An investigation into the care and treatment of K

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A report for NHS London
Undertaken by Verita

NHS London

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1. Introduction

1.1 In January 2008 K was involved in a violent incident which resulted in him killing a teenager and stabbing two others. The killing took place in a flat that was often used for taking drugs. K had previously been under the care and treatment of Oxleas NHS Foundation Trust. K was found guilty of murder and sentenced to serve a minimum term of 26 years before being considered for parole. He also received concurrent sentences of 13 years for attempted murder and nine years for wounding with intent.

1.2 K was first referred to services in 1998. He presented with a complex set of problems including a personality disorder, a history of offending behaviour going back to childhood and drug and alcohol problems.

1.3 NHS London commissioned Verita to conduct an independent investigation into K's care. Verita is a consultancy that specialises in the management and conduct of investigations, reviews and inquiries in public sector organisations.

2. Terms of reference

Commissioner

2.1 This independent investigation is commissioned by NHS London in accordance with guidance published by the Department of Health in circular HSG (94) 27, *The discharge of mentally disordered people and their continuing care in the community,* and the updated paragraphs 33-6 issued in June 2005.

Terms of reference

2.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to K to include:

- a review of the trust's internal investigation to assess the adequacy of its findings, recommendations and action plans
- reviewing the progress made by the trust in implementing the action plan from the internal investigations
- involving the families of K and the victim as fully as is considered appropriate
- a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident
- an examination of the mental health services provided to K and a review of the relevant documents
- the extent to which K's care was provided in accordance with statutory obligations, and relevant national guidance from the Department of Health, including local operational policies
- the appropriateness and quality of assessments and care planning
- consider the effectiveness of interagency working
- consider other such matters as the public interest may require
- complete an independent investigation report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication.

3. Executive summary and recommendations

3.1 K is a 36-year-old man whose first contact with Oxleas NHS Foundation Trust (the trust) was in September 1998. This followed a referral by the South East London Probation Service. He presented with a complex set of problems including personality disorder. He had a history of offending behaviour going back to childhood, which included offences of violence. K was also involved in bare knuckle fighting. These difficulties were made more complex by drug and alcohol abuse. In 2005 he was placed on the prolific offenders programme.

3.2 K presented the services with a significant challenge. His engagement when in crisis and then disengagement when he felt that he no longer needed help is typical of individuals with personality disorder. He is amongst the group of patients who are the most difficult and challenging to treat. We concur with the trust investigation that this homicide could not be predicted or prevented.

3.3 On the 5 January 2008, he was involved in a violent incident in a flat in Erith which was regularly used as a venue for drug-related activity. K told us that he had gone to the flat to confront the occupants who were involved in drug dealing on the estate because his partner had been assaulted by them. The occupants had previously demanded to know where K was growing and storing cannabis. He cannot remember whether he went with a knife or picked one up in the course of the argument with the occupants. He also told us that he had taken heroin just prior to going to the flat. During the incident an 18-year-old man was stabbed twice in the chest; two other teenagers were also injured in the attack. When K was subsequently arrested he was found to be in possession of a quantity of drugs.

3.4 Following the stabbings K was remanded into custody. In December 2008 he was found guilty of murder and sentenced to serve a minimum term of 26 years before being considered for parole. He was also convicted and sentenced to 13 years for attempted murder and nine years for wounding with intent, to run concurrently. He is serving his sentence in prison.

3.5 Following his arrest K was assessed by a forensic psychiatrist. The forensic psychiatrist did not recommend K be transferred to hospital for further assessment or treatment and suggested that he could be managed within the prison system.

3.6 K's contact with the mental health services was with the Bexley Community Mental Health Team (CMHT) and with the psychological treatment services at the Bracton Centre. K's forensic and offending history was extensive and as a result the mental health services were in frequent contact with his various probation officers and with the local police service.

3.7 K's contact with the trust's services was characterised by frequent non-engagement with services and re-engagement when he felt he was in crisis or when he was required to as part of a court order.

3.8 Throughout most of his contact with the trust's services he received regular and consistent treatment and support from professionals who came to know him well.

3.9 K had been admitted once to a psychiatric hospital; this was on a voluntary basis following a crisis and was for two days. He was discharged in a much calmer state. He was never assessed for compulsory admission under Mental Health Act powers.

3.10 His last contact with the trust's community services was in September 2007. The closure of his case was agreed by Bexley CMHT on 7 November 2007, following his failure to attend appointments with the CMHT consultant psychiatrist, community nurse and with the Bracton Centre psychologist.

3.11 Our overall conclusion is that the services offered to K between 1998 and 2007 were at a standard that was reasonable at that time for patients with problems related to personality disorder, substance misuse and offending in the community.

3.12 The new services the trust commissioned in 2008 for people with personality disorder and the new guidance it has produced for clinical and team work with this group is of a good standard. These new arrangements provide a greater opportunity to assist individuals like K to engage more consistently with treatment and thereby help to reduce the risks associated with their diagnosis.

3.13 We set out below our findings and recommendations from this review. The context of the findings and recommendations are found in the body of this report.

Findings

F1 The services offered to K between 1998 and 2007 were appropriate to his mental health needs and were delivered at a standard that was reasonable at that time for patients with problems related to personality disorder, substance misuse and offending in the community. The trust offered a range of services in a timely manner but these were clearly of limited effectiveness.

F2 If K had been receiving services from the trust in 2008 and had been willing to engage with the trust's new personality disorder service it may have assisted him to overcome some of his anger responses.

F3 The trust's new personality disorder service assertive outreach to clients and the arrangements for transport pick-up and telephone chase-up is an important part of the service.

F4 The trust's ten core personality disorder service principles provide valuable guidance for all staff working with this group of clients.

F5 If the trust's ten core personality disorder principles had been available prior to 2007 and followed by professionals involved with K, he may have engaged more consistently with psychological treatment.

F6 The trust's draft document, *Clinical guidance and care pathway for the management of patients with common personality disorder* provides valuable advice on how services for this group of clients can be coordinated and effectively delivered.

F7 We conclude that the evaluation by clinical staff that K did not meet the 2007 criteria for MAPPA[1] inclusion was correct.

F8 The trust has considerably improved staff understanding and contribution to the working of local MAPPA processes.

[1] Multi Agency Protection Arrangements (MAPPA) are the means by which local agencies work together to protect communities from the serious harm that some offenders may still present after being convicted or released from prison.

F9 The trust has not put in place local risk panels across the whole trust.

F10 The psychological services offered to K by the Bracton Centre were of a high standard.

F11 The care programme approach assessments and reviews were complied with by the trust community mental health services.

F12 The Bexley CMHT worked together to ensure that the care offered to K was coordinated within the team and with other NHS professionals and external agencies.

F13 The consistent support offered by U, CPN was helpful to K and was of a high standard.

F14 Our review supports the view of the trust's panel report that comprehensive risk assessments were carried out and adhered to by staff involved in K's care.

F15 In the light of K's forensic history trust staff should have made more use of advice from the trust forensic service.

F16 Although compulsory admission for clients with personality disorders should be a last resort, we support the trust guidance that at times of crisis this is an option that clinical teams should consider.

F17 K's record of non-engagement except in times of crisis would make treatment for substance abuse problems unlikely to be successful.

F18 Despite the trust panel's recommendations, the current guidance to staff on personality disorder services does not include advice on working with families.

Recommendation

R1 The trust should review the arrangements for local risk panels across the trust and ensure that there is consistency across all boroughs and that the panels can provide effective support for clients with risk histories similar to those of K.

R2 The trust should include within its guidance on services for people with personality disorder how partnership working with families should be carried out.

4. Approach and structure

4.1 It was agreed with NHS London that this investigation would be principally a documentary review of K's clinical care, supported by group interviews with clinicians and managers to assess the progress of the implementation of the recommendations from the trust's internal investigation carried out by a panel of board members.

4.2 This approach was agreed with NHS London as the trust's board-level investigation report appeared to cover all the relevant issues and had been informed by two previous trust investigations/reviews into K's care and treatment.

4.3 Our approach was to review all the clinical care notes and documents and transcripts of panel interviews and to compile a chronology. Also available to us was copies of the transcripts of the interviews undertaken by the trust and minutes of the trust panel meetings. A list of the documents reviewed is given in appendix A.

4.4 At the beginning of the investigation we interviewed K in prison who was accompanied by his mother. We also interviewed him when a draft of the report was available for his review and comment.

4.5 After our first stage analysis we identified a number of themes which we discussed with staff from the trust in two group interviews. We also discussed with staff the implementation of the trust panel's recommendations.

