VERITA

IMPROVEMENT THROUGH INVESTIGATION

An independent investigation into the care and treatment of VS

A report for
NHS East Midlands

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Acknowledgements

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1. Introduction

1.1 In the early hours of 20 October 2003 VS killed LW with a single stab wound to the abdomen. VS told the police that he stabbed LW after he told him to get out of his house and had punched him in the face. The killing took place at the home of AW, the mother of the victim. LW was living with his mother at the time of the incident. VS and AW are described as being in a relationship. AW was believed to be 70 years of age and VS would have been 31 years old in 2003.

1.2 VS had been a patient of forensic psychiatric services of Nottingham Healthcare NHS Trust, first as an inpatient following a severe brain injury sustained in a motorbike accident in 1996, and from March 1999 as an outpatient. Nottingham Mental Health NHS Trust became part of Nottinghamshire Healthcare NHS Trust in April 2001.

1.3 VS was arrested and sent to HMP Nottingham on 22 October 2003. VS's fitness to stand trial was contested and he was admitted to Rampton Hospital under section 48 of the Mental Health Act 1983 in November 2004.

1.4 On admission to Rampton Hospital, VS was assessed as having an untreatable antisocial personality disorder and psychopathic disorder. No evidence of a mental illness was found. However, the Crown Prosecution Service decided not to contest VS's fitness to plead and at a court hearing in February 2005 he was found unfit to plead and returned to Rampton Hospital.

1.5 In March 2006 VS's clinical team at Rampton notified the Home Office (now the Ministry of Justice) that VS was fit to stand trial. VS pleaded guilty to manslaughter, and on 5 March 2007 was sentenced to be detained at Rampton Hospital without limit of time under section 37 (with section 41 restrictions) of the Mental Health Act 1983.

1.6 Nottinghamshire Healthcare NHS Trust carried out an internal serious untoward incident review of VS's care in 2004.

1.7 In October 2008 East Midlands Strategic Health Authority (now referred to as NHS East Midlands) commissioned Verita to undertake an independent investigation into the care and treatment of VS in accordance with health service guidance that stipulates that an independent review is required when a homicide has been committed by a person who is or has been under the care of specialist mental health services in the six months before the event. Issues concerning VS's consent delayed the start of the investigation. Work started in June 2009 after a Caldicott guardian gave consent to disclose VS's medical records because VS was not considered to be able to give informed consent himself.

1.8 This independent investigation (see section 2 for terms of reference) builds on the serious untoward incident review carried out in 2004 by the trust.

2. Terms of reference

Commissioner

2.1 This independent investigation was commissioned by NHS East Midlands with the full cooperation of Nottinghamshire Healthcare NHS Trust (the trust). The investigation was commissioned in accordance with guidance published by the Department of Health in HSG 94(27), *Guidance on 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 investigation was to undertake a systematic review of the care and treatment provided to VS by Nottinghamshire Healthcare NHS Trust and to identify whether there was any aspect of his care and management that could have altered or prevented the events of 20 October 2003.

2.3 The investigation team reviewed the quality of the health and social care provided by the trust and assessed whether this adhered to trust policy and procedure, paying particular attention to the following:

- identifying whether the care programme approach (CPA) had been followed by the trust with respect to VS
- identifying whether the risk assessments of VS were timely, appropriate and followed by appropriate action
- examining the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records
- The Mental Health Act 1983 assessment process

- considering the adequacy of liaison, communication and involvement between health professionals and other agencies (particularly the police, social services and Direct Health) relevant to VS's care

- considering if the decision not to involve VS and his relatives or the victim's family in the internal investigation process was appropriate

- establishing whether the recommendations identified in the trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the trust in response to these recommendations

- identifying any learning from this investigation through applying root cause analysis (RCA) tools and techniques as applicable

- reporting the findings of this investigation to NHS East Midlands.

2.4 The full terms of reference are given in appendix A.

3. Executive summary

3.1 In the early hours of 20 October 2003 VS killed LW with a single stab wound to the abdomen. The killing took place at the home of AW, the mother of the victim. VS and AW were described as being in a relationship. AW was believed to be 70 years of age and VS would have been 31 years old in 2003.

3.2 VS had been a patient of forensic psychiatric services of Nottingham Healthcare NHS Trust (which became part of Nottinghamshire Healthcare NHS Trust in April 2001), first as an inpatient following a severe brain injury sustained in a motorbike accident in 1996, and from March 1999 as an outpatient.

3.3 NHS East Midlands commissioned Verita to carry out an independent investigation to identify whether there was any aspect of VS's care and management that could have altered or prevented the events of 20 October 2003.

Changing attitudes to personality disorder

3.4 It is over six years since VS killed LW, and attitudes towards the care of people with personality disorders have changed radically in that time. We have reviewed the care and treatment that Nottingham mental health services were attempting to provide VS between 1996 and 2003 in the context of what was happening elsewhere in the country, and not by the standards of care that we would expect to see today.

3.5 Although there were some noticeable exceptions, before 2003 little effort was being made nationally to develop specialist services or adapt mainstream services to cater for people with a diagnosis of personality disorder. Many mental health practitioners used the 'treatability' clause of the 1983 Mental Health Act to exclude patients with personality disorder either because they did not believe that they had the appropriate skills or resources to help them, or because they believed that there was nothing that mental health services could usefully offer.

3.6 As a result, people with personality disorders who were more difficult to manage would often come under the care of forensic services.

3.7 Nottinghamshire Healthcare NHS Trust was a pilot site for developing specialist personality disorder services and started to put services in place from 2004/05.

VS personal history

3.8 VS was born on 22 March 1972. He grew up in Nottingham with his older brother and sister. His father emigrated to Canada when VS was three years old.

3.9 VS has a history of impulsive and explosive behaviour and mood swings starting in early childhood. Although there are no reports of VS being seen by a child and adolescent psychiatrist until he was 16, his mother said that he had shown 'suicidal tendencies' from the age of 12 associated with his episodic moods.

3.10 He attended a special school for the last two years of his education. He struggled with numeracy and literacy and obtained no external examinations. On leaving school VS started an apprenticeship as a brick layer.

3.11 Soon after leaving home he met his future wife. She was eight years older than him. They lived together from the middle of 1993 with VS's wife's son and daughter from previous relationships. They married in 1994. His wife filed for divorce in September 1998.

3.12 VS had a history of offending before 1989 when he sustained his first brain injury. He had been charged with theft, shop lifting, resisting a charge and traffic offences with motorbikes. On 17 February 1993 when he was 21 years old he was convicted for assaulting a police woman.

VS's care and management

3.13 VS's case was particularly complex and challenging. Even before his first head injury in March 1989, he had been prone to aggressive and violent outbursts. His behaviour deteriorated after his first and second motorcycle accidents in which he sustained head injuries, and incidents of self harm increased. His behaviour deteriorated even further after his third, most serious, motorcycle accident in September 1996.

3.14 After his third accident on 17 September 1996 he was admitted to the Queen's Medical Centre with severe brain injuries and multiple fractures of the skull. He remained unconscious for four weeks. On 21 October he was transferred to Linden Lodge Rehabilitation Unit where he became increasingly aggressive both verbally and physically. His aggression was described as "*explosive in nature*". On 28 January 1997 VS was transferred to Grafton Manor, a specialist brain injury rehabilitation centre.

3.15 It was while at Grafton Manor that VS was first diagnosed as having a pre-existing psychopathic personality disorder. Various attempts were made to find a more appropriate placement for VS, including approaches to Arnold Lodge Regional Secure Unit and St Andrew's Hospital. On 26 January 1998 consultant forensic psychiatrist 1 assessed VS and agreed that he could be transferred to The Wells Road Centre.

3.16 VS was admitted as an informal patient to Thurland Ward, The Wells Road Centre, on 27 January 1998.

3.17 VS's behaviour while an inpatient was typified by numerous attempts of deliberate self harm, disinhibited and sexually inappropriate conduct, destruction of property, fire setting, verbal hostility, and verbal threats and physical violence towards other patients and staff (particularly women). He threatened to kill himself, staff, his wife and fellow patients.

3.18 VS was sectioned twice under section 2 of the Mental Health Act 1983, first on 30 January 1998 and then on 15 May 1998. On each occasion he was assessed as

having a pre-existing antisocial personality disorder that did not meet the treatability criteria under the act. His status as an informal patient was therefore re-instated on both occasions.

3.19 On 17 March 1998 his two stepchildren (then aged 12 and 7 years old) were placed on the child protection register under the category of physical harm because of the risk VS posed to them during his visits home and when his wife brought them to visit him (VS's notes record incidents where he "*terrorised his wife and children"* during a weekend visit home, and shook his step daughter during a visit to Grafton Manor). On 14 April 1998, less than a month later, VS's wife and stepdaughter were allowed to visit him on Thurland Ward.

3.20 In May 1998, VS started setting fires which led to his arrest on 13 May 1998. On 18 July 1998, VS threatened to kill a female patient. The police interviewed VS, but did not charge him.

