact with psychiatric services include:

- non compliance;
- erratic attendance;
- superficial engagement;
- a "hands off" approach to his care and treatment;
- a variety of diagnoses;
- a lack of CMHT involvement as Mr TG was predominantly see by a psychiatrist in an outpatient clinic.

Overview of Mr TG's Contact with Psychiatric Services (Medical Timeline)

10.7 In **April 1996** a probation officer wrote to Mr TG's GP[xxxi] informing him of his imminent discharge from prison. She noted Mr TG's concerns about his aggressive behaviour, the fact that he had been seen by a psychiatrist during a previous sentence and that he would like to be referred for an out-patient appointment to the Queen Elizabeth II Hospital to see a psychologist 'who would help him explore the root of his violent behaviour'. Mr TG was first seen by the adult psychiatric services on **12 August 1996** for a new assessment out-patient clinic appointment. He was seen by Consultant 1 and his presenting difficulties were formulated using a DSM Multi-Axial approach, Consultant 1 noted diagnostic categories as follows:

Axis I - Panic disorder with agoraphobia, recurrent brief depression now in remission, minor depression currently active,

Axis II - Borderline personality disorder, personality disorder not otherwise specified (antisocial paranoid traits),

Axis III - Migraine, undiagnosed headaches,

Axis IV - Recent imprisonment pending court case,

Axis V - 48 points for marked impairment in function.

10.8 Consultant 1 commented that Mr TG was 'an extremely complex case' and made a clear treatment plan for him which involved medication (paroxetine – an antidepressant) and a referral for 'long term personal therapy'. The nature of this therapy or to whom Mr TG was being referred was not noted.[xxxii]

10.9 Mr TG was next seen in the out-patient clinic on **14 October 1996** when he presented with 'memory blanks' and 'bouts of violent temper, having arguments with his wife as well as smashing the place up occasionally'. He also presented with distressing panic attacks and some obsessional symptoms. He had discontinued his medication in August because of side effects and was started on another antidepressant (Imipramine) with a plan to gradually increase the dose upwards and review him again in four weeks. The letter to the GP following that consultation also noted that 'he sees the psychologist once a week'. It is of note however that there is no other reference to this psychological intervention, no record of who was delivering it and no record in Mr TG's notes of his attendance or a psychological formulation of his difficulties.[xxxiii]

10.10 Mr TG attended his review appointment in **November 1996** where he stated that he felt improved, although he was still on low dose medication because he was unable to tolerate a higher dose. He was seen again in **January 1997**[xxxiv] and in **May 1997**[xxxv] where his poor tolerance of antidepressant medication was noted and an alternative medication regime prescribed i.e. Flupenthixol (an antipsychotic medication used in low dose as an anxiolytic) and Fluvoxamine (an antidepressant). His pending court case and the possibility of a custodial sentence were noted.

10.11 Mr TG attended out patients again in **October 1997**[xxxvi] at which time he seemed improved. It was noted that he was possibly moving to Watford as he was leaving home because of 'interpersonal conflict' with his wife. It was also noted that 'the serious charges which had been pending against him had been dropped and, compared with the terrible history, he now seems to be fairly law abiding'. The next out-patient clinic review appointment appears to have been left dependent on where Mr TG was going to reside. The GP notes refer to Mr TG having been seen as a psychiatric emergency on **27 October 1997** and, as a result of his presenting mental state, he was deemed unfit to attend court. There were no medical records available to the Independent Investigation Panel of this particular assessment.

10.12 Mr TG was subsequently received into custody and convicted of burglary in **December 1997**. His psychiatric history was noted on assessment and he was reviewed by a psychiatrist while in prison in **January 1998**.[xxxvii] During this sentence he moved through a number of prisons. Prior to his release from prison the Senior Medical Officer wrote to Mr TG's GP in **June 1999**[xxxviii] informing him that 'during his stay in prison Mr TG has exhibited frequent episodes of threats and actual self harm in the form of cutting his arms…. Mr TG has insisted on a number of occasions that he sees specialists (psychiatrist and skin specialists for example). However, although he has been seen by NHS consultants while in prison no serious illness has been definitely diagnosed….. He shows no signs of serious mental health problems. He probably has a personality disorder rather than any serious psychotic illness'. This letter was followed up by another letter to Mr TG's GP in **October 2000** by the prison Senior Medical Officer with a copy of Mr TG's complete IMR (inmate record) at his own request.[xxxix]

10.13 Mr TG was next seen by the Queen Elizabeth II Psychiatric Services in **March 2000**[xl] which noted his release from prison and his expression of panic attacks and obsessional thoughts. The out-patient review letter noted Mr TG's diagnosis to be 'Obsessive Compulsive Disorder with Panic Disorder, Mood Disorder, Borderline Personality Disorder and Antisocial Personality Disorder'. He was prescribed 'Fluvoxamine 300mg, Flupenthixol 2mg'. Follow-up was that Mr TG should be reviewed by Consultant 1 but Mr TG did not attend an out-patient appointment in October 2000.[xli]

10.14 In **November 2000** Mr TG referred himself to the A & E Department complaining that he 'can't handle things' at the moment. He presented with a number of difficulties of relatively recent duration - 'a few months'. He complained of poor sleep, appetite, energy and concentration, suicidal thoughts and thoughts of deliberate self harm. A comprehensive assessment carried out refers to Mr TG having attended A & E 'several times' under police custody with self harm, also 'voices' and noted that he had stopped his medication. Numerous old self harm scars were also observed. The impression on that assessment was that Mr TG was presenting with a personality disorder and mild adjustment depression. His care was discussed with the senior doctor on call who advised against admission. He was given four tablets of Stelazine (an antipsychotic) 10mg nocte (at night) and assured a

follow-up appointment with Consultant 1 would be organised as soon as possible. Mr TG presented again later that night at the A & E Department having superficially cut his left arm. He was again advised that he would be seen at the out-patient clinic.[xlii]

10.15 Mr TG was reviewed at the out-patient clinic in **January 2001**. He told the doctor that there was no change, that he felt the same and he referred to voices telling him to harm himself. Again the diagnosis was as above and his medication was reviewed. He presented as being on different medication from previous contacts which was started by his GP. This included Chlorpromazine (antipsychotic) 100mg bd. and 200mg nocte, and Sertraline (antidepressant) 50mg (which was increased at the out-patient review to 100mg). Oxazepam (Benzodiazepine) 10mg bd.(by day) was added to his medication regime. The assessment noted that Mr TG 'helps his wife to do the housework and take the children to school'.[xliii]

10.16 In **April 2001** Mr TG's wife applied to the Court for an occupation order of their home. Mr TG later presented to the A & E Department having been brought in by the police when he was found standing on a bridge and threatening deliberate self harm. This appears to have been precipitated by a social crisis relating to the fact that he was going to be evicted the next day. A comprehensive assessment carried out in A & E referred to the fact that Mr TG was 'upset about break-up of relationship with wife and possibly losing children and home'. Mr TG was not admitted to hospital but referred to the out-patient department.[xliv]

10.17 Mr TG attended the out-patient clinic in **May 2001**. He had separated from his wife and presented as being well. His medication remained the same and the plan was to review him in two months time. At that time the assessing doctor noted that Mr TG did not have a social worker or CPN involved in his care and he 'wants to talk to someone. Interested in OT.' (Occupational Therapy). However, there is no note of a discussion regarding potentially meeting this need. **Mr TG did not attend for appointments in July 2001 or August 2001.** [xlv]

10.18 In **October 2001** Mr TG presented to the A & E Department after an episode of deliberate self harm. The precipitants were social stressors, including divorce. He was not on any medication as 'the GP insisted on seeing him for three weeks' (before prescribing further medication). He was reassured at that appointment and discharged home. [xlvi]

10.19 Mr TG was seen for review again six weeks later in **December 2001** at which time he presented as being more settled. He had a new girlfriend who he described as being supportive and he was taking his medication, assuring the doctor that he was '100% compliant'.[xlvii]

10.20 Mr TG's GP wrote to Consultant 1 in **January 2002** to inform him that Mr TG had not in fact been dispensed any medication from the practice since June 2001.[xlviii]

10.21 In the **summer of 2002** Mr TG moved from Hatfield to Ware. In **September 2002** the GP referred Mr TG to Cygnet House for a psychiatric out-patient clinic appointment. This was accompanied by a letter from Consultant 1 dated 19 August 2002 which summarised TG's contact with the Queen Elizabeth II Hospital Mental Health Services and their assessment of him.[xlix]

10.22 Mr TG was seen in **October 2002** for assessment and a new patient history was taken by the team junior doctor. At that time Mr TG complained of 'obsessional and repetitive behaviour, feeling low most of the time, poor sleep, poor concentration and memory, low self esteem and low energy levels – all of two weeks duration'. He told the assessing doctor that 'he has a good relationship with his partner and they have a two week old baby who he wants to bring up properly' and 'he wants to lead a responsible life for the sake of his baby'. There is no mention of any other children. At that appointment Mr TG was not on any medication and a plan was drawn up that he should be started on Citalopram (antidepressant) 20mg daily and a note was made to consider psychotherapy "at some point in the future".[l]

10.23 In **November 2002** Mr TG was seen again when he presented with some improvement, although he was still anxious and agitated with some obsessional symptoms and auditory hallucinations persisting but no suicidal or homicidal thoughts. He was requesting Oxazepam and Chlorpromazine and, at the out-patient review, was restarted on a small dose of Chlorpromazine. His Citalopram was continued. There was a plan mentioning that 'we will be referring him to anxiety management therapy' but there is no further note in the records as to what happened to this referral. **Mr TG did not attend appointments in January 2003 and February 2003.**[li]

10.24 Mr TG attended in **April 2003** and was seen by a locum Consultant Psychiatrist, Consultant 3, who felt that Mr TG's history suggested ADHD persisting into adulthood. The letter from Consultant 3 states 'his current presentation is dominated by irritability, dysphoria, impulsiveness, frustration intolerance, free floating anxiety and insomnia, as well as some compulsive symptoms in the form of checking rituals'. He proposed to get a history from Mr TG's mother.[lii] There is no reference in the case notes to Mr TG's current relationship, children or social circumstances. Later that month Consultant 3 spoke to Mr TG's mother[liii] and he wrote that 'the history is supportive of a diagnosis of ADHD persisting into adulthood' and goes on to say that 'it is worth a therapeutic trial of Ritalin' (Methylphenidate).[liv]

10.25 Mr TG was next seen by another locum Consultant Psychiatrist, Consultant 2, in **May 2003** who noted that Mr TG said he was feeling better and asked for an increase in the dose of Ritalin which was prescribed. Mr TG did not attend for a review appointment one month later in **June 2003**.[lv]

10.26 On **9 June 2003** the locum consultant psychiatrist Consultant 2 recorded in the case notes that he 'received an invitation letter to attend a child protection conference' regarding Child 1, and a report was requested. The report sent to the conference is not in the medical records and neither are the minutes of the meeting. A social worker's name is written in the margin of this file entry. A Child Protection Conference was held on 23 June 2003. There are no records in the clinical file information available to the Panel of mental health service involvement or presence at this meeting.[lvi] It is clear however, from a discussion in interview with one of the Local Authority staff that a report was available to the Child Protection Conference and that it was provided by Consultant 2.[lvii].

10.27 On **11 June 2003** GP 1 referred Mr TG to an anger management counsellor at Cygnet House for anger management classes.[lviii] A letter from GP 1 to the Child Protection Department, dated **3 July 2003** seems to confirm that Mr TG attended for an assessment but 'he didn't enjoy the 1:1 consultation and has asked to be referred elsewhere'. Mr TG subsequently complained to the Community Mental Health Team Manager about a breach of his confidentiality relating to information given to the child protection meeting which was subsequently upheld.[lix] Again it is clear from an interview with one of the Local Authority staff that the Children, Schools and Families

Department paid for Mr TG to attend an anger management course which he completed.

10.28 Mr TG was next reviewed by Consultant 4, Consultant Psychiatrist, in **December 2003**. Consultant 4 had not met Mr TG before. Consultant 4 noted that Mr TG 'feels much better as far as his anger is concerned…. His relationship with his wife has improved and it is his wife who gives him his medication regularly'. No changes were recommended, just a review in three months time.[lx] Consultant 4 met Mr TG's wife at this meeting.

10.29 On **10 March 2004** Mr TG was seen again by Consultant 4 as he needed his Disability Living Allowance (DLA) form completed. Consultant 4's account of the interview noted a variety of symptoms but there had been 'no history of physical or verbal abuse during the last year'. Consultant 4 made a note of 'paranoid delusions' and continued prescribing anti-psychotic medication for Mr TG, but changed it from Chlopromazine to Risperidone. Consultant 4 was essentially looking back rather then moving forward in order to provide an accurate history for the Department of Work and Pensions. The DLA form completed stated that Mr TG's diagnosis over the years had been:

- '1. ADHD.
- 2. Depression.
- 3. OCD.
- 4. Anxiety, panic attacks.
- 5. Paranoid.
- 6. Personality Disorder'

  His medication was: Ritalin 10mg daily, Ciatalopram 20mg daily, Oxazepam 10 mg pm, Risperidone 1mg b.d. and Procyclidine 5mg b.d.

10.30 **Mr TG did not attend appointments in April 2004 and July 2004**, despite the latter having been arranged with Mr TG by phone at his request.[lxi]

10.31 In **December 2004** Mr TG's GP wrote to Consultant 4 requesting another appointment for Mr TG as he was now willing to comply with follow-up and the GP also wanted Consultant 4 to take over responsibility for the prescribing of Ritalin. His

medication at that time was 'Citalopram 20mg once a day, Oxazepam tablets 10mg one prn, Chlorpromazine tablets 25mg b.d. and Ritalin 10mg three times a day'.[lxii]

10.32 Mr TG was seen by Consultant 4 in **February 2005**.[lxiii] There is reference to a long history of paranoid delusions and he started Mr TG on Risperidone and Procyclidine. He planned to review his total medication at another appointment in four weeks time. Unfortunately **Mr TG did not attend out-patient appointments in April 2005 and June 2005**.[lxiv]

10.33 Mr TG was seen by Consultant 4 and his junior doctor in **July 2005** when he reported being paranoid which he gave as the reason he could not attend his previous out-patient appointments. He mentioned that he was able to attend that day because he was accompanied by a friend. He requested that his DLA forms be filled in and signed.[lxv]

10.34 Consultant 4 noted his illnesses as: 'Schizophrenia, Obsessive and Depressive symptoms and ADHD – not doing any work, remains homebound, says he can't go out alone because of his paranoid ideas, remains low in mood most of the time, complains of checking and re-checking doors and cooker'. Consultant 4 listed the diagnoses Mr TG had had over the years in order to provide a history of his illness. In his interview Consultant 4 stated that he had seen Mr TG's wife and that she had confirmed his symptoms and reported that she was monitoring his medication. He was advised to increase his Citalopram and Risperidone and that he would be reviewed in three months time.[lxvi] **This was Mr TG's last contact with the mental health services prior to the homicide in August 2005.**

Conclusion

10.35 In reviewing Mr TG's contact with the psychiatric services, the Independent Investigation Panel is mindful that his presentation was complex and he appeared to engage in a superficial way on his own terms to have his needs met. That said, the Panel makes further comment on specific aspects of Mr TG's psychiatric care and treatment under the four headings:

- Psychiatric Assessment
- Risk Assessment
- Diagnosis

- Treatment Plans

Psychiatric Assessment

Context:

10.36 'A high standard of clinical recording is the hallmark of good medical practice and is nowhere more important than in psychiatry. The situation is more complex here than in other fields of medicine because so many different types of information are relevant to the evaluation and management of clinical problems. Many disciplines are involved in psychiatry and there are several contrasting approaches both to theoretical and practical issues. For this reason there can be no final and comprehensive statement about clinical methods which would apply to all patients in all situations and which would be regarded as appropriate by all experienced clinicians…… the examination of a psychiatric patient resembles a general medical examination in many respects, but there are important differences. These derive partly from the fact that in psychiatry much more attention needs to be paid to psychological and social phenomena, but the main difference arises from the fact that it is the interview itself which serves as the psychiatrist's main tool of investigation. Psychiatric interviewing is thus a specialised technique of great importance.