4.6 The first of the group interviews was with senior managers. It was attended by:

- A, director adult acute mental health crisis services
- B, clinical director for forensic & prison services and head of psychological services
- C, medical director

4.7 The second group meeting was with clinical staff and was attended by:

- D, senior nurse, nursing and management support services, forensic prisons
- E, clinical lead, forensic personality disorder service
- F, community psychiatric nurse (CPN), forensic services clinical pathways coordinator
- G, social worker, forensic services

4.8 The trust was invited to provide an update on changes made to services in the light of its board-level panel report and to comment on the draft report.

4.9 The investigation team comprised of Tariq Hussain from Verita and Dr Andrew Payne, forensic psychiatrist, West London Mental Health NHS Trust. Advice was given by Rosie Mundt-Leach the head of nursing for the addictions clinical academic group of the South London and Maudsley NHS Foundation Trust. Biographies of the team are given in appendix E.

5. Chronology

5.1 This chronology does not cover every contact by mental health service staff with K but sets out the key contacts that are important to evaluating the care offered to him.

Background

5.2 K was the fourth of seven siblings. Although K enjoyed primary school, he was involved in fights and was bullied. At secondary school he truanted and was suspended. He left school with no qualifications.

5.3 K had several relationships with women and has a son but was prevented from seeing him, by his mother, for a considerable period of time. He denied any violence towards women or children, although his clinical notes indicated that one of his relationships ended because he was violent towards his partner.

5.4 K had been using illicit substances from an early age and his drugs of choice were cannabis and crack cocaine. He also had a history of excessive consumption of alcohol.

5.5 K had a long-standing forensic history dating back to 1992. He had been convicted for assault, theft, wounding and drug offences and had received custodial sentences. He was also involved in bare knuckle fighting. Set out below is a table that shows the extent of K's forensic history. When considering K's mental health issues his involvement with the police and courts is a major feature.

5.6 Forensic history

Date	Nature of offence	Conviction
1992	Common assault on an adult	Bound over for 12 months
1992	Common assault	Bound over for 12 months
1992	Theft from a vehicle	Conditional discharge
1993	Theft from a vehicle	Conditional discharge
1993	Theft from a vehicle	Conditional discharge
1993	Aggravated vehicle taking	Attendance centre disqualified from driving
1994	Burglary and theft	12-month probation order
1994	Wounding	6 months at young offenders' unit
1995	Possessing a controlled drug	Conditional discharge
1996	Aggravated burglary	5 year sentence at young offenders unit (reduced on appeal)
1998	Handling/theft	3 weeks' imprisonment
1998	Possessing controlled drugs (class B)	Fine
1998	Breach of licence condition	12 weeks' imprisonment
June 1999	Possession of class B drugs	No separate penalty
1999	Using a vehicle whilst uninsured	Fine
June 1999	Driving whilst disqualified	28 days' imprisonment
November 1999	Using a vehicle whilst uninsured	No separate penalty
February 2000	Possession of class B drugs	Fine
March 2000	Possession of class B drugs	12-month probation order
July 2000	Theft from a vehicle	18-month probation order
July 2000	Theft	No separate penalty
2001	Common assault	12-month community rehabilitation order
2004	Common assault	Not known
2005	Not known	Community rehabilitation order
May 2005	Non payment of fines	Not known
July 2005	Criminal damage x2	Dismissed?

Outline chronology of care and treatment

5.7 In September 1998 South East London Probation Services referred K to the Bracton Centre[1], Oxleas NHS Trust (now Oxleas NHS Foundation Trust).

5.8 K was seen by Z, a clinical psychologist, on 16 September 1998 and 9 October 1998. K told him that he cut himself and enjoyed violence.

5.9 K's first contact with the community psychiatric service was in October 1998, when he was referred to the Arsenal locality team by his GP. He was seen by Y, SHO to X, consultant psychiatrist, on 7 October 1998, having been referred by his GP. He told Y that he had violent thoughts and was unable to control himself he said *"I keep hurting people and I don't want to but I can't stop"*.

5.10 K described ideas of reference[2], including the feeling that other people were talking about him and laughing at him. He described voices in his head telling him to be violent. He said he had been in prison on two occasions for violence and that a relationship with a girlfriend had broken up because of his violence.

5.11 K said he was on probation and he gave an account of his family and background, including his history of substance misuse. Y, SHO, in consultation with X, consultant psychiatrist, diagnosed K with a dissocial personality disorder (also known as an antisocial personality disorder) with paranoia and ideas of reference secondary to his personality (see appendix B for a description of this diagnosis).

5.12 Y noted that K had been taking trifluoperazine[3] 5-10mg daily with little effect. Y advised K to continue taking trifluoperazine 10mg daily and to keep his appointments with Z, clinical psychologist at the Bracton Centre.

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[1]The Bracton Centre provides a range of specialist forensic mental health services for people aged 18 to 65 living in the boroughs of Bromley, Bexley, Greenwich and Lewisham and other boroughs when requested. The centre offers assessment, treatment and rehabilitation.

[2] Ideas of reference involve the belief that casual events, people's remarks, etc are referring to oneself when, in fact, they are not.

[3] Trifluoperazine is effective in helping symptoms of schizophrenia such as hearing voices, loss of energy, thought disturbances, difficulties communicating with others, worry, depression, and overcoming feelings of wanting to be alone. It is also useful in treating agitation and behavioural problems.

5.13 Following the appointment on the 9 October 1998 K did not attend any further appointments with Z despite five letters from him. K made at least two phone calls to request an appointment, but did not attend those offered him. Between March 1999 and June 2000 he failed to attend appointments after being referred by a resettlement officer, his probation officer and a forensic mental health liaison officer from HMP Belmarsh. He was discharged from the service by Z on 21 July 1999.

Comment

***This pattern of attendance by K when in some sort of crisis (often related to criminal matters) and then non-attendance when it appears the matter had passed was a recurring theme. K told us that he did not want to admit his mental health problems. He told us that he missed some of his appointments at the Bracton Centre because he just forgot and at other times he could not afford to get there. He contrasted this with seeing his CPN who he said* "was just around the corner".**

5.14 K was re-referred to psychology services by the CPN at HMP Belmarsh in December 1999 after K served a short sentence for a driving offence. An appointment was made for March 2000 however K did not attend but was seen in June 2000 by Z. K cancelled a further appointment made for July.

5.15 K's probation officer rang Z, clinical psychologist, on 6 June 2000 and expressed concern about his violence, self harm and his mental state. She told Z that he had been unable to attend the Beresford Project[1] for his substance misuse. Z arranged an appointment, which K attended with his girlfriend and his probation officer on 20 June 2000. He again described problems with violence and self harm. He said he had been involved in frequent fights in prison and that he sometimes felt out of control. Whilst his violence resulted in some distress he also found it gratifying. He said he had taken an overdose of trifluoperazine and procyclidine earlier in 2000 and had been placed on a probation order for 12 months in March 2000 for possession of cannabis.

[1] The Beresford Project is a specialist service for drug and alcohol users with complex needs. This service is not part of the trust.

5.16 K saw Z again on 29 June 2000, but he failed to attend on 11 July 2000. On 18 July 2000 he arrived late and said he did not want to attend but the court had insisted. He reported feeling angry and depressed and said that he had recently hit someone.

Comment

It is of note that Z arranged to see K quite quickly. The records show that when K was referred to the Bracton Centre for advice or treatment by a range of professionals this was responded to at most times with commendable speed.

5.17 K was re-referred to the Bracton Centre by probation services and seen by Z, in July 2000. Z wrote to probation explaining that K had been seen on three occasions but he did not regularly attend. Z described K as someone who had a disregard for the violation of the rights of others and dealt with his negative affect through cannabis and violence. He described K as having a borderline and antisocial personality disorder. He carried out a number of psychological assessments and, based on an assessment of his risk of violence, would have 55 per cent chance of re-offending violently within seven years.

5.18 Z referred K for a forensic opinion in July 2000 with regards to his medication. At that time K expressed a wish for psychological treatment and further appointments were arranged. He had further appointments with Z on 22 August and 7 September 2000.

Comment

The risk assessment by Z was an accurate prediction of future events. K told us that he found the work done by Z with him as very helpful.

5.19 K saw the specialist registrar in forensic psychiatry at the Bracton Centre on 18 September 2000. The specialist registrar advised K about the link between his alcohol misuse and violence. He also wrote to K's GP noting the diagnosis of a borderline personality disorder with frequent feelings of rage and anger. He suggested that he may benefit from a low dose of antipsychotic medication and suggested to his GP that he should be started on olanzapine[1] 5mg daily to reduce his levels of arousal and that he should continue to see Z. He also told his GP that K had informed him that he was attending the Beresford Project for his substance misuse.