3.21 VS started a fire in the ladies' toilets on 29 September 1998, and was suspected of setting more fires in October. He was charged with arson (relating to the fires he started in May 1998) and convicted of criminal damage on 24 November 1998. He received a six-month conditional discharge.

3.22 While at Wells Road, VS was secluded twice. The first time was on 27 August 1998 for three hours after he attacked a nurse. The police were informed but no action was taken. A mental state examination carried out by the duty senior house officer concluded that there was no evidence of *"exacerbation of mental illness*" and that VS was not detainable under the Mental Health Act 1983. The second time was on 23 September 1998 when VS became verbally and physically threatening while his room was being searched. He was placed in seclusion for 35 minutes. On this occasion VS's mental state was not assessed.

3.23 The options open to his care team were limited: continued stay in hospital was not resulting in any improvement in his situation; and, compulsory detention was ruled out due to his diagnosis. We believe that the care team concluded that discharge into

the community with an intensive package of care in place to manage the risk he presented to himself and others was the only logical option.

3.24 The risk of VS continuing to set fires after he was discharged was carefully considered. Consultant forensic psychiatrist 1 was of the opinion that VS started fires because he was bored and frustrated, and that this behaviour was unlikely to continue once discharged. Consultant forensic psychiatrist 1's assessment proved to be correct.

3.25 After VS was discharged to a bungalow in Town B his aggressive and violent behaviour continued.

3.26 On 1 June 1999 VS threatened one of his carers with a knife (because he was frustrated that the other one was off sick). The police were not informed.

3.27 The presence of two carers for 18 hours a day did not prevent VS exhibiting aggressive and inappropriate behaviour. Although seemingly counter-intuitive, his multi-disciplinary team came to the conclusion that a reduction in the number of carers would be likely to help moderate his behaviour by reducing VS's frustration at being so closely supervised. Over the next few months, the intensity of VS's care package was gradually reduced.

3.28 By 17 August his support package had been reduced to two carers for 15-hours a day, and one for three hours. From November 1999, VS's support was reduced to one carer at any one time. From January 2000, levels of support were reduced to one carer for one to two hours a day for three to five days a week after VS attacked one of his carers with a hammer in December 1999. The police were not informed of the attack.

3.29 On 29 June 2001 VS grabbed one of his carers by the throat and punched him. This attack led to all one-to-one care being withdrawn in July 2001. The police arrested VS on 31 July for assault but he was not charged.

3.30 In his final year in the community (2003) VS's support consisted of regular telephone contact and some visits by his forensic social worker. His family,

particularly his mother also continued to support him. Consultant forensic psychiatrist 1 continued to attend CPA review meetings even though he had discharged VS from his own case list in February 2001.

3.31 On 14 May 2001, VS's mother told the acting forensic social work manager that VS visited the cafe at a local children's adventure playground where he sometimes volunteered to clear up and wash up. There is no indication that she notified the managers at the adventure playground about the potential risk VS posed to children because of his explosive outbursts. VS continued to help out at the cafe until at least January 2002.

3.32 In many respects VS managed much better in the community than anyone had predicted once his package of care was withdrawn. His main difficulty was reported to be social isolation because his aggressive, and potentially aggressive behaviour, made it difficult for him to access resources that other people with his high level of need would be able to access. He was also banned from numerous day centres and groups, local shops – and his local pub.

3.33 VS moved to Town A in June 2003 because he had become the target of taunts by children in Town B. Soon after he met and formed a relationship with AW who lived in the same road. VS's behaviour became more erratic as he struggled to cope with his relationship with AW and his hostile feelings towards her son, LW, who lived with her.

3.34 VS attacked LW with a hammer on 25 September 2003, and head butted him three days later after LW had allegedly threatened him with a hammer. VS took an overdose of Nurofen (14 tablets) on 8 October.

3.35 The increased risks that VS presented to himself and others were identified at an enhanced CPA health and social care assessment, review and care planning meeting 8 October 2003. The risk management plan advised staff to support VS in coping with his relationship with AW and to advise VS to avoid contact with LW.

3.36 Two days later, on 10 October 2003, consultant forensic psychiatrist 1 and the forensic social worker requested a multi-agency meeting with Nottinghamshire Police's Dangerous Persons Management Unit – a precursor of MAPPA. The meeting was arranged for 20 October 2003.

3.37 In the early hours of 20 October, VS killed LW.

Findings and conclusions

Diagnosis

3.38 There was consensus amongst all the health professionals involved with VS between 1989 and 2003 that his brain injuries had exacerbated a pre-existing personality disorder, and that he was 'untreatable' within the meaning of the Mental Health Act 1983. The internal review accepted this diagnosis.

3.39 VS may well have displayed antisocial personality traits before his first significant head injury in 1989 at the age of 16. However, we found evidence that his behaviour worsened after both this head injury and the further head injury in 1996. Therefore we wonder whether a diagnosis of ICD F07.0 or ICD F07.8 might have better reflected the true picture in VS's case recognising VS's condition as a mental illness rather than a psychopathic disorder.

3.40 We believe that, under the International Classification of Diseases (ICD), diagnostic category F07.0 (organic personality disorder) or F07.8 (other organic personality and behavioural disorders due to brain disease, damage and dysfunction) might have been a more accurate fit for VS.

3.41 We stress that this may have had no material effect on the eventual outcome but could have freed up the professionals involved to consider assessment under the Mental Health Act when violent incidents occurred.

3.42 Although we asked to see VS, he told his responsible clinician at Rampton that he did not want to see us. We acknowledge that our assessment of his case has been somewhat limited by this, although we do not believe that interviewing him would have significantly altered our conclusions.

Detention under the Mental Health Act 1983

3.43 VS was twice detained under section 2 of the Mental Health Act while at The Wells Road Centre. The first time was on 30 January 1998 within a few days of his admission when the team was assessing whether or not his personality disorder was such that it merited further detention under section 3 of the act. The second time, on 15 May 1998, was because the team were not sure whether his symptoms were related to mental illness or a direct consequence of his strained relationship with his wife and his move to a locked ward. On both occasions it was decided that VS's section was not renewable.

3.44 We conclude that if VS had been given a diagnosis of F07.0 (organic personality disorder) or F07.8 (other organic personality and behavioural disorders due to brain disease, damage and dysfunction), resistance to use of the Mental Health Act might have been removed. We stress that this may have had no material effect on the eventual outcome but may have changed the therapeutic emphasis for those involved in considering his care needs.

Seclusion and assessment

3.45 VS was placed in seclusion on two occasions while at The Wells Road Centre – on 27 August 1998 and on 23 September 1998.

3.46 We conclude that VS was treated appropriately in respect of restraint and seclusion and that the trust was right to seek legal advice from the trust solicitor. Staff could have used section 5.2 (doctors holding order) or section 5.4 (nurses holding order) of the Mental Health Act 1983 to ensure the legality of their actions.

3.47 However, when VS was secluded for the second time in September 1998, we could find no evidence that a formal assessment under the Mental Health Act 1983 was carried out. Although we accept that such an examination would in all likelihood have concluded that VS was not detainable, we agree with the internal report that the deprivation of an individual's liberty, especially in the case of an informal patient, demands formal process and this should have been carried out.

3.48 The trust's seclusion policy at the time gave no guidance on the seclusion of informal patients. The trust revised its seclusion policy in November 2008 to include such guidance.

Care programme approach and record keeping

3.49 The forensic services' CPA document is in our view comprehensive and clear and should be commended. Nationally, at this time (1999 to 2003) most forensic services would have followed the CPA policy for adult mental health services which often did not reflect the complexities of community treatment for patients being managed by the forensic services.

3.50 We conclude that the trust's CPA policy had been followed in respect to VS. Meetings were regular and well attended.

3.51 The records in relation to VS's care and treatment were detailed and comprehensive. There were only a few occasions when we were unable to source documents relating to his care, for example the initial service level agreement with Direct Health.

Risk assessment and management

3.52 The risks that VS posed to himself, property and others (including children) were well known and carefully documented. However, we conclude that staff had no

effective strategies to manage those risks. Risk management plans focused on advising staff on how to protect themselves with little mention of protecting the wider public beyond referring the case to the police 'Dangerous Persons Management Unit' (DPMU).

3.53 Risk assessment and management in relation to safeguarding and child protection was inconsistent. Consequently we have been left with the impression that many professionals working with VS did not see child protection as a priority and did not take it seriously enough.

3.54 The internal review did not comment on the standard of risk assessment and management, other than to note that consultant forensic psychiatrist 1's view that VS would cease to pose a fire risk after he was discharged had been vindicated. It did not comment on child protection issues.

Multi-agency working

3.55 The health and social care staff of the forensic team were working in a positive and effective way throughout their involvement with VS. The care programme approach was proactively used to enhance the multi-agency working arrangements. Similarly The Nottingham Traumatic Brain Injury Service worked well alongside forensic services and played an important part in VS's assessment and care package in the community.

