1. Acknowledgements

We acknowledge the help that Mr H and his mother gave us at a time of great distress to them. The open and frank discussions that they had with the inquiry panel were of great help in their investigations.

We also wish to thank the professionals involved in Mr H's care and treatment and the way in which they cooperated with us with a candour and commitment which was commendable

Despite the reorganisation of the two local NHS Trusts there was a commitment to provide the inquiry with the necessary information and ensure that we had access to the relevant documentation. This applied equally to those other agencies approached for help.

2 Executive Summary

Mr H killed Mr G in August 2003. They had known each other for several years.

Mr H pleaded guilty to Manslaughter on grounds of diminished responsibility and was sentenced in April 2004 to five years imprisonment

As Mr H was known to the mental health services provided by the (then) East Sussex County Healthcare NHS Trust an internal review was set up to examine the care and treatment received by Mr H. That review reported in May 2004.

This independent mental health inquiry was formally set up in May 2005 by the Surrey and Sussex Strategic Health Authority as required by the Health Service Guidance, HSG (94)27 and addendum 2005. The guidance states that *"in cases of homicide committed by persons in receipt of mental health services, it will always be necessary to hold an inquiry which is independent of the providers involved."*

Chronology

Mr H was born in Durham in 1980, one of 5, two younger brothers and two older sisters. In 1985 his parents separated. Mr H was described as being very demanding and difficult as a child.

In 1993/4 Mr H moved with his family to Hastings.

Mr H began drinking when he was about 15 years old with the amount increasing when at 17, he was drinking most days. It was during this time that he met Mr G and became friendly with him.

In August 1997 Mr H was charged with a street robbery of a foreign student whom he threatened with a knife; he was subsequently sentenced in November 1997 to 18 months imprisonment in a Youth Offenders Institution (YOI).

In September 1997 Mr H's GP referred him to a Consultant Paediatrician for consideration of the possibility that his behaviour might be *"explainable as part of an Attention Deficit Disorder"*. The paediatrician made a diagnosis of Attention Deficit Hyperactive Disorder (ADHD) and prescribed Ritalin.

During 1998 he lived mainly at home although this could be tense because he was not working for most of the time and drinking heavily, eventually he was asked to leave the family home. He stayed with Mr G intermittently where they drank heavily together, occasionally with other young men including Mr H's younger brother.

In the latter part of 1999 there were separate incidents which involved the police and the following contacts were made with the local mental health services.

November - GP referred Mr H for treatment of depression and heavy drinking. An outpatient appointment letter was sent to Mr H for early December.

3rd December, - second GP referred Mr H to the Crisis Response Service (CRS) as he had been expressing suicidal thoughts and experiencing depression and panic attacks. An assessment visit was made that same evening by the CRS but they were unable to assess Mr H as he was *"significantly intoxicated".*

4th December - he was assessed by the CRS and accepted onto their caseload.

9th December - Mr H was admitted to Queen Charlotte's Hospital, diagnosed as having a mental and behavioural disorder due to use of alcohol and cannabinoids.

The intention was to discharge Mr H on the 22nd and that he would be helped to find accommodation through the Homeless Persons' Unit. However in the event he left the ward on the 21st December and was discharged on the 22nd.

In June 2000 the GP wrote to the catchment area Consultant Psychiatrist asking for Mr H to be seen because Mr H's mother had asked the GP to recommence him on Ritalin due to her continuing concern and her son's continuing behavioural difficulties.

The Consultant Psychiatrist saw Mr H and diagnosed *"a generalised anxiety disorder with continued use of alcohol and cannabis (but in lesser quantities)".*

Mr H did not attend follow up appointments offered in October and November 2000 nor February, June and November 2001. It was decided not to offer him any further appointments.

However in June 2001, Mr H was arrested for being drunk and disorderly and the following day (27th June) caused a disturbance at Mr

G's flat when he threatened to kill him. The police attended but no further action was taken as Mr G did not wish to press charges.

From the information provided to the Inquiry Panel it would seem that at this time Mr H turned up at his mother's home in a very distressed state but was not prepared to tell her the cause of his distress. She then saw that his underpants were bloodied when Mr H left his washing while showering. When she raised her concern about the cause of the bloodied underpants with her son, Mr H vigorously denied that anything had happened.

On 26th October 2002 Mr H was informally admitted to the Eastbourne Clinic following an overdose of a mixture of prescription drugs and alcohol. The suicide attempt took place in his mother's home to whom he had left a suicide note. His mother found him and called the emergency service.

On 31st July 2003 Mr H told his mother he had been sexually assaulted by Mr G since he was 17 years. Mother persuaded him to go to the police station with her, they waited for an appropriately trained police officer to become available for about 3 hours but they were unable to speak to an officer and eventually left. A police officer, not specially trained, subsequently followed up with a visit to Mr H's mother's home the same evening. But as no one was home, a note was put through the door and no further action was taken by the police or by Mr H or his mother.

On the evening of the 17th August 2003 Mr H phoned the police to report that he had killed Mr G. He was arrested and charged with murder.

Findings and Recommendations

Predictability and possibility of preventing this offence

The pattern of engagement with services throughout his involvement with them was that Mr H was unlikely to follow-up appointments and specific service interventions. When he was on a Probation Combination Order there appears to have been better contact and it may be that the element of coercion through the court was instrumental in his better engagement. Throughout, it is clear that he was not regarded as having a major mental health condition and that the primary concern related to his alcohol misuse, and the short term effect of that on his mental state. He was not subject to any sections of the Mental Health Act, other than the Section 136 by the Police at a

specific time, and from our consideration of the circumstances of this case this is entirely acceptable.

The formal Risk Assessment that was carried out, and the other observations about his state and the risks he might pose are consistent in noting the potential risk of possible self harm when in a depressed state.

Although there were threats and actions against Mr G at what appear to have been stress points in their relationship, there was no reason to interpret these as sufficient to predict that Mr H carried the potential to kill Mr G as in fact happened. In the view of the Inquiry Panel the killing of Mr G was neither preventable nor predictable

The unknown aspect is what might have happened if Mr H and his mother had discussed with police the alleged sexual assault in July 2003. But it is not possible to know what the outcome of this might have been or if it might have caused a difference.

It is also worth noting that there have been significant difficulties in diagnosing Mr H's mental state subsequent to the offence, and he is now diagnosed as suffering from a schizophrenic illness.

Engagement of Mr H with and between Agencies

Mr H is not an untypical case in terms of his dependence on alcohol and on the misuse of other substances. It would seem that his mental state was heavily influenced by excessive consumption of alcohol and illegal drugs over time, and that at times this, coupled probably with the stress generated within the relationship with Mr G, would trigger the distress and behaviour that lead to referrals for psychiatric support from his GP and the admissions to hospital.

The difficulty for services within the local area, and more nationally, is that there are significant numbers of people like Mr H who will tend to disengage from services if they feel themselves to be under pressure and/or are faced with options that require changes to their life style that they do not want to make or are unable to make. As we have indicated the involvement with the Probation Service under a Combination Order did generate better compliance and engagement of Mr H. It enabled the probation officer to recognise changes in Mr H's mental state. However because there was no formal or informal contact between Mr H and probation at this time intelligence was lost.

Recommendation One

That where a person currently in receipt of mental health services has involvement from other statutory agencies the mental health services should take a proactive role in establishing contact with those agencies to facilitate appropriate sharing of information.

Mr H did not figure high on the radar of any of the agencies involved, he was generally well liked and personable in his relationships with those professionals who worked with him. Apart from being detained under Section 136 by the police, he was never sectioned under the Mental Health Act, and his treatment as an Informal patient appears to have been appropriate.

It is not difficult to understand the situation faced by mental health services when he chose to discharge himself from hospital and indeed although the services contributed to his failures to attend follow up appointments by their mistakes in respect of his address and contact details, it does not seem material to the outcome of this situation, that there were repeated errors in contacting him. We were pleased to note that the Trust has introduced a policy on Managing DNA or Cancelled Appointments in October 2005.

Recommendation Two

It is recommended that the Trust audit the operation and effectiveness of the policy on Managing DNA or Cancelled Appointments implemented in the Autumn 2005. This is to ensure that there is an effective follow up of people who do not attend for appointments.

The GP's consistent involvement with clear referrals to mental health services is a positive contribution in this case. But even with a practice well attuned to mental health conditions and supports, without the willing cooperation of Mr H and a much smoother pick up of work by the mental health services, other than in December 1999 when the services worked well and crisply in engaging with Mr H, sustaining purposeful intervention is very difficult to achieve.