10.37 Three aspects may be distinguished. In different contexts each may assume prime importance but skilled interviewing aims at incorporating all three whenever possible:

- the interview is a technique for gathering information, its objective is to obtain as accurate an account as possible of the patient's illness, the facts of his background and significant events in his life and to gain some understanding of his experiences and his attitudes towards a variety of people and circumstances;

- the interview also serves as a standard situation in which to assess the patient's emotions and attitudes;

- the interview, and especially the first interview, fulfils in addition a valuable supportive role and serves to establish an understanding with the patient which will be the basis of the subsequent working relationship'.[lxvii]

10.38 **A good psychiatric examination and assessment** will record the reason why the patient is referred, details of the presenting complaint, a detailed family history which should include information about parents, siblings and other relatives as well as early childhood experiences. There are essentially two parts to the examination: the history and the mental state examination. The history should include details of early development, behaviour during childhood, school, occupation, sexual history, marital history, children, medical history, previous history of mental illness, use and abuse of alcohol and drugs, antisocial behaviour/forensic history and life situation at present.

10.39 **An assessment of personality** is also important i.e. 'the personality of a patient consists of those habitual attitudes and patterns of behaviour which, together with his physical characteristics, distinguish him as an individual to others and to himself". The patient's personality is one of the prime determinants of his response to treatment. It is therefore very important to obtain adequate information from a variety of sources. Some of the relevant information may already have been recorded under the various headings in the personal history – for example 'how the patient has behaved in different social roles as a child, parent, sibling, spouse, employee etc'. The examiner should 'aim to build up a picture of an individual'. It is important, where possible, to corroborate history through other sources e.g. family members, GP, significant others, school records, old psychiatric notes, probation records etc.

10.40 **The mental state examination** records behavioural and psychological data elicited by examination at the time of the interview and information gathered under the following headings: Appearance and general behaviour, Talk, Mood, Thought content, Abnormal beliefs and interpretation of events, Abnormal experiences referred to environment, body or self in the cognitive state (orientation, attention and concentration, memory and intelligence), Insight and the interviewers reaction to the patient.

10.41 All clinical notes should be signed and dated. The assessment should be followed by a summary, case formulation and treatment plan.

10.42 The Independent Investigation Panel is aware that it is not always possible to complete a thorough assessment of this nature on the first visit. The assessment and formulation will often evolve over time as new information becomes apparent and, as a trusting and therapeutic relationship with the patient develops that allows them to disclose sensitive information - hence the importance of continuity of care where possible. This allows a picture of a patient to emerge and develop over time. Similarly, effective engagement of the patient lends itself to this development, particularly when it is accompanied by a willingness to cooperate on the patient's behalf. When the patient is disengaged consideration needs to be given as to the reasons why.

10.43 The Independent Investigation Panel are also cognisant of the fact that Outpatient Clinics and A & E Departments are busy places. Sometimes there is a selectivity regarding what parts of the assessment are prioritised. However, all teams need to bear in mind that assessment is a dynamic and ongoing process and that it may not be appropriate to take all initial information obtained at face value.

Findings

10.44 Mr TG's psychiatric care can be divided into two parts:

- his contact with Queen Elizabeth II services when he lived in Hatfield
- his contact with Cygnet House CMHT base when he lived in Ware.

Hatfield : Queen Elizabeth II Hospital

10.45 Mr TG was seen by the Queen Elizabeth II Psychiatric Services between August 1996 and December 2001. His initial assessment was by an experienced clinician who gave a comprehensive formulation of Mr TG's psychiatric and characterological difficulties in his ensuing letter to Mr TG's GP. This was accompanied by a treatment plan which referred to medication and personal therapy. Over the next few years he was seen on a number of occasions in the out-patient clinic. There was a thorough assessment documented from his attendance to the A & E Department in 2000 and he was reviewed by Consultant 1 and his Staff Grade Staff Grade 1 on a number of occasions. There is a sense that Mr TG became

reasonably well known and was ‘contained’ within the team. Certainly the transfer letter written by Consultant 1 in April 2002 would have given the new team a good sense of Mr TG, who he was and what he was about.

Ware : Cygnet House CMHT

10.46 Mr TG was seen by the Cygnet House Psychiatric Services from October 2002 up until the time of the homicide in August 2005. His initial assessment at Cygnet House was also thorough and accompanied by a treatment plan. Over the course of the next few years however he was seen by a series of locum consultants and junior doctors until Consultant 4 took up post and saw him for the first time in December 2003.

10.47 In April 2003 Consultant 3, locum Consultant Psychiatrist, on reviewing Mr TG’s diagnosis considered his presentation might fit with with Adult ADHD. The Independent Investigation Panel understands that psychiatric diagnoses are polythetic with significant overlap between categories and no pathgnomic symptoms. Such early or initial diagnoses are regarded by most clinicians as being provisional until a more detailed understanding of complex disorders may emerge in the future. Adult ADHD is significantly co-morbid with other psychiatric conditions, including conduct disorder, Antisocial Personality Disorder, anxiety, unipolar and bipolar affective disorder and substance misuse. ADHD in childhood has been reported to be highly associated with the diagnosis of borderline disorder in adulthood and adult ADHD often occurs with borderline disorder.

10.48 The ICD-10 does not contain diagnostic criteria for Adult ADHD and there are no absolutely agreed criteria, but assessment usually takes account of DSM-IV criteria for ADHD (rather then ICD-10 criteria for ADHD in children) although it is recognised that the symptom profile in adults may be different in a number of respects from that in children

10.49 Consultant 3 did speak to Mr TG’s mother on the telephone and gained the view that he had displayed early childhood overactivity, persisting inattention, distractibility and restlessness. Consultant 3 explained to the Chair of the Independent Investigation Panel that far from dismissing the various diagnoses

attributed to Mr TG over the preceding years he was suggesting that ADHD had not been previously considered. Consultant 3 felt that Mr TG's history and his presentation to him, together with the evidence provided by his mother, was sufficient to support a diagnosis of ADHD persisting into adulthood. Consultant 3 therefore decided to prescribe a trial of psychostimulants, namely Ritalin, which was suggested to the GP in a letter dated 27 April 2003.

10.50 Mr TG's next outpatient appointment was on 22 May 2003 when he was seen by Consultant 2. Mr TG reported that he was feeling much better on Ritalin, with better concentration and being more settled. His dose of Ritalin was increased. [lxviii] It is noted that Consultant 3 was trained in the diagnosis and management of Adult ADHD at the Maudsley Hospital's National Adult ADHD Unit and was therefore skilled in this diagnostic area.

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Recommendation 1

When the psychiatrist, or other member of the mental health services, wishes to review the diagnosis of a service user this should be undertaken with a review of the complete history of that service user and the treatment and care plans which have been used. Any change in plan should be fully recorded with the reasons clearly stated. In addition if there is any consideration of a specific diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) there should be consultation with one of the Trust's four specialist consultants.

10.51 In June 2003 Consultant 2, locum Consultant Psychiatrist, noted the receipt of a letter of invitation to a child protection case conference. There was no letter available to the Independent Investigation Panel in the clinical file information. The Independent Investigation Panel would expect that new information indicating that a child of Mr TG was the subject of a child protection case conference, should have prompted a medical reassessment of Mr TG. There are no records indicating that this was considered and Mr TG was not asked to come in for a review appointment. In fact, he was not seen again until nearly six months later at which time there is no evidence that child protection issues were given any consideration. However, in our opinion, any clinician who received this type of information has a duty to ensure that

it is recorded, acted upon and integrated into the team's assessment of the patient. The Independent Investigation Panel is highly critical of the way in which this matter was medically managed and regards this failure to act as a critical juncture in Mr TG's care and treatment.

Recommendation 2

The National Service Framework for Children includes a recommendation that CPA meetings (and their equivalent) should take account of children's needs and any risk of harm to them. Therefore, when a service user is the parent of a child for whom a child protection/safeguarding conference is called, and the mental health services are asked to attend the conference and to provide a report, this should be treated as a priority. A request for information should trigger a reassessment of the service user and the risks he/she may pose to children and others. The Trust should audit attendances at child protection case conferences.

10.52 Mr TG's attendance at out-patient clinic appointments over the next two years from June 2003 was erratic and very much conformed to Consultant 1's assessment of him as someone who was 'quite skilled at navigating the statutory services to acquire what is needed at any given time'. He tended to present looking for medication or to have Disabled Living Allowance (DLA) forms completed. Throughout Mr TG's notes there is scant reference to his children with no comprehensive account of his parental responsibilities. We accept that Mr TG was not a reliable historian and indeed the Independent Investigation Panel has had difficulty in establishing exactly how many children Mr TG had with a number of women. However, there is no evidence that these enquiries were made with any vigour. Mr TG does not appear to have been seen in the context of his role as a father, except on one occasion in October 2002 when he said that he wanted to change for the sake of his new baby.

10.53 During the interviews conducted by the Independent Investigation Panel the CMHT manager mentioned having seen Mr TG at Cygnet House with his partner (CMHT Manager 1 interview) and at those times there was no evidence of disharmony. Unfortunately there are no records to indicate whether or not Mr TG's partners ever attended at interview. There was also no evidence that a Carer's

Assessment was considered or offered, despite Mr TG noting on a number of occasions his reliance on his partner for support and managing his medication.

Recommendation 3

In situations where a service user is usually seen alone without any family or friends and there is no corroborative information to support the 'history' or symptoms described by the service user, any opportunity to speak to another person who knows them should be used. The person may be a carer and be entitled to an assessment of their specific needs as a carer, and may also be able to provide additional information about the service user, subject to issues of consent and confidentiality.

10.54 During Mr TG's contact with the psychiatric services his care and treatment was held by the medical members of the CMHT. On two occasions he was referred to other disciplines for treatment. In 1996 he was referred for 'personal therapy'. There is one reference to him seeing a psychologist weekly and no further references to therapy. A psychological assessment, formulation, treatment and engagement history would have been enormously helpful in contributing to the team view of Mr TG and in planning his ongoing treatment. There were no records of this in any of the clinical notes available to the Independent Investigation Panel. In our opinion this was not best practice and was a lost opportunity to contribute to a fuller overall assessment of Mr TG.

10.55 The treatment provided to Mr TG was almost exclusively medication which was altered almost every time he described different symptoms or queried whether the medication was effective. He was also a poor attendee at outpatient appointments and tended to only come when he needed some practical help.

Recommendation 4

Service users who are only being seen by the psychiatrist should be asked about their family and social circumstances so that they are viewed within an overall context. This is particularly important where the only informant is the service user and there is no other source to corroborate the history given. All

mental health professionals should complete the form designed by the Lead Nurse for Safeguarding Children which records information about children with whom the service user has contact.

10.56 In June 2003 Mr TG's GP referred him to an anger management counsellor at Cygnet House for anger management. The Independent Investigation Panel has not been able to trace this counsellor and no staff that we spoke to have any memory of who she was. She would appear to have seen Mr TG on one occasion as the GP notes in his letter of 3 July 2003 that 'he didn't enjoy the 1:1 consultation'. The potential significance of this assessment cannot be underestimated. Mr TG was present at his young son's child protection panel with concerns from the Children's Schools and Families Department (CSF) that his son was being emotionally neglected. At the Child Protection Meeting issues about anger were raised, but there are no notes about the assessment for an Anger Management Course Mr TG attended nor information explaining why he refused to engage further. It is known that Mr TG did subsequently undertake an anger management course provided by the Children's Schools and Families Department. Such information would have been helpful in seeing Mr TG as a member of a family group and provided some confirmative evidence of information provided by him, or it could have cast doubts on some of his evidence.

Risk Assessment

Context

10.57 A recent report by the Royal College of Psychiatrists [lxix] made the point that:

> *Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk however cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risk posed by those with mental disorders are much less susceptible to prediction because*

of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour.

10.58 Tragic events such as a homicide are very rare. The National Confidential Inquiry into suicide and homicide reported that *of perpetrators with personality disorder, 42* (over four or five years) *were current or recent patients, around 10 cases per year.* [lxx]

10.59 During the period from 2002 to August 2005 the HPT was working with Issue 2 of the Policy on Clinical Risk Assessment and Management for Individual Service Users. [lxxi] This Policy sets out the underpinning values, key standards, staff training and support and monitoring arrangements for risk management and assessment. It also stated that the risk assessment and risk management process should be recorded and suitable for audit, but did not specify any particular form for recording nor the other documentation to be used.

10.60 Within the section on implementation criteria the Policy stated that each directorate was responsible for developing local policies and methods of risk assessment. The directorates were also responsible for implementing and evaluating those local methods and for training staff in their use.

10.61 Within the CPA policy at the time [lxxii] there was also a paragraph on risk assessment which stated that an assessment of risk would form part of a needs assessment and was an integral part of CPA.

Findings

10.62 There was only one completed risk assessment form in Mr TG's clinical notes. This was the undated (possibly October 2001) Assessment and Management of Risk form apparently completed by a psychiatric SHO in the Accident and Emergency Department. In his judgement Mr TG should have been on Enhanced CPA. He recorded risk to self (overdose and self harm) and to others (injury to another which resulted in prison) and said that he should not be seen by a lone worker, and definitely not by a lone female.