Comment

We have seen no record that K attended the Beresford Project.

5.20 The following day K attended the Accident and Emergency Department at Greenwich District Hospital having been assaulted with a pool cue. He had consumed alcohol and was agitated and threatened to harm himself and others. He was referred to the duty psychiatrist and said he felt like *"a walking time bomb"*. He said he felt he needed medication. The duty psychiatrist spoke to his mother who said he was getting worse and may need admission for his own and others' safety. The duty psychiatrist diagnosed a borderline personality disorder and allowed him home and planned to liaise with the Bracton Centre.

5.21 K was referred to the First Step Trust[2]. K did not attend, but First Step advised Z, clinical psychologist, in a letter dated 20 October 2000 that they would be happy to see him if he decided to go.

5.22 K had three further appointments with Z on 5 and 20 October 2000 and 10 November 2000, all of which he attended although he appeared intoxicated at his appointment on 20 October.

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[1] Olanzapine is used for schizophrenia and moderate to severe episodes of mania in bipolar disorder (manic depression).

[2] The First Step Trust is a charity that provides work, training and employment opportunities for people excluded from ordinary working life because of mental health problems or other disabilities or disadvantages.

5.23 K was again referred to the Bracton Centre by probation for a court report after pleading guilty for common assault in 2001. W, a clinical psychologist, carried out a psychological assessment. In her report dated 22 January 2001, she recommended that the court might want to consider a custodial sentence given the seriousness of the offence, but if not, a probation order with a condition to reside in a hostel specialising in personality disordered offenders. W suggested that such a placement would provide on-going monitoring of K's alcohol and substance use and thus reduce his risk of offending. She also advised that K had agreed to such a placement if it were ordered.

5.24 Along with the recommendation to stay at a probation hostel she advised that K did not return to live with his mother or stay in the same neighbourhood due to her influence on his behaviour.

Comment

The report by W was prepared in 2001. We have not therefore examined any further the relationship between K and his mother at that time as it has no direct bearing on the events of 2007/2008

5.25 It appears that the court ignored W's advice and K was given a 12-month community rehabilitation order.

5.26 K failed to attend an appointment with Z on 22 January 2001. K had no further appointments with Z and was effectively discharged from the service.

5.27 The trust provided us with a document, *Forensic psychological therapies service (community) DNA and cancellation policy*. The document is undated and we are therefore unsure if it applied at this time. The document says that if clients do not attend appointments they effectively remain on the case load of the service and if they reoffend this places the service at risk. Therefore the guidance in the documents states:

> *"It is always preferable to close a case in the absence of engagement, and encourage the client to be re-referred (or to self refer) at a point in the future when they feel able to engage."*

In the light of this guidance and general good practice closure should always be a positive act and not happen by default.

Comment

At this time there were no other teams engaged with K and he was being seen by the specialist staff at the Bracton Centre having been referred by the probation service. He was not on CPA and therefore not subject to the requirement for a review to be held before discharge. Despite this good practice should have ensured that K's discharge from the Bracton Centre was carried out more positively. At a minimum the discharge process should have included letters to referrers explaining why discharge was taking place and what action should take place if a new referral was needed.

Up to this point K had been referred to mental health services by his GP, probation services and a CPN from prison. In response to these referrals he was seen by the following professionals for either assessment or treatment:

- ***two clinical psychologists***
- ***SHO to consultant psychiatrist***
- ***specialist forensic registrar***

He was also referred to the First Step Trust for potential work training.

Our review of records shows that there was good communication between the various professionals and efforts made to ensure that K's care was coordinated.

The chronology also shows that K was quite erratic in his compliance with appointments which made it difficult for those working with him to help him address some of the psychological and personality issues that caused him to behave in the ways he did.

5.28 K was referred to the CASSIUS[1] Project at the Bracton Centre by the probation service on 26 November 2001; he did not complete the screening questionnaire so his file was closed. At the time he was subject to a community rehabilitation order for 12 months imposed on 22 February 2001 for an offence of common assault. He also told his probation officer that he had stopped taking his olanzapine six months earlier.

5.29 A contact form was completed with adult mental health services in Erith on 27 September 2002. This appears to have originated from a referral from the probation service due to concern about his substance misuse in the context of the recent death of his grandparents. Further attempts to contact him by telephone in October 2002 were unsuccessful and no further action was taken.

Comment

We have not examined why the service was not able to contact K. This was almost ten years ago and had little bearing on events that occurred in late 2007 and just prior to the homicide.

The last face to face contact with K in this period by a member of the mental health services was with W, clinical psychologist, when she assessed him for a court appearance in January 2001.

[1] The CASSIUS project was a community-based anger management project for violent men. It is no longer operational.

5.30 There was then a long gap before K was seen again after a referral by his GP in October 2004 (see below). In this period (three years and 10 months) his forensic record shows one offence for common assault in 2004. We therefore surmise that this was a relatively quiet and settled period for K.

5.31 K was referred by his GP to the Bexley CMHT on 6 October 2004 and he was assessed on 14 October 2004 by U, CPN, who became his care coordinator. At the time of the assessment he had an injury to his left hand caused by hitting either objects or people. Following the assessment U, who was worried about the risk that he posed, referred him back to the Bracton Centre.

5.32 K was offered an appointment with V, forensic counsellor, for 18 February 2005. K attended only three of the six appointments made for him.

Comment

This was one of the longest waits for K to be seen by a professional, recorded in the clinical notes, but in terms of counselling waiting times it is not excessive.

5.33 Whilst waiting for his counselling appointment he saw U, CPN on 16 November 2004 and 21 January 2005 and on the latter occasion spoke about feeling upset that his girlfriend had terminated her pregnancy against his wishes. We are uncertain when this occurred.

5.34 On 12 February 2005 he attended an accident and emergency department on two occasions in a violent and agitated state. When informed that the police had been called he left the accident and emergency department and went directly to the Woodlands Unit at Queen Mary's Hospital, Sidcup.

5.35 When assessed at Woodlands he complained of reduced appetite, poor sleep and agitation with thoughts of harming himself and others, including cutting people's throats. He was angry that his girlfriend had had a termination of pregnancy. On admission he was hostile and threatening; urine drug screening was positive for cannabis and cocaine and breathalyser testing indicated an alcohol level of 0.62, eight times over the legal driving limit.

5.36 He reported that he had been taking olanzapine 10mg daily, but had not taken any for five days and that he was in contact with the CMHT in Bexley. After being admitted on an informal basis he appeared more settled the following day and discharged himself. The discharge summary by the SHO noted that he had an appointment at the Bracton Centre on 18 February 2005 and a court hearing on 25 February 2005 regarding an assault.

5.37 The discharge summary sent to his GP assessed him on discharge in the following manner:

> *"On discharge he was found to be cooperative and a good eye contact was established with normal speech and euthymic mood with no suicidal/homicidal ideations. He was cognitively intact and had well preserved insight."*
>
> *"There was a low risk of self harm, neglect or harm to others which increases on drug abuse (alcohol, cocaine, cannabis) but he mentioned a desire to cut down on drug abuse."*

5.38 The discharge summary demonstrates that the inpatient team was not aware of the full extent of K's forensic history. There is no mention in the discharge summary of whether K had been placed under CPA.

Comment

K told us that he was devastated by his girlfriend's termination and that this caused him to self harm. His self referral to accident and emergency department and then to the Woodlands Unit shows that he was aware of the danger of his anger. The staff at Woodlands could have considered a Mental Health Act assessment for a compulsory admission under section, but as he had voluntarily agreed to admission this was not

necessary. His discharge two days later could have been stopped and he could have been detained if the staff felt he was still ill and a continuing danger to himself or others, but as seen in the discharge summary this was not the case.

5.39 K moved into a new flat in April 2005, which had been found for him by Safelet[1].

5.40 Over the course of 2005 he attended three out of six appointments with V, forensic counsellor, in relation to managing his anger. On 15 April 2005 V wrote to the Homeless and Advisory Department in Bexleyheath providing information to help with his housing needs. On 10 May 2005 V received a letter from K's solicitors asking for details of his condition and treatment in relation to an offence of assault.

5.41 K saw U, CPN on 9 May and 12 May 2005. U wrote to V expressing his concerns about K's mental state, as he had reported that the police were watching his flat and had installed microphones. He requested a psychiatric assessment by a consultant at the Bracton Centre.