In this particular case information exchange between services does not seem to have been a major impediment. However the opportunity to examine this case in detail has demonstrated inadequacies in the exchange and sharing of information at the right time between agencies.

Recommendation Three

It is recommended that the Trust puts into place more robust systems for acquiring and coordinating available information:-

- **An explicit policy and operational guidance is required on the process of acquiring, collation and recording pertinent information.**

- **In each case the responsible team should identify a designated named person to carry out this task.**

- **In order to avoid a partial consideration of the person and their history which regards each new context as a stand alone episode.**

We noted in our Consideration and Review of Evidence that Mr H's mother could have given information that would have better informed the clinical team had she been contacted in October 2002. The opportunity to learn more from a concerned relative appears not to have been recognised.

Recommendation Four

It is recommended that all staff receive guidance to encourage and facilitate the gathering of information from carers and significant others, (recognising the confidentiality issues), which should be incorporated into the assessment and care planning process.

The Police were proactive in engaging the local Court Assessment and Diversion Scheme in July 2002 based on their knowledge of a previous diagnosis of ADHD, which led to a helpful assessment by a mental health worker.

The most significant concern about the engagement with services relates to the time in July 2003 when Mr H and his mother attended the Police Station at a key point for Mr H when it appears that he was prepared to discuss allegations of sexual assault. Although the Police

process was constructive, operational pressures meant that it was not enacted and no discussion took place which meant that this key moment was lost. The panel welcomes the new procedure that the police have implemented whereby all enquiries are discussed at a daily team meeting and follow up actions are taken when relevant.

The situation at the YOI is not one we have examined but as reported by Mr H the difficulties in receiving prescribed medication is a failing in the discharge of the institution's responsibilities to care for young people in their care. The high level of young men in YOI with mental health problems is well documented. In this case it would seem that a practical impediment to Mr H receiving medication was not addressed, it is unclear whether any sort of Mental Health Screening Tool was employed in 1997, but it seems unlikely as reported to us and the fact that Mr H stopped taking Ritalin in the YOI.

The panel are encouraged by the national recognition of this issue and the attention now being given to screening and supporting young offenders with mental health problems and or substance misuse.

Leadership and Clinical Accountability

The panel heard convincing evidence from senior management recognising the central position CPA must take in the clinical management of patients receiving services within the Trust and acknowledge their commitment to achieving this goal. We also heard evidence from a broad cross section of staff representing a number of services which suggests that Consultant Psychiatrists are not participating in CPA planning in the way one would expect if CPA was recognised as the fundamental process for organising patient care. While some individual consultants are regularly involved in CPA meetings, the panel heard that few have participated in the Trust's CPA training events.

The panel received copies of CPA policies dated 2000 (covering most of the period relevant to Mr H) and the most recent document dated March 2004. The later document is much more detailed and comprehensive and conveys more convincing commitment and enthusiasm for the CPA process on behalf of senior management and the Trust Board. The Trust audit review report dated March 2005 shows some improvement but there is a significant way to go.

The policy was due for review in December 2004 and may have been updated but if not then those responsible may wish to consider the arrangements for ensuring the participation of senior medical staff in enhanced CPA meetings, criteria for screening inpatients as requiring standard CPA and advice with regard to screening patients with dual diagnosis and with personality disorder.

At the time of the Mental Health Act Assessment in July 2003, the Approved Section 12 doctor did not complete the necessary written paperwork. Although the Medical Director did subsequently write to Trust doctors reminding them of their responsibility, this is not sufficient because not all Approved Section 12 doctors are employees of the Trust.

Recommendation Five

It is recommended that all Approved Section 12 doctors liable to make recommendations within the Trust's catchment area are written to and reminded of the requirement to complete a written record of an assessment under the Mental Health Act 1983, and that this correspondence is also sent to the Local Medical Committee and Primary Care Trust.

The lack of clarity about the senior medical input into the Crisis Response and Home Treatment Service at the time of the Inquiry Panel interviews was a particular concern. Members of the team and doctors involved were very uncertain about who was providing medical leadership within the team and there appeared to be confusion about the role of doctors. Since the CRHT provides a major component of the Trust's front line service the team seemed to be inadequately supported by the Trust's Medical Management Structure.

Recommendation Six

The Trust Board need to satisfy themselves that all doctors in consultant positions are aware of and have clear lines of clinical and managerial responsibility and accountability.

Recommendation Seven

That the Trust continues to promote the improvements in clinical accountability and practice already underway but with a greater

emphasis on ensuring that doctors at all levels are incorporated into the training arrangements and required to attend risk assessment and CPA multidisciplinary practice development events.

Organisation of Trust Services

Whilst during the period that Mr H was receiving services the Trust was experiencing pressures of reorganisation and uncertainty, these issues have not had a direct bearing on the care that Mr H received. However, we would comment from the information that has been given to us through our detailed discussions with clinicians involved in this case, that the scale of this task remains significant. The aspirations at senior management level are not fully appreciated by clinical staff whose practice and approach, as described to the Panel appears to be, at the time of writing, relatively untouched by the developments underway. In particular the need to engage with senior and middle grade doctors is essential to the success of initiatives to ensure the proper introduction of CPA, rather than for it to continue as a parallel process to that carried out by doctors in the Trust.

3 General Introduction

In August 2003 Mr H killed Mr G whom he had known for some years since he was 17 years old, alleging that Mr G had made sexual advances to him over this period. Mr H said at the time of the killing that he was "sick and tired" of Mr G "trying his luck" with him.

Mr H pleaded guilty to Manslaughter on grounds of diminished responsibility and was sentenced in April 2004 to five years imprisonment

Following the death of Mr G as Mr H was known to the mental health services provided by the (then) East Sussex County Healthcare NHS Trust an internal review was set up to examine the care and treatment received by Mr H. That review reported in May 2004.

This independent mental health inquiry was formally set up in May 2005 by the Surrey and Sussex Strategic Health Authority as required by the Health Service Guidance, HSG (94)27 and addendum 2005. The guidance states that *"in cases of homicide committed by persons in receipt of mental health services, it will always be necessary to hold an inquiry which is independent of the providers involved."*

Over the 5 years or so that they knew one another Mr H had stayed at Mr G's for several periods. Heavy use of alcohol was a characteristic of these times and there were occasions when the police were involved because of flair-ups between them, one of which went to court.

Mr H had a period in youth custody following a street robbery when he was aged 17 in 1997. He had been in touch with adult mental health services on and off since 1999, never with great intensity although there had been two periods of inpatient treatment in December 1999 and October 2002. Throughout his adolescence and up to the time of this offence he had drunk heavily and used cannabis.

Throughout his contact with mental health services the major concern was with the extent and effect of his alcohol and drugs misuse. He was referred to the local community alcohol service where he had periods of attendance and engagement although overall his engagement with the service, and with health services generally, was of failure to follow through on appointments or maintain a commitment to moderate or stop his abuse of alcohol.

Throughout his engagement with services he was not regarded as a major risk to himself or others and it must be stated that although Mr H's responsibility was diminished at the time of the killing he does remain responsible for the death of Mr G.

4 Purpose of an Inquiry

The purpose of an inquiry is to thoroughly review the patient's care and treatment in order to establish the lessons to be learnt; to minimise the possibility of a recurrence of similar events, and to make recommendations for the delivery of mental health services in the future incorporating what can be learnt from a thorough analysis of an individual case.

The role of the Inquiry Panel is to gain a full picture of what was known, or should have been known, at the time by the clinicians and to form a view of the practice and decisions made at that time with that knowledge. It would be wrong for the Inquiry Panel to form a view of what should have happened based on hindsight, and we have tried throughout this report to base our findings on information available within the local mental health services at the time.

The process is intended to be a positive one, serving both the individuals involved, and the needs of the general public. It is important that those who have been bereaved are fully informed of the individual circumstances and are assured that the case has been fully investigated by an impartial and independent inquiry panel.

5 Terms of Reference

1. To consider the quality and scope of the health, social care and risk assessment.

2. To consider the suitability of treatment, care and supervision in the context of:

    - Actual and assessed health and social care needs
    - Actual and assessed risk of potential harm to themselves or others
    - History of medication and compliance with medication
    - Any previous psychiatric history, including alcohol and drug misuse
    - Any previous forensic history

3. The extent to which the care of Mr H complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies, relevant guidance from the Department of Health including the care programme approach and guidance on suspension registers.