10.63 There were a number of further direct or indirect references to risk of harm to others in the records, including the following:

- In October 1996 Dr H's SHO referred in a letter to Mr TG's GP to *bouts of violent temper, arguments with his wife and 'smashing up the place',* and went on to refer to Mr TG having spent four months in prison during the year due to violent behaviour;
- Between 1997 and 1999 Mr TG had several spells in prison for burglary, car theft and assault;
- At his first appointment with Staff Grade 1 in January 2001 Mr TG's multiple diagnoses included anti-social personality disorder, and also referred to him living with his wife and children. However in April 2001 he was taken by the police to A&E following a 'suicide attempt' and it was noted that he *was upset as he was breaking up with his wife and losing his child, and was about to be evicted. He was assessed as low suicide risk and high risk of 'acting out;*
- In June 2003 there was a child protection meeting about Mr TG's son who was then around nine months old. Part of the child protection plan was for Mr TG to take an anger management course, to be arranged by his GP. He was also referred for anger management training by social services, which he completed successfully;
- In September 2003 Mr TG told his GP that he had been gassed with CS gas by the police, although he did not tell him the circumstances. By December 2003 he was telling his consultant that he was feeling much better in relation to his anger, and his relationship with his wife had improved.
- There are also several references in the records to him being paranoid and suspicious about food.

10.64 There is a picture of partial information being given to different agencies and different individuals. When this is gathered together from a number of different sources it can be seen that Mr TG was someone who might pose a significant risk to others, both in terms of his behaviour and the issues and concerns he occasionally raised with psychiatrists. However there was little or no communication about Mr TG amongst the various individuals and organisations who were involved with him or his

partners or children. At different times the following professionals had contact with him:

- consultant psychiatrists;
- CMHT staff;
- the health visiting team;
- social work staff in the Children, Schools and Families Dept;
- his GP;
- police officers.

10.65 There was little or no sharing of information or concerns between the individuals or agencies in the list above. It is possible that each individual episode was viewed as not reaching the threshold that would have led to a decision to share information. However it is clear that had information and concerns been put together there was sufficient evidence to alert services to the need to consider a joint risk management plan. Information and concern sharing could have been facilitated by stronger links and channels for communication (possibly through an identified link worker) between the CMHT and Mr TG's GP.

10.66 According to the Trust's Policy there should have been regular recording of risk assessment and management. The Independent Investigation Panel were told that medical staff

> *were meant to use the* (risk assessment forms), *so there was an omission in not recording the risk assessment in that way. The sense one had was that, having gone through the history, they would have extracted what they had in the history to put in the risk assessment.*[lxxiii]

10.67 The Panel found that risk assessment was more implicit than explicit in much of the records. However it was the opinion of those who conducted the Internal Investigation that the completion of formal risk assessment forms would have made little or no difference to his care or the eventual tragic outcome. This view

was largely gauged by the fact that the information he was telling people didn't highlight the risk that he posed to other people, that's for sure. He rarely, if ever, alluded to being violent towards other people.

10.68 There were, nevertheless, some weaknesses in the recording of, and communicating about, Mr TG's risk of harm to others which may have resulted in him receiving less holistic and purposeful care, and did not give him many tools (other than medication and a brief anger management programme) to help him manage his admitted occasional violent temper.

10.69 In summary, there had been no systematic risk assessment and consequent risk management plan, despite there being information available which indicated the need, during the period of time when he was being seen in the outpatient clinic at Ware CMHT. This was in breach of the Trust's policy on risk assessment. There were also no attempts to share information about risk behaviour amongst the different teams and individuals involved with his care.

Conclusion

10.70 The Independent Investigation Panel accepts that Mr TG was not a reliable historian and was not a reliable attendee at out-patient appointments. We accept that this made ongoing assessment difficult, and discontinuity of medical care further disabled the assessment process.

10.71 The Independent Investigation Panel considers that the dynamic and continuous nature of the assessment process was lost. There was over-reliance on old information and the teams missed several opportunities to re-visit their assessment of Mr TG. There is little evidence of attention to seeking collateral information and confirming Mr TG's accounts of his symptoms, although it was known that he was an unreliable historian. There is no evidence of a Carer's Assessment being considered. Mr TG does not appear to have been viewed or understood in the context of his role as a father. We are particularly critical at the lack of a medical response to child protection issues when they were raised – this matter will be dealt with in more detail in a separate section of the report. (Page 78; Child Protection Conference June 2003)

Recommendation 5

When a service user is being seen by only one member of the mental health services there should be a review, at least annually, to include: diagnosis, care plan and treatment plan, current risk assessment, social and family circumstances, risk to any children in the household and consideration of their needs. This review should set out how the treatment plan is designed to assist the service user and overcome/alleviate the symptoms being experienced.

Diagnosis

Context

10.72 Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. Diagnosis is used in many different disciplines with slightly different implementations on the application of logic and experience to determine the cause and effect of relationships. In medicine diagnosis is the process of identifying a medical condition or disease by its signs, symptoms and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the patient, collateral information from carers/family/GP/interested or involved others, mental state examination and observation.

10.73 The process of reaching a diagnosis can be assisted by a manual known as ICD10. The International Statistical Classification of Diseases and Related Health Problems (commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. Psychiatry uses ICD10 (tenth revision published in 1992) for classification of mental and behavioural disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

10.74 Also commonly used is the DSM IV i.e. Diagnostic and Statistical Manual of Mental Disorders published in 2000. This uses a categorical approach to diagnosis. It describes patients' presentations along five axes namely:

Axis I - Clinical Disorders, other conditions that may be a focus of clinical attention,

Axis II - Personality Disorders, Mental Retardation,

Axis III - General medical conditions,

Axis IV - Psychosocial and environmental problems,

Axis V - Global assessment of functioning.

10.75 Diagnosis is important for a number of reasons. It gives clinicians, service users and their carers a framework that can allow a conceptualisation and understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis should never take away from the treatment and management of the patient as an individual, but can provide a platform on which to address some care, treatment and risk management issues.

Findings

10.76 Mr TG attracted a variety of diagnoses during his contact with the psychiatric services. These included:

- panic disorder with agoraphobia,
- depressive disorder,
- borderline personality disorder,
- personality disorder with antisocial traits,
- obsessive compulsive disorder,
- ADHD (Attention Deficit Hyperactivity Disorder),
- Schizophrenia.

10.77 It is accepted that many service users have complex needs and a variety of diagnoses may co-exist, particularly with Axis I and Axis II diagnoses.

10.78 The Independent Investigation Panel were of the view that Mr TG's psychiatric difficulties were appropriately summed up by Consultant 1 in his transfer letter of August 2002 - 'Mr TG has been known to Queen Elizabeth II on and off since 1996. One can describe Mr TG's psychiatric condition as being multi-mode. In terms of Axis 1 diagnosis he has attracted, these include: panic disorder with agoraphobia, minor depression, substance abuse and obsessive compulsive disorder. However, it is the Axis 2 characterological features that are the dominant influences. He definitely meets the criteria for borderline personality disorder to which one could add antisocial and paranoid features. Mr TG knows that psychiatrists consider that borderline personality is the main issue.' [lxxiv]

10.79 The Independent Investigation Panel accepts that a diagnosis of borderline personality disorder was appropriate. Borderline personality disorder is shorthand for emotionally unstable personality disorder, borderline type code F60.31 in ICD10. Emotionally unstable personality disorder is described as 'a personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal and outbursts of intense anger often lead to violence or behavioural explosions. These are easily precipitated when impulsive acts are criticised or thwarted by others. Two variants of emotionally unstable personality disorder are specified (borderline and impulsive) and both share this general theme of impulsiveness and lack of self control. In Borderline type – several of the characteristics of emotional instability are present. In addition, the patient's own self image, aims and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness, a propensity to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self harm (although these may occur without obvious precipitants).

10.80 Antisocial traits and antisocial personality disorder are also described. Antisocial Personality Disorder is referred to as dissocial personality disorder (F60.2

in ICD10). This is ‘a personality disorder usually coming to attention because of a gross disparity between behaviour and the prevailing social norms and is characterised by:

- callous unconcern for the feelings of others;
- gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations;
- incapacity to maintain enduring relationships, though having no difficulty in establishing them;
- very low tolerance to frustration and a low threshold for discharge of aggression including violence;
- incapacity to experience guilt or to profit from experience, particularly punishment;
- marked proneness to blame others or to offer plausible rationalisations for the behaviour that has brought the patient into conflict with society. There may also be persistent irritability as an associated feature. Conduct disorder during childhood and adolescence, though not invariably present may further support the diagnosis.

10.81 The Independent Investigation Panel accepts that Mr TG met the diagnostic criteria for a diagnosis of emotionally unstable personality disorder, borderline type and dissocial personality disorder. The presence or absence of other mental illness and mental health problems should be understood in the context of the existing personality disorder, particularly when emotional instability is a factor in the patient’s presentation. It is accepted that Mr TG, on occasions, would have met the diagnostic criteria for depressive episodes, although more often than not his presentation portrayed depressed symptoms in the context of a crisis or life adjustment. We also accept that he may well have experienced panic disorder, anxiety disorder and some obsessional symptoms. He also had a history of substance misuse. It is not uncommon to find a mix of these mood disorders and a history of substance misuse in someone with a personality disorder which has a prominent affective presentation.

10.82 To obtain a truer picture of Mr TG's mental state and the appropriate treatment would have required getting to know him better either through more frequent appointments initially (which we accept he may not have attended) or the appointment of a CPN or other CMHT member. Assessment may have clarified whether or not Mr TG's symptoms were persistent and therefore required medication or if he required assistance in terms of lifestyle strategies.

10.83 The Independent Investigation Panel is cognisant of the fact that it is neither appropriate nor realistic to offer every service user who presents to the out-patient department an appointment to see a member of the CMHT, and that sometimes the service user's commitment to, and engagement in, a particular therapeutic pathway needs to be tested before valuable resources in terms of personnel are allocated to their care if this is appropriate. There is little evidence however that this was considered in the case of Mr TG.

10.84 The Independent Investigation Panel considered the diagnosis of ADHD persisting into adulthood. It was unfortunate that the Panel was not in a position to discuss this with Consultant 3 at the initial hearings although it appreciates his later discussions with the Panel Chair and his expertise in this area. The Investigation Panel is not critical of the decision to re-look at Mr TG's diagnosis, and indeed his subsequent reported improvement after having been prescribed Ritalin supports this diagnosis.

10.85 ADHD is classified under Hyperkinetic disorders, disturbances of activity and attention code F90.0 in ICD10, this is contained in the section that deals with "Disorders of childhood and adolescence" – there are not contained diagnostic criteria for Adult ADHD . These are described thus: 'Hyperkinetic disorders always arise in early development (usually in the first five years of life). Their chief characteristics are lack of persistence in activities that require cognitive involvement and a tendency to move from one activity to another without completing any one, together with disorganised, ill-regulated and excessive activity. These problems usually persist through school years and even into adult life but many affected individuals show a gradual improvement in activity and attention. Several other abnormalities may be associated with these disorders. Hyperkinetic children are often reckless and impulsive, prone to accidents and find themselves in disciplinary

trouble because of unthinking (rather than deliberately defiant) breaches of rules. Their relationships with adults are often socially disinhibited with a lack of normal caution and reserve. They are unpopular with other children and may become isolated… the cardinal features are impaired attention and over-activity, both are necessary for the diagnosis and should be evident in more than one situation (e.g. home, classroom, clinic)'.

10.86 As mentioned above in Paragraph 10.48 the ICD-10 does not contain diagnostic criteria for Adult ADHD and there are no absolutely agreed criteria, but assessment usually takes account of DSM-IV criteria for ADHD (rather then ICD-10 criteria for ADHD in children) although it is recognised that the symptom profile in adults may be different in a number of respects from that in children.

10.87 The Independent Investigation Panel is also critical of the recorded information that led to Mr TG being described as having "paranoid delusions". A delusion is 'a fixed false idea held in the face of evidence to the contrary and out of keeping with the patient's social milieu, held unshakably, not modified by experience of reason, content often bizarre, not dependent on disintegration of general intellectual functioning or reasoning abilities, often infused with a sense of great personal significance' (ref: Examination notes in Psychiatry). There is evidence in the records of self referential and paranoid thinking but the consultant was clarifying the diagnosis which had been made a considerable time prior to his involvement. There was a suspicion of schizophrenia in the past and Mr TG did report to Consultant 4 his fear that the food he bought at the market was being interfered with.

10.88 If the assessing doctor really did think that Mr TG had paranoid delusions then this should have automatically prompted a reassessment of his level of CPA and consideration of involving a CPN or another member of the CMHT. There is no evidence that this was given consideration.

10.89 The Independent Investigation Panel has made the assumption that it was on the basis of the existence of these 'paranoid delusions' that a diagnosis of Schizophrenia is recorded. The Independent Investigation Panel is critical of the recording of this diagnosis. ICD10 diagnostic criteria state that "the normal requirement for a diagnosis of Schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear cut) belonging to any of one of the

groups listed as a-d below or symptoms for at least two of the groups referred to as e-h should have been clearly present for most of the time during a period of one month or more. Those diagnostic symptoms are as follows:

a. Thought echo, thought insertion or withdrawal and thought broadcasting.
b. Delusions of control, influence or passivity clearly referred to body or limb movements or specific thoughts actions or sensations, delusion or perception.
c. Hallucinatory voices giving a running commentary on the patient's behaviour or discussing the patient amongst themselves or other types of hallucinatory voices coming from some part of the body.
d. Persistent delusions of other kinds that are culturally inappropriate and completely impossible such as religious or political identity or super human powers and abilities (for example being able to control the weather or being in communication with aliens from another world).
e. Persistent hallucinations in any modality when accompanied either by fleeting or half formed delusions without clear affect of content or by persistent over valued ideas or when occurring every day for weeks or months on end.
f. Breaks or interpellations in the train of thought resulting in incoherence or irrelevant speech of neologisms.
g. Catatonic behaviour such as excitement, posturing or waxy flexibility, negativism, mutism and stupor.
h. Negative symptoms such as marked apathy, porosity of speech and blunting or incongruity of emotional responses usually resulting in social withdrawal and lowering of social performance. It must be clear that these are not due to depression or to neuroleptic medication.
i. A significant or consistent change in the overall quality of some aspects of personal behaviour manifests as loss of interest, aimlessness, ideas of self absorbed attitude and social withdrawal."

10.90 It is the opinion of the Independent Investigation Panel that there is no evidence that any systematic enquiry was made into Mr TG's mental state that would support a diagnosis of Schizophrenia. If he had met the diagnostic criteria for Schizophrenia then we would expect that, at the very least, his CPA status would have been reviewed and he would have been allocated a CPN or other community worker.