5.42 V wrote to K's solicitors on 13 May 2005 suggesting that he could either receive help in prison or could be referred to the Douglas House Project, a specialist hostel for individuals with personality disorder. On 27 July 2005 K's solicitors wrote to V again requesting information about his condition and treatment in relation to two charges of criminal damage. V replied to the solicitors stating that K had attended three out of six of his appointments and did not appear motivated to engage with therapy. V also wrote to U, CPN stating that K missed his last two appointments. He was discharged from the services at the Bracton Centre by V in August 2005.

Comment

As stated previously our review has shown that K would participate in treatment/therapy when he was in crisis or required to do so by the courts. If not required to attend or when he perceived the crisis to be over he would disengage.

[1] Safelet is an organisation that provides single homeless people with advice and support to help them find a safe place to live.

5.43 K saw U, on 17 June 2005 and reported that he had damaged his flat and cut his right arm with a knife the previous evening and had needed sutures.

5.44 He was seen in outpatients on 28 June 2005 by T, consultant psychiatrist with the Bexley CMHT. He informed T that he was being harassed by the police and that he was due to appear in court on 8 August 2005 in relation to a charge of criminal damage. T diagnosed an antisocial personality disorder and believed that he had been helped by his medication (olanzapine), which he had been taking for some time. In his letter to his GP, T stated that he clearly posed a danger to others, particularly in the context of use of alcohol. In view of his involvement with a number of agencies, including the probation service and the Prolific Offenders Unit, he was placed on enhanced CPA and a review meeting was organised.

5.45 K saw T again on 5 August 2005 by which time his court case had been dismissed and he was not facing any legal proceedings. He reported that he was doing well, but had difficulty attending appointments as he could not afford the fares for public transport. T wrote to his GP advising that K was doing well and was back with his girlfriend and had some access to his son.

Comment

K's non-attendance at meetings has already been mentioned and had a number of causes. One of those identified a number of times in the papers we have reviewed was his difficulty in affording the fares to attend appointments. K also raised this with us in interview. We have seen no evidence that this matter was addressed at any point. It may be that practical help in this regard, or arrangements to see him at more local venues would have helped him engage more fully with specialist services.

5.46 K continued to be seen by the CPN from the Bexley CMHT throughout 2005.

5.47 A review meeting was held on 4 November 2005 with T, consultant psychiatrist, U, CPN, his probation officer and a detective constable from the Prolific Offenders Unit in Bexleyheath. The meeting noted that K was subject to a community rehabilitation order, which had been imposed on 16 June 2005 for 12 months following an offence of common assault, which had taken place in May 2004. As a result of the order he was required to attend the Prolific Offenders Programme run by the probation service and police in order to address issues relating to his housing, employment and substance misuse. He was subject to monitoring up to four times a week. Anger management was not included in the order as the court had been informed that he was seeing V, forensic counsellor at the Bracton Centre.

5.48 The meeting discussed his use of alcohol and cannabis, his difficulties with housing and his involvement in violence, both as a victim and perpetrator, including his involvement in bare knuckle fighting. The notes of the meeting states that he continues on standard CPA. The meeting noted that he may move to Maidstone with his mother.

Comment

The record shows* "standard CPA"** ***but this was obviously a mistake as K had previously been placed on enhanced CPA.

It is also of note that at this meeting there were representatives from the police and probation. This was a CPA meeting not a MAPPA meeting but clearly served the purpose of bringing together the key agencies working with K to assist in coordinating his care and to reduce his risk to himself others and his risk of re-offending. This shows that the key professionals were alert to the need to coordinate their approaches towards K.

5.49 K remained in contact with U and during 2006 it appears that he moved in with his girlfriend, was no longer abusing illegal drugs and was only using olanzapine occasionally. In view of his progress, which was corroborated by his probation officer, he was discharged from the service by T on 5 May 2006.

5.50 There then follows a gap of just over a year before K is seen again, which seems to accord with the assessment that he was more settled when he was discharged in May 2006.

Contact with K in the six months before the homicide

5.51 K's GP referred him to the Bexley CMHT on 1 August 2007. This was the first contact with the Oxleas services since K was discharged in May 2006, other than a telephone call in April 2007 between his GP's receptionist and the team seeking confirmation of his medication prescribed previously by T, consultant psychiatrist.

5.52 K had visited the surgery requesting medication. He told the GP that he had stress and anger problems and had ten fights with his neighbours in the last month. The GP was willing to prescribe medication but wanted information regarding his past treatment before doing so. K reported to the GP that he only wanted to see T or U his CPN. Information was faxed to the GP and his CPN offered to speak to the GP.

5.53 K's mother contacted the CMHT social worker on 3 August and expressed concerns about her son. She said she had not been in contact with K for about a month and then received a telephone call saying that he needed help. He had been staying with his mother for the last two weeks. She said his mental health had deteriorated and he had lost some weight. She confirmed that he had been quite aggressive and anything could set him off. She stated that he had been hearing voices telling him to kill people. She believed he may still be taking some illegal drugs. He had been staying with his girlfriend. His mother agreed to ask K to contact the CMHT duty team.

5.54 K telephoned the CMHT on 3 August 2007, and spoke to the social worker.
He said he had been bad for a while and that he had smashed somebody's face approx two months ago due to his paranoia. He reported that he had not slept for a couple of months and felt that he needed some medication to help him sleep. He agreed to attend the fast track clinic on the 8 August 2007. His mother was also informed of this appointment.

5.55 He was assessed by U, CPN on 8 August in the fast track clinic. During his assessment U discussed K with T, consultant psychiatrist who prescribed risperidone as K had said he did not wish to take olanzapine. K was offered an appointment in the clinic in the following week.

5.56 K was seen by T on 14 August 2007. Following this meeting T referred K to the Bracton Centre. In his referral letter he set out a full picture of the meeting he had just had with K. He stated that K relayed again the aggressive episodes that had occurred recently. He also described being *"completely depressed all the time"*. He said he had difficulty sleeping (although this is mainly because he forces himself to stay awake for fear of being attacked in his home). He denied ever carrying a weapon. He admitted to smoking a couple of joints a day. He denied any other drug use and also denied that he had been drinking heavily.

5.57 T said that K was now willing to take olanzapine which he prescribed along with mirtazapine, an antidepressant. He also referred K to the Bracton Centre. He stated that *"I do think that, in his present aroused state,* [K] *does pose a significant risk to other people. I would therefore be grateful for your opinion and advice."*

5.58 On 21 August 2007 K did not attend a planned appointment with T, consultant psychiatrist. T contacted K's girlfriend who reported that he was sleeping better but apart from this there was no difference.

5.59 On 28 August 2007 K turned up without an appointment at the CMHT centre asking to see his CPN. He was advised to return the following day. On 29 August K was seen by U his former CPN/care coordinator. The electronic record contains the following:

> *"Met with* [K] *on the 29th of August, he presented feeling calmer and told me that he has started writing a book about his life.* [K] *feels that he and his girlfriend will have to move away from this area as two days ago a live bullet was put through his letter box at home.* [K] *has spent some time in the Midlands and this is where he would go. It appears that* [K] *has had little alcohol. I will see him again on the 4th September."*

Comment

The CPN that saw K on the 8 August and 29 August knew him well. In his interview with us K was complimentary about the relationship with the CPN. It is clear that at the beginning of August K was again unable to control his anger. He had previously been seen by V forensic counsellor at the Bracton Centre and a referral back to the centre was an appropriate response supported by restarting his medication and appointments with T and U who both knew him well.

5.60 K saw the CPN again on 4 September 2007. The record states:

> *"Met with* [K] *on the 4th of September, he presented much calmer and told me he was taking his medication regularly. Talked about his past life and how it affected him.* [K] *agreed to attend his appointment at the Bracton Centre."*

Comment

This was the last face-to-face meeting by a mental health professional with K before the homicide. K had now been taking prescribed medication since 8 August 2007. U, his CPN, had seen K on the 8 and 29 August and this latest meeting seems to show that K's acute crisis had lessened and he was willing to attend the Bracton Centre to see V, forensic counsellor.

5.61 K had an appointment to see T, consultant psychiatrist, on 4 September 2007 but he did not attend. He also had an appointment with V, on 7 September, he did not attend this either.