4. The extent to which prescribed treatment and care plan was adequate, documented, agreed with, carried out, monitored and complied with.

5. The adequacy of the risk assessment training of staff involved.

6. The adequacy of the collaboration and communication between the agencies involved (East Sussex Health and Social Care Trust, East Sussex Social Services and general practitioner).

7. The adequacy of support given to Mr H's family and the family of of Mr G.

8. To prepare a report for Surrey and Sussex Strategic Health Authority containing findings and recommendations concerning the care and treatment available to mentally ill people, and the safety of mental health users, the public and staff.

6 Panel Membership

This inquiry has been undertaken by the following panel of professionals who were independent of the local mental health services provided by the East Sussex County Healthcare NHS Trust.

Panel Chair	
Nick Georgiou	Formerly Director of Social Services, and with experience as an NHS manager of an inner London mental health service
Panel Members	
Jose Wood	Deputy Director of Nursing, Central and North West London Mental Health NHS Trust. Former CMHT Manager and Senior Practitioner
Clive Robinson	Consultant Psychiatrist in General Adult Psychiatry at West London Mental Health NHS Trust
Inquiry Manager	
Lynda Winchcombe	Director of a Management Consultancy company which specialises in Serious Untoward Incident reviews

7 Documents Seen

East Sussex County Healthcare NHS Trust

Internal Review
Press Cuttings
New Leadership Team for both Trusts
Revised Meetings Structure and Dates 2005/06
Protocol for Trust Board Agendas and Papers
Business Plan 2005/06
Management Structure Discussion Paper
Clinical and Social Care Governance and Risk Management Revised Structures
Clinical & Social Care Governance Committee
Mental Health Services Commissioning Strategy
Medical Records
Procedure for reporting and managing a serious untoward incident
Letter from Director of Nursing
Mental Health Act Assessment Documentation
Examples of blank Mental Health Act documentation
Access and Response Team (ART) Operational Policy
Care Programme Approach (CPA) audit review results and clinical risk review.
East Sussex County Council Social Services Department and East Sussex County Healthcare NHS Trust – Joint Protocol for the Management of Staff in Integrated Services.
Working Protocols with the Police (included in this section): -
Requests for Police Involvement in Mental Health Act Assessments
MAPPA Guidance
Overarching Protocol for the Secure and Confidential Sharing of Person Identifiable Information between Organisations
Trust Merger Consultation Documents
Trust Presentation Pack

1. Overheads
2. CPA training pack
3. Clinical Governance and social care structure
4. Service strategy

Releasing the potential for nurses
East Sussex County Healthcare NHS Trust Bulletin September 2005
136 monitoring meetings
Safeguarding Adults Strategy
Team Development programme
Crisis Resolution and Home Treatment Teams Operational Policy
Crisis Resolution and Home Treatment Teams
Consultant Job Description East and West
Clinical and Social Care Governance Structure

Mentally Disordered Offenders Annual Report 2004
Dual Diagnosis Strategy
Action Plan to implement the recommendation of the inquiry into DT
Revised Action Plan
Email plus Overarching Information Sharing Protocol
Letter to all medical staff from the Medical Director
Draft policy and procedure for managing DNA
Action plan Appendix 1

Prison

Healthcare Records
General Notes

Police

Records

GP

Records

Solicitor

Records

Action for Change

Chronology
Annual Report 2004
Documents

Other

Correspondence provided to the Panel by Mr H's mother

8. East Sussex County Healthcare NHS Trust and Services Profile

Extracts produced from the report by the Health Care Commission December 2004:

East Sussex County Healthcare NHS Trust (the Trust) was established in April 2002. It serves a population of 492,000 people and covers an area of 666 square miles on the south coast of England. The main centres of population are in Hastings, Bexhill, Rye, Eastbourne, Polegate, Lewes, Seaford, Newhaven, Peacehaven, Hailsham, Heathfield, Uckfield and Crowborough. The area encompasses five district and borough local authorities, East Sussex County Council, and four Primary Care Trusts (PCTs). Away from the coast, the area is more thinly populated and rural.

The five district and borough local authorities have varied demography and demonstrate a wide range of deprivation. Hastings is ranked at 37 out of 354 local authorities, making it one of the most deprived districts in the country.

When the Trust was created in 2002 it absorbed mental health, learning disability, substance misuse and community dental services from Hastings and Rother NHS Trust. The same services in the Ouse Valley area of South Downs Healthcare NHS Trust came into the Trust at the same time. The community health services formerly provided by Eastbourne and County Healthcare NHS Trust were transferred to the local PCTs in 2002.

The Trust was originally established on an interim basis, with the expectation that a new organisation integrated with social services would come into existence in April 2004. In the spring of 2003, it was proposed that a Care Trust be established, but not all local health community partners supported this proposal.

In March 2004 an option appraisal exercise concluded that it would not be appropriate at that time to consult formally about a merger of the three Mental Health Trusts providing services across Sussex. However, it recommended the development of joint commissioning strategies and strengthened cooperation between partner agencies on achieving integrated service provision. A steering group to take this forward has been established and is chaired by the Chief Executive of Surrey and Sussex Strategic Health Authority.

The Trust provides specialist mental health, substance misuse and community learning disabilities services in partnership with East

Sussex County Council Social Services Department, and employs 1,414 staff. Care is provided from over 50 sites through a range of inpatient, outpatient, day care and community settings, as well as in people's homes. The average number of beds available in 2002/2003 totalled 292, of which 141 were for older people and 20 were for secure provision.

The Trust received a zero star rating in the July 2004 performance ratings, failing to achieve key targets relating to assertive outreach team implementation, CPA systems implementation, financial management and mental health minimum data set implementation. Targets relating to community mental health team integration, hospital cleanliness and improving working lives were successfully achieved. However in the 2005 performance ratings the Trust was awarded a one star rating. In addition the Healthcare Commission Review reported that they were extremely positive regarding the progress that the Trust had made since the last review.

Joint health and social care appointments have been made for all care groups at service manager level and joint commissioning arrangements are being progressed.

A consultation process has recently taken place in Sussex to present three options to the county's population in regard to future Mental Health and Learning Disability Services.

The option that has been agreed is that the three NHS mental health and learning disability Trusts would be dissolved and a new Trust set up with the appointment of a new executive board.

All staff from the current trusts would transfer automatically with the exception of the directors.

The benefits of the merger have been identified as: -

Providing the greatest potential to improve services in line with service direction.

- The ability to develop highly specialist services.
- The ability to recruit and retain best staff.
- The provision of cost effective infrastructure.
- Ability to become more financially stable.

It is anticipated that these changes will be effective from April 2006.

8.1 Relevant Current Services

The following is a summary of the services that are available at the time of writing and most were operating at key points during Mr H's engagement with services.

Community Mental Health Teams (CMHTs)
Each team is multi-disciplinary and consists of a team manager and one or more of the following: psychiatrists, psychologists, approved social workers, community mental health nurses, occupational therapists and community support workers. Each team operates from a single address with referrals coming from a variety of sources to the Crisis Resolution Home Treatment duty desk in East Sussex and the CMHT in the West.

Crisis Resolution Home Treatment Team
There is currently one team in the East of the County and one being developed in the West. This is multi-disciplinary service, including community mental health nurses, social workers, psychiatrists and administrative staff. It is the first point of contact to access mental health services for working age adults in the Hastings and Rother area. The Team also provides a crisis intervention and home treatment service to prevent hospital admission and to facilitate early discharge from hospital.

Assertive Outreach Team
There are two teams in East Sussex, one based in St. Leonards, the other at Amberstone. Each team provides a service for adults living in the community who are suffering from severe and enduring mental health problems. Referrals are taken from the local CMHTs. It has a specialist role in building and maintaining supportive care relationships.

Accident and Emergency including Psychiatric Liaison Service
People frequently present at A & E with some combination of intoxication, injury and mental illness. Assessing and managing the appropriate course of action in these circumstances can be extremely difficult. Mental health nurses are on duty to provide advice and support to 'casualties' and colleagues in the department.

Addaction Hastings
Addaction provides the gateway into drug services in Hastings and Rother and provides non-prescribing community treatment. Service users include offenders with a 'drug rehabilitation' requirement case

managed by Sussex Probation Area. Referrals are taken from any source.

Hastings Substance Misuse Service and Eastbourne Community Drug Team

The consultant-led teams comprise doctors, nurses, psychologist, occupational therapist and social workers. Integrated treatment programmes (including programmes for offenders with a 'drug rehabilitation' requirement case managed by Sussex Probation Area) are delivered in partnership with other community drug services, and other agencies.