3.56 Attempts by forensic services to engage other support services, including the trust's adult mental health services, all failed. Similarly, for various reasons, attempts to refer VS to more specialist services such as St Andrew's Hospital, also failed. We conclude that other services and agencies were reluctant to get involved in such a complex and challenging case.

3.57 However, we believe that forensic services should have worked better with child protection services to identify and manage the risks that VS presented to his

stepchildren, nieces and the children at the adventure playground where he worked as volunteer.

3.58 We also conclude that forensic services should have reported all incidents of criminal damage and assaults of staff and other patients to the police. This would have made it possible for the police to build up a more accurate picture of the risks VS presented and made it more likely that they would have worked with forensic services to manage those risks.

Care package provided to VS in the community

3.59 The care that VS received during his time in the community between 1999 and 2003 was well planned and considered given the complexity of his case. The initial support package was very intensive, and VS responded adversely to such close supervision. Reducing the level of supervision helped reduce his frustration levels and moderate his behaviour. However, when the care package support ceased in 2001 there seems to have been few options open to the forensic team. The shared clinical view was that VS did not warrant admission to hospital and did not fulfil the criteria for compulsory admission under the Mental Health Act. Attempts to have VS accepted by other support services, including the trust's adult mental health services, all failed.

3.60 There is no reason to believe that VS would have responded well to the re-introduction of a care package – even if new carers prepared to work with VS could have been found – or that this would have made any difference to his behaviour and the eventual outcome of this case.

The internal review's recommendations and the trust's action plan

3.61 The recommendations in the internal review were consistent with the report, but not all the issues were identified (for example, other diagnostic classification and child protection issues).

3.62 Although the resulting action plan is signed off as completed, fundamental issues still need to be addressed. For example, the trust has told us that despite a concerted effort on its behalf to encourage Nottinghamshire police to prosecute people with mental health problems, joint work to manage risk is still weak.

3.63 We have concluded that there were not robust systems in place at the trust between 2004 and 2007 to ensure the quality of action plans and monitor progress against them.

Preventability of VS killing LW

3.64 We have considered a number of important factors when reviewing VS's care and treatment:

- the attitudes that prevailed at the time towards personality disorder
- the lack of specialised provision
- the reluctance of other services and agencies – with the notable exception of The Nottingham Traumatic Brain Injury Service - to take on such a complex and challenging case
- and the fact that clinicians felt powerless to detain VS under the Mental Health Act.

3.65 It is not possible, even with the benefit of hindsight, to have predicted whether the deterioration in VS's behaviour would have led to him killing someone. Given the prevailing attitudes to people with a personality disorders at the time and the lack of any available specialised services we conclude that the staff who did engage with VS did their best to manage the challenges that he presented.

Recommendations

3.66 The attitudes to the care and management of people with personality disorder at the trust are today very different from those that prevailed between 1996 and 2003. We therefore focus our recommendations on the three main areas where we believe the trust still has work to do.

R1 Working with the police. This report has concluded that issues remain about how the trust worked with the police to manage the risks that VS presented. The trust needs to assure itself that it has effective working relations with local police. Attempts by the trust to engage the police in prosecuting mental health patients who commit a criminal offence have been largely unsuccessful. To bring fresh impetus to resolving this issue, we recommend that this report is formally tabled at a meeting between the trust and the police to consider how both agencies handled the individual incidents that occurred, and consider whether similar situations are occurring today. A nominated trust lead should be appointed to identify outstanding issues in relation to multi-agency working and risk assessment and management, and to develop a plan of how they should be addressed within six months of publication of this report.

R2 Safeguarding children. This report has highlighted a number of concerns about the risk presented to children. There are also examples of when these risks were handled well. We recommend that this report is tabled at the local safeguarding children's board to consider these risks and whether similar situations are occurring today. A nominated trust lead should be appointed to identify outstanding issues and develop a plan of how they should be addressed within six months of publication of this report.

R3 Recommendations and action plans from the internal review. This report concludes that the trust's system for ensuring the quality of action plans and their timely implementation was inadequate between 2004 and 2007. The trust has already taken steps to ensure that recommendations of serious untoward incident reviews and

action plans are routinely followed up. However, we recommend that this report is tabled at the Serious Clinical Incident Review Group, and that the group is tasked with developing a plan within six months of the publication of this report to improve the quality of action plans and ensure that progress continues to be made in their timely implementation.

4. Methodology

4.1 The investigation team comprised of:

- Peter Hasler, senior investigator, Verita
- Lesley Sargeant, investigation manager, Verita
- Dr Tim Amor, consultant psychiatrist and professional adviser.

4.2 We carried out a detailed review of VS's case notes covering the period from his first motorcycle accident in March 1989 to 20 October 2003 when he killed LW, numerous policy documents from the trust, and the action plan that resulted from the recommendations of the internal serious untoward incident review produced in 2004.

4.3 We also interviewed staff from Nottinghamshire Healthcare NHS Trust about VS's care and treatment, and the progress the trust had made in implementing the recommendations made in the internal review. We were unable to interview VS, his mother, or AW, the victim's mother (see section 5 for more information on involving families).

4.4 The investigation team followed established good practice in the conduct of interviews, for example giving interviewees the opportunity to comment on the factual accuracy of relevant extracts of the report while it was in draft. All interviewees were given the opportunity to be accompanied. All but two of the interviews were recorded and transcribed. Transcripts were sent to interviewees so that they could check the factual accuracy of their evidence. Notes were taken of the interviews that were not recorded and these were sent to the interviewees for checking.

4.5 Appendix B lists the people we interviewed, and appendix C the documents reviewed.

5. Family involvement

5.1 The internal serious untoward incident review was completed in 2004 long before the criminal case against VS was resolved (VS was not found fit to stand trial until March 2006, and it was not until March 2007 that he was sentenced for manslaughter). Although the internal review team stated that it would have liked to have heard the views of VS and his family regarding the care that he received, it decided that it would not have been appropriate to speak to them in the midst of the criminal trial. We were therefore particularly keen to speak to VS and to his mother for this investigation.

5.2 Given that a Caldicott guardian had given consent to disclose VS's medical records because VS was not considered to be able to give informed consent himself, we approached VS's responsible clinician at Rampton Hospital to ask her opinion on whether VS was able to consent to see us. In her view, VS was not able to understand the reasons for us interviewing him or what would happen to the information he gave us. We therefore did not seek to interview him.

5.3 VS's mother had previously told VS's responsible clinician that she did not want any involvement in the independent investigation. We did however write to her on two occasions to ask if she wanted to meet with us. She did not reply. VS's social worker at Rampton Hospital was able to tell us the she had received both letters but had not changed her mind. We respect her view not to be involved in the investigation.

5.4 We also wrote two letters to AW to seek her views on the events leading up to her son's death. Both letters were sent to her last known address. We received no reply. No attempts were made to contact other members of the family.

5.5 This report therefore does not contain the views of VS, his mother or the victim's mother. Notes of contemporaneous comments about VS's care made by his mother and brother are included in the detailed chronology of his inpatient care (see appendix D).

6. Changing attitudes to personality disorder

6.1 At the time covered by this investigation (1996 to 2003), attitudes in British psychiatry towards services for patients with mental illness and those with personality disorders were significantly different.

6.2 The so-called 'treatability' clause of The Mental Health Act 1983 was often used as a way of excluding people with personality disorders from mental health care, particularly those who required inpatient care. The 'treatability' clause of the act allowed for adequate justification to exclude patients who were assessed to be 'untreatable'.

6.3 With some noticeable exceptions little effort was made nationally before 2003 to develop specialist services or adapt mainstream services to cater for people with a diagnosis of personality disorder. As a result, the management of people with personality disorders who were not excluded would often fall to forensic services which were able to assess need, manage risk and even offer possible treatment strategies.

6.4 The publication in January 2003 of guidance from the National Institute for Mental Health in England, *Personality disorder: no longer a diagnosis of exclusion*, provided a clear direction for the first time on what people should expect from services. Prior to this mental health trusts had no clear directive or incentive to develop specialised services.

6.5 We learnt that in Nottingham, specialist personality disorder services effectively got off the ground in 2004/2005. Nottinghamshire Healthcare NHS Trust was one of the pilot sites for these developments and was therefore at the leading edge nationally. However, the trust has told us that these community personality disorder services specifically exclude people with histories of violence and aggression and people with forensic histories, so would not have been appropriate for VS even if they had existed at the time.

6.6 Even after the publication of national guidelines on developing specialised services, the 'treatability' clause of The Mental Health Act 1983 was still used to exclude people with personality disorders.

6.7 Many mental health practitioners were reluctant to work with people with personality disorder because they believed that they did not have the skills, training or resources to provide an adequate service, and because many believed there was nothing that mental health services could usefully offer.

6.8 The 'treatability' clause was removed in April 2007 and a much broader definition of mental disorder specifically designed to include personality disorders applied.