5.62 Another entry by his CPN is dated 12 September 2007, and it appears from the record that K did not have a face-to-face meeting with his CPN but some contact had been made. The record states:

> *"*[K] *remains as before, he missed his appointment with V at the Bracton Centre as he lost the letter, I have asked V to send another appointment and I have written to* [K] *to this effect."*

5.63 K did not attend a further planned appointment with V at the Bracton Centre on 28 September 2007. A further appointment was made for 18 October 2007 but K did not attend. The CMHT sent a letter to K advising him to make contact. K's case was closed on 7 November 2007 as no response was received from him. A letter was written to K and his GP confirming this. This is the last contact that K had with services before the homicide.

Comment

K was out of contact with the service after being discharged in May 2006. He then reappeared following contact with his GP at the beginning of August 2007. Following this referral and up to 12 September K had:

- ***two telephone conversations with the CMHT social worker.***
- ***three face-to-face meetings with U, his CPN, and a further phone call contact.***
- ***an assessment from T, consultant psychiatrist, who had reviewed his medication, referred him to the Bracton Centre and, when he failed to attend an appointment spoke on the telephone with his girlfriend.***
- ***been offered appointments with V, forensic counsellor, following his referral to the Bracton Centre.***

5.64 After the 12 September 2007 K missed appointments with V, forensic counsellor and U, CPN. Follow up letters were sent but no response was received.

5.65 U on the 6 November made the following entry in the clinical records:

> *"No response to letter sent on the 19th October, recommend that file be closed to the CMHT. Letter to GP advising closure has been sent."*

5.66 S, team manager, made the next note in the records on the 7 November:

> *"Closure suggested. Notes reviewed. Closure agreed."*

Comment

It is clear from the clinical entries for the 6 and 7 November that before K's case was closed the decision to close was reviewed.

K's involvement with services at times of crisis and need followed by disengagement had been a pattern throughout his period of contact with the CMHT. The last face-to-face contact with K had been with U, CPN. At that meeting he is recorded as being much calmer and taking his medication regularly. The decision to close the case at this stage was based on the last assessment of his mental state and because his failure to attend appointments when a crisis had resolved was a familiar pattern with him. It was known that K had a good relationship with his community nurse, T, his consultant psychiatrist and his GP and past patterns of behaviour suggested that K would seek help when he felt he needed it as he had done in the past.

5.67 K told us that in November 2007 he had gone to the CMHT centre with his partner, without an appointment, because he was in a *"bad state"* and had been cutting himself. He told us that his partner spoke to T, consultant psychiatrist requesting admission for K and was told that this was not possible. K also told us that he met U, CPN and spoke to him briefly. K told us that following this his mother also phoned the CMHT requesting admission.

5.68 K told us that in December he and his partner took his partner's daughter to stay with family in Lincolnshire because of difficulties they were having with local drug dealers and other acquaintances. They then brought her back for Christmas.

Comment

There is no record of the visit to the CMHT in the clinical notes, or of a telephone call from K's mother. There is evidence that professionals from the CMHT were diligent in recording contacts with K even brief ones. We have not sought to verify when or if this visit to the CMHT was made and if made why there is no record. What is clear from K is that he was well enough to continue to make arrangements for his partner's daughter and that his difficulties were principally related to pressures with

acquaintances in the locality which would indicate that admission was unlikely to have been granted in these circumstances.

5.69 On 7 January 2008 K was arrested for the murder of a man in Erith.

5.70 Following the index offence he was referred back to the Bracton Centre and was assessed by R, consultant forensic psychiatrist, in HMP Belmarsh. R diagnosed a personality disorder with dissocial, emotionally unstable and paranoid features. Whilst noting his personality disorder and his history of substance misuse R did not recommend transfer to hospital for further assessment or treatment and suggested that he could be managed within the custodial system in relation to the risks to himself and others. R suggested that within the prison system he could be considered for the dangerous and severe personality disorder (DSPD) service or a therapeutic prison.

Overall conclusions from K's chronology

5.71 The trust was able to provide some consistency and a focal point for K's interactions with services, particularly at times of crisis. The work of U, CPN and his care coordinator, and the CMHT in Bexley was particularly important and helpful.

5.72 The trust attempted to support K in the community and to give him opportunities to engage with therapy, such as anger management. The services offered advice, support and medication, but were not able to engage K in any sustained relevant therapy, or effect any change in his behaviour. The services could have taken a more assertive approach with a focus on establishing his engagement with therapy rather than taking a reactive approach consisting almost entirely of crisis management.

5.73 The trust staff acted appropriately to requests for information from different agencies, such as the probation service, police and housing, particularly with the arrangement of a professionals meeting involving different agencies in November 2005.

5.74 This professionals meeting held in November 2005 provides evidence of a multiagency approach but this was not a strong feature of the care offered. K had a long history of offending, multiple court appearances, a mental disorder and substance misuse.

This should have led to a more consistent coordination of care and a multiagency approach.

5.75 K had poor attendance at appointments, with a failure to engage with therapy and a tendency to use services at times of crisis, particularly when facing legal proceedings. Despite the diagnosis of an emotionally unstable and dissocial personality disorder there was a tendency for services to overly rely on letters to arrange appointments despite his itinerant lifestyle and to discharge him in response to his lack of engagement and poor attendance rather than institute a more assertive follow-up approach. His explanation that at times he could not afford to attend appointments appears not to have been acted upon.

5.76 Links with the forensic services could have been improved, prior to 2007 when despite the concerns about his risk he was only seen by a forensic psychiatrist on two occasions - in 2000 and after the index offence in 2008. In planning the approach to K's care there was also a lack of consideration of the possible role of admission or use of the Mental Health Act given the consensus about his diagnosis and risk.

Finding

F1 The services offered to K between 1998 and 2007 were appropriate to his mental health needs and were delivered at a standard that was reasonable at that time for patients with problems related to personality disorder, substance misuse and offending in the community. The trust offered a range of services in a timely manner but these were clearly of limited effectiveness.

6. Oxleas NHS Foundation Trust Board of Directors report

6.1 The trust carried out three investigations into the care of K:

- management report that set out a brief summary of the trust's involvement with K, provided a summary chronology, a list of those involved in K's care and the principal aims of treatment that was offered
- directorate-level investigation carried out and reported in March 2008
- board-level investigation.

6.2 The board-level investigation was informed by the previous investigations but was a completely new investigation.

6.3 The board-level investigation was conducted by:

- the director of psychological therapies (panel chair)
- the trust chair
- a trust consultant psychiatrist (not involved in K's care)
- an elected governor of the trust
- head of adverse incident management.

6.4 The panel interviewed five individuals, three of whom were directly involved in K's care, plus the head of forensic psychological services and the trust medical director.

6.5 The panel received feedback from a manager who had attended meetings with the police in relation to K.

6.6 The panel also interviewed K's mother, sister and fiancée.

6.7 The panel had access to all clinical information related to K including police records and correspondence.

6.8 The trust board investigation used root cause analysis methodology to review the care offered to K and took account of guidance from the National Patient Safety Agency.

6.9 The main body of the report is 25 pages. It includes a chronology. The report is short but comprehensive. The report identified the following care delivery problems in relation to K's care:

- *"There was a lack of availability of intensive specialist treatment services for patients with personality disorder.*
- *K became disengaged from services on a number of occasions.*
- *Extensive efforts to contact or provide information to the family did not take place.*
- *Alternatives to detention under the Mental Health Act were not available."*

6.10 For each of these care delivery problems the panel identified causes and recommendations. The report's recommendations were:

- *"The further development of trust-wide specialist services making treatment, clinical consultation and supervision available to all teams in the trust who work with patients with a diagnosis of personality disorder.*
- *Developing the role of multiagency public protection arrangements (MAPPA) for this client group.*
- *Providing families and carers of people with a diagnosis of personality disorder information, explanation, engagement and support.*
- *Producing a statement clarifying the use of the Mental Health Act in this area of mental health practice within the trust."*

6.11 We were provided with two versions of action plans dealing with the panel's recommendations. They both deal with three of the four recommendations. The recommendation related to guidance on the Mental Health Act as it applies to individuals with personality disorders is not dealt with in either plan. We comment on the use of the Mental Health Act for individuals like K in a later section.

Comment

If a trust panel investigation makes a recommendation then the trust board should ensure that the subsequent action plan shows how it will be dealt with. This may simply mean that no further action will take place but recommendations should not be lost.

6.12 The first action plan shows the interim steps that the trust took and completed in 2008. This action plan deals with:

- regular reviews
- family involvement
- updating of forensic histories
- review of local MAPPA processes
- MAPPA training for team managers.

6.13 The second action plan shows the recommendation as being completed in 2009. We met with a number of clinicians and managers to assess the continuing progress with the recommendations and we comment on this later in the report.