Court Assessment Scheme

The Court Assessment and Diversion Scheme provides information to the criminal justice system (Defence, Prosecution and Probation) about the part mental illness and substance misuse and may have played in a persons offending behaviour. Referrals come from the Police, the Court, Probation and Bail Information. Reports are provided for the Courts and recommendations made on support and treatment options.

Action for Change

Action for Change is a voluntary organisation that provides a community alcohol team service for people who are experiencing problems associated with the amount of alcohol they are using. They provide a service to the population of Sussex setting up local specialist schemes within certain communities such as working with street drinkers in Hastings.

There are strong links established with other statutory agencies within the area. In East Sussex nurses and social workers work within the service providing a joint adult treatment plan.

Action for Change also works in partnership with the Probation Service taking 100 referrals across East Sussex. This is a fast track assessment at pre-sentence report stage with recommendations for 12 sessions of "Brief solution focussed alcohol counselling". At the discretion of the court clients will be court ordered to attend.

The service is funded from a variety of sources including the NHS.

It should be noted that this summary of services is not intended to be inclusive of all the services provided by the Trust since 2002.

9. Chronology

This chronology is set out in 5 phases:

Phase 1: 1980 to 1997
Phase 2: August 1998 to March 2000
Phase 3: June 2000 to November 2001
Phase 4: June 2002 to April 2003
Phase 5: July 2003 to April 2004

9.1 Phase 1

1980 to 1997
Mr H was born in Durham in 1980, one of 5, two younger brothers and two older sisters. In 1985 his parents separated.

As a child Mr H's mother described him as very demanding, *"he couldn't sit still…a very difficult child"*. In 1989 he was referred to a child psychiatrist with whom he had 3 or 4 appointments. As part of this engagement he had an EEG which showed him *"within the normal range. There is no more than a mild, non-specific abnormality and no evidence of a focal lesion or of epilepsy"*. Then in 1990, Durham Area Child Protection Committee considered him and his younger brother in a case conference because of bruising caused by their stepfather who had hit them with a belt after they ran away from home. Neither child was placed on the At Risk register, the GP who attended the case conference records that this *"was thought to have been a 'one-off' occasion by normally very caring parents".* There was a period of social work support to the family that was recorded as having been appreciated by them.

In 1993/4 Mr H moved with his family to Hastings.

Aged 14 years in 1994 Mr H was suspended from school for taking in an axe in order to frighten a bigger fellow pupil who had been bullying him.

Mr H began drinking when he was about 15 years old with the amount increasing when at 17, he was drinking most days. It was during this time that he met Mr G and became friendly with him.

In August 1997 Mr H was charged with a street robbery of a foreign student whom he threatened with a knife; he was subsequently sentenced in November 1997 to 18 months imprisonment in a Youth Offenders Institution (YOI).

In September 1997 Mr H's GP referred him to a Consultant Paediatrician for consideration of the possibility that his behaviour might be *"explainable as part of an Attention Deficit Disorder"*. The paediatrician made a diagnosis of Attention Deficit Hyperactive Disorder (ADHD) and prescribed Ritalin.

In the event Mr H started to take the Ritalin prescribed and continued for some time while in Feltham YOI, where, by his mother's and his own report, the medication was beneficial. However due to the difficulties experienced in obtaining the medication within the YOI he stopped taking it after about 6 months. While in the YOI Mr H gained an NVQ in building work.

9.2 Phase 2

August 1998 to March 2000
Mr H was conditionally released from the YOI in August 1998, and was supervised by the Probation Service on his release.

During 1998 he lived mainly at home although this could be tense because he was not working for most of the time and drinking heavily, eventually he was asked to leave the family home. He stayed with Mr G intermittently where they drank heavily together, occasionally with other young men including Mr H's younger brother.

During September, October and November 1999 there were separate incidents involving the police for which he received fines and for one, a conditional discharge. One of these offences involved an assault on Mr G and the taking of his car.

The conditions in the Probation Combination Order resulting from the 1997 offence and subsequent offences, required 2 years of Probation, Community Service and an additional condition that he attend sessions of the Community Alcohol Team (CAT). The Probation Officer subsequently obtained a variation of the Community Service Order in March 2000, but effectively he was not required to follow through this aspect of the Order from about October with the emphasis placed on his need for support in relation to his alcohol misuse.

November 1999
The Probation Officer wrote to the GP about her concerns and his *"behaviour and depressed mood"*. Just prior to this, his GP had made a referral to the Consultant Psychiatrist based at Westwood House making reference to Mr H's depression and heavy drinking. An outpatient appointment letter was sent to Mr H for early December.

December 1999

On the 3rd December, a second GP at the same Practice referred Mr H to the Crisis Response Service (CRS) as he had been expressing suicidal thoughts and experiencing depression and panic attacks. An assessment visit was made that same evening by the CRS but they were unable to assess Mr H, as he was *"significantly intoxicated".*

On the 4th he was assessed by two nurses from the CRS. He is described as anxious with some agitation and suffering from a substantial hangover. Mr H denied hearing voices but his friend Mr G stated that he did hear a voice calling his name.

On the 7th:

1 The CRS wrote to the GP, advising him that they had accepted Mr H onto their caseload and planned to further assess and monitor his mental state, linking him into the Community Alcohol Team (CAT) to address alcohol problems, and with assessment by a team Social Worker to look at his living and financial situation. A second letter, this time from the doctor involved in the CRS assessments on 4th and 8th December 1997, was sent on 29th December 1997.

2 At the CRS visit to Mr H during the afternoon, he was described as *"visibly showing signs of alcohol withdrawal"*. It was also reported that *"he was planning to get some alcohol later"*. He confirmed that he had an appointment for the following day to see a doctor and the CAT liaison nurse at Westwood House and would attend.

3 The CRS received a phone call at 10.00 pm from Mr G stating that Mr H was on the balcony and threatening to jump. The CRS asked for Mr H to come to the phone to talk but he refused, Mr G was advised on calming actions to take and to call the police. The CRS planned to follow up after the police contacted, when they phoned back shortly after giving Mr G time to call the police, Mr H had voluntarily walked back inside.

On the 8th the appointment at Westwood House was not kept, Mr H was phoned without reply and the doctor and liaison nurse visited Mr G's home but Mr H was not there. There was a later phone conversation with Mr G who said Mr H had had *"a few drinks but looks ok".* The decision was taken to admit him the next day to investigate his mental state and the influence of alcohol on him. It was stated that there were no beds available for alcohol detoxification in the hospital, but that there would have been a risk in trying to achieve a detoxification at home in the community.

On the 9th following a telephone conversation with Mr H, he was admitted to Queen Charlotte's Hospital, diagnosed as having mental and behavioural disorder due to use of alcohol and cannabinoids. During his stay in hospital in December he was consistently described in the notes as *"settled", "pleasant"* and *"polite".* The admitting doctor wrote to his GP "*I reviewed him briefly on the ward and he was a completely different person, confident with stable mood and presented to me as a stronger person."*

The Ward Round notes state that *"it is most likely that the symptomology he had presented with had been directly linked to substance misuse and there is no evidence of mental illness per se".*

The intention was to discharge Mr H on the 22nd and that he would be helped to find accommodation through the Homeless Persons' Unit. However in the event he left the ward on the 21st December and was discharged on the 22nd. On the 21st an unidentified friend, who sounded inebriated phoned to say that Mr H was upset at the plans for being discharged as he felt he needed more help. The friend was advised to ask Mr H to come back to the ward to discuss this; there was a subsequent similar phone call later in the evening when Mr H was reported to be drunk. He was again asked to return to the ward but did not do so.

January 2000

28th A Discharge summary letter was written to the GP giving Mr H's diagnosis as:

1) Mental and behavioural disorder due to use of alcohol (harmful use) ICD10CodeF.10.1

2) Mental and behavioural disorder due to use of cannabinoids (psychotic disorder). ICD10CodeF.12.5

with a Care plan after discharge of:

1) Social Services input as homeless on discharge. Social Worker helped in finding interim accommodation

2) Advised to maintain contact with drug and alcohol advisory services.

No medication was prescribed.

February 2000

The Probation Officer notified the GP of her intention to apply to the court to have the Community Service element of his probation order revoked on the grounds of Mr H's ill-health and to focus on continuing support and engagement with the CAT.

March 2000

The CAT records show that Mr H's attendance at sessions was sporadic in the period January to March and then ceased in March.