6.9 In 2009, at the time of writing this report, there are still many areas of England where services provided for people with personality disorders are under developed and inadequate.

6.10 It is therefore important to consider the care that mental health services were attempting to provide VS between 1996 and 2003 in the context of what was happening elsewhere in the country.

7. Changes to the trust

7.1 Nottingham Healthcare NHS Trust and Rampton Hospital Authority became part of Nottinghamshire Healthcare NHS Trust in April 2001. Since then Nottinghamshire Healthcare NHS Trust has provided mental health and learning disability services for the whole county. It is one of the largest mental health trusts in the country with over 6000 staff operating from more than 100 sites and an annual budget of £293 million.

7.2 The trust is divided into two operational divisions: the local services division responsible for services provide in the community and acute settings, and the forensic services division.

7.3 The local services division covers:

- adult mental health services
- child and adolescent mental health services
- mental health services for older people
- learning disability services
- drug and alcohol services.

7.4 The forensic services division covers:

- Rampton Hospital
- Arnold Lodge
- Wathwood Hospital
- Wells Road Centre
- community forensic services.

8. VS's personal history

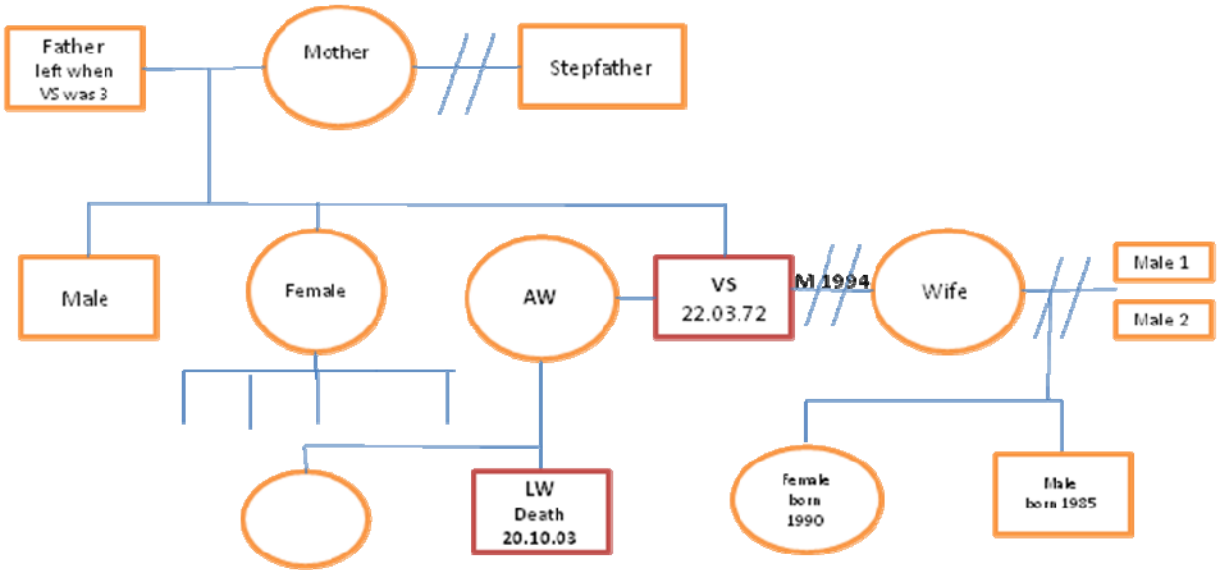
Early childhood

8.1 VS was born on 22 March 1972. He grew up in Nottingham with his older brother and sister. His father emigrated to Canada when VS was three years old. VS has had little contact with his father since then. VS is reported to have said that he never came to terms with his father leaving.

8.2 His mother later re-married. VS alleged that his stepfather hit him as a child and prevented contact with his mother. VS is reported to have said that he was "*only able to remember the bad things"* about his childhood.

8.3 VS's mother said VS had difficulty controlling his temper from an early age. VS's behavioural problems led to increasingly strained relationships throughout his childhood and adolescence both at home and at school.

Genogram of VS's family



School

8.4 VS attended Fernwood infant and junior school which he initially described as *"all right"* but went on to say that he was bullied and frequently beaten by other children as they did not like him and he was not very strong. He then attended Fernwood Comprehensive School until the fourth form when he was expelled for putting drawing pins under a teacher's tyres. He attended a special school for the last two years of his education. He struggled with numeracy and literacy and obtained no external examinations. On leaving school VS started an apprenticeship as a brick layer and gained NVQ level 3.

Relationships

8.5 In 1991 when VS was 19 his volatile behaviour led his mother to throw him out of the family home. He had no contact with his family from that time until 1996 when he sustained a serious head injury in a motorcycle accident (his third).

8.6 Soon after leaving home he met his future wife. She was eight years older than him. They lived together from the middle of 1993 with VS's wife's son and daughter from previous relationships. They married in 1994. Initially, VS's wife described his behaviour as *"settling down"* but by May 1995 she is reported as no longer being able to cope and feeling that the marriage was under threat because of VS's behaviour. The relationship with his wife is described as volatile and dysfunctional. His wife filed for divorce in September 1998.

Employment

8.7 VS had a number of jobs after leaving school. He worked as a brick layer, roofer, scrap-yard dealer and car valet, but his volatile temper and moods made it difficult for him to hold down a job. After the age of 19 he worked as a door-to-door salesman selling household items, a job he got from a friend.

Family history of psychiatric illness

8.8 We are not aware of any psychiatric illness in VS's family. Before being admitted to The Wells Road Centre, the case notes indicate that VS had contact with psychiatrists on four occasions. The first occasion was after his first motorcycle accident in 1989, and then again in 1992 after his second accident. He was subsequently seen in 1993 and 1995 after taking impulsive overdoses. On both occasions, there was no evidence of underlying mental illness although family difficulties and aggressive episodes were described.

Alcohol and drug use

8.9 VS described his drinking before he married as excessive saying that he drank as much beer as he could afford. He also reported that he turned to illicit drugs to make him feel happy and relaxed — he admitted to the occasional use of LSD, amphetamines, magic mushrooms and 'black zero'. VS is reported to have said that he stopped drinking and taking drugs after he got married. Alcohol reportedly made him extremely violent.

Police record and criminal convictions

8.10 VS had a history of offending before sustaining his brain injuries. He had been charged with theft, shop lifting, resisting a charge and traffic offences with motorbikes.

8.11 On 17 February 1993 VS was convicted for assaulting a police woman. He was 21 years old. Police records relating to charges of arson while VS was an inpatient indicate that VS was charged with another offence in 1993 but no details are given. On 12 July 1994 VS was convicted of criminal damage and given a conditional discharge of 12 months and bound over for 12 months.

Medical history

8.12 VS has a history of impulsive and explosive behaviour and mood swings starting in early childhood. Although there are no reports of VS being seen by a child and adolescent psychiatrist until he was 16, his mother said that he had shown 'suicidal tendencies' from the age of 12 associated with his episodic moods.

8.13 On 13 March 1989, when VS was 16, he was involved in the first of three motorcycle accidents (possibly due to some sort of 'fit') in which he sustained head injuries. The narrative chronology (section 9) takes up VS's story from the first of these accidents.

8.14 Two months before VS's first motorcycle accident VS was seen in the neurological department of Nottingham University Hospital. The medical records sent to us start from the date of VS's first accident, so we do not know why he was referred to neurology or the outcome.

9. Narrative chronology of VS's care and treatment

9.1 This narrative chronology summarises care and treatment between 13 March 1989, when VS sustained his first head injury, and 20 October 2003 when he killed LW. It is based on the detailed chronologies given in appendices D and E.

9.2 Appendix D covers from 13 March 1989 to 29 March 1999 when he was discharged from The Wells Road Centre; and appendix E covers the period from 30 March 1999 when VS was living independently in the community to 20 October 2003 when he killed LW.

9.3 We have described VS's behaviour as an inpatient and after he was discharged in some detail because it is important to understand the extent of the challenge he presented to those responsible for his care and management.

9.4 On 13 March 1989, VS was found in a ditch apparently having come off his moped (possibly because of some form of epileptic fit). A CT scan carried out on 16 March revealed haemorrhagic contusions in the left and right thalamic regions, and mild hydrocephalus. A small, right-sided brain infarct was also possible. He was treated conservatively with tranquillisers and carbamezepine (an anti-epileptic drug).

9.5 VS's physical condition improved and he was discharged on 22 March 1989. But once home he became violent and was re-admitted to Nottingham University Hospital because his mother was unable to cope.

9.6 On 29 March, an electroencephalogram (EEG) showed appearances suggestive of either an encephalopathy or right hemisphere haemorrhage/infarction. Case notes described VS as having been *"initially distractable, emotionally labile and sexually disinhibited"*. He is reported to have attacked nurses and his mother and is described as a danger to himself (he had fallen down the stairs) and to members of staff and the public.