6.14 The trust panel made the following overall conclusion to its investigation:

> *"The panel considered all available evidence relating to this incident and concluded that, whilst there were aspects of service provision from which lessons can be learnt and recommendations made to improve services, the fatal stabbing of Q could not have been predicted or prevented by Oxleas mental health services. The teams involved with the case employed notable practice by assigning experienced staff on a consistent basis who responded rapidly when K made contact, made comprehensive risk assessments and liaised well with each other and external agencies."*

6.15 We concur with this overall assessment and the care delivery problems identified by the trust panel. In the following section of our report we will analyse the care given to K and identify key sections of the trust's report which relate to our analysis.

7. Analysis of care

7.1 Our review of K's care and the trust board-level investigation identified a number of care issues. We analyse these below. We also set out the changes that have occurred in service provision or professional practice that relates to the areas we have analysed.

Services for individuals with personality disorder

7.2 It is clear from our chronology that K presented the services with a significant challenge. His engagement when in crisis and then disengagement when he felt that he no longer needed help is typical of individuals with personality disorder. The trust's report stated:

> *"K presented with a complex set of problems including personality disorder and a history of offending behaviour going back to childhood. These difficulties were compounded by drug and alcohol abuse. He is amongst the group of patients who are the most difficult and challenging for mental health services to treat effectively."*

7.3 We agree with this analysis. During K's contact with services, attempts were made to engage him with psychological treatment as well as treatment and support from the local community teams. At the time there were no specific services for people with personality disorder within the trust. These services were still in their infancy in many parts of the country then and are still not widespread.

7.4 The head of forensic psychological services in interview with the trust panel stated that:

> *"K's reluctance to engage with the Bracton is typical of PD's* [People with personality disorder] *of his age. Generally young men in his situation are not interested in changing. They'll engage during a crisis and avoid the service once that's over. In time provided they are alive and not doing time, they mature and become ready for therapy at around 40 when the Bracton are able to offer intervention."*

This concurs with our interview with K who told us that he *"Didn't want to admit to a problem"*.

Current personality disorder service provision

7.5 In 2008 (after K was arrested) the trust was in the process of setting up a service for people with personality disorders at the William Morris Centre, part of the Bracton Centre. The service started in May 2008.

7.6 The service is part of the forensic psychological therapies service, but works in partnership with the trust's forensic directorate and general adult mental health services.

7.7 The aim of the service as set out in trust documentation is as follows:

> *"The service is designed for individuals – men or women - who have a diagnosis of personality disorder which is associated with anti-social behaviour and concerns about the risk posed to others as well as to self."*

7.8 The trust describes a number of different problems that would qualify someone to access this service and one of the criteria is:

> *"A tendency to act in an anti social manner – often aggressively – which results in problems for the person or those around them."*

This criteria is likely to apply to someone with similar problems to K.

7.9 The service is a day service operating on a three-day a week basis. Clients of the service are likely to need to attend for approximately a year. The day programme involves group work, individual sessions and communal activities, and the multidisciplinary team works closely with each client's care coordinator and care team.

7.10 If this service had been available prior to 2008 then it is likely K would have been referred to it. The service requires a commitment on the part of the individual to maintain engagement.

7.11 The head of forensic psychological services was asked by the trust panel if the new service was likely to have more success in engaging with K. Her response was:

> *"Yes, but would he have stayed? [She] explained that the new service has an outreach team which takes the burden off the CMHT and brings the clients in for treatment. There is lots of support with transport pick-up and telephone chase-up but whether K would have remained is open to debate."*

7.12 One of the reasons that K gave for his erratic attendance at the Bracton Centre for appointments with the forensic psychologist and forensic counsellor was the cost of transport. The new service has recognised that the location of the centre makes it difficult to reach by public transport, which combined with the frequent non-engagement by individuals with personality disorders, needs a more assertive outreach approach. This new approach may have assisted K.

Findings

F2 If K had been receiving services from the trust in 2008 and had been willing to engage with the trust's new personality disorder service it may have assisted him to overcome some of his anger responses.

F3 The trust's new personality disorder service assertive outreach to clients and the arrangements for transport pick-up and telephone chase-up is an important part of the service.

Team work

7.13 K received treatment and support from a wide range of trust staff. There is considerable evidence in the documentation that the different professionals within the trust communicated well and shared information about K's needs. What is not evident within the clinical records was regular meetings to ensure coordination of interventions, except when K was placed on enhanced CPA and a multiprofessional and multiagency meeting took place in November 2005.

7.14 The personality disorder steering group of the trust issued a document entitled *Ten core principles in managing individuals with a personality disorder: A guide for Oxleas staff*[1] in November 2008. The text of the document is attached at appendix C. It says:

> *"Clients may present predominantly at times of crisis, leading to reactive care provision. When this pattern becomes evident, it is important to develop a proactive crisis care plan which the client and his/her carers fully understand."*
>
> *"It is preferable for case management (or care planning responsibility) to be separated from responsibility for the delivery of therapy, although there must be good communication between professionals and agencies involved. Reflective practice in the form of multidisciplinary case formulation meetings are often invaluable with this client group."*

Findings

F4 The trust's ten core personality disorder service principles provide valuable guidance for all staff working with this group of clients.

F5 If the trust's ten core personality disorder principles had been available prior to 2007 and followed by professionals involved with K, he may have engaged more consistently with psychological treatment.

[1] Drawn up with reference to the NIMHE guidance (2002) on personality disorder, and to the NICE guidelines on the care of people with borderline and antisocial personality disorder

7.15 In December 2010 the trust issued a draft document entitled *Clinical guidance and care pathway for the management of patients with common personality disorder*. This 12 page document covers the following areas:

- key principles of treatment for all patients
- treating patients with personality disorder in the most appropriate location
- assessment including risk assessment
- care management including management of crisis
- rehabilitation and recovery teams
- guidance for other care pathways
- inpatient services.

Finding

F6 The trust's draft document *Clinical guidance and care pathway for the management of patients with common personality disorder* provides valuable advice on how services for this group of clients can be coordinated and effectively delivered.

MAPPA meetings

7.16 The trust panel report states that clinical staff considered a referral to the MAPPA panel but that this was rejected by clinical staff as clients in this group do not meet the threshold for consideration. The categories of individuals who could be included in MAPPA arrangements as at 2007 are set out at appendix D. The criteria would not exclude individuals with a diagnosis of personality disorder if their offences fall into the categories set out in the guidance, or they have been subject to detention with restrictions under provisions of the Mental Health Act.

7.17 K had a long forensic history which included some violence but his sentences were not of 12 months or more (other than possibly in 1996 when he received five years at a youth offenders institute but this was reduced on appeal and he was evidently back in the community in 1998). He also had not been the subject of detention under provisions of the Mental Health Act.

7.18 The head of forensic psychological services told the trust panel that:

> *"…staff can't just provide names of risky people that they think might be a bit worrying. When cases are presented to MAPPA staff have to be clear about what is expected of the panel. [She] noted that the case of K is like hundreds of others."*

Finding

F7 We conclude that the evaluation by clinical staff that K did not meet the 2007 criteria for MAPPA inclusion was correct.

7.19 One of the trust panel's recommendations was that the role of MAPPA panels should be reviewed in collaboration with other relevant agencies. The report says:

> *"MAPPA panels need re-examination of their function and a 'sub-MAPPA' group should be established to allow patients who do not meet the MAPPA threshold to be systematically identified, monitored and reviewed."*

7.20 The trust's investigation report's action plan shows that the trust carried out the following action in relation to MAPPA:

Action	***Action plan update***	***Timescale***
Liaise at senior level via existing meetings with police to agree role description	*There is a quarterly police liaison meeting with the three boroughs*	*June 2009*
Development of local risk panels	*Commanders with the trust being represented by the trust chair*	*April 2009*
Promote new MAPPA roles within Oxleas	*As above*	*As above*
Ensure a senior member of clinical staff is MAPPA coordinator for each borough.	*There is a MAPPA representative for each borough*	*May 2009*

7.21 We discussed this action plan with clinical and managerial staff and were told that there is a variation of provision of local risk panels in each borough. We were supplied with detailed information on this point in subsequent correspondence from the clinical director for forensic and prison services and head of psychological services who told us:

> *"In terms of the meetings, Bexley and Greenwich do not have 'sub-MAPPA' risk management meetings. They do however have MARAC (domestic violence) meetings which Oxleas attend. In Bromley, there is a risk panel system (sub MAPPA) which meets one for west and one for east of the borough for which there is a representative from general mental health services."*

7.22 The trust recommendation that there should be trust-wide risk panels (that operate at sub-MAPPA level) has not been fully implemented. The head of forensic psychological services stated that the *"…case of K is like hundreds of others."* It is therefore all the more pressing that a structure that allows careful consideration of risk and coordination of care for individuals with similar problems to K should be available across the trust.