10.91 Standards and practice guidance for all psychiatrists are laid down by two organisations: the General Medical Council and the Royal College of Psychiatrists. Both are clear that honesty in the doctor's practice is an essential core attribute for all psychiatrists. The Independent Panel was concerned about the recording of the diagnosis of Schizophrenia in July 2005 as part of the illness and disability list recorded on the DLA form, but accepts that the consultant was trying to clarify and simplify the diagnostic history of the case for the DLA staff.

Conclusion

10.92 The Independent Investigation Panel concludes that Mr TG was a man with complex mental health problems and met the diagnostic criteria for personality disorder. We agree that this diagnosis was appropriate. The Panel was concerned however, that the main treatment modality considered for Mr TG appears to have been medication with no involvement of another member of the CMHT, even after the knowledge that Mr TG was attending a Child Protection Conference about his child. The Panel also found that there was not always a clear link shown between his diagnosis and his treatment plan. (Please see Recommendation 1 on Page 47.)

Treatment Plans

Context

10.93 The treatment of any mental disorder should have a multi-pronged approach dependent on assessed need. The treatment plan should be clear, reviewed regularly and include the views of the service user and their carer/family whenever possible. Treatments may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho-education, social skills training, family interventions), in patient care, community support, occupational rehabilitation, and pharmacological interventions (medication).

10.94 Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatment falls into a number of broad groups: antidepressants, antipsychotics, anxiolytic (anti-anxiety) and mood

stabilisers. Psychiatrists in the UK tend to use the Maudsley prescribing guidelines and/or guidance from the National Institute for Health and Clinical Excellence (NICE) as well as their own experience and judgement in determining appropriate pharmacological treatment for mental disorders. Specific advice is available from NICE on depression, anxiety, schizophrenia, anti-social personality disorder, borderline personality disorder, obsessive compulsive disorder, self harm, attention deficit hyperactivity disorder and violence. The Independent Investigation Panel is cognisant of the fact that much of this guidance was ***not*** available during the late 1990's and early 2000's.

10.95 In prescribing any form of treatment there are a number of factors that the doctor must bear in mind. These include the service user's level of engagement, informed consent to treatment, compliance and monitoring of side effects. The service user's ability to comply with their recommended treatment can be influenced by their level of insight, their commitment to treatment and level of personal organisation (i.e. do they remember to take their medication, keep their appointments etc?)

Findings on Treatment Plans

10.96 When Mr TG was first assessed by the mental health services in 1996 Consultant 1's letter gave a clear rationale for treatment and the treatment plan, 'the most practical thing to do is to focus on the disorders which are most readily accessible to treatment, or which treatments are the most readily accessible. Hence the recommendation for Paroxetine as an anti-panic drug and a personal therapy for the personality disorder'. Other than a reference at his next review appointment there is no further reference in his Queen Elizabeth II notes regarding the progress/compliance/outcome of any psychological treatment.[lxxv]

10.97 In 1996 Mr TG was referred for 'personal therapy' but there is no further reference to whether or not he attended, or that psychological work and progress was an integrated part of his care management.

10.98 Mr TG could not tolerate the Paroxetine and at the next review was started on another antidepressant with only limited success. In May 1997 an alternative medication regime of Fluvoxamine (an antidepressant) and low dose of Flupenthixol (an antipsychotic used as an anxiolytic at low dose) was agreed in discussion with Mr TG and appears to have helped him. He was next seen in 2000 after his release from prison and was continued on the same medication.

10.99 Mr TG's medication regime begins to get complicated and appears to lose focus in late 2000. At that time he was on Chlorpromazine 100mg b.d. and 200mg nocte (antipsychotic), Sertraline (antidepressant) 50mg increased to 100mg and Zopiclone (sleeping tablets) as necessary. Staff Grade 1 also added Oxazepam (Benzodiazepine) without a clear rationale or plan as to how long this was to be continued - prolonged use of Benzodiazepines is habit forming and dependence forming, and Mr TG was a man with a known history of substance misuse.

10.100 In October 2001 Mr TG was seen in the A & E Department after an episode of deliberate self harm when he told staff he had been off his medication. He was recommenced to continue the same regime as before which the Independent Investigation Panel regards as a missed opportunity for a review of the medication. His GP subsequently wrote to say that Mr TG had not in fact been getting medication from the surgery, thus alerting the team to his non-compliance and lack of transparency in his dealings with the mental health services.

10.101 Mr TG's care was referred to Cygnet House in August 2002 by Consultant 1 and he was first seen there in October 2002. When he was first assessed the SHO noted that he had stopped his medication three months previously. The doctor started him on another antidepressant, Citalopram, and noted that psychotherapy should be considered at "some point in the future". When next seen there was reference to a referral for anxiety management but no evidence of this being followed up or any action having been taken. Over the ensuing months Mr TG's medication regime became increasingly complex with the addition of Chlorpromazine, Ritalin, Risperidone (another anti-psychotic) and Procyclidine (anti-muscarinic for the treatment of side effects of antipsychotics).

10.102 The Independent Investigation Panel noted that Consultant 4 was concerned when he first met Mr TG to review the past history in order to help make a diagnosis, and that he also reviewed the medication.

10.103 While Consultant Dr 4 did note that Mr TG's medication needed review he did not attend his next appointment. It is clear that Consultant 4 was developing a whole diagnostic picture of Mr TG and had increased his Risperidone and was planning to take over the prescription of Ritalin from the GP with a view to seeing Mr TG monthly to monitor the effect. There is note on occasions of Mr TG's social circumstances but no full description of these. It is known that when Consultant 4 saw Mr TG's wife she confirmed his symptoms. Given the nature of his presenting complaint it might have been helpful to have attempted the use of psychological interventions. Mr TG did not report thoughts of harming others.

10.104 In May 2001 Mr TG is noted to have requested to have "someone to talk to" but no note was made of any consideration being given to this request and if not why not?

10.105 In 2002 consideration was given to psychotherapy. There is reference to an anxiety management referral but again no reference to what happened to this referral or why it wasn't followed up.

10.106 We assume from the records that Mr TG was seen in 2003 on one occasion for an assessment regarding anger management work but there are no notes regarding this interview and why he did not engage with / continue the work. There is no evidence that it formed part of a coordinated care plan and no evidence that any further thought was given to psychological interventions. It is known from one of the staff interviewed that he successfully completed an anger management course provided by the Children, Schools and Families Department and from the June 2003 Child Protection Case Conference minutes.

10.107 The Independent Investigation Panel accepts that Mr TG was not a reliable historian, he was not a reliable attendee at out-patient appointments which compromised engagement, and he was not compliant with prescribed medication.

10.108 We do consider that Mr TG's care and treatment at times concentrated too much on the prescription of medication and lacked clear direction. An arms-length approach was taken to him without the benefit of a full assessment, multi-disciplinary team involvement and without giving him a trial with a clear treatment plan to test his motivation and potential for engagement.

10.109 We are also critical of the open ended prescription of benzodiazepines to Mr TG given his history of substance misuse. In our opinion the multiplicity of medications prescribed demonstrates a lack of clarity regarding what exactly was being treated. In our experience this was not an uncommon phenomenon in patients with a diagnosis of personality disorder – which is why the recently published NICE guidelines are particularly helpful.[lxxvi]

10.110 There was little evidence that other forms of treatment (other than medication) were considered for Mr TG and when they were mentioned, they were not followed through.

10.111 The Independent Investigation Panel is critical of the absence of record keeping by those individuals outside the medical profession that did see Mr TG. In the Panel's opinion this hampered his assessment and treatment. Insufficient attention was given to Mr TG's psychological and social needs.

Care Programme Approach

10.112 The Care Programme Approach (CPA) was developed to provide a framework for effective mental health care. Its four main elements are:

- Systematic arrangements for assessing the health and social care needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care required from a variety of providers;
- The appointment of a key worker (later referred to as care co-ordinator) to keep in close touch with the service user and to monitor and co-ordinate care; and
- Regular review and, where necessary, agreed changes to the care plan.[lxxvii]

10.113 The Hertfordshire Partnership NHS Trust developed its joint CPA and care management policy in 2004[lxxviii]. This policy set out the requirements, standards and professional responsibilities for using CPA throughout the mental health service, and described the system for registration at the point of referral or engagement with a team or professional. The policy made clear that CPA was applicable once a service user had been assessed and accepted by the specialist mental health service.

10.114 The 2004 Hertfordshire policy contained a section on needs assessment which should include:

- Social and family life
- Accommodation
- Physical health
- Risk to self and others.

10.115 The policy also stated that:

"Staff have a duty to ensure that any risks to children residing or in regular contact with service users are recognised and that appropriate action is taken to safeguard children's welfare. In line with the Hertfordshire Child Protection Procedure, managers need to ensure that clinical staff receive child protection training at an appropriate level. The number, ages and gender of children under 18 years residing with mentally disordered service users must be identified and recorded.

Assessment of a service user should take full account of their current social and family context. This should include the composition of their household, their roles and responsibilities within their household and their wider social network. This assessment should encompass parenting and other caring roles of service users." [lxxix]

10.116 In line with current Dept of Health guidance at that time the Hertfordshire Policy described the criteria for both standard and enhanced levels of CPA. According to the policy a service user would be placed on enhanced CPA if they met some of the following:

- They are only willing to co-operate with one professional or agency but have multiple care needs

- They may be in contact with a number of agencies (including the criminal justice system)
- They are likely to require frequent and intensive interventions, perhaps with medication management
- They are more likely to have mental health problems co-existing with other problems such as substance misuse
- They are more likely to be at risk of harming themselves or others because of their mental health problems
- They are more likely to disengage from services or not comply with treatment
- They are receiving inpatient care (other than planned respite care)
- They have multiple care needs which require multi-disciplinary or interagency co-ordination.

10.117 The new Dept of Health Policy 'Refocusing the Care Programme Approach' [lxxx] was issued in 2008 and has been incorporated into the most recent Hertfordshire policy[lxxxi].

Findings on CPA

10.118 It is quite clear in the 2004 CPA Policy for HPT that all service users being cared for within the specialist mental health service should have been on CPA and therefore have had a care co-ordinator. This was not the case with Mr TG who appears to have been only notionally on CPA. The Independent Investigation Panel was informed by interviewees that Mr TG would have been on CPA as all service users were at that time, and his consultant would have been his care co-ordinator.

10.119 There was, however, only one reference to CPA within Mr TG's mental health records, and that was a reference to him needing to be on enhanced CPA which was made in an undated risk assessment conducted by an SHO, possibly in Accident and Emergency. There was no reference to any CPA needs assessment, care plan or allocated care co-ordinator. The absence of any record of these

elements was clearly not in line with the Trust's own CPA policy at the time. The Trust CPA Policy reflected the national situation regarding the CPA requirements for service users who were seen by a psychiatrist in outpatient clinics but by no other member of the CMHT.

10.120 The situation now is that the current HPFT Care Coordination Policy follows the recent guidance from the Dept of Health[lxxxii]. This guidance reviewed the need for standardised documentation for assessments, care plans and reviews and concluded that for those on what was previously standard CPA, normal record keeping, letters and plans could be sufficient. The term CPA now only applies largely to those service users with multiple complex needs who might have previously been on enhanced CPA.

10.121 In the Hertfordshire policy those described as not needing (new) CPA would be on standard care. There is still a requirement for a needs assessment, risk assessment and care plan, but these would not necessarily be recorded on standardised paperwork and could be covered in, say, a letter to the service user's GP. The Independent Investigation Panel asked the two staff who conducted the Trust's Internal Investigation if they thought they could identify a care plan in the records. They replied:

The only thing that would be available would be on the care notes, which would be the clinic letters, a plan to continue taking medication, to be booking in outpatients in two or three months' time. That's probably the bare bones of the care plan.

10.122 Other staff interviewed were asked if they thought psychiatrists who saw patients in out-patients would think of themselves as care co-ordinators and were told:

If he was on standard CPA his care coordinator would be the person who was seeing him, and in this case it was the doctors. I suppose the question is what does it mean to think of yourself as the care coordinator? They would have known they were seeing him and I think they would have seen themselves as the person organising and responsible for the care of that person. Would they have necessarily been aware of all the information requirements the system wanted from them as a care coordinator? The answer is probably not. They might be aware of some of

them, and they should have been aware of the need to do a risk assessment, but they might not have been aware of absolutely everything.

10.123 However, the Panel was also told that:

We have a new care coordination policy which makes it clear what care coordinators' responsibilities are. It's fair to say we are still implementing that because it is a problem where doctors are identified as the care coordinator, because they may not be undertaking the full range of care co-ordinator roles and responsibilities. We are still working through that within the Trust.

10.124 Although there is no specific reference to CPA in Mr TG's clinical records (except when he attended the A&E Department on 31October 2001) it appears to the Panel that the Trust viewed him as having been on standard CPA. The Panel has therefore considered whether that was an appropriate level for him. The Trust's criteria for enhanced CPA could be seen to indicate that Mr TG should have been on the enhanced level, i.e. his contact with a number of agencies (including the criminal justice system); more likely to be at risk of harming himself or others, and multiple care needs, and mental health problems co-existing with other problems. However if he had been placed on enhanced CPA this could have been at odds with the recommendation in Consultant 1's transfer letter when Mr TG moved to Stanstead Abbots. In this letter he stated that Mr TG was not a regular or consistent user of services but someone who dropped in and out depending on his needs, and was skilled at navigating the system. The plan had been not to admit him, nor to explicitly encourage or discourage engagement. This Panel understands this recommendation was based upon the diagnosis of personality disorder and the wish not to encourage Mr TG into a psychiatric career. In the light of this recommendation the panel agrees that enhanced CPA would have been inappropriate.

10.125 Irrespective of the level of CPA there was an expectation, in both the policy at that time and in the later policy, that the CPA elements of assessment, care planning and review would be reflected in the outpatient records and letters. The Panel found that these elements were present to some extent in the record keeping prior to his move to Stanstead Abbotts but that after his care was transferred to Ware

CMHT there was little evidence of them. One minor exception to this was the telephone discussion between one of the locum consultants and Mr TG's mother when he asked about Mr TG's childhood. This could also be seen as a missed opportunity to gather further information.

10.126 There was little clarity about assessment and planning in the frequent letters sent to Mr TG's GP. His care appeared to be rather reactive to his psychological complaints and issues. There was no evidence of assessment which looked beyond the narrow parameters of Mr TG's reported psychological symptoms. His reviews did not consider in any depth his social, family or home circumstances, employment, accommodation, physical health, his financial situation, or any of the wider issues which we know affect and are affected by mental ill-health.

10.127 There was another missed opportunity to talk to his partner who accompanied him to outpatient appointments on at least two occasions, but was not, it appears, included in any part of the discussions. There was no planning of care beyond responding to his reported problems with further changes to medication and making a further outpatient appointment. There were a few references in the records to Mr TG asking to see a CPN or social worker, or someone to talk to, but no evidence that these requests were followed up.