On the 20th a letter was sent from a Staff Grade psychiatrist to the GP advising that Mr H had failed to keep his outpatient appointment on March 9th 2000 and therefore was discharging him back to his GP.

9.3 Phase 3

June 2000 to November 2001
In June the GP wrote to the catchment area Consultant Psychiatrist asking for Mr H to be seen because Mr H's mother had asked the GP to recommence him on Ritalin due to her continuing concern and her son's continuing behavioural difficulties. The GP reported that Mr H was no longer drinking or using cannabis and was attending the CAT; he also advised that Mr H had a new address and that may be why he had not attended an outpatient's appointment in early March.

In September the GP wrote again as he heard from Mr H that there had not been any contact.

In October the Consultant Psychiatrist saw Mr H and diagnosed *"a generalised anxiety disorder with continued use of alcohol and cannabis (but in lesser quantities)".* The Care Plan was to offer relaxation training; subsequent to that a possible referral to Clinical Psychology; support through CAT and routine outpatient reviews. She also prescribed Stelazine Spansules 2mg nocte. The Consultant Psychiatrist's letter to the GP acknowledged that her letter following the June referral offering a July appointment was sent to an old address

In October and November there were follow up letters offering Mr H appointments but he did not attend these.

There were also letters **in February and June 2001** offering appointments that were not kept

In November 2001 a letter from a locum staff grade psychiatrist was sent to the GP explaining that Mr H had not kept a further appointment in November, and that no further routine outpatient clinic appointments would be offered.

9.4 Phase 4

June 2002 to April 2003

June 2002
On 26th June Mr H was arrested on a warrant for being drunk and disorderly a week earlier. The Police were concerned due to risk of

self-harm and a description that he had a diagnosis of ADHD. Mr H reported that he had attempted suicide by hanging in 2000 but there is nothing on the file or that has emerged in our interviews about this. He was assessed by the Court Diversion and Assessment Scheme nurse. The Risk Assessment noted a medium risk of suicide, low risk of violence and medium risk of neglect. Mr H was advised to see the CAT and a letter was sent to the Community Mental Health Team.

On 27th June Mr G phoned the police (999) stating that Mr H was inside his flat threatening to kill him and that he had a Stanley knife. Police attended, entered the flat and arrested Mr H. No further action was taken however as Mr G declined to prosecute.

From the information provided to the Inquiry Panel it would seem that at this time Mr H turned up at his mother's home in a very distressed state but was not prepared to tell her the cause of his distress. She then saw that his underpants were bloodied when Mr H left his washing while showering. When she raised her concern about the cause of the bloodied underpants with her son, Mr H vigorously denied that anything had happened. She spoke with the police officer who had been involved in the incident referred to above but her response is reported to be that they were of age as two consenting adults and what happened between them was up to them. In the event Mr H's mother kept the underpants for some weeks as evidence of her concern that her son had been sexually assaulted before throwing them away for fear of one of her other sons finding them.

July 2002
On 27th July the manager of the Hastings and St Leonards CMHT wrote to the CAT advising that Mr H had been directed to see them by the Court Diversion and Assessment Scheme. The letter asked the CAT to contact him if Mr H got in touch and stated that there was a history of ADHD but that the primary issue was to do with alcohol.

October 2002
On 26th October Mr H was informally admitted to the Eastbourne Clinic following an overdose of a mixture of prescription drugs and alcohol. The suicide attempt took place in his mother's home to whom he had left a suicide note. His mother found him and called the emergency service.

On 27th October a Risk Assessment completed at the Eastbourne Clinic noted an attempt at suicide in 2001 by cutting his wrists (nothing in the file). The Summary noted a medium risk of suicide, low risk of violence and low risk of self-neglect.

On the 31st October Mr H was transferred to the Woodlands Unit as a bed had become available. The Transfer Summary notes that *"He presented as low/flat in mood but articulate and pleasant in approach.*

He settled quickly and expressed feeling safe and relieved by his admission". A Risk Assessment was completed – not signed or dated – which stated a low risk of suicide, violence and neglect.

November 2002
On the 1st November he left the ward on leave but failed to return, the Absence Without Leave (AWOL) procedures were initiated. The next day Mr H's mother phoned the ward to report that he had returned home in the early hours.

On the 3rd November he discharged himself against medical advice after returning to the ward. A Standard CPA form was completed but not signed. He was prescribed an antidepressant and sleeping tablets.

On the 7th November the staff grade psychiatrist wrote to the GP stating that Mr H did not attend the appointment for that day and that no further appointment would be offered.

On the 13th November the GP replied to the Consultant Psychiatrist asking for a follow up after Mr H's self discharge following the attempted suicide.

On the 21st November a discharge summary was sent to the GP.

December 2002
On the 18th December the consultant spoke with the GP and asked that Mr H be seen. The Consultant Psychiatrist arranged for the CMHT to see him and for an outpatient appointment slot to be booked if needed.

On the 23rd December the Assessment and Response Team (ART) wrote to the GP noting his letter of 13th November to the Consultant Psychiatrist which had not reached them until 17th December and which they had passed onto the CMHT. There was also a letter to Mr H from ART advising him that the St Leonard's CMHT would be contacting him following a referral from his GP.

January 2003
On 15th January the CMHT wrote to Mr H asking that he make contact with the team to arrange an appointment.

February 2003
On 12th February the CMHT wrote to the GP advising that the team had written to Mr H but not received a response from him. He was then discharged from their waiting list.

March 2003
On 12th March the GP wrote to the consultant asking her to note Mr H's new address and to make contact with him as he stated that he had not received the previous letter offering an appointment.

On 25th March the CMHT wrote to Mr H asking him to contact the team for an appointment.

April 2003
On 12th April the CMHT wrote to the GP advising that as there was no telephone number for Mr H he had been written to but had not responded. His file was closed.

9.5 Phase 5

July 2003 to April 2004

July 2003
On 21st July Mr H was detained by the police under S136 and assessed under the Mental Health Act 1983 (MHA). He was seen by a Staff Grade psychiatrist and an Approved Social Worker (ASW) accompanied by an ASW in training. The assessing team were agreed that the criteria for detention under the MHA were not met at that time and a referral was made to CAT by the ASW. This was done by telephone at 2.50 pm on the 21st July.

Mr H was assessed as having a primary alcohol problem but no other mental health problem at that time.

There is no paperwork from the assessing doctor on the file. We have seen the ASW Report and Record of Work Done,(MH1).

On 31st July Mr H told his mother he had been sexually assaulted by Mr G since he was 17 years. Mother persuaded him to go to the police station with her, they waited for an appropriately trained police officer to become available for about 3 hours but they were unable to speak to an officer and eventually left. A police officer, not specially trained, subsequently followed up with a visit to Mr H's mother's home the same evening. But as no one was home, a note was put through the door and no further action was taken by the police or by Mr H or his mother.

August 2003
On the evening of the 17th August Mr H phoned the police to report that he had killed Mr G. He was arrested and charged with murder.

On 1st April 2004 Mr H was sentenced to 5 years imprisonment for manslaughter on grounds of diminished responsibility.

10 Consideration and Review of Evidence during Engagement with services

10.1 Overall summary of engagement

10.1.1 Childhood and Adolescence

As a child his mother described Mr H as never sitting down, always active and provocative with his brothers. Throughout his childhood and adolescence there were various incidents that generated concern about his behaviour and the cause of it, but there was no concerted engagement with social or health care support services. There had been some minimal contact with services including a short period of sessions with a child psychiatrist when he was 9 years old; this involvement included an EEG that showed him to be *"within the normal range".* The family moved to Hastings a few years later when he was about 13/14 years old. It is reported that settling into the area and at a new school was problematic, and indeed there was a serious incident shortly afterwards which resulted in him being suspended from school.

Mr H was seen by a Consultant Paediatrician when he was 17 and diagnosed with Attention Deficit Hyperactivity Disorder. He was prescribed Ritalin which both he and his mother report had a positive and calming effect on his state of mind and behaviour. However, shortly after being diagnosed with Attention Deficit Disorder he was given a custodial sentence in a Youth Offenders Institution and the practicalities of receiving and continuing to take this prescribed medication in the YOI proved too great an obstacle and he stopped taking the Ritalin.

It would seem that he started to drink alcohol at about the age of 15 gradually increasing his consumption until at 17 he was drinking most days. It was also when he was 17 that he met and was befriended by Mr G.