9.7 VS's behaviour gradually settled and he was discharged on 4 April. The consultant psychiatrist at the hospital wrote to VS's GP on 7 April to tell him that VS showed no sign of psychiatric illness and that the frontal lobe haematoma sustained in the accident *"probably accounts for the majority of his behavioural problems".*

9.8 VS attended an outpatient clinic on 12 April 1989, when he was thought to be much improved, but did not attend for a follow-up CT scan in August 1989.

9.9 On 21 March 1990 VS tried to cut his wrists and had to be restrained by his family. VS's GP requested an urgent domiciliary visit and arrangements were made for him to be seen by the Regent Street Community Mental Health Service team on 2 April. He did not attend.

9.10 Three months later, on 25 June 1990, VS had a second accident on his motorcycle in which he hit his head. He was admitted to hospital for observation and discharged after 24 hours. No follow up was thought necessary.

9.11 Nearly two years later, in April 1992, VS was referred to the psychiatric outpatient department of the Queen's Medical Centre, University Hospital Nottingham, because he thought that his personality had changed since his first head injury in 1989.

9.12 VS said he was suffering from blackouts three to four times a week, but more frequently when he was feeling frustrated. He said that he could not keep jobs or girlfriends because of his temper. He also complained of shaking attacks when stressed. He was engaged in deliberate self harm — banging his head against walls, cutting his wrists, smashing glass in his face and jumping from his bedroom window. He also said that he was drinking alcohol excessively at weekends, and admitted to using LSD, amphetamines, magic mushrooms and 'black zero'. VS also reported that he felt that people were talking about him and that in the past he had heard voices in his head.

9.13 The case notes recorded a diagnosis of possible frontal lobe syndrome, personality disorder and anxiety problems. VS's mother is quoted as saying that living with VS was like "*living with a time bomb"*.

9.14 On 13 April 1992 the consultant psychiatrist referred VS to consultant neurologist 1 at the Queen's Medical Centre to exclude hydrocephalus, and arranged for him to have an EEG in order to exclude epilepsy. VS failed to attend two appointments made for him to have an EEG.

Finding

VS's failure to attend for an EEG resulted in a lost opportunity to investigate his alleged fits and/or blackouts. From the notes, it appears that no other attempt was made to determine the nature of the blackouts that VS reported. No attempt appears to have been made to assess his fitness to ride his motorcycle. VS's medical notes contain no other references after April 1992 of him having blackouts.

9.15 The consultant psychiatrist wrote to VS's GP on 19 May 1992 with the results of his assessment emphasising that VS's *"personality difficulties preceded his head injury/brain damage, but these seem to be merely exaggerated by the accident. Consequently, any benefit from (drug treatment) is likely to be limited".*

9.16 On 22 October 1993 VS presented at Queen's Medical Centre's accident and emergency department having overdosed on 13 paracetamol tablets and three tins of beer after his girlfriend (later his wife) shouted at him. Two days before, VS had attempted to hang himself after an argument with his girlfriend but was prevented by a neighbour. VS reported hearing voices inside his head in the four years since the accident. The voices told him to do things, *"always bad things".* He also reported seeing big black shadows with red eyes coming off walls most of the time.

9.17 VS was offered admission to hospital but he refused; he said he wanted to go home to see his girlfriend but that he would like help. Outpatient appointments were made, and he was offered a place at a day hospital, but did not attend.

9.18 In February 1995 VS went to his GP about ongoing problems with controlling his temper. VS reported that he continued to engage in self harm and had attempted to hang himself in front of his wife. VS was referred to the psychiatric outpatients department but failed to turn up to two appointments.

Finding

In the period between VS's first motorbike accident (March 1989) and his last motorbike accident (September 1996), there are multiple examples of difficulties and self-harming behaviour. VS appears to have some insight into the fact that his personality had changed for the worse since his first accident. Psychiatric services offered help on a number of occasions but these offers were refused or not followed through by VS.

9.19 A few months later, in April 1995, VS took 25 paracetamol tablets, followed by another 25 the next morning. His wife was present on both occasions. Following the second incident he barricaded himself into the house, and his wife called the police. The police arrived in large numbers with riot shields and broke the door down. VS was taken to the accident and emergency department at the Queen's Medical Centre but his paracetamol levels were below treatment levels and he was allowed home. According to his wife, VS was known to the police for aggressive and violent behaviour which probably explains why they reacted as they did.

9.20 At the time of the incident, VS was bound over to keep the peace following an incident with his neighbours. He was not thought to be clinically depressed or actively suicidal. The case notes describe VS's main concerns as aggressive behaviour, a fear of losing control and a sense of having lost his identity following his road traffic accident and having been *"replaced"* by a different person.

Finding

It is clear that VS's aggressive and behavioural problems and history of repeated self harm pre-date the severe brain injury sustained in September 1996. However, although VS had had difficulty controlling his temper and been prone to sudden mood changes since childhood, it is equally clear that his behaviour deteriorated after sustaining brain injuries in 1989 and 1990.

9.21 On 17 September 1996 VS sustained a very severe head injury as a result of a motorcycle accident on Mansfield Road, Nottingham. VS was reported to have been travelling at high speed when he collided with a vehicle (he was considered to have been 70 per cent responsible for the accident).

9.22 VS was admitted to the intensive care unit at Queen's Medical Centre. He was deeply unconscious on arrival (Glasgow Coma Scale 3). A CT scan showed multiple skull fractures, most notably in the left occipital area extending to the foramen magnum and through the left petrous temporal bone and the middle ear. He had multiple frontal contusions and blood over the right frontal areas of his brain and between the hemispheres. There had been a haemorrhage in the pons, and he had left seventh nerve palsy and a right hemiplegia.

9.23 He remained unconscious for about four weeks. He was ventilated for six days. During this time he developed pneumonia and needed a tracheostomy on 22 September (this was maintained for about three weeks). He was transferred to the neurosurgical ward around the 28 September, and on 4 October 1996 he had a gastrostomy.

Linden Lodge Rehabilitation Unit

9.24 By the time VS was transferred to the Linden Lodge Rehabilitation Unit at Nottingham City Hospital on 21 October 1996, he was fully conscious, obeying commands, but showing no verbal responses (Glasgow Coma Scale 10). At this stage he still had a urinary catheter but this was removed during his stay. As he began to

make progress, he became increasingly aggressive, verbally abusive and uncooperative with any attempts at rehabilitation. His aggression was described as extremely explosive and was thought to represent three separate problems:

- an adjustment reaction to his head injury
- an organic personality disorder with impulsivity, disinhibition and aggressive outbursts
- family conflict.

9.25 On the advice of the liaison psychiatrist he was treated with thioridazine (an antipsychotic tranquillizer).

9.26 His anger and agitation reached such a point that it was decided that VS needed to be moved to a more specialist rehabilitation centre.

Grafton Manor

9.27 On 28 January 1997, VS was admitted to Grafton Manor, a private hospital in Northamptonshire run by the Partnerships in Care organisation that provides highly specialised services for people with complex and challenging behaviours that typically follow a brain injury.

9.28 On admission to Grafton Manor, VS had left-sided facial weakness with a drooping left eye, speech impairment, and a severe tremor of the right arm and head centred on the shoulder, and a tremor in his right leg. His left arm was reasonably normal.

9.29 The right-sided tremor severely affected VS's co-ordination and dexterity and was a major factor in preventing him from walking.

9.30 VS was initially described as being friendly towards staff and other residents. But as soon as he had 'settled in' a pattern of aggressive behaviour began to emerge particularly towards female staff and more vulnerable residents, often involving racial

abuse. At this time his explosive and impulsive outbursts of temper were deemed by consultant neuropsychiatrist 1 to be beyond his control and therefore consistent with brain injury. VS was initially successfully treated with medication (carbamezepine and propranolol) and a consistent behavioural programme.

9.31 VS's practical and physical functioning increased significantly during his stay at Grafton Manor, and his explosive aggressive behaviour stemming from neurological dysfunction was controlled using medication. However toward the end of 1997, VS's behaviour changed.

9.32 During a weekend at home in September 1997, VS is reported to have terrorised his wife and stepchildren, and *"trashed"* a number of rooms in the house. He was taken to police cells before being returned to Grafton Manor. Between 23 October and 18 December 1997, VS was responsible for 17 separate incidents of violence, damage to property and verbal abuse at Grafton Manor - including seven assaults on members of staff (mainly female).

Finding

According to a written assessment, dated December 1997, The Nottingham Traumatic Brain Injury Service knew VS was terrifying his step children on their visits to Grafton Manor and the case manager was already concerned about home visits because of the children's safety. Nevertheless VS's home visit went ahead. This was a missed opportunity for the brain injury service and Grafton Manor to engage the child and family team, and appears to demonstrate a lack of priority given to safeguarding and child protection issues.

9.33 By the end of 1997 the Grafton Manor team had come to the conclusion that VS's escalating aggressive and violent behaviour represented an underlying personality disorder. All those working with VS agreed that he was in control of his behaviour and that his behaviour was becoming increasingly calculating.