Findings

F8 The trust has considerably improved staff understanding and contribution to the working of local MAPPA processes.

F9 The trust has not put in place local risk panels across the whole trust.

Recommendation

R1 The trust should review the arrangements for local risk panels across the trust and ensure that there is consistency across all boroughs and that the panels can provide effective support for clients with risk histories similar to those of K.

Psychological treatment

7.23 During K's contact with Oxleas NHS Foundation Trust he was referred to the psychological services at the Bracton Centre. He was first seen By Z, clinical psychologist, between 1998 and 2000 and assessed as having a borderline and antisocial personality disorder. K was referred for a forensic assessment by Z and as a result K was prescribed olanzapine. In interview with us K told us that he found these appointments helpful although he failed to attend a number of them.

7.24 K was then referred back to the Bracton Centre and was seen by V, forensic counsellor. Over the course of 2005 he attended three out of six appointments with V in relation to managing his anger. V had contact with the housing department to assist with K's housing needs and with his solicitor. K was discharged from the Bracton Centre in August 2005. He was referred again to V in 2007 but failed to attend any of the appointments.

7.25 Our review of the clinical notes shows that psychological services at the Bracton Centre made a considerable effort to assist K. The team at the Bracton Centre liaised regularly with other professionals within the trust and with other agencies such as probation, police, housing and solicitors.

7.26 The clinical notes are well written and, within the limitations of K's sporadic engagement, show that treatment offered to K was focused on helping him control his anger.

Finding

F10 The psychological services offered to K by the Bracton Centre were of a high standard.

Care Programme Approach (CPA)

7.27 The chronology shows that T, consultant psychiatrist, placed K on enhanced CPA in August 2005. As K was on enhanced CPA this should have triggered a CPA care planning meeting, with an invitation to K to attend. Following the CPA review there should also have been the completion of a CPA form and risk assessment. Our review of the documentation has not shown such a review or completed CPA form. As this investigation is taking place almost six and half years later and because a professionals meeting did take place (see below) we have not examined why a formal CPA meeting did not take place.

7.28 Though a CPA review did not take place U, K's CPN and care coordinator organised a multiprofessional and multiagency review meeting. The meeting 4 November 2005 was attended by:

- U, CPN (chair)
- T, consultant psychiatrist
- P, probation officer
- N, detective constable, prolific offenders unit
- M, minute taker

7.29 The minutes do not show K as attending or being invited. The minutes are comprehensive. They contain a review of K's forensic history, assessments and contacts with T and U, his diagnosis and treatment provided by the Bracton centre. The meeting set out the following action:

- K to continue to see T as an outpatient
- K to be seen by U over the next six months *"as and when"*
- standard CPA to remain (this is likely to be a mistake as he had been placed on enhanced CPA)
- meeting with housing officer as K had recently moved into new accommodation provided by the Shaw Trust
- meet again in six months, with invitation to K and his partner to attend.

7.30 The clinical records show K was seen regularly by U over the next six months.

7.31 A professionals meeting took place again on 5 May 2006. The probation officer was not present but was contacted by telephone. The report from the probation office in the clinical notes says:

> *"K had done extremely well. Seems to have stopped drug use, has not been in trouble and is likely to be discharged when period of probation ends. Working with Shaw Trust[1] and hopes to get work."*

7.32 K is reported in the clinical notes as stating that he had:

> *"Taken no medication past six months except for V occasional ½ tablet olanzapine when he feels wound up. Says he has sorted self out, knows he was violent, bad person* 'and doesn't want to go back'*."*

7.33 As a result of that meeting K was discharged from the service. U, completed a closing summary form on the 9 May 2006.

Finding

F11 The care programme approach assessments and reviews were complied with by the trust community mental health services.

Community Mental Health Team

7.34 K was principally cared for in the community by the Bexley CMHT. A review of the notes shows that a number of the team members were involved in supporting K between 2005 and 2007. The notes also show that there was regular and frequent liaison between the team members and good contact with the Bracton Centre, K's probation officer and the police. Therefore we are assured that care management of K at that time was at a standard that would generally be accepted as reasonable for patients with problems related to personality disorder, substance misuse and offending in the community.

[1] The Shaw Trust is a national charity which works with employers, social services and the disabled to help people with disabilities find employment.

Findings

F12 The Bexley CMHT worked together to ensure that the care offered to K was coordinated within the team and with other NHS professionals and external agencies.

F13 The consistent support offered by U, CPN was helpful to K and was of a high standard.

Risk assessment

7.35 The clinical records contain an Initial Contact Details form dated 27 September 2002. The form contains the following:

- contact details
- reason for referral and initial presenting needs
- perceived risk factors
- perceived risks to staff
- initial action/care plan to meet assessed needs.

These sections were appropriately completed.

7.36 The clinical records also contain a Full Assessment of Risk Form (Form AOR2) completed by U on 14 October 2004. This is a six page assessment form. All sections of the assessment were completed except section 13 *Risk Management Plan*. U stated in section 12, *Formulation*:

> *"The risk is extremely serious both to self and others. I feel the risk could be either specific or general. The risk could quite easily be immediate depending on mental state and social situation. This could be affected by alcohol and drug use."*

7.37 This risk assessment was completed after K had been re-referred to the service by his GP. In the light of the assessment U referred K back to the Bracton Centre to be seen by V, forensic counsellor.

7.38 Risk assessments were also carried out by professionals within the Bracton Centre and T, consultant psychiatrist. They are described in earlier sections of this report. The trust panel report states that:

> *"Comprehensive risk assessments were carried out by senior clinical members of the team and adhered to by staff involved in this case."*

Finding

F14 Our review supports the view of the trust's panel report that comprehensive risk assessments were carried out and adhered to by staff involved in K's care.

Links with forensic services

7.39 Links with the forensic services could have been improved as despite the concerns about his risk he was only seen by a forensic psychiatrist on two occasions - in 2000 and after the index offence in 2008.

7.40 The trust personality disorder services now available from the William Morris Centre is offered in partnership with the forensic directorate. Whilst psychological therapies may be the treatment of choice for this group of individuals, forensic services can provide support and expertise in risk assessment and risk management in particular to professionals within the CMHT.

Finding

F15 In the light of K's forensic history trust staff should have made more use of advice from the trust forensic service.

Use of the Mental Health Act 1983

7.41 We have seen no evidence that K was assessed under the Mental Health Act. Whilst the use of the Mental Health Act to secure admission of individuals with a personality disorder may be difficult, the records do not show whether it was ever considered as part of the care of K.

7.42 The trust panel interviewed the trust medical director on this point and his opinion was that in respect of the Mental Health Act 1983:

> *"…the service is unable to detain patients for an untreatable set of behaviours that are not medical. Should a section take place the appeal process would almost certainly overturn the decision and this would then damage any relationship the individual might have been able to have with the service, severing the link and support available.*
>
> *[The medical director] also warned that should the service take charge of an individual this can diminish the client's responsibility for themselves and raises the question of 'who is responsible for what they do'."*

7.43 He was also asked his opinion about the 2007 amended Mental Health Act[1] and *"…felt that this case would not reach the threshold criteria and the question of responsibility would still exist."*

7.44 The draft document, *Clinical guidance and care pathway for the management of patients with common personality disorder* makes the following statements in relation to admission:

> *"Treating chronic risk with admission to hospital is rarely beneficial and may result in unhelpful dependence. However, when there are severe acute exacerbations of risk, well-managed hospital admission can be beneficial and keep the patient safe."*

[1] The 2007 amended Mental Health Act removes the 'treatability test' for compulsory admission and replaces it with an 'appropriate treatment test', the new test applying to all long-term powers of detention.

7.45 In a section on inpatient services the document states:

> *"(i) Patients with Personality Disorder do not need routine admission to hospital and in general the benefits of admission need to be set against some serious drawbacks. Patients who display prominent suicidal agitation with unpredictable behaviour may need to be admitted to hospital until the crisis passes.*
>
> *(ii) A core function of admission is safety and support. A second function can be offering patients help in learning how to manage states of acute agitation.*
>
> *(iii) Managing dependency and the risks of admission. Admissions should be as brief as is consistent with the functions of the admission.*
>
> *(iv) Admissions should be informal, detaining patients using a section of the Mental Health Act should be considered only as a last resort.*
>
> *(v) Admission should be local.*
>
> *(vi) During the admission patients should be encouraged to take as much responsibility for their own safety as possible, but great care should be taken to ensure that this encouragement is not read as dismissal and abandonment by the patient."*

7.46 At this distance from events prior to 2007 we cannot say that K should have been compulsorily admitted. The records do show that there were times when he was in crisis when consideration could have been given to whether he should have been compulsorily admitted but there is no record that admission was considered.