The degree of involvement with services was not strong and the pattern of getting by - known to the agencies but not high on the radar of the health, social services or education services - is a consistent theme from childhood through to when, shortly after his 23rd birthday the offence was committed.

10.1.2 Initial engagement with adult mental health services

In the year or so after his release from the YOI Mr H's primary contact was with his supervising Probation Officer. He was drinking more steadily and appears to have become more dependent on Mr G in

terms of staying in his home more and as a drinking companion, apparently with Mr G financing the cost of their shared alcohol.

In the lead up to the admission to hospital in December 1999 there were various incidents involving the police between Mr G and Mr H of assault and the taking of Mr G's car. The Probation Officer became more concerned about his mood and alcohol consumption, "*behaviour and depressed mood"* and contacted the GP just prior to the GP himself making a referral to mental health services. The Crisis Response Service had difficulty in making an assessment because of his intoxicated state; during these few days there was also an incident between Mr G and Mr H when Mr H made a suicidal gesture threatening to jump from a roof.

In the event Mr H was admitted as an in-patient and was in hospital for about a fortnight before leaving, just before his planned discharge date, immediately before Christmas. The view of those involved in his care while he was in hospital is that he was an unremarkable patient being pleasant in his manner and settled in his behaviour. The firm view of the professionals involved in his care was that his symptoms were *"directly linked to substance misuse and there is no evidence of mental illness per se".* This view of Mr H's condition is clearly described in the Discharge letter to the GP in both the diagnosis and the care plan. At the time of the admission there was consideration of the interplay between his mental condition and alcohol misuse. There is no record in the notes of any structured approach or programme that was designed to help with detoxification, and it would seem that he presented very differently after a short period without alcohol.

Subsequently there was intermittent involvement with the Community Alcohol Team (Action for Change) and he did not attend an outpatient follow-up which resulted in the mental health service ceasing their involvement.

At the time of the referral in December 1999 the CRS responded positively to the referral to them and as an inpatient his needs were identified with a care plan put in place.

There is no reason to question the assessment and diagnosis made at the time and the identification of substance misuse as the primary concern and trigger for the distress and symptoms shown by Mr H at that time.

Subsequently in June 2000 the GP re-referred Mr H asking for an assessment with a view to recommencing Ritalin. This letter also gave Mr H's current address as previous correspondence from the mental health services had not reached him. Mr H was eventually seen by the

Consultant Psychiatrist for the catchment area in October after a further referral in September from the GP. An appointment had been made for

July on receipt of the first referral but had been sent to the wrong address despite the GP giving the right address.

The GP's second referral did not carry the explicit reference to Ritalin and described him as *"remaining off alcohol and cannabis"* while describing some symptoms including *"paranoid ideas about dangerous situations"* for which he felt *"sure that there is a psychological explanation".* The Consultant Psychiatrist's diagnosis was of *"Generalised anxiety disorder"* and that he was *"Still continuing to use alcohol and cannabis (in lesser quantities)".* He was prescribed stelazine spansules. The Consultant Psychiatrist made no reference to the diagnosis of ADHD or to the initial request regarding Ritalin. Other interventions were offered to Mr H of relaxation training, a possible referral to Clinical Psychology, support through re-referral to Action for Change, and routine outpatient reviews.

None of these interventions were followed through by Mr H, there were follow up letters, but these were not responded to and in November 2001 no further outpatient appointments were offered.

There was clearly an administrative error in respect of the address used to contact Mr H at least twice. Initially in the follow up after his discharge from the in-patient ward and then subsequently in not acting on the clear information contained in the GP's letter.

At the time of Mr H's contact with the mental health services there were no clear guidelines or policy for the management of Loss of Contact or DNA (patients who did not attend for their appointments). The onus for arranging an appointment with a member of the CMHT fell to Mr H.

Subsequently the Trust has produced a draft Policy and Procedures document for Managing DNA or Cancelled Appointments dated 28th October 2005.

10.1.3 Engagement with services, June 2002 to April 2003

During the second half of 2002 there was intermittent involvement with both the police and with mental health services.

There were a number of significant incidents in June 2002 with Mr H arrested for being drunk and disorderly. At that time because of police concerns about his mental condition he was seen by the Court Assessment and Diversion Scheme nurse who concluded that he was at medium risk of suicide, low risk of violence and medium risk of neglect. Mr H was referred to the Community Mental Health Team and advised to see the Community Alcohol Team.

Then the following day there was an incident when Mr G called the police reporting that Mr H was threatening to kill him with a Stanley knife. The police attended and defused the situation with Mr G choosing not to prosecute.

It was at this time that Mr H's mother construed by what she saw on her son's clothing and his behaviour, evidence that he had been sexually assaulted; although Mr H denied that anything had happened. She spoke with the police officer who had been involved in the incident with the Stanley knife who appears to have considered that the mother's concerns about a possible assault on her son was a private matter between Mr G and Mr H.

No further incidents were reported in the rest of that summer but in October Mr H was admitted to hospital following a suicide attempt at his mother's home. He was in hospital for a few days only before taking his own discharge against medical advice. It is noted that at this time reference is made to earlier suicide attempts in 2000 and 2001 but there is nothing on file about these and we have no further information.

For some months after, there was correspondence between parts of the mental health services and the GP about Mr H and letters offering appointments. However there were internal and external communication problems with the GP's letter to the consultant psychiatrist not reaching the Assessment and Response Team until more than a month after it had been written, and at least some of the intended contact with Mr H was not received because of difficulties either with the team knowing his address at the time, or Mr H being in different places at different times. Whatever the cause, other than the GP who maintained good and strong contact with Mr H, there was no further direct contact between Mr H and mental health services and he was not seen after his discharge until a new event in July 2003.

10.1.4 July and August 2003

Mr H was detained by the police in July under Section 136 of the Mental Health Act. He was properly assessed by a doctor and social worker (two, as the assessing social worker was accompanied by a colleague in training) who concluded that he did not fit the criteria to be detained under the Mental Health Act. The assessment pointed, as others had done, to him having a primary alcohol problem rather than a mental illness.

The doctor involved in this assessment was also a member of the local mental health services, acting at that time as a Section 12 Approved Doctor under the Mental Health Act. No paper work was completed by this doctor relating to the assessment; although this is a failing, it was not material to the course of the assessment. The Internal Inquiry was

right to raise concerns about this and to recommend actions to improve practice. However a letter from the Trust's Medical Director in April 2005, attempting to address this issue will not affect the practice of Approved Section 12 doctors not employed by the Trust.

On the 31st July Mr H confided in his mother that he had been sexually assaulted by Mr G over several years. His mother persuaded him to report this to the police and they went together to the Police Station in Hastings to do so. In the event, a positive approach by the Police Service to ensure that allegations such as this are dealt with by specially trained officers proved to be a barrier to this initiative. As no officers with the training were available they waited for about 3 hours before leaving the station without talking with anyone. The police did follow up in an unsatisfactory way later that same day when a uniformed officer, without the specialist training, visited Mr H's mother's home as a routine follow up but as no one was at home a message confirming they had visited was put through the letter box but no further action was taken by the police or by Mr H or his mother. The moment had passed.

The absence of a contingency to deal with this sort of situation and pressure appears to have not been worked through within the police force at the time. We understand that this has subsequently been addressed with a regular Divisional Management Meeting each morning when all the previous day's contacts are checked to ensure that they have been followed through. As described, the nature of this concern would now be followed through more conclusively than a note through the door asking for contact back to the police.

The next contact was on the 17th August when Mr H phoned the police to report that he had killed Mr G. When he was arrested outside Mr G's home it is recorded in the Police Officer's notebook that he made comments that imply he was told to kill Mr G by the appearance of the late President Kennedy in the mirror.

10.2 Care Programme Approach and Risk Assessment

Mr H was first referred to the local adult psychiatric services in November 1999 and was waiting to be seen by a Consultant Psychiatrist in December, but came into contact with members of the Crisis Response Service on 3rd December 1999 at the request of another doctor in the GP Practice.

Over the next almost four years, prior to the offence, Mr H was referred to and seen by representatives of at least eight different services within the Trust, plus other local voluntary and statutory services such as probation, police and alcohol services. Contact was in a variety of

settings including telephone conversations at home, home visits, outpatients' appointments and inpatient admissions. Contact varied in intensity from inpatient care or daily contact in the community to intermittent outpatient appointment and periods of no contact.

During this period a number of professionals were involved to varying degrees and a significant amount of information was recorded. The challenge as always was to have systems in place to ensure relevant information was available and appropriately considered when clinical decisions were being made.