10.128 In summary, there was some evidence of a systematic approach to assessment and care planning during his care at QEII, but little evidence of these once he had moved to Stanstead Abbotts. Although there was a reasonably comprehensive history taken by an SHO at Ware CMHC in October 2002, there was no clearly described plan for his care and treatment and no further assessment or review.

Social Care/Safeguarding Issues

Adequacy of Communication regarding the Safeguarding of Children

Context

10.129 The overall aim of the Safeguarding of Children Policy is to ensure that children and young people are healthy, safe, enjoy life and achieve their potential

and make a positive contribution to society and are well prepared to secure their economic well-being in future years. (Every Child Matters (2003) and Section 11 of the Children Act 2004)

10.130 Since April 2006 all local authorities are required to have a Local Safeguarding Children Board which replaced the Area Child Protection Committee. The prime objective of the Safeguarding Children Board is to coordinate and to ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children. The HPT is an important member agency and has responsibilities to assist the local authorities in their work and to identify any children where their safety is considered to be at risk, and to help assess and promote their safety. The Serious Case Review conducted by Hertfordshire following the homicide by Mr TG was conducted under the requirements of The Children Act 1989 and Working Together to Safeguard Children (1999).

10.131 The National background to Safeguarding Policy has since 2003 comprised the following documents and initiatives:

- Laming (2003 Climbie Report) providing safeguarding recommendations and influencing the future developments in safeguarding guidance and policy;
- Every Child Matters (2003) which responded to the Laming Report and outlined the five key improvement outcomes – be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing;
- National Service Framework for Children which including a recommendation for Care Programme Approach meetings to take account of children's needs and any risks of harm to them;
- Children Act (2004) which stated that all organisations have a responsibility to prioritise safeguarding and to ensure that effective arrangements are in place;
- Working Together (2006) provided the benchmark for all organisations to ensure that safeguarding arrangements are in line with national requirements;

10.132 The Mental Health Trust was unaware until June 2003 that there were any concerns regarding the safety of children with whom Mr TG had contact or his parenting skills. As none of the consultations with Mr TG between his first contact

with Adult Mental Health Services in Hertfordshire in 1996 and the homicide of Mrs S on 3 August 2005 had included details of the names of any of his partners, his children or any other children he had parented, there was minimal appreciation of Mr TG in the context of family relationships.

Adequacy of Assessment

10.133 As the information recorded in mental health records was almost exclusively derived from Mr TG's own reports, with no evidence of any probing, even when disclosures were made, he managed to keep information about his involvement in sexual partnerships and families private. There were a few opportunities when he provided sufficient information to enable mental health professionals to explore issues relating to parenting responsibilities and his dependence upon family members for care or assistance.

10.134 On 28 October 2002 Mr TG provided the most explicit information that, if explored further, may have provided an opportunity to better assess his mental health needs. He revealed that he had a two week old son by his then partner and that he "wanted to lead a settled and responsible life for the sake of the baby."

10.135 If this information had been explored further it may have been possible to assess his risk to others, and to engage him in dialogue that could have led to an offer of appropriate therapy other than solely using medication. As it was the opportunity was lost.

10.136 Whilst serial failed relationships and the production of children by multiple partners is not uncommon in cases involving men like Mr TG, there is no evidence that the reasons for his failed relationships were ever explored. No attempt appears to have made to understand his attitudes towards women, his expression of anger in the domestic setting, or his potential for developing insight into his relational problems and motivation to change behaviours that may have contributed to relationship breakdown.

10.137 There is limited evidence in his mental health records of his difficulties controlling anger and its effect on his life at home. On 4 October 1996 Mr TG did mention to Consultant 1's Senior House Officer his bouts of violent temper,

arguments with his wife and ‘smashing up the place’. This letter also refers to Mr TG having spent four months in prison during the year due to violent behaviour. The only treatment plans were in the letters following Outpatient consultations sent to his GPs. The letters were mainly about treating Mr TG’s self-reported symptoms.

10.138 It is evident from close examination of the clinical records that Mr TG only attended appointments when he perceived the need to do so. The provision of medication for Mr TG, and the chopping and changing of medications, all depended on his self-reported symptoms. There was also some evidence that he was non-compliant with taking prescribed medication which meant that pharmacological treatment had minimal or no useful effect.

10.139 The number of missed appointments in certain periods are shown in the two tables on the next page. Table 2 shows the Outpatient appointments and Accident and Emergency Department attendances from November 2000 to June 2003.

10.140 Table 3 shows the Outpatient appointments from December 2003 to July 2005. In both time periods there were several missed appointments, particularly in the second period when Mr TG was living in Ware (Stanstead Abbotts).

Table 2: Outpatient Appointments November 2000 to June 2003

Date of Outpatient Appointment	**Attended**	**Did Not Attend**
19 November 2000	✔	
9 January 2001	✔	
12 March 2001		**X**
18 April 2001 (taken to A&E by police	✔	
22 May 2001	✔	
9 July 2001		**X**
20 August 2001		**X**
17 October 2001		**X**
31 October 2001 (Mr TG Presented to A&E)	✔	
10 December 2001	✔	
9 January 2002		**X**
11 February 2002		**X**
11 June 2002		**X**
19 August 2002	✔	
28 October 2002	✔	
25 November 2002	✔	
27 January 2003		**X**
24 February 2003		**X**
24 March 2003		**X**
9 April 2003	✔	
22 May 2003		**X**
5 June 2003		**X**
Total 20 Appointments (excluding the 2 A&E attendances)	**8**	**12**

10.141 The period covered by Table 2 was when Mr TG was living in the Hatfield area and was seen at the Queen Elizabeth 11 Hospital in Welwyn Garden City under the care of Consultant 1 and his SHOs. As can be seen Mr TG attended 40% of the appointments offered to him.

Table 3: Outpatient Appointments December 2003 to July 2005

Date of Outpatient Appointment	**Attended**	**Did Not Attend**
9 December 2003	✔	
10 March 2004	✔	
22 March 2004		**X**
5 April 2004		**X**
5 July 2004		**X**
25 January 2005		**X**
I February 2005	✔	
3 March 2005		**X**
12 April 2005		**X**
16 June 2005		**X**
12 July 2005	✔	
Total 11 Appointments	**4**	**7**

10.142 The period covered by the above Table 3 was when Mr TG was under the care of Consultant 4 at the Ware CMHT. As can be seen in the 20 months from 9 December 2003 to 12 July 2005 Mr TG was only seen on four occasions. The first two outpatient appointments in December 2003 and March 2004 were kept. Following this Mr TG did not attend four appointments in the next 11 months. He attended 36% of the appointments offered.

10.143 Mr TG did attend the outpatient appointment on 01 February 2005 but then failed to attend another three appointments in the five months until he attended the last appointment on 12 July, just three weeks before the homicide. A further

appointment had been made for 13 October 2005, so the plan appears to have been to review him quarterly.

Recommendation 6

Where there is irregular attendance and a number of missed appointments by a service user to outpatient appointments it is particularly important that there is a clear plan, which has been discussed between the medical staff and at least one other member of the CMHT, for either the continuation of appointments or an alternative strategy for engagement or discharge from the service.

Recommendation 7

In situations where it is difficult to engage service users with a complex personality disorder a needs led approach may be taken. This should be preceded by an assessment of the risk that the patient may pose to others in order to be sure this treatment modality is appropriate. This may include consultation with the specialist personality disorder team.

Recommendation 8

All health professionals responsible for completing DWP forms relating to a patient's application for State Benefits, should be reminded of their legal duty only to include information that they know is true, or have good grounds for believing to be true.

Child Protection Conference June 2003

10.144 From June 2003 when the Ware CMHT received an invitation to a Child Protection Conference and a request for a report on Mr TG, the Community Mental Health Team knew that Mr TG had a child (Child 1) about whom there were safeguarding concerns. Although a report was provided by Consultant 2 for the Child Protection Conference on 23 June 2003 (from the interview with the Deputy Head of Child Protection) there is no evidence that serious consideration was given by Consultant 2 or any other CMHT team member to attend the Child Protection Conference.

10.145 There is no evidence in the mental health records that the Minutes of the Child Protection Conference or a copy of the Child Protection Plan for the child were received by Consultant 2 or the CMHT. On the balance of probability, Ware CMHT did receive a copy of the Minutes of the Conference and the reviews that occurred in September 2003 and February 2004, which should have been filed in Mr TG's clinical records. There is no evidence that this Conference or its outcomes, or Mr TG's involvement in the care of Child 1, were ever discussed with him by his Psychiatrist at any time even though the child was placed on the Child Protection Register under the category 'emotional abuse'.

10.146 It is clear that Mr TG made a formal complaint to the Trust that his right to confidentiality had been breached by the provision of more information than was necessary to the Child Protection Conference about him. He received a letter of apology from CMHT Manager 1, dated 24 September 2003. The Independent Investigation Panel understand that the complaint was not dealt with under the NHS Complaints procedure although this should have happened. We have been unable to locate any complaint file even although SH stated in his interview that he held a file at Ware CMHT, separate from the Trust's central Complaints Department.

10.147 CMNT Manager 1 confirmed he had taken formal disciplinary action against the person releasing the information about Mr TG to the CSF Department. (It is unclear who was disciplined about this). CMHT Manager 1 had told Mr TG this by telephone and in a letter the Independent Investigation Panel has seen. No record that this person was employed in the CMHT has been found, nor any record that the

Trust's Human Resources Department was involved in disciplinary action involving a member of the CMHT at this time in relation to Mr TG's complaint. Indeed it became clear in an interview with the Deputy Head of Child Protection that a social worker from the Children, Schools and Family Services contacted the CMHT and asked for information about Mr TG. It seems clear that the information was provided by Consultant 2 the locum psychiatrist, which he was entitled to do within the context of a Child Protection Conference.

10.148 The CMHT Manager informed Mr TG of the disciplinary action that had been taken and in a letter dated 24 September 2003 informed him that his confidentiality would not be breached again, stating that "all approaches for access to confidential information now needs to go through the designated care coordinator or if attending outpatients only, through myself for clearance. As discussed on the telephone we have had a recent request for further information by the same social worker and this has been refused without proper written authorisation and consent from yourself."

10.149 It appears that Consultant 2, Mr TG's locum psychiatrist, was not given advice and support about how best to deal with Mr TG's complaint. No consideration appears to have been given by CMHT Manager 1 as to whether Mr TG's objection to the information provided was reasonable or related to his diagnosis of Personality Disorder. There is no evidence that the fact of his complaint was communicated to the agencies actively involved in trying to safeguard his son.

Recommendation 9

The Trust should ensure that when complaints by service users are made and investigated, the process complies with the current Trust Policy and a complete record of that investigation is held corporately by the Trust and is not retained in local managers' offices

Context

10.150 The CMHT Manager wrote a letter (as above dated 24 September 2003) to a patient with complex personality disorder upholding his complaint and promising to ask his permission before sharing information in future, without appearing to check

with Mr TG's psychiatrist that the terms of that letter were consistent with the therapeutic approach Consultant 2 was taking with him.

10.151 Two panel members interviewed Mr TG in March 2010 and he said he had understood that Consultant 2 had been disciplined for inappropriately breaching his confidentiality and took his leaving the Trust to be related to this incident. The Independent Investigation Panel considers it most likely, given the comments of the Deputy Head of Child Protection, that it was indeed Consultant 2 who spoke to Social Services. It was also clear that the information provided to the Child Protection Conference held on 23 June 2003 was the minimum needed to safeguard the child and that therefore, Mr TG's right to confidentiality was not breached without good reason, given the principle of the child's rights being paramount. However, the person providing the information to Social Services should have told Mr TG that he was sharing the information and the reasons for this.

10.152 It is evident that Mr TG did have sight of the Social Worker's report to the Child Protection Conference before it was held, and he was present at the Conference. He did not tell Social Services that he objected to the information being shared until 23 September 2003 at the Safeguarding Review meeting (three months after the Conference.) Mr TG told that meeting that his confidentiality had been breached, that his complaint had been upheld and that he had disengaged from Mental Health Services as a consequence. When the minutes of this meeting were received by the CMHT (in accordance with the practice at the time) as the Independent investigation Panel believes they were, no record was made of Mr TG's perception of events and there was no discussion with him about it at his next Outpatient consultation on 12 December 2003. As stated before there was no trace of these minutes in the medical records.

10.153 Notification of the Child Protection Conference alone should have initiated a clinical reassessment of Mr TG at his next Outpatient appointment with specific reconsideration of the risks he might pose to others.

10.154 The knowledge that there was to be a Child Protection Conference made no difference to Mr TG's management and did not lead to a reassessment of his needs and the risks he posed. This was despite the Child Protection Plan referring to Mr TG

attending an anger management course paid for by the Local Authority. GP 1, was aware of the anger management course.

10.155 The information provided to the Child Protection Panel on 23 June 2003 was in fact just a brief summary of Mr TG's involvement with the mental health services. It did not really breach his right to confidentiality as it gave the minimum information necessary to show the involvement and its relevance to his son's welfare, as required by the child's safety and welfare being regarded as paramount. The information provided was purely factual:

> *"Mr TG is currently seeing a locum psychiatrist at Cygnet House and he has been recently diagnosed with ADHD and he has been prescribed Ritalin, which he reports has impaired his mood and agitated his behaviour.*
>
> *Mr TG's psychiatric history reports he suffered from borderline personality disorder, obsessive compulsive disorder and a variety of panic attacks, depression and drug-induced schizophrenia. Mr TG says he suffered suicidal thoughts and has seriously self-harmed in the past. He is currently prescribed 10mgs Ritalin and Citalopram 20mgs once daily. He sees his psychiatrist monthly and is shortly due to start an anger management course yet to be confirmed."*

10.156 There is one reference to Mr TG attending an anger management course. His GP referred him to an anger management course, but Mr TG reported that he had not liked the first session and would not attend further sessions. He did attend and complete a different course following the Child Protection Conference in September 2003.

10.157 In the report of the social worker to the Child Protection Conference held in September 2003 there is a reference about the initial meeting between Mr TG and the person who would be running the anger management course held on 3 October 2003:

> "Children, Schools and Families would provide anger management provision for Mr TG. An initial meeting was held between the social worker, the course leader and Mr TG to assess the terms of engagement and the number of sessions was agreed to be between six and ten. Mr TG said at this meeting that he wanted to learn how to deal with his anger should he be in a situation in the future."

10.158 The mental health service did not discuss the anger management course with Mr TG, nor did they reassess his risk to himself, his partner, his child or others.