9.34 In a written assessment of VS dated 22 December 1997, consultant neuropsychiatrist 1 at Grafton Manor said "*He skilfully deploys his aggression, gross*

destructiveness and threatening behaviour in order to dominate and try to control both our other residents and our staff." By this time, his view was that VS's behaviour represented his pre-existing psychopathic personality disorder rather than any direct effect of the head injury. Consultant neuropsychiatrist 1 wrote: *"We have reached the point where our staff are no longer able or prepared to work with him. The rest of our residents are having a constantly fraught and unpleasant time because of the atmosphere he deliberately engenders".*

9.35 A more appropriate placement was sort for VS. He was first assessed by consultant forensic psychiatrist 2 at Arnold Lodge Regional Secure Unit on 30 December 1997. Consultant forensic psychiatrist 2 concluded that a secure placement was not necessary and that VS could be managed in a forensic psychiatric ward such as Thurland Ward at The Wells Road Centre where he could be nursed by staff experienced in the management of disturbed and challenging behaviour. Thurland Ward also had the added advantage of allowing VS access to his family which was said to be uppermost in his mind at the time.

9.36 Consultant neurologist 2 of the Kemsley Unit at St Andrew's Hospital (which provides specialist services for people with brain injury) is reported to have assessed VS between 30 December 1997 and 12 January 1998 and concluded that the unit was not appropriate for VS (although there are conflicting reports about whether this assessment took place and the conclusion reached). No notes of the assessment have been found.

9.37 Consultant forensic psychiatrist 2 was under the impression that consultant neurologist 2 was due to assess VS on the afternoon of 30 December. He wrote to consultant forensic psychiatrist 1 on 12 January 1998 stating that, although he had not seen consultant neurologist 2's report, he understood from the nurse manager at Grafton Manor that he had recommended further rehabilitation at St Andrew's Hospital for VS (although a bed was not immediately available). However, notes of a comprehensive risk assessment that took place when VS was admitted to the Trent Unit at The Wells Road Centre state that he was refused a place at St Andrew's *"due to 'psychopathic' behaviours".*

9.38 VS was also assessed for a medico-legal report in January 1997 by consultant neuropsychologist. He suggested that St Andrew's Hospital would be more appropriate for VS than a regional secure unit.

Finding

St Andrew's Hospital told us that it had no record of an assessment taking place in 1997. However, we were subsequently told that initial assessments for the Kemsley Unit were not held in central medical records at St Andrew's unless the patient was accepted for care. We did not contact the Kemsley Unit to ask whether it had a record of the assessment.

9.39 On 26 January 1998 consultant forensic psychiatrist 1 from the Nottingham Mental Health Team at The Wells Road Centre, assessed VS. Consultant forensic psychiatrist 1 noted that while at Grafton Manor VS *"was effectively being contained using antipsychotic medication and one to one nursing. His therapy programme has entirely broken down and he lives largely as a recluse".* Consultant forensic psychiatrist 1 came to the conclusion that VS should be transferred to a psychiatric unit.

Finding

It is clear that, apart from forensic services, none of the other services felt able to offer VS a place. Consultant forensic psychiatrist 1 stepped in to offer VS a place even though forensic services were not ideally suited to him. In our view, consultant forensic psychiatrist 1 is to be commended for offering VS an alternative when no others were open to him. If consultant forensic psychiatrist 1 had not offered to help VS, there was a risk that Grafton Manor may have discharged him into the community without any support.

Thurland Ward, The Wells Road Centre

9.40 VS was admitted as an informal patient to Thurland Ward, The Wells Road Centre, on 27 January 1998. On the day of his transfer he assaulted two members of staff, was verbally abusive towards another patient and spat in a member of staff's face.

9.41 On 28 January consultant forensic psychiatrist 1 wrote a report on VS. He stated that VS's history "*suggests that his premorbid personality has predisposed him to the current behavioural problems which have caused considerable management difficulties in recent months*". He also noted that VS's treatment programme at Grafton Manor had entirely broken down.

9.42 On 29 January consultant neuropsychiatrist 1 at Grafton Manor, wrote to consultant forensic psychiatrist 1 to give further information about VS's behaviour in which he stated that *"(VS's) behaviours were clearly planned, quite skilfully thought out and set up, and equally clearly malicious in nature."*

9.43 VS made several attempts to leave Thurland Ward that culminated in him being placed under section 2 (28 day assessment) of the Mental Health Act 1983 on 30 January 1998. This order was allowed to lapse as it was decided that VS had a pre-existing antisocial personality disorder that did not meet the treatability criteria under the act. VS's status as an informal patient was therefore resumed on 26 February 1998.

Finding

The internal report notes that for someone to be detained under the Mental Health Act 1983 on the basis of a personality disorder, the individual must meet the criteria for a psychopathic disorder that can be alleviated or prevented from deteriorating by treatment (the so called 'treatability' cause). It goes on to say that although whether or not a particular personality disorder is likely to respond to psychiatric or psychological intervention is often a source of disagreement amongst mental health professionals, there was consensus on VS. All the

professionals involved at different stages of VS's inpatient and outpatient care thought that he was not treatable.

Having reviewed VS's medical records and interviewed professionals involved with his care, we support the internal panel's finding that VS was universally regarded as 'untreatable' throughout the period under review. As was common practice at the time, the so called 'treatability' clause was used to exclude from services patients who were assessed to be 'untreatable'.

We comment on VS's diagnosis in section 11.

9.44 On the same day that VS's informal status resumed (26 February 1998), the head injury care manager for The Nottingham Traumatic Brain Injury Service (part of the multi-disciplinary team looking after VS) phoned social services to raise concerns about the risk VS posed to his stepchildren, particularly the youngest.

9.45 Around the same time (letter undated), the head injury care manager wrote to VS's GP at the Daybrook Health Centre to express her concerns about VS moving back into the community because of the risk he posed to his wife and stepchildren, and to carers and health professionals working in the home. The head injury care manager said that *"the mental health team fully expect to have contact with VS in the future via the judicial system."* The letter was copied to members of the forensic team and the consultant clinical neuropsychologist at The Nottingham Traumatic Brain Injury Service. However, by the 3 March 1998, VS's care plan from The Wells Road Centre indicated that he was being prepared for discharged.

Finding

Both the brain injury service and VS's GP were aware of the potential risks VS posed to his stepchildren. In our view these risks should have been raised with social services much earlier, particularly as several reports of his threatening behaviour towards the children were noted as far back as September 1997 (VS was reported to have shaken one of the children during a visit to Grafton Manor

in October 1997). We comment further on the lack of priority given to safeguarding and child protection in section 12.

Plans to discharge VS were made at a time when his behaviour was particularly threatening and despite concerns raised by the head injury care manager. This was presumably because of the threat that VS posed to other patients and staff – and because his clinical team believed that no other option was available to them.

9.46 VS continued to exhibit aggressive and violent behaviour throughout March 1998. He was particularly hostile towards women, and made repeated threats to kill his wife, female members of staff and female patients. He also threatened to kill himself. He had to be restrained on 30 March when he attempted to head butt a member of staff, and on 31 March when he threatened to kill one member of staff and attempted to head butt another.

9.47 On 17 March 1998 his two stepchildren (then aged 12 and 7 years old) were placed on the child protection register under the category of physical harm. In the report for the child protection conference, the consultant clinical neuropsychologist at The Nottingham Traumatic Brain Injury Service noted that *"it does appear that (VS) will have to commit some sort of offence to see his freedom restricted on a formal basis."*

9.48 Despite being prevented from seeing his stepchildren, VS continued to see his sister's children. A social worker from City of Nottingham Social Services Department wrote to the charge nurse on Thurland Ward on 9 April expressing the view that VS's family would take appropriate action to protect his nieces during visits to his sister's house with his mother.

9.49 On 14 April 1998, less than a month after VS's stepchildren were put on the child protection register and he was prevented from seeing them, VS's wife and daughter were allowed to visit him on Thurland Ward. There is no record of children's services being told about the visit.

Finding

The basis on which Nottingham social services department came to the conclusion that VS's family would protect his nieces from his outbursts is not clear. Given his unpredictability and explosive nature, we feel that VS should not have been allowed to see his nieces. Apart from the risk of them witnessing one of his outburst or being hurt (even unintentionally), the apparent inconsistency may well have encouraged his wife to continue take the children with her when she visited VS. Staff on Thurland Ward should have been aware that VS was not allowed to see the children and asked VS's wife to take them home and notified children's services about what had happened.

9.50 VS continued to act violently and aggressively towards staff and fellow patients throughout April 1998, although at a treatment planning meeting on 21 April his aggression was said to be *"de-escalating due to staff management".* At the meeting, the consultant clinical neuropsychologist from The Nottingham Traumatic Brain Injury Service was guarded about VS's prognosis because in his opinion he had a pre-existing immature antisocial personality in addition to problems caused by his head injury. VS's wife was pessimistic about the possibility of VS changing his aggressive ways, saying he had always been that way even before she met him.