The two inpatient admissions in December 1999 and October 2002 might have provided an opportunity to collate the information available but the admissions were relatively short and the information was with a number of different teams. The Care Programme Approach should act as the process by which all relevant individuals contribute to the formulation of an agreed management plan for the individual. Inpatient treatment can provide a setting that facilitates this process, in particular gathering the information needed. In Mr H's case a detailed Ward Round note made by his consultant during the 1999 admission includes information about his forensic history, the diagnosis of ADHD as well as his alcohol problems and personality difficulties. These notes do not appear to have been available during the 2002 admission although some of the clinical information is recorded in the notes. It is unclear as to where the CPA process for Mr H fits into the clinical management process for the inpatient unit.

The 1999 admission does not appear to be associated with any CPA or formal risk assessment record despite CPA being introduced in 1991. It remains uncertain as to who was involved in completing the care planning for Mr H at the end of his stay as the paperwork is not signed and he was not present when the plan was made. The lack of coordination is further demonstrated by information included in a signed risk assessment document dated 27th October 2002 not being included in a risk assessment dated 31st October 2002. This is particularly significant because the earlier document included the history of threats at knifepoint and the later indicates no previous history of violence.

The decision in 2002 to assess Mr H as requiring services under standard CPA arrangements based on the diagnosis of a primary alcohol problem is in keeping with widespread practice. During the 1999 admission Mr H's mother was invited to attend the ward round and provided useful information about her son's difficulties. It may have been the case that Mr H would not have given permission to contact his mother on the second admission and in any case his leaving the ward precipitated his discharge. Had she been contacted she was in possession of a wealth of information about the many

disturbing events in the months leading up to his admission in October 2002.

10.3 Organisation of Trust Services

During the period of Mr H's engagement with services the Trust was experiencing pressures of reorganisation and uncertainty.

As an Independent Panel we have had the benefit of discussion with the senior managers and clinical leadership of the Trust now, and are aware of the difficult circumstances that the management team inherited, and of the scale of organisational development necessary to sharpen up the application of clear procedures and lines of accountability, both managerial and clinical. There is no doubt about the commitment of the management team to secure change with the introduction of clearer procedures, quality assurance arrangements and managerial structures.

11 Findings and Recommendations

11.1 Predictability and possibility of preventing this offence

The pattern of engagement with services throughout his involvement with them was that Mr H was unlikely to follow-up appointments and specific service interventions. When he was on the Probation Combination Order there appears to have been better contact and it may be that the element of coercion through the court was instrumental in his better engagement. Throughout, it is clear that he was not regarded as having a major mental health condition and that the primary concern related to his alcohol misuse, and the short term effect of that on his mental state. He was not subject to any sections of the Mental Health Act, other than the Section 136 by the Police at a specific time, and from our consideration of the circumstances of this case this is entirely acceptable.

The formal Risk Assessment that was carried out, and the other observations about his state and the risks he might pose, are consistent in noting the potential risk of possible self-harm when in a depressed state.

Although there were threats and actions against Mr G at what appear to have been stress points in their relationship, there was no reason to interpret these as sufficient to predict that Mr H carried the potential to kill Mr G as in fact happened. In the view of the Inquiry Panel the killing of Mr G was neither preventable nor predictable

The unknown aspect is what might have happened if Mr H and his mother had discussed with police the alleged sexual assault in July 2003. But it is not possible to know what the outcome of this might have been or if it might have caused a difference.

It is also worth noting that there have been significant difficulties in diagnosing Mr H's mental state subsequent to the offence, and he is now diagnosed as suffering from a schizophrenic illness.

11.2 Engagement of Mr H with and between Agencies

Mr H is not an untypical case in terms of his dependence on alcohol and on the misuse of other substances. It would seem that his mental state was heavily influenced by excessive consumption of alcohol and illegal drugs over time, and that at times this, coupled probably with the stress generated within the relationship with Mr G, would trigger the distress and behaviour that lead to referrals for psychiatric support from his GP and the admissions to hospital.

The difficulty for services within the local area, and more nationally, is that there are significant numbers of people like Mr H who will tend to disengage from services if they feel themselves to be under pressure and/or are faced with options that require changes to their life style that they do not want to make or are unable to make. As we have indicated in 11.1, the involvement with the Probation Service under a Combination Order did generate better compliance and engagement of Mr H. It enabled the probation officer to recognise changes in Mr H's mental state. However because there was no formal or informal contact between Mr H and probation at this time intelligence was lost.

Recommendation One

That where a person currently in receipt of mental health services has involvement from other statutory agencies the mental health services should take a proactive role in establishing contact with those agencies to facilitate appropriate sharing of information.

Mr H did not figure high on the radar of any of the agencies involved, he was generally well liked and personable in his relationships with those professionals who worked with him. Apart from being detained under Section 136 by the police, he was never sectioned under the Mental Health Act, and his treatment as an Informal patient appears to have been appropriate.

It is not difficult to understand the situation faced by mental health services when he chose to discharge himself from hospital and indeed although the services contributed to his failures to attend follow up appointments by their mistakes in respect of his address and contact details, it does not seem material to the outcome of this situation, that there were repeated errors in contacting him. We were pleased to note that the Trust has introduced a policy on Managing DNA or Cancelled Appointments in October 2005.

Recommendation Two

It is recommended that the Trust audit the operation and effectiveness of the policy on Managing DNA or Cancelled Appointments implemented in the Autumn 2005. This is to ensure that there is an effective follow up of people who do not attend for appointments.

The GP's consistent involvement with clear referrals to mental health services is a positive contribution in this case. But even with a practice well attuned to mental health conditions and supports, without the willing cooperation of Mr H and much smoother pick up of work by the mental health services, other than in December 1999 when the services worked well and crisply in engaging with Mr H, sustaining purposeful intervention is very difficult to achieve.

In this particular case information exchange between services does not seem to have been a major impediment. However the opportunity to examine this case in detail has demonstrated inadequacies in the exchange and sharing of information at the right time between agencies.

Recommendation Three

It is recommended that the Trust puts into place more robust systems for acquiring and coordinating available information:-

- **An explicit policy and operational guidance is required on the process of acquiring, collation and recording pertinent information.**

- **In each case the responsible team should identify a designated named person to carry out this task.**

- **In order to avoid a partial consideration of the person and their history which regards each new context as a stand-alone episode.**

We noted in our consideration and Review of Evidence at 10.2 that Mr H's mother could have given information that would have better informed the clinical team had she been contacted in October 2002. The opportunity to learn more from a concerned relative appears not to have been recognised.

Recommendation Four

It is recommended that all staff receive guidance to encourage and facilitate the gathering of information from carers and significant others, (recognising the confidentiality issues), which

should be incorporated into the assessment and care planning process.

The Police were proactive in engaging the local Court Assessment and Diversion Scheme in July 2002 based on their knowledge of a previous diagnosis of ADHD, which led to a helpful assessment by a mental health worker.

The most significant concern about the engagement with services relates to the time in July 2003 when Mr H and his mother attended the Police Station at a key point for Mr H when it appears that he was prepared to discuss allegations of sexual assault. Although the Police process was constructive, operational pressures meant that it was not enacted and no discussion took place, which meant that this key moment was lost. The panel welcomes the new procedure that the police have implemented whereby all enquiries are discussed at a daily team meeting and follow up actions are taken when relevant.

The situation at the YOI is not one we have examined but as reported by Mr H the difficulties in receiving prescribed medication is a failing in the discharge of the institution's responsibilities to care for young people in their care. The high level of young men in YOI with mental health problems is well documented. In this case it would seem that a practical impediment to Mr H receiving medication was not addressed, it is unclear whether any sort of Mental Health Screening Tool was employed in 1997, but it seems unlikely as reported to us and the fact that Mr H stopped taking Ritalin in the YOI.

The panel are encouraged by the national recognition of this issue and the attention now being given to screening and supporting young offenders with mental health problems and or substance misuse.

11.3 Leadership and Clinical Accountability

The panel heard convincing evidence from senior management recognising the central position CPA must take in the clinical management of patients receiving services within the Trust and acknowledge their commitment to achieving this goal. We also heard evidence from a broad cross section of staff representing a number of services which suggests that Consultant Psychiatrists are not participating in CPA planning in the way one would expect if CPA was recognised as the fundamental process for organising patient care. While some individual consultants are regularly involved in CPA meetings, the panel heard that few have participated in the Trust's CPA training events.