Finding

F16 Although compulsory admission for clients with personality disorders should be a last resort, we support the trust guidance that at times of crisis this is an option that clinical teams should consider.

Dual diagnosis

7.47 Throughout K's contact with services he was regularly taking illicit drugs and consuming excessive alcohol. He told us in interview that he would take cocaine/cannabis/crack and alcohol. He also told us that he took heroin just before the index offence. K told us that he was not sufficiently motivated to engage with treatment for his drug and alcohol use.

7.48 The trust report states the following:

> *"The team involved in this case concluded that K's substance abuse problems were secondary to his more fundamental problems in the area of his personality disorder."*

Finding

F17 K's record of non-engagement except in times of crisis would make treatment for substance abuse problems unlikely to be successful.

Partnership working with K's family and partner

7.49 The trust interviewed K's mother, sister and fiancé. The records show that K's mother was in contact at various times with the CMHT when he was in crisis. The interview also identified that K's fiancé had attended some of his appointments with him. We also met with K's mother when we interviewed K in prison.

7.50 K's mother told us that she contacted the service in 2007 when he was in crisis and wanted him admitted to hospital. The events of 2007 are dealt with in the chronology earlier in this report.

7.51 The trust report states that:

> *"K expressed inconsistent wishes concerning the contacting of, and sharing information with, his family."*

7.52 The report makes the following recommendation:

> *"Provide families and carers of people with a diagnosis of personality disorder information, explanation, engagement and support."*

7.53 The trust's action plan identifies two actions to meet this recommendation:

- *"PD Steering Group to develop guidance for clinicians, patients and families.*
- *Incorporate into work of family inclusive practice initiative."*

7.54 We have reviewed two documents related to services for individuals with personality disorder:

- *Clinical Guidance and Care Pathway for the Management of Patients with Common Personality Disorder*
- *Ten core principles in managing individuals with a personality disorder: a guide for Oxleas staff*

Neither of these documents deals with partnership working with families.

Finding

F18 Despite the trust panel's recommendations, the current guidance to staff on personality disorder services does not include advice on working with families.

Recommendation

R2 The trust should include within its guidance on services for people with personality disorder how partnership working with families should be carried out.

Appendix A

Documents reviewed

Clinical records and information which included:

1. RIO progress notes for K and other RIO documentation
2. Various correspondence and reports
3. CMHT notes

Other documents:

4. Incident form, 6 January 2008, Oxleas NHS Foundation Trust
5. Level 4/5 Adverse Incident Management Report, Oxleas NHS Foundation Trust
6. Board of director's report on the inquiry into the alleged homicide committed by K, Oxleas NHS Foundation Trust
7. Trust-wide action plan – K inquiry
8. Terms of reference - level 5 inquiry
9. Minutes from inquiry panel meetings, including staff interviews
10. Bracton psychology information, the Bracton centre, psychology department, Oxleas NHS Foundation Trust
11. Transcript of interview with K, Greenwich police report
12. Solicitor letters
13. Correspondence relating to offence by K before Crown court at Southwark
14. Forensic psychological therapies service (community) – DNA and cancellation policy
15. Clinical guideline and care pathway for the management of patients with common personality disorder
16. Bexley psychotherapy service – K inquiry
17. Greenwich psychotherapy service leaflet
18. Ten core principles in managing individuals with personality disorder: A guide for Oxleas staff
19. Cluster 8 care pathway in Oxleas NHS Foundation Trust

Appendix B

Dissocial (antisocial) personality disorder

Personality disorder, usually coming to attention because of a gross disparity between behaviour and the prevailing social norms, and characterized by at least 3 of the following:

20. callous unconcern for the feelings of others;
21. gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations;
22. incapacity to maintain enduring relationships, though having no difficulty in establishing them;
23. very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
24. incapacity to experience guilt and to profit from experience, particularly punishment;
25. marked proneness to blame others, or to offer plausible rationalizations, for the behaviour that has brought the patient into conflict with society.

World Health Organisation definition according to IC-10

Appendix C

Ten core principles in managing individuals with a personality disorder: a guide for Oxleas staff

1. Individuals living in Bexley Bromley & Greenwich with a primary diagnosis of personality disorder should have the ***same access*** to Oxleas mental health services as all other individuals within the catchment area.

2. Individuals with personality disorder have core difficulties with ***attachment and relationships***; this has an impact on their social circumstances and their potential relationship with professionals and services.

3. Their needs are best understood within a ***formulation based approach*** which integrates presenting problems and interpersonal difficulties within the context of their life history and social environment.

4. Priority needs to be given to building a consistent collaborative relationship with the client. Disturbance tends to be heightened by rigid, authoritarian or invalidating responses. Supervision and good team working is crucial in this regard.

5 Whilst recognising the high levels of ***distress*** which individuals with a personality disorder can experience, empathic concern for the individual is different from taking ***responsibility*** for all aspects of the individual client's behaviour and life choices.

Mental health services need to consider three broad areas:

6 ***Dual diagnosis*** is a common presentation in individuals with a personality disorder, and mental illness should be considered as with any other client (although mental health problems may be masked by complex behaviours and/or by changes over time). It is important to carry out a careful assessment and to review this assessment over time.

7 Clients may present predominantly at times of ***crisis***, leading to reactive care provision. When this pattern becomes evident, it is important to develop a proactive crisis care plan which the client and his/her carers fully understand.

8 There is growing evidence for the potential benefits of some ***psychological therapies*** for individuals with a personality disorder, although engagement with therapy may be difficult to establish. Such approaches can cause harm if provided by inexperienced or ill-informed practitioners; however, there is therapeutic experience and expertise within Oxleas which can be accessed.

9 It is preferable for ***case management*** (or care planning responsibility) to be separated from responsibility for the delivery of therapy, although there must be good communication between professionals and agencies involved. Reflective practice in the form of multidisciplinary case formulation meetings are often invaluable with this client group.

10 There is good evidence to suggest that individuals with a personality disorder and their carers respond positively to a ***psycho-educational approach***, in which they are empowered to understand the diagnosis, the risks to themselves and others, and the way in which they can access Oxleas' services.

Oxleas PD steering group, November 2008

Appendix D

Definitions from MAPPA guidance 2007, produced by the National MAPPA Team, National Offender Management Service, Public Protection Unit

Category 1 offenders (registered sexual offenders).

Category 2 offenders (violent offenders sentenced to 12 months custody or more and other sexual offenders and those subject to hospital orders with restrictions).

Category 3 offenders (other dangerous offenders). This could be offenders who have been previously managed at MAPPA level 2 or 3 under Category 1 or 2 and still pose a risk of harm or other persons who, by reason of offences committed by them (wherever committed), are considered by the RA [responsible authority]to be persons who may cause serious harm to the public.

Appendix E

Team biographies

Tariq Hussain

Tariq Hussain is a former nurse director who brings to Verita his considerable experience of leading change management in the fields of learning disability and mental health services. Tariq has undertaken a wide range of projects for Verita which have included mental health homicide investigations and an investigation into sexual abuse by an eating disorder clinic manager. In September 2010 he completed a three year term of appointment as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

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

Dr Andrew Payne

Andrew Payne is a consultant forensic psychiatrist with West London Mental Health NHS Trust at Broadmoor Hospital. He has been a consultant at the hospital for 16 years and has been a clinical director at the hospital and deputy medical director for information governance within the trust. For many years he was the consultant on the male admission ward for the hospital and has extensive experience in the assessment of mentally disordered offenders.

Rosie Mundt-Leach

Rosie Mundt-Leach is the head of nursing for the addictions clinical academic group of the South London and Maudsley NHS Foundation Trust. In this capacity her responsibilities include assisting the group with child and adult safeguarding, mandatory training and professional development for nurses, complaints and serious incidents.

She has carried out a number of internal investigations into serious incidents for the addictions group and oversees all clinical incidents that are reported. She has worked as a mental health nurse since 1994 and has specialised in the community treatment of substance misuse since 2000. Her particular focus for several years has been on improving physical healthcare for drug users and on improving substance misuse nurses' access to training in physical health provision. She has completed her training as a nurse prescriber.