9.51 In May, VS threatened to kill his wife who he suspected of having an affair. He was verbally abusive and threatening towards staff and patients. He also started setting fires which led to his arrest on 13 May 1998.

9.52 The police were not prepared to take VS into custody so he was returned to The Wells Road Centre where he threatened to kill members of staff and himself. VS was moved to an intensive care bedroom where he was put under 'high observation' by two members of staff.

Comment

We comment in section 11 on the difficulties staff experienced in obtaining appropriate support and action from the police when patients engaged in acts that would normally be regarded as criminal.

Trent Unit, The Wells Road Centre

9.53 On 15 May VS was detained under section 2 of the Mental Health Act 1983 and transferred to the Trent Unit (a locked ward) because it offered a higher level of security while his mental state and the risk he posed to himself, others and his environment was re-assessed. He continued to be verbally abusive and aggressive to staff and fellow patients (including threatening to kill a female patient because she ate the last slice of pizza), although there were periods when he was described as *"co-operative and pleasant in manner".*

Finding

We agree with the finding of the internal panel that it is unusual for an individual to be detained under section 2 of the Mental Health Act 1983 on two separate occasions during one period of inpatient admission. The internal panel discussed this with professionals involved in the case at the time and we accept the reasons given.

VS was first detained on 30 January 1998 within a few days of being admitted to The Wells Road Centre when, according to consultant forensic psychiatrist 1, he was a **"relatively unknown quantity"** *and the team were assessing whether or not his personality disorder was such that it merited further detention under section 3 of the Mental Health Act 1983. The second time, on 15 May 1998, was because the team were not sure whether his symptoms were related to mental illness or a direct consequence of his strained relationship with his wife and his move to a locked ward. The internal review notes***: "Symptoms of the nature and degree**

with which VS was now presenting had not been seen by the multi-disciplinary team".

9.54 Between June and August 1998 VS started spending more time in The Wells Road Centre coffee bar where he enjoyed more freedom. VS's violent and aggressive behaviour continued, and he started setting fires again reportedly because he was bored.

9.55 At a treatment planning meeting held on 11 June, it was decided that VS's section was not renewable, but that he should stay in the Trent Unit while his suitability for living in the community was assessed. On 16 June VS told the cognitive behaviour therapist from The Nottingham Traumatic Brain Injury Service that he wanted to divorce his wife. On 22 June, the cognitive behaviour therapist, the case manager from the brain injury service and a representative from the Care Management Service (a provider organisation based in Derby) visited VS and agreed to arrange funding to enable him to move to sheltered accommodation in the community.

9.56 On 18 July, VS threatened to kill a female patient. The police interviewed him about this on 19 July, but he was not charged.

9.57 At a treatment planning meeting on 21 July it was agreed that VS should be discharged to supported accommodation provided by either Care Management Services or the trust's own rehabilitation and community care services. On the same day of the meeting, VS threatened to kill a female member of staff.

9.58 On 14 August, a letter from Nottingham Health Authority to Nottingham City Social Services confirmed that VS would need the *"most intense package"* of support, and that the cost would be split equally between the two organisations. Initially, two carers providing 24-hour care were thought necessary, but that the care arrangements should be reviewed monthly to see if they could be scaled down.

Finding

A decision to move towards a plan of discharge would seem incongruous with the clinical picture at the time. VS continued to exhibit frequent episodes of violent and aggressive behaviour. He was also threatening to kill staff, his wife and fellow patients. The options open to his care team were limited: continued stay in hospital was not resulting in any improvement in his situation; and, compulsory detention was ruled out due to his diagnosis. We believe that the care team concluded that discharge into the community with a very intensive package of care in place to manage the risk he presented to himself and others was the only logical option.

Thurland Ward, The Wells Road Centre

9.59 VS returned to Thurland Ward on 20 August 1998. Within five days, he had set fire to paper towels in the toilets near The Wells Road Centre coffee shop, in the coffee bar and in the tea bar. He also threatened to kill his wife, mother, brother and doctors, and expressed suicidal thoughts. He was placed under high levels of observation.

9.60 On 27 August VS had to be restrained when he broke a light and began kicking doors, spat in a nurse's face and made to attack her. He was placed in seclusion for three hours. The police were informed but no action was taken.

9.61 A mental state examination carried out by the duty senior house officer concluded that there was no evidence of "*exacerbation of mental illness*" and that VS was not detainable under the Mental Health Act 1983. The notes of the mental state examination include a brief history of VS's condition and state that a previous assessment on Thurland Ward had concluded that VS was most likely to have dis-social personality disorder and that there was no evidence of mental illness.

Finding

We agree with the internal panel that there were good grounds for placing VS in seclusion. VS clearly posed a risk to himself and others, and the police felt they were unable to offer support. Interestingly, the internal report implies that VS's mental state was not assessed as soon as possible after seclusion and quotes a member of staff justifying why it was not carried out. We however found evidence that the duty senior house officer carried out a formal Mental Health Act assessment on the same day that VS was secluded.

9.62 Plans for VS's discharge were discussed at a treatment planning meetings on 1 and 15 September. Initially two carers would provide 24-hour care. In addition, consultant forensic psychiatrist 1 agreed to see VS every two weeks as an outpatient. The Nottingham Traumatic Brain Injury Service also agreed to continue to be involved: the case manager would see VS once a week at home; the cognitive behaviour therapist would provide cognitive behavioural therapy; and the consultant clinical neuropsychologist would provide a three-month follow up.

9.63 On 15 September 1998 VS attended Nottingham Magistrates' Court in relation to the fire-setting incident on 13 May 1998. The case was adjourned until 13 October 1998, and VS given unconditional bail.

9.64 VS's stepchildren were taken off the child protection register on 21 September 1998 because his wife had started divorce proceedings and had made it clear that she did not want VS to be involved in her life or the lives of her children.

9.65 On 23 September VS became verbally and physically threatening while his room was being searched and was placed in seclusion for 35 minutes.

Finding

On this occasion we could find no evidence that a formal assessment under the Mental Health Act 1983 was carried out. Although we accept that such an examination would in all likelihood have concluded that VS was not detainable,

we agree with the internal report that the deprivation of an individual's liberty, especially in the case of an informal patient, demands formal process and should have been carried out.

9.66 On 29 September 1998 VS set fire to paper towels in the sink in the ladies' toilets. He said he lit the fire because he was bored and frustrated. He also smashed a chair and a window in the quiet room. He was arrested and taken to Carlton Police Station and charged with arson and criminal damage. He was bailed back to Thurland Ward that evening.

9.67 VS's fire-setting behaviour was discussed at a treatment planning meeting on 5 October. VS's mother, who was present, said he did it because he was bored. She was angry that the police had been involved because "*he's not normal".* The minutes state that consultant forensic psychiatrist 1 explained that VS was normal in the sense that he understands that he is setting a fire in a public place, that it is morally wrong and that it is against the law. VS's mother is reported to have become angry at this point because she did not think her son had received good care.

9.68 The case notes indicate that VS was suspected of setting more fires on 13 October, but that in consultant forensic psychiatrist 1's opinion the risk of VS setting fires was likely to decrease once he was discharged.

9.69 On 7 November VS refused his medication. He received a telephone call from his wife that reportedly made him angry. That afternoon VS visited his wife at home (staff had informed his wife about his angry thoughts earlier in the day).

9.70 The next day VS told staff that during the visit he had taken a knife and told his wife that he felt suicidal and was going to use the knife to harm himself. He also said he wanted to get back at his wife for refusing to have sexual intercourse with him. He threatened to hurt her if he found out she was having an affair.

9.71 On 10 November VS hit a member of staff over the head with a dinner plate and shouted at other patients. He told a member of staff that he had tried to hide a knife with the intention of stabbing a fellow patient.

9.72 The weekly summary and evaluation report prepared on 15 November noted that VS was *"more angry",* that he posed a fire risk (lighters were found in his possession), was at risk of harming himself with a knife and possibly posed a risk to his stepchildren if he continued to see his wife.

Finding

Despite VS's wife saying that she did not want anything more to do with VS, he continued to visit her at home where there was the risk of him coming into contact with his stepchildren. The children had been taken off the child protection register on 21 September 1998. Although being on the register had had little impact on preventing VS seeing the children, it did at least highlight the risk VS posed to them. In our view the children should have remained on the child protection register until all contact with VS and his wife had ceased, and the requirement that he had no contact with the children should have been enforced by establishing effective communication with children's social services.

9.73 On 19 November 1998 consultant forensic psychiatrist 3 from Nottingham Forensic Service wrote a confidential psychiatric report on VS in preparation for his appearance on 24 November at Nottingham Magistrates' Court to faces charges of arson and criminal damage.