The panel received copies of CPA policies dated 2000 (covering most of the period relevant to Mr H) and the most recent document dated March 2004. The later document is much more detailed and comprehensive and conveys more convincing commitment and enthusiasm for the CPA process on behalf of senior management and

the Trust Board. The Trust audit review report dated March 2005 shows some improvement but there is a significant way to go.

The policy was due for review in December 2004 and may have been updated but if not then those responsible may wish to consider the arrangements for ensuring the participation of senior medical staff in enhanced CPA meetings, criteria for screening inpatients as requiring standard CPA and advice with regard to screening patients with dual diagnosis and with personality disorder.

At the time of the Mental Health Act Assessment in July 2003, the Approved Section 12 doctor did not complete the necessary written paperwork. Although the Medical Director did subsequently write to Trust doctors reminding them of their responsibility, this is not sufficient because not all Approved Section 12 doctors are employees of the Trust.

Recommendation Five

It is recommended that all Approved Section 12 doctors liable to make recommendations within the Trust's catchment area are written to and reminded of the requirement to complete a written record of an assessment under the Mental Health Act 1983, and that this correspondence is also sent to the Local Medical Committee and Primary Care Trust.

The lack of clarity about the senior medical input into the Crisis Response and Home Treatment Service at the time of the Inquiry Panel interviews was a particular concern. Members of the team and doctors involved were very uncertain about who was providing medical leadership within the team and there appeared to be confusion about the role of doctors. Since the CRHT provides a major component of the Trust's front line service the team seemed to be inadequately supported by the Trust's Medical Management Structure.

Recommendation Six

The Trust Board need to satisfy themselves that all doctors in consultant positions are aware of and have clear lines of clinical and managerial responsibility and accountability.

Recommendation Seven

That the Trust continues to promote the improvements in clinical accountability and practice already underway but with a greater emphasis on ensuring that doctors at all levels are incorporated into the training arrangements and required to attend risk assessment and CPA multidisciplinary practice development events.

11.4 Organisation of Trust Services

Whilst during the period that Mr H was receiving services the Trust was experiencing pressures of reorganisation and uncertainty, these issues have not had a direct bearing on the care that Mr H received. However, we would comment from the information that has been given to us through our detailed discussions with clinicians involved in this case, that the scale of this task remains significant.

The aspirations at senior management level are not fully appreciated by clinical staff whose practice and approach, as described to the Panel appears to be, at the time of writing, relatively untouched by the developments underway. In particular the need to engage with senior and middle grade doctors is essential to the success of initiatives to ensure the proper introduction of CPA, rather than for it to continue as a parallel process to that carried out by doctors in the Trust.

12 Internal Inquiry Report

The Internal Inquiry Report was produced by a multi-agency group which met in November and December 2003 to review the available information and to report in line with their terms of reference. The Joint Internal Review reported in May 2004.

In our view, the Terms of Reference for the Joint internal Review were satisfactory, as was the membership of the group and the timing of their work. However the content and conclusions of the review were sketchy and it is not considered that the review demonstrates a robust consideration of the circumstances of the case, a detailed analysis of the issues or conclusions.

The Trust has developed an Action Plan to ensure action is taken on the recommendations from this report. Our comments are included on the Action Plan as set out on the following four pages.

RECOMMENDATION	RESPONSE	ACTION	LEAD-PERSON/AGENCY	TIMESCALE
10.1 patients who fail to engage with services In circumstances where there are repeated referrals from a GP due to difficulties in engagement and active treatment of a client, there should be a multi-disciplinary review held, to which the GP should be invited. This review should look at the appropriateness of the approach taken and to consider any other lines of action or care	East Sussex County Healthcare NHS Trust (ESCH) to review and revise Trust policy on Did Not Attends (DNA), that incorporates general good practice advice and more specific procedural responses required for each care group	Draft DNA Policy approved at ESCH Top Team and has been shared with West Sussex and will possibly be adopted on a pan-Sussex basis. Copy attached with appendix 1	Russell Hackett, Assistant Director – Specialist Services and ESCH Top Team	Dec 2005
Independent Inquiry Panel Comment This recommendation is endorsed. In addition please see Recommendation Two on page 39.				

RECOMMENDATION	RESPONSE	ACTION	LEAD-PERSON/AGENCY	TIMESCALE
10.2 Sharing information with Alcohol Services The protocol and policies for communication and the sharing of confidential information between alcohol substance misuse and community mental health teams should be reviewed and updated	In recognition of the NHS responsibility to readily share information with other stakeholders an overarching multi-agency information sharing protocol has been developed. ESCH in conjunction with the lead PCT has developed a dual diagnosis strategy which incorporates the following priorities 1) establishing a clinical network 2) developing a training programme 3) reviewing dual diagnosis pathways 4) health promotion 5) **Information sharing** 6) Primary care working	To review the protocol to ensure it is specific to the needs of dual diagnosis client groups, and amend as necessary prior to dissemination across all stakeholder agencies.	Russell Hackett, Assistant Director – Specialist Services/David Fordham, Mental Health Commissioner (Chair of Dual diagnosis clinical network)	April 2006
Independent Inquiry Panel Comment This recommendation is endorsed.				

RECOMMENDATION	RESPONSE	ACTION	LEAD-PERSON/AGENCY	TIMESCALE
10.3 Risk Assessment Risk Assessments should always be signed and dated	Risk assessments are part of the Trust's CPA process and it is clear with all CPA documentation that it should be signed and dated accordingly.	All professionals working with propels with mental health problems should be fully trained in risk assessment techniques and receive regular updates within the ongoing regular CPA training programme ESCH undertakes random audits to ensure risk assessment protocols are being adhered to by annual audit of CPA documentation carried out with Clinical and Social Care Governance Department	Morag Murray, Head of Service WAA and CPA Lead Morag Murray, Head of Service WAA and CPA Lead/Helen Greatorex, Director of Nursing/Clinical and Social Care Governance Department	Ongoing Annual monitoring
Independent Inquiry Panel Comment This recommendation is endorsed. In addition please see Recommendation Seven on page 43.				

RECOMMENDATION	RESPONSE	ACTION	LEAD-PERSON/AGENCY	TIMESCALE
10.4 Assessments under the Mental Health Act There should always be a written record of mental health act assessments	Medical staff should be reminded that it is essential to complete a written file record of assessment under the MHA. Mental Health Act Assessment documentation should be monitored on a regular basis.	Medical Director to issue a reminder to medical staff of their responsibilities and to arrange an audit process.	Dr Hamid Naliyawala, Medical Director	Completed May 2005
Independent Inquiry Panel Comment This recommendation is endorsed. In addition please see Recommendation Five on page 42.				

13 Glossary

ADHD – Attention Deficit Hyperactivity Disorder

Approved Social Worker (ASW) – A qualified Social Worker who has done further training in mental health and the Mental Health Act. An ASW plays a key role in assessing whether or not someone should be detained in hospital under the Mental Health Act.

Cannabinoids - these are the active chemicals contained within all forms of cannabis.

Care Programme Approach (CPA) – this is a system for looking after people with mental health problems, and of ensuring that they receive the help and support they need from mental health services, and that this care is well organised. There are two levels of CPA, Enhanced, for more complex cases and Standard for all other cases.

Court Assessment and Diversion Scheme – A service usually provided by mental health Services to the courts and prisons to facilitate the rapid recognition of people with significant mental health problems coming before the courts. Where appropriate, individuals may be diverted out of the judicial system or alternatively, receive psychiatric treatment within the system.

Electronic Care programme Approach (ECPA) – An electronic system which improves collation and access of information by responsible professionals.

Electro Encephalogram (EEG) - An electrical reading of the brain used to detect any abnormalities

Section 12 Approved Doctor – A doctor who has had special training and experience in the diagnosis and treatment of psychiatric conditions. At least one such doctor is involved in assessing patients in relation to possible detention under the powers contained within the Mental Health Act.

Section 136 of the Mental Health Act – This is part of the Mental Health Act which describes the power exercised by a police officer, which enables the officer to remove someone from a public place to a 'Place of Safety' so that they may be assessed by a doctor and ASW.

Staff Grade psychiatrist – An experienced doctor who is working under the supervision of a Consultant Psychiatrist**.**

Stelazine Spansules – Capsules of a medicine called Trifluoperazine which is one of a large number of drugs used to treat psychotic illnesses such as schizophrenia and bipolar affective disorder. They are also sometimes used in small doses to reduce disabling anxiety symptoms.