Anger Management

10.159 Part of the Child Protection Plan agreed at the Child Protection Conference in June 2003 was for Mr TG to be funded to attend an anger management course arranged through CSF. He attended the course and a positive report was received which contributed to the decision to remove Child 1's name from the Child Protection Register in February 2004. Although Mental Health Services were invited to attend that conference and supplied information to it in advance, there is no evidence in Mr TG's records that his Psychiatrist knew the outcome of that conference (at which no-one attended from the Mental Health Partnership Trust), that he was aware Mr TG later enrolled on an anger management programme which he completed, nor was there any discussion with Mr TG regarding the emotional abuse his son had sustained.

10.160 The minutes of the Child Protection conference would have been sent to Mr TG's Psychiatrist and would have included within them the date for the first review meeting in September 2003. No apologies were sent to the September meeting nor any information and there is no evidence in Mr TG's records that the minutes of that meeting or subsequent review meetings were received. However, the Panel has no reason to believe that they were not so received and has therefore concluded that they were probably disregarded even though the September 2003 minutes recorded Mr TG's report that he had complained to the CMHT that his confidentiality had been breached through the sharing of information about his medical condition and

treatment, and that as a result he had withdrawn from engaging with Mental Health Services. It is reasonable to consider that such a statement merited a note in his clinical records and discussion of the same at the next Outpatient appointment consultation on 9 December 2003. (Mr TG did not attend any appointments between 5 June and 9 December 2003.)

10.161 One of the outcomes of the initial Child Protection Conference on 23 June 2003 was that Mental Health Services would communicate with the Child Protection core team put in place to protect Child 1. There is no evidence that any contact was initiated by Mental Health Services, not even when Mr TG made what he considered to be a formal complaint about his perception that his confidentiality had been breached. This was significant for two reasons. One reason being that CMHT Manager 1 wrote to Mr TG upholding his complaint. The other, of more significance to the safeguarding of Child 1 was that Social Services needed to know that Mr TG's sole concern was to protect his right to privacy.

Domestic Violence, Child Abuse and Mental Health Services

10.162 Another recommendation at the Child Protection Panel was that Mr TG's former partner was to be seen on her own without Mr TG. If this information was known to the CMHT through the Minutes of the Child Protection Conference, this should have prompted a reassessment of Mr TG's potential for occasioning harm to other people.

10.163 It is probable that his former partner accompanied Mr TG to some Outpatient appointments. The Independent Investigation Panel is unable to be certain whether she was present during the consultations with Psychiatrists or whether she sat in the waiting room outside. Either way, the Panel considers the Psychiatrist had opportunities to speak to her about Mr TG's condition, his behaviour in the home and her role and responsibilities as his carer as long as Mr TG gave consent to this.

10.164 Even if he had refused to permit his former partner to see the Psychiatrist by herself, or even if he had refused to involve her at all, there were at least two opportunities for doing so. The first was two weeks after Child 1's birth when Mr TG volunteered that he wanted to change his behaviour for his new son's sake. The second was in the context of the completion of the Disability Living Allowance form

when the doctor could, probably without too much difficulty, have interviewed his former partner as part of a carer's assessment before completing a form confirming that she was his carer and detailing the care that she provided to him.

Context

10.165 The psychiatrists treating Mr TG from 1996 to 2005 gave little or no consideration to the need to place him in a social context in order that a valid risk assessment could be made. Given his diagnosis no attempt was made to validate the information he presented to psychiatrists who would have known that he would be guarded in the amount of information he would reveal, would present it from his own perspective, and would try to manipulate consultations to achieve his own purposes.

10.166 There were three clear opportunities for the CMHT to engage with Mr TG's close family members in order to better understand his needs for services and/or risk to himself and others:

- the first was when Consultant 3 contacted Mr TG's birth mother to find out what he was like as a child. His brief summary of their conversation does not suggest that much of his birth mother's potential information about him as a child and as an adult was shared with him (24 April 2003).

- the second opportunity for involving Mr TG's family was when his former partner, attended both meetings CMHT Manager 1 said he had had with Mr TG between April and July 2003. The Panel considers it probable that his former partner accompanied Mr TG to some Outpatient appointments as well. There is no evidence that she was ever asked to contribute to any assessment of Mr TG's needs or to provide information about his behaviour at home. There is no evidence that a Carer's Assessment was completed despite her entitlement to this and the evidence from Mr TG's application for Disability Living Allowance dated 26 March 2004 in which his psychiatrist recorded that his partner was his carer.

10.167 It was the lack of regular health assessments, risk assessments and goal-oriented treatment/care plans that explains why little was known about Mr TG's family circumstances. It was the absence of these that left the CMHT knowing less than they needed to in order to contribute to any safeguarding of women from domestic violence and children from abuse. It is understood and accepted that Mr TG was selective about the information he was willing to share with the mental health services, and more evidence was available once he had been arrested for this offence.

10.168 The CMHT Manager confirmed that between 1 April 2003 and July 2003 Mr TG made the complaint about the information disclosed to the Child Protection Conference when he attended a planned appointment in Outpatients with his Psychiatrist. At that appointment CMHT Manager 1 stated that he was asked to intervene because Mr TG became verbally aggressive and abusive. There is no record of this outburst in Mr TG's clinical notes so it either occurred between April and July 2003**,** or on another occasion not mentioned at all in his records which record that Mr TG was not seen again until 9 December 2003. In any event, there is no evidence in the records that the episode occurred or that the discussion the CMHT Manager said he would have had with Mr TG about his behaviour, was made. Nevertheless, the Panel believes, on the balance of probabilities, that this episode did take place and, therefore, it should have led to a discussion at the Multi-disciplinary Team Meeting (Friday Allocation Meeting) on the Friday following this consultation, and there should be evidence of the outcome of that discussion in Mr TG's clinical records.

10.169 Such a reassessment would have involved a review of Mr TG's clinical notes which would have revealed other clues and evidence of his difficulty in controlling his temper and his propensity for violence. The prophetic assessment by an SHO in an A&E Department on 31 October 2001 would have been read. Together with his presentation during the Outpatient consultation that led to the risk reassessment, this would, on the balance of probability, have led to an amendment to his risk profile and it may have led to a review of his CPA status, treatment/care plan and behavioural management plan. Instead, nothing happened.

- the third opportunity arose when the request was received for someone from the CMHT to attend a Child Protection Conference on 23 June 2003. As it was known to the CMHT that Mr TG was the father of Child 1, the subject of the Child Protection Conference whose mother was his former partner, this should have led to a discussion within the CMHT and a decision to review him in the light of this information. This is notwithstanding the CMHT's attendance at the Child Protection Conference or any issues about the disclosure of information to the agencies involved in the Child Protection Conference.

The Serious Case Review

10.170 The local Safeguarding Children's Board (LSCB) established a Serious Case Review (SCR) following the homicide. The Terms of Reference stated that events between January and August 2005 were to be considered. This meant that the Review dealt only with the three children of Mrs S, the partner murdered by Mr TG, who were present when she died. The Mental Health Partnership Trust's Named Nurse for Child Protection was asked to provide information for the Serious Case Review, and the Mental Health Partnership Trust was asked to produce an Internal Management Review for the Serious Case Review. As the SCR was only examining Mr TG's treatment and care in 2005, the other nine years from 1996 were not relevant. As a result information and evidence for the risk he did or may have posed to his partners and their children was not provided to the Serious Case Review.

10.171 In accordance with practice at the time, the Serious Case Review Team was multi-agency and included both Police and Primary Care Trust representatives, a community paediatrician and a representative from the NSPCC. The group was chaired by an independent safeguarding expert who also wrote the Overview Report.

10.172 More importantly, on the evidence the Independent Investigation Panel has seen, the Serious Case Review failed to address the care and safeguarding services provided to Mr TG's other children, including and especially his son Child 1 who had been the subject of a Child Protection Plan in 2003/2004, who was a child under the care of the Child Development Centre for developmental delay, and who had escaped with his mother to a refuge because of Mr TG's domestic violence in the

months preceding the homicide. As far as the Independent Investigation Panel is aware, Child 1''s unborn sibling was also excluded from consideration by the Serious Case Review.

10.173 The Independent Investigation Panel understands that 'post-Laming' Serious Case Reviews are now independently chaired, address inter-agency issues more, and would be less likely to exclude consideration of all the children who were or may have been significantly harmed. Current Serious Case Reviews have clear practice guidance and independent scrutiny. The Statutory Guidance changed twice with the publication of Working Together 2006 and Working Together 2010 with further change anticipated from the Munroe Review of Child Protection in England 2011.

PARTNERSHIP WORKING

Sharing Lessons to be Learned

10.174 The Independent Investigation Panel considers the agencies in Hertfordshire missed an opportunity to share the learning from the Serious Case Review and the sole agency internal investigations. If there had been more cooperation between the agencies it would have been possible to produce practical recommendations that would improve practice in relation to safeguarding children and the victims of domestic violence. It is recognised that there was a significant time gap between the SCR and the Independent Investigation.

10.175 HASCAS was refused access to the full Serious Case Review Report by the Local Authority Legal Department, but was provided with The Executive Summary of the Hertfordshire Local Safeguarding Children Board Serious Case Review Re Case A15. HASCAS received help from the Children, Schools and Family Department although there was a delay in identifying a manager with knowledge of the period 2003 to 2005. In the end helpful assistance was provided by the Deputy Head of Child Protection which greatly assisted the completion of the Independent Investigation.

Recommendation 10

The Strategic Health Authority should ensure that Independent Investigations following a homicide are conducted promptly. The SHA should ensure where there is also a Serious Case Review being conducted by the Local Safeguarding Children Board, that there is good liaison and joint planning between these reviews, particularly at the stage of drawing up Terms of Reference, to maximise learning and to minimise duplication.

The SHA should endeavour to ensure that there is full information sharing between the reviews insofar as this is compatible with data sharing legislation. Thought should also be given to careful liaison between the two reviews in relation to the involvement of children, parents and other family members and to the timing of publication of the two reports.

Status and Purpose of Independent Homicide Inquiries

10.176 The Independent Investigation Panel recommends that the East of England Strategic Health Authority ensures that Local Safeguarding Children's Boards are advised of the legal framework for Independent Inquiries Following a Homicide. The advice should be clear so that Local Safeguarding Children's Boards are enabled to understand their duties to cooperate with the inquiry process when safeguarding is included in the Terms of Reference, and to embrace the opportunities such inquiries present to learn lessons following homicides where children have been victims or where children with whom the perpetrator was involved were a subject of a Child Protection Plan.

Staffing

10.177 From time to time in Mental Health Services, there are services or teams in which it is difficult to recruit and retain Psychiatrists. Although it is no longer the case, this was the situation in the Ware Community Mental Health Team between 2001 and 2004. This inevitably meant that Mr TG and all other patients whose only contact with Mental Health Services was through Outpatient appointments where they were

seen only by a Psychiatrist, were or may have been adversely affected by lack of continuity of care.

10.178 The Independent Investigation Panel considers this has implications for the quality of care those service users received, some of which may be avoided by reviewing the appropriateness of continuing to manage them as Outpatients without access to other members of the CMHT during periods when there are frequent changes of locum psychiatrists.

Recommendation 11

NHS organisations should be alert to the inherent risks of a long period with a shortage of senior medical staff, or a rapid turnover of such staff. In such circumstances the Human Resources Strategy should ensure that the caseload in psychiatric outpatients is reviewed to make certain that all cases have an appropriate care plan which is being fully implemented, and to address any gaps that the review identifies.

11. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

RCA Third Stage

11.1 This Section of the Report will examine all of the evidence collected by the Independent Investigation Panel. This process will identify the following:

1. Areas of good practice;
2. Areas of practice that fell short of both national and local policy expectation;
3. Key causal factors.

11.2 The Independent Investigation Panel thoroughly examined all the relevant factors in Section 12 of this report. There were 12 issues identified and these are listed below.

Medical Factors/Mental Health Issues

- Psychiatric Assessment;
- Diagnosis;
- Treatment Plans;
- Risk Assessment;
- Care Programme Approach.

Social Factors/Safeguarding Issues

- Adequacy of Assessment;
- Child Protection Conference June 2003;
- Domestic Violence, Child Abuse and Mental Health Services;
- Inter-Agency Information Sharing;
- The Serious Case Review;
- Partnership Working;
- Staffing.

11.3 The Independent Investigation Panel examined all the evidence from the clinical records, the interviews it conducted and the appropriate National Guidance, Policies and Operational Policies in the Hertfordshire Partnership NHS Trust in order to identify any causal factors relevant to the homicide.

11.4 There are three types of factors to be identified in independent investigations into the care and treatment of people who have committed a homicide whilst under the care of mental health services or having been under their care in the preceding six months of the homicide. These are:

Key Causal Factors:

11.5 This term is used in this Report to describe an issue or critical juncture that the Independent Investigation Panel has concluded ***had a direct causal bearing upon*** Mr TG and the homicide. When considering mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives and any subsequent suicide, or a homicide perpetrated by them.

Contributory Factors:

11.6 This term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Panel to conclude that it made a direct contribution to the state of Mr TG's mental health and/or the failure to manage it effectively.

Service Issues:

11.7 The term Service Issues is used in this Report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 03 August 2005, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

12. Findings and Conclusions

12.1 The Independent Investigation Panel carefully examined and scrutinised all the written and oral evidence it had available. Consideration was given to the main points raised during the detailed analysis of all the information and the Panel agreed that it had not identified any key causal factors nor any contributory factors.

12.2 As described in the last section the main issues identified were:

Medical Factors/Mental Health Issues

- Psychiatric Assessment;
- Diagnosis;
- Treatment Plans;
- Risk Assessment;
- Care Programme Approach.

Social Factors/Safeguarding Issues

- Adequacy of Assessment;
- Child Protection Conference June 2003;
- Domestic Violence, Child Abuse and Mental Health Services;
- Inter-Agency Information Sharing;
- The Serious Case Review;
- Partnership Working;
- Staffing.

12.3 These factors will now be briefly examined to determine whether there could be said to have directly or indirectly contributed to the homicide of Mrs S in August 2005.

Medical Factors/Mental Health Issues

Psychiatric Assessment (Including Diagnosis, Treatment Plans and Risk Assessment)

12.4 Mr TG was seen by the Queen Elizabeth II Psychiatric Services between August 1996 and December 2001. His initial assessment by Consultant 1 was fairly full and provided a comprehensive formulation and description of Mr TG's psychiatric difficulties which were shared with his GP. There was also a treatment plan which referred to medication and personal therapy (although the latter was not pursued according to the medical records).

12.5 Mr TG was only seen in the out-patient clinic. There was, however, a further thorough assessment made when he attended the A & E Department in 2000. The overall impression from this period is that Mr TG was reasonably well known and understood by the mental health service and was 'contained' within the team. The transfer letter written by Consultant 1 in April 2002 when Mr TG moved to the Ware area would have given the new team a good understanding of him and his needs.

12.6 At Ware Mr TG was seen by the Cygnet House Psychiatric Services from October 2002 up until the time of the homicide in August 2005. His initial assessment at Cygnet House was also thorough and accompanied by a treatment plan. Over the course of the next few years however he was seen by a series of locum consultants and junior doctors until Consultant 4 took up post and saw him for the first time in December 2003. He continued with Consultant 4 until the homicide, seeing him for the last time on 12 July 2005.

12.7 In April 2003 Consultant 3, locum Consultant Psychiatrist, decided to review Mr TG's diagnosis to include ADHD and the prescription of Ritalin.

12.8 An opportunity to critically review Mr TG and his mental health problems, and to see him within a familial and domestic situation, was lost in June 2003 when Consultant 2, a locum Consultant Psychiatrist, was invited to a child protection case conference, and asked for a report. Consultant 2 did not attend, and neither did he consider seeing Mr TG and asking him about his family situation and why a case conference was taking place regarding Child 1. He did not consider reassessing Mr

TG's risk to himself, his children and family or others. The knowledge of there being a Child Protection Conference should have triggered such a response.

12.9 The Care Programme Approach (CPA) was not fully adhered to by the medical staff involved with Mr TG. Consultant 1 at Welwyn Garden City did review his situation, albeit within the diagnosis of personality disorder and the need to avoid fostering dependence on mental health services by Mr TG, and trying to avoid having to admit him to hospital. The HPT CPA Policy stated that people subject to Standard CPA should have their care plan reviewed at least once a year, This did not formally occur during Mr TG's time with the Hertfordshire Mental Health Services.

12.10 Despite one person giving evidence to the Independent Investigation Panel there is no documentary evidence that Mr TG was accompanied by his partner to Cygnet House on at least two occasions. In any event the chance to interview his former partner was not taken. This meant that the picture of Mr TG remained a monochrome one when a different view could have emerged had he been assessed within his social context. Mr TG said in his interview to two members of the Panel that it may have been helpful if his partner had been contacted about his condition as she may have been able to help him cope; in the end she had had enough and left. Mr TG explained that the relationship got to a point where he didn't want her around. His partner would sometimes come to appointments but would not be asked any questions. He explained that she would come sometimes as he didn't like leaving the house as he thought people were talking about him and following him. On reflection Mr TG thought that it may have been helpful to involve her his former partner as he would lose touch with things and find it hard to explain to the psychiatrist what was going on. It is an open question as to whether he would have agreed to his partner being seen by a member of the CMHT.

After the missed opportunity to attend the Child Protection Conference Consultant 4 in his interview with the Panel Chair did confirm that he had met Mr TG's wife on two occasions when she accompanied him to his outpatient appointments.

Comment

12.11 Whilst the Independent Investigation Panel did consider that those treating Mr TG could have sought to gain a better overall understanding of him by either visiting

him at home, involving a social worker or psychologist, or taking the opportunities to speak to his partner, the failure to do so cannot be seen as a causal or a contributory factor leading to the homicide.

Social Factors/Safeguarding Issues

Child Protection Conference June 2003

12.12 As mentioned in the previous section, the knowledge of the situation regarding a Case Conference about Child 1, , should have prompted some action by the Ware CMHT. No member of the CMHT attended the case conference and there were no minutes of the meeting within the case records, as there should have been.

12.13 It was clear from the minutes of the conference that Mr TG was referred for an Anger Management Course which he successfully completed.(As the Deputy Child Protection Manager confirmed). In his interview Mr TG stated that he had attended a six week anger management course run by the British Association of Anger Management at Hertfordshire County Hall. He attended all his appointments and saw the course through to the end, as confirmed by the Local Authority. Mr TG was unsure if the course had been helpful to him as he still had "things in his head."

12.14 One recommendation at the Child Protection Panel was that his former partner was to be seen on her own without Mr TG. If this information was known to the CMHT through the Minutes of the Child Protection Conference, this should have prompted a reassessment of Mr TG's potential for occasioning harm to other people, and also for them to have tried meeting with his former partner to discuss her role as a carer and how Mr TG was managing his illness.

Comment

12.15 The Independent Investigation Panel did consider the level of sharing information in the case of Mr TG. HASCAS found it difficult to obtain the necessary information from the Local Authority to fulfil its work in relation to the Terms of Reference relating to the need to consider "the effectiveness of interagency working, including communication between the mental health service and the other agencies with particular reference to the sharing of information for the purpose of safeguarding children". The decision to refuse to share the full SCR Report was based on the

need to provide confidentiality for the family involved and was taken following legal advice within the Authority.

12.16 It was unfortunate that the Serious Case Review A13 did not examine the situation with Mr TG and other children before January 2005, and did not involve the mental health services in the longer timeframe as relevant information could have been shared, especially about the need to take invitations to Child Protection/Safeguarding Conferences seriously.

13. HERTFORDSHIRE PARTNERSHIP NHS TRUST

Response to the Incident and the Internal Investigation

The Internal Investigation

Structure

13.1 The Internal Investigation was published in July 2007 almost two years after the homicide in August 2005. The Investigation Team comprised:

- Team Manager 2, Community Mental Health Team Manager and Approved Social Worker;
- Consultant 5, Consultant Psychiatrist.

13.2 Team Manager 2 was the lead investigator and the author of the Internal Review and Consultant 5 advised on medical issues.

13.3 The Terms of reference for the Internal Investigation were:

1) To review care provided by HPT teams involved. To include:
   - risk assessment;
   - risk review;
   - level of CPA;
   - general management of Service User's condition;
   - effectiveness of care plan;
   - reviews.

2) To review the need for referral to or information sharing with / from Other agencies, i.e.:
   - MAPPA
   - Probation
   - Prison
   - Police
   - Forensic Team - Were they aware of our involvement?

3) To review this care under the Trust's 'Learning from Adverse Events' Policy

13.4 Team Manager 2 had undertaken other investigations for the Trust, but Consultant 5 had not been involved in such an investigation before and had not received any specific training in root cause analysis. The panel was not able to obtain any medical notes prior to 2000, although there was some mention of Mr TG having been under the care of mental health services in Hatfield during the 1990s.

13.5 The Internal Investigation Team interviewed only one person, Consultant 4 who had treated Mr TG as an outpatient from December 2003 until 12 July 2005, the last time he saw him prior to the homicide three weeks later.

Findings

13.6 The Internal Investigation examined the notes and constructed a timeline from January 2001 to 12 July 2005. The findings were based on an examination of the case records from 2001 using both paper records and the electronic 'Care-notes'. Other information was also collated by Trust Manager 2 and this included:

- various witness statements taken by the police including those from previous partners of Mr TG;
- transcripts of police interviews with Mr TG relating to the murder investigation;
- a summary of convictions taken from the Police National Computer;
- Minutes to The Multi Agency Lifer Risk –Assessment Panel (MALRAP) held at Belmarsh Prison on 6 August 2006
- Three Policies from the HPT
  - 'Integrated Care Management and Care Programme Approach'
  - Policy 'Risk Assessment and Management For Individual Service User' (2002)

- Hertfordshire Multi-Agency Protection Panels Policy and Procedure.

13.7 The findings were presented under the headings of the Terms of Reference and were:

Risk Assessment and Risk Review

13.8 The Investigation concluded that only one formal risk assessment had been completed in the Accident and Emergency Department in November 2002. This was a paper based record and stated that Mr TG should have been on enhanced CPA rather than Standard CPA (which he was on for the whole nine years he was in contact with HPT services) and that he posed a threat to women and no female staff should see him alone. This risk assessment was not adhered to, and the anger management consultant who was female saw Mr TG alone.

> The Investigation decided that it had "found that the lack of systematic risk assessment recording not only fails to highlight Service user's known and admittedly partial risk history, it also fails to highlight the clinical efforts to minimise the known / reported risk.
>
> We have found no causal or contributory relationship between the divergence from Trust policy on risk assessment for Standard CPA, and the eventual act of homicide."

Level of CPA

13.9 The Panel considered that a case could be found for Mr TG to be assessed as being suitable for enhanced CPA but also for standard CPA as it was basically down to clinical assessment and opinion. It concluded that "in our view, this was both clinically appropriate and in accordance with Trust policy." (Mr TG was on Standard CPA).

Effectiveness of the Care Plan and Reviews

13.10 The Panel decided that the care plan was appropriate as Mr TG would probably not have complied with any more rigorous intervention.

Multi-Agency Involvement

13.11 The Internal Investigation decided that there was "no evidence of information sharing between secondary mental health services and other agencies including: police; probation; prison; MAPPA and HPT's Forensic Team after Service user's initial contact with psychiatric services in 1996. This is not unexpected in light of the fact that Service user's known offending behaviour did not meet the necessary criteria to trigger the need to seek or share information."

Overall Conclusions

13.12 The Internal Investigation made four recommendations and concluded that:

"It is to be expected that any close examination of practice in a particular case will produce some areas of divergence from Trust policies, procedures, and other good practice standards. In this case, some instances have been found, principally around clinical risk assessment and the recording of this. The following recommendations pertaining to this are listed below:

1. The Trust in its review of risk assessment and risk management procedures should consider introducing a reminder system to remind psychiatrists when an annual risk review is due for a patient, before they are seen in outpatients. An alternative may be for secretarial staff to print the most recent risk review prior to each out-patient appointment, to prompt & facilitate doctors in considering whether it is up-to date and appropriate.

2. The Trust to consider surveying psychiatrists to assess the way in which they use Care notes at out-patients, including whether they access information from Care notes at the time of conducting out-patients and whether they input any information at the time and the reasons for doing so or not doing so.

3. Consultants and Managers should consider whether it is achievable, where cases are transferred from keyworker to keyworker under Standard CPA, for a formal risk review to be carried out, recorded and communicated appropriately in every case and whether this should be by the originating or receiving keyworker

and how this may best ensured when keyworkers may change unexpectedly or large caseloads may need to be transferred

4. When it becomes apparent that a mental health Service user is part of a child protection investigation this should trigger contact with Children Schools and Families to determine the nature of the concerns and any known history of risk.

13.13 There is no evidence to suggest that mental health professionals could have foreseen or prevented the homicide. The information available to secondary mental health services was partial and Service user deliberately misled professionals and withheld information that would have allowed for a far more accurate assessment of risk. Nor was there any information held by other agencies that may have helped predict this tragic incident.

13.14 The general management of Service user's condition and the care planning via outpatient appointments was appropriate to needs that Service user chose to present.

13.15 There is no evidence to suggest that any act or omission by mental health professionals had a causal or contributory impact on the tragic outcome."

Actions Taken as a Result of the Internal Investigation

13.16 The two members of the Internal Investigation Panel were unclear as to whether their report was seen by the Trust Board. It had been commissioned by The Director of Nursing and Team Manager 2 felt that he would have signed it off. It does not appear that the Report was considered by the Trust Board.

13.17 An Action Plan was developed in 2007 based on the four recommendations, and HASCAS has seen the latest progress chart on how well the recommendations had been implemented. The Table on the next page illustrates how the recommendations had been implemented.

Table 4 : Recommendations and their Implementation

Rec. Number	Agreed Action	Action Taken	Complete Yes ✔ No X
1	The Trust in its review of risk assessment and risk management procedures to consider introducing a reminder system either via Care Notes or out-patient administration systems to alert psychiatrists when the minimum yearly risk assessment review is due	A revised Risk Assessment and Risk Management Policy has been produced. This was completed by the set target date of April 2008	✔
2	The Trust to consider surveying psychiatrists to assess the way in which they use Care Notes at out-patients. The trust to consider issuing guidance with regard to its expectations of psychiatrists and their use of Case Notes	A written response was sent to The Director of Nursing, who had commissioned the Internal Investigation. This was to have been completed by November 2007 and was signed off as having been done.	✔
3	The Trust in its review of risk assessment and risk management procedures should survey Consultants and managers with a view to determining minimum expectations when a case is transferred from one care coordinator to another under Standard CPA.	A revised Risk Assessment and Risk Management Policy has been produced. This was completed by the set target date of April 2008	✔
4	When it becomes known that a mental health service user is part of a child protection investigation this should trigger contact with the Children, Schools and families Department to determine the nature of the concerns and any known history of risk.	The necessary steps have been taken to disseminate the necessary information to mental health teams and/or have been incorporated into Safeguarding Children Guidance	✔

Comments on the Internal Investigation

13.18 The Independent Investigation Panel considered that the Internal Investigation was flawed in that it took nearly two years to complete its work, and it did not examine in sufficient detail the care and treatment received by Mr TG. The lost opportunity to contact the Children, Schools and Families Department when Consultant 2 was invited to attend a Child Protection Conference and asked for information about Mr TG's mental health should have triggered an assessment and a discussion about what information there was about Mr TG and his potential danger to children and women.

13.19 A recommendation was made, but its relevance to Mr TG and the potential difference this could have made was not pursued. Knowing that the Local Authority did know about Mr TG and had approached the Ware CMHT this could have raised the question of whether a joint investigation should have been undertaken by the HTP and the Children, Schools and Families Department of the Local Authority. In the event the Internal Investigation took a long time to complete its work while the Serious Case Review decided to only look at the three children of Mrs S and to limit the time scale to the period from January 2005, during which time she had known Mr TG.

13.20 The Internal Investigation Archive, comprising its working papers, has been lost. The HPFT has searched for the Archive, as have Team Manager 2 and Consultant 5, but no trace has been discovered. As a result the Independent investigation has made a final recommendation that once the Internal Investigation has been completed the Archive and all the relevant notes and paperwork be secured to await the commissioning and start of any independent investigation.

Recommendation 12

When a homicide occurs there will necessarily be an Independent Investigation. The HPFT should ensure that the clinical records and all relevant documents are held securely, including the records which comprise the archive of the Internal Investigation undertaken by the Trust until the Independent Investigation is complete.

14. Notable Practice

14.1 Whilst the emphasis of this Report is to examine the care and treatment provided to Mr TG and to highlight areas where processes could be improved, during the Independent Investigation the Panel noted three examples of good practice:

- The Accident and Emergency Department assessment made by the Senior House Officer in October 2002
- The case summary of Mr TG prepared by Consultant 1 when he transferred from Hatfield/Welwyn Garden City to Ware which provided a good outline of the nature of Mr TG's medical needs and the treatment provided
- The development of a specialist service for people with personality disorder which can offer advice to clinicians across the Trust (this has been developed since the homicide).

15. Lessons Learned

15.1 The main lessons learned from this Independent Investigation were the need to consider any service user within the context of their family and social life, rather than almost exclusively concentrating on the symptoms of the service user which were at times thought to be unreliable. Throughout most of his nine year contact with the HPT Mr TG was seen by a psychiatrist within an outpatient clinic setting, even when the appointments were held within the Ware CMHT base. Medical matters were always the priority and little attention was given to other matters, and whilst involving another professional was considered on a few occasions this was not acted upon.

15.2 Mr TG was technically on Standard CPA but there was no formal six monthly or annual reassessments of his needs as required by the HPT Care Programme Approach Policy. His risk to himself and others was not regularly assessed and there were no attempts made to visit him at home so that the family context could be observed.

15.3 The contact between the Ware CMHT and the Local Authority Child Protection/Safeguarding Team was poor. The CMHT was informed that Mr TG was to attend a Child Protection Conference on 23 June 2003 but no member of the team attended the conference. The fact that Mr TG had a young child who was the subject of a Child Protection Conference did not trigger any thought of reassessing Mr TG in the light of this information, or reviewing his risk to himself and others.

15.4 The Local Authority undertook a Serious Case Review following the homicide of Mrs S, but was unaware that the HPT was also reviewing the care and treatment Mr TG had received as part on their internal investigation. The Local Authority did request information from HPT about their involvement with Mr TG from January 2005, but this timescale was too short for much relevant information to be relevant. This meant that the lack of working more closely together in 2003, when the CMHT

was asked for information to inform a Child Protection Conference about Mr TG's young son, was not included.

15.5 The Independent Investigation has made 12 Recommendations which it considers necessary to improve practice within the mental health services and to assist closer joint agency working. Despite there being several service issues identified the Panel found no causal factors. There were clearly ways in which the care and treatment could have been improved, but given the information available to the psychiatrists who treated Mr TG, no causal factor or combination of contributory factors could be identified to explain the reasons for the murder of Mrs S.

15.6 The service issues themselves would have improved the knowledge of the overall situation, but cannot be identified as being a reason for the homicide, which has to be ascribed as due to Mr TG and his now well identified propensity for violence to his partners, and his tendency to resort to violence when losing his temper. This information was only very partially known among several agencies in August 2005, and did not amount to conclusive evidence that Mr TG would commit such an offence.

17. LIST OF RECOMMENDATIONS

Recommendation 1

When the psychiatrist, or other member of the mental health services, wishes to review the diagnosis of a service user this should be undertaken with a review of the complete history of that service user and the treatment and care plans which have been used. Any change in plan should be fully recorded with the reasons clearly stated. In addition if there is any consideration of a specific diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) there should be consultation with one of the Trust's four specialist consultants.

Recommendation 2

The National Service Framework for Children includes a recommendation that CPA meetings (and their equivalent) should take account of children's needs and any risk of harm to them. Therefore, when a service user is the parent of a child for whom a child protection/safeguarding conference is called, and the mental health services are asked to attend the conference and to provide a report, this should be treated as a priority. A request for information should trigger a reassessment of the service user and the risks he/she may pose to children and others. The Trust should audit attendances at child protection case conferences.

Recommendation 3

In situations where a service user is usually seen alone without any family or friends and there is no corroborative information to support the 'history' or symptoms described by the service user, any opportunity to speak to another person who knows them should be used. The person may be a carer and be entitled to an assessment of their specific needs as a carer, and may also be able to provide additional information about the service user, subject to issues of consent and confidentiality.

Recommendation 4

Service users who are only being seen by the psychiatrist should be asked about their family and social circumstances so that they are viewed within an overall context. This is particularly important where the only informant is the service user and there is no other source to corroborate the history given. All mental health professionals should complete the form designed by the Lead Nurse for Safeguarding Children which records information about children with whom the service user has contact.

Recommendation 5

When a service user is being seen by only one member of the mental health services there should be a review, at least annually, to include: diagnosis, care plan and treatment plan, current risk assessment, social and family circumstances, risk to any children in the household and consideration of their needs. This review should set out how the treatment plan is designed to assist the service user and overcome/alleviate the symptoms being experienced.

Recommendation 6

Where there is irregular attendance and a number of missed appointments by a service user to outpatient appointments it is particularly important that there is a clear plan, which has been discussed between the medical staff and at least one other member of the CMHT, for either the continuation of appointments or an alternative strategy for engagement or discharge from the service.

Recommendation 7

In situations where it is difficult to engage service users with a complex personality disorder a needs led approach may be taken. This should be preceded by an assessment of the risk that the patient may pose to others in order to be sure this treatment modality is appropriate. This may include consultation with the specialist personality disorder team.

Recommendation 8

All health professionals responsible for completing DWP forms relating to a patient's application for State Benefits, should be reminded of their legal duty only to include information that they know is true, or have good grounds for believing to be true.

Recommendation 9

The Trust should ensure that when complaints by service users are made and investigated, the process complies with the current Trust Policy and a complete record of that investigation is held corporately by the Trust and is not retained in local managers' offices

Recommendation 10

The Strategic Health Authority should ensure that Independent Investigations following a homicide are conducted promptly. The SHA should ensure where there is also a Serious Case Review being conducted by the Local Safeguarding Children Board, that there is good liaison and joint planning between these reviews, particularly at the stage of drawing up Terms of Reference, to maximise learning and to minimise duplication.

The SHA should endeavour to ensure that there is full information sharing between the reviews insofar as this is compatible with data sharing legislation. Thought should also be given to careful liaison between the two reviews in relation to the involvement of children, parents and other family members and to the timing of publication of the two reports.

Recommendation 11

NHS organisations should be alert to the inherent risks of a long period with a shortage of senior medical staff, or a rapid turnover of such staff. In such circumstances the Human Resources Strategy should ensure that the caseload in psychiatric outpatients is reviewed to make certain that all cases have an appropriate care plan which is being fully implemented, and to address any gaps that the review identifies.

Recommendation 12

When a homicide occurs there will necessarily be an Independent Investigation. The HPFT should ensure that the clinical records and all relevant documents are held securely, including the records which comprise the archive of the Internal Investigation undertaken by the Trust until the Independent Investigation is complete.

18. GLOSSARY

General (The Medical Glossary is on Page 114)

Agoraphobia	A set of fears which involve activities such as leaving home, entering public places or travelling alone. The person may feel vulnerable and exposed, with nowhere to escape to or hide if things go wrong.
Area Child Protection Committee (ACPC)	An inter-agency forum for agreeing how the different services and professional groups should co-operate to safeguard children in that area, and for making sure that arrangements work effectively to bring about good outcomes for children.
Attention deficit hyperactivity disorder (ADHD)	A childhood disorder which can continue into adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behaviour, impulsivity and hyperactivity (over-activity).
Caldicott Guardian	A senior member of staff within an NHS organisation responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure mental health assessment and care planning occur in a timely and user centred manner. The four main elements are: assessment, care planning, the role of the key worker (now care co-ordinator) and review. Prior to 2008 there were two levels of CPA - standard or enhanced. The enhanced level required a robust level of supervision and support.
Community Mental Health Team (CMHT)	A multi-professional team providing health and social care to people with mental health problems being treated in the community. A CMHT will often operate from a community mental health centre (CMHC).
Community psychiatric nurse (CPN)	A mental health nurse who is based in a community team. A CPN will often take on the role of care co-ordiantor.
Depressive disorder	A combination of symptoms, including persistent sad, anxious or "empty" feelings, feelings of hopelessness and/or pessimism, or feelings of guilt, worthlessness and/or helplessness that interfere with a person's ability to work, sleep, study, eat, and enjoy once–

	pleasurable activities.
Department for Work & Pensions	The public service delivery government department responsible for welfare and pension policy.
Disability Living Allowance (DLA).	A tax-free benefit for children and adults who need someone to help look after them, and/or have walking difficulties because they are physically or mentally disabled.
HSG (94) 27	Dept of Health guidance on investigations. *Independent investigation of adverse events in mental health services.*
Local Safeguarding Children's Board	These boards have replaced Area Child Protection Committees. In addition to protecting vulnerable children they have a responsibility for the prevention of harm and promotion of welfare for all children. The boards develop local arrangements for safeguarding children and ensure that partners are working effectively together to achieve objectives.
Inmate medical record (IMR)	Record of a prisoner's contact with health services whilst in prison.
Manic symptoms	The symptoms of mania include excessive energy, activity, and restlessness and euphoria. The person may also experience irritability, racing thoughts and talking very fast, and distractibility. They often have a decreased need for sleep. They may also demonstrate poor judgement and aggressive behaviour.
Multi-agency public protection arrangements (MAPPA)	The process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.
National Patient Safety Agency (NPSA)	An arm's length body of the Department of Health which seeks to lead and contribute to improved and safe patient care by **informing**, **supporting** and **influencing** organisations and people working in the health sector. This is in part achieved by the publication of best practice guidelines.
National Service Framework for Children	The National Service Framework (NSF) for children, young people and maternity services was published by the Dept of Health in 2003. NSFs set national standards, aiming to improve the quality of care and reduce unacceptable variations in health and social services.
Obsessive compulsive disorder (OCD)	A chronic mental health condition that is usually associated with both obsessive thoughts and compulsive behaviour. An obsession is defined as an unwanted thought, image or urge that repeatedly enters a person's mind. A compulsion is defined as a repetitive

	behaviour or mental act that a person feels compelled to perform.
Panic disorder	A disorder in which the person has recurring and regular panic attacks, often for no obvious reason. People with panic disorder experience feelings of anxiety, stress and panic regularly and at any time.
Paranoia	A thought process characterised by excessive anxiety or fear, often to the point of irrationality and delusion. Paranoid thinking typically includes persecutory beliefs concerning a perceived threat towards oneself.
Personality disorder	Someone may be described as having a 'personality disorder' if their personal characteristics cause regular and long term problems in the way they cope with life, interact with other people and in the way in which they can respond emotionally. Borderline personality disorder typically involves unusual levels of instability in mood; black and white thinking, or splitting; chaotic and unstable interpersonal relationships. People diagnosed as borderline or paranoid personality disorder may be at higher risk of self harm and/or suicide than other people. Antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood.
Psychotic symptoms	Symptoms of a psychotic disorder vary from person to person and may change over time. The major symptoms are auditory or visual hallucinations (unusual sensory experiences or perceptions of things that aren't actually present) and delusions (false beliefs that are persistent and sometimes organised, and that do not go away after receiving logical or accurate information).
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
Schizophrenia	A psychiatric diagnosis that describes a mental disorder characterised by abnormalities in the perception or expression of reality. Distortions in perception may affect all five senses, including sight, hearing, taste, smell and touch, but most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganised speech and thinking with significant social or occupational dysfunction.
Senior House Officer (SHO)	A grade of junior doctor between House officer and Specialist registrar – generally the most junior medical grade in psychiatry.
Staff Grade psychiatrist	A staff grade doctor is one who is in a non-training middle grade post, who does not plan to move on to a consultant post.

Glossary : Medication

Benzodiazepines	Medication which acts as a sedative which reduces anxiety and helps with muscle spasms which are sometimes the side effects of antipsychotic drugs
Chlorpromazine	An anti-psychotic phenothiazine
Citalopram	A selective serotonin reuptake inhibitor (SSRI) anti-depressant.
Co-dydramol	An analgesic which contains dihydrocodeine and paracetamol
Flupenthixol	An anti-psychotic neuroleptic which is used in low doses to treat depression.
Fluvoxamine	An antidepressant which functions as a selective serotonin reuptake inhibitor and is predominantly used to treat obsessive–compulsive disorder.
Imipramine	A tricyclic anti-depressant
Lorazepam	A benzodiazepine used to treat anxiety disorders.
Olanzapine	An atypical anti-psychotic used for treating patients with schizophrenia and manic episodes associated with bipolar disorder.
Oxazepam	A benzodiazepine prescribed for the treatment of anxiety and insomnia
Paroxetine	A selective serotonin reuptake inhibitor (SSRI) used to treat depression, obsessive-compulsive disorder and anxiety disorders
Procyclidine	An anticholinergic medication for the treatment of side effects of antipsychotics.
Risperidone	A newer (atypical) anti-psychotic used to treat schizophrenia and symptoms of bipolar disorder
Ritalin	A central nervous system stimulant related to amphetamine used to treat ADHD. Its use may cause dependence and psychotic states.
Sertraline	A selective serotonin reuptake inhibitor (SSRI) used to treat depression and obsessive-compulsive disorder.
Trifluoperazine	An antipsychotic phenothiazine. Also referred to as Stelazine, one of its brand names.
Zopiclone	Hypnotic used for the short-term treatment of insomnia

References

[i] GP notes, pages 217-218
[ii] GP notes p215
[iii] GP notes p208
[iv] Case notes p41-45
[v] Case notes p45-47
[vi] Case notes p34 & 57
[vii] GP notes p171 and Case notes p51-52
[viii] Case notes p33 & 56
[ix] Case notes p31-32
[x] GP notes p164-165
[xi] Case notes p28
[xii] Case notes p95
[xiii] Case notes p25-27 and 60-65
[xiv] GP notes p64
[xv] Case notes p68
[xvi] Case notes p20-21 & p69
[xvii] Case notes p70
[xviii] GP notes p63
[xix] Case notes p18
[xx] GP notes p133
[xxi] GP notes p62
[xxii] GP notes page 121
[xxiii] Case notes p1-2
[xxiv] Case notes p71
[xxv] Case notes p19 & 38
[xxvi] Case notes p5-7
[xxvii] Statement 3
[xxviii] Case notes p 80
[xxix] Case notes p73
[xxx] Case notes p12-13 & 72
[xxxi] medical records page 221
[xxxii] medical records page 217.
[xxxiii] medical records p215.
[xxxiv] medical records page 210
[xxxv] medical records page 209
[xxxvi] medical records page 208
[xxxvii] medical records page 37.
[xxxviii] medical records page 200
[xxxix] medical records page 174
[xl] medical records page 187
[xli] case notes page 57
[xlii] case notes page 41-47
[xliii] case notes page 34
[xliv] case notes, pages 51-52
[xlv] case notes page 54 - 56
[xlvi] medical records page 167
[xlvii] medical records page 166
[xlviii] medical records page 164
[xlix] medical records page 157-159
[l] medical records page 153-155
[li] case notes page 66
[lii] medical records page 144
[liii] case notes page 68

[liv] medical records page 143
[lv] case notes page 70
[lvi] case notes page 70
[lvii] Interview with Jane Page X
[lviii] medical records page 136
[lix] case notes page 18
[lx] notes page 71
[lxi] case notes page 5-7 and page 88
[lxii] medical records page 108
[lxiii] case notes page 15-16
[lxiv] case notes page 72
[lxv] Case notes p14
[lxvi] case notes pages 12-13 and page 72
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[lxviii] Case Notes Page 68

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[lxxiii] Interview of X Page X
[lxxiv] case notes page 29
[lxxv] medical records page 218
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