9.74 He concluded that:

- VS was fit to attend court and to plead
- VS did not suffer from a treatable mental disorder within the meaning of the Mental Health Act 1983
- VS's brain injuries had appeared to have exacerbated some of his previous antisocial behaviours *("It is certainly clear that he does have full control of his mood and actions and this is characterised by his impulsive aggression and acts of violence, with little regard for their consequences.")*
- VS's fire setting was not in response to any form of mental illness

- VS was at risk of setting fires again
- if imprisoned, VS would be likely to become either very aggressive (and be a risk to others) or depressed (and be a risk to himself).

9.75 If convicted, consultant forensic psychiatrist 3 recommended that VS be subject to a probation order as this would allow ongoing supervision once he was discharged into the community in addition to the ongoing supervision from psychiatric services. Both consultant forensic psychiatrist 3 and consultant forensic psychiatrist 1 were willing to work with the probation service.

9.76 On 24 November 1998 VS was convicted of criminal damage in relation to the fires at The Wells Road Centre on 13 May 1998. He received a six-month conditional discharge.

Finding

In our opinion consultant forensic psychiatrist 3's recommendation of a probation order was innovative, and would have provided ongoing supervision if VS had been living in the community. The opportunity to use a probation order to supervise VS once he was living independently did not arise as incidents were either not reported to the police, or the police took no action if they were.

9.77 The charge nurse on Thurland Ward wrote to the Continuing Care Panel, Nottingham Rehabilitation and Community Care Services, on 30 November to request VS's transfer to Darwin Ward (an open long-stay ward) at The Wells Road Centre.

9.78 On 4 December VS was in a fight with another patient, and was verbally abusive to a member of staff and threatened to kill her. He had to be restrained by staff. He then made racist statements about another patient.

9.79 Medical records indicate that VS had used his leave to visit his wife (who had begun divorce proceedings) without informing staff.

9.80 On 10 December VS was offered the tenancy of a two-bedroom detached bungalow in Town B.

9.81 VS's pattern of abusive and threatening behaviour continued throughout December 1998 and January 1999. Verbal abuse, damage to property, racist remarks and attacks on staff and other patients were typical. One incident — when VS kicked down his bedroom door — led to him being cautioned by the police on 23 January 1999. However, by 5 February 1999 the notes of a care plan review indicate *"great overall improvement"* in his behaviour with a decrease in intensity of his outbursts and more independence.

9.82 On 8 February, the consultant clinical neuropsychologist at The Nottingham Traumatic Brain Injury Service, wrote:

> *"It would appear that there has been a gratifying improvement in (VS's) intellectual functioning in the period leading up to the second anniversary of his serious head injury. There can be no confidence there will be further positive change in the future and the combination of his personality change and continuing physical disability mean, obviously, that he will not be able to return to the type of employment which he had before the accident. It must be doubted that he would be able to maintain himself independently in the community."*

Finding

There is little evidence to support this optimistic view.

9.83 At a treatment planning meeting on 9 February 1999 it was reported that a private care agency — Direct Health — had been identified to provide VS's care. It had selected eight possible carers for interview. The selected carers were encouraged to get to know VS while he was an inpatient and to take him on outings. The cognitive behaviour therapist agreed to provide support to VS's carers.

9.84 VS was suspected of setting a fire in the bin in one of the toilets on 22 February 1999. He denied involvement.

Finding

Despite VS's history of fire setting, he was not assessed as being a serious fire risk. Consultant forensic psychiatrist 1 was of the view that VS set fires because he was frustrated and bored as an inpatient and that this behaviour would diminish after he was discharged. Given that during the four years VS lived in the community there were only two minor incidents involving fire — and an alleged false call to the fire brigade — we agree with the internal report that consultant forensic psychiatrist 1's assessment was vindicated.

9.85 On 29 March 1999 VS was discharged from The Wells Road Centre on 160mg propranolol and 300mg carbamazepine twice a day. Although the case notes make it clear that the clinical team shared the view that hospitalisation was having no impact on VS's core personality disorder, they were reported to feel under an obligation to manage some of the risks posed by his behaviour.

9.86 A comprehensive care package — which included two carers from Direct Health for 18-hours a day and ongoing support and management from The Nottingham Traumatic Brain Injury Service and forensic services — was put in place to support VS living in the community. The care programme also included a wide range of social activities such as horse riding, trips to the cinema and swimming.

Finding

By the time of VS's discharge it was clear that he had multiple and complex needs. Although the members of his clinical team shared the view that they were not making any progress in treating VS's personality disorder, they agreed to continue to support him because they felt under an obligation to manage some of the risks he presented - and presumably in the knowledge that other services might be reluctant to get involved or less able to cope with his behaviour.

Like the internal inquiry panel, we were unable to track down a copy of the service level agreement with Direct Health, but VS's case notes provide comprehensive evidence of the care he received immediately after discharge.

Town B

9.87 On 29 March 1999, 18 months after sustaining serious brain injuries, VS started living in a two-bedroom bungalow in Town B with two carers from Direct Health providing support for 18-hours a day (see paragraph 9.86 for details of support provided).

9.88 Notes of the first review meeting held on 13 April report on the one hand that his carers had said that *"as each day goes he gets better"* and on the other that he had exhibited rages. Some members of the multi-disciplinary team thought that some of his outbursts were spontaneous while others appeared to be planned. On one occasion VS had thrown an ashtray at a wall. One of his carers had also found a burnt piece of toilet paper in the toilet.

9.89 In early May 1999 VS was assaulted by an inpatient in The Wells Road Centre coffee bar. He was not accompanied by his carers at the time. It was reported that VS used sexually lewd language to female patients before the assault and that this, and rude hand gestures that VS had made to the male attacker earlier in the week, had provoked the attack. It is also suggested that VS retaliated.

9.90 The minutes of a team meeting held on 11 May 1999 reported that VS's mood swings were far worse, and that VS *"acts and believes he is indestructible".* The carers reported that VS displayed two to five outbursts a day. Concerns that VS was not taking his medication were discussed.

9.91 The next day VS was seen in the outpatient department of The Wells Road Centre where he admitted to being frustrated at being unable to do things because of his disability. He had some fleeting suicidal thoughts that he had expressed to his mother over the telephone. A social worker from the City of Nottingham social

services department wrote to the specialist registrar to consultant forensic psychiatrist 1 to tell him that VS's mother was concerned that VS was depressed.

9.92 On 1 June 1999 VS threatened one of his carers with a knife (because he was frustrated that the other one was off sick). VS cut himself with the knife in the process. Later VS told the carer that he had no intentions of harming him but was going to go around to the other carer's home (the one who was off sick) to *"stab him".* There is no indication that Direct Health notified the police or that the trust, once informed of the incident, took any action.

Finding

Given the severity of this incident, our opinion is that the police should have been notified and consideration given to carrying out an assessment under the Mental Health Act.

No reason for not informing the police was given. We speculate that the police's reluctance to press charges on other occasions may have dissuaded VS's clinical team from bothering to contact them in this instance.

9.93 VS expressed his anger towards the carer for several days but later said that he would not have acted on his homicidal thoughts because he was aware that this would result in him either being detained in hospital or receiving a custodial sentence.

9.94 The cognitive behaviour therapist from The Nottingham Traumatic Brain Injury Service agreed to see VS for individual therapy session.

9.95 VS was interviewed on 2 June 1999 about the incident with the knife. Informal temporary admission was offered but declined. The carer who was threatened by VS was advised to stay off work for a few days to allow the situation to settle.

Finding

The offer of temporary admission seems to be a genuine attempt to defuse the situation.

9.96 VS was seen in outpatients on 4 June 1999 when he was told that sharp knives would be removed from his home. He was initially angry saying *"you're treating me like a child"* but came round to the idea.

9.97 VS's eligibility for detention under the Mental Health Act 1983 was discussed at a care planning meeting on 8 June. He was not thought to be eligible. The minutes state *"should (VS) reoffend, the criminal justice system should be allowed to run its course".*

9.98 The specialist registrar to consultant forensic psychiatrist 1 wrote to VS's GP on 10 June to tell him about the incident with the knife and raise concerns that (1) VS's care package could break down if his carers were unable to tolerate further abusive behaviour, and (2) VS might actually harm someone.

9.99 The letter stated that VS was not sectionable by means of the Mental Health Act 1983, and that he suffered from a personality disorder exacerbated by head injuries:

> "*Following two assessments under section 2 of the Mental Health Act and a lengthy admission under our care, we have concluded that his personality disorder is largely untreatable. If any of these two points of concern do arise, it is therefore unlikely that detention by means of the Mental Health Act will be an option (although this shall have to be assessed at the time).*"

9.100 A clinical team meeting held on 22 June 1999 heard that VS had caused some criminal damage to his home. The police had been notified but no charges were made. VS complained that he felt like a child because he "*had to be watched all the time*".

Finding

The approach to notifying the police of criminal activity is inconsistent (see section 11).

9.101 The failure of VS's carers to keep records was discussed at the clinical team meeting on 6 July. Consultant forensic psychiatrist 1 and the social worker from the City of Nottingham social services department said that it was unacceptable that records were not kept. The social worker subsequently wrote to the manager of Direct Health asking daily records to be kept and discussed at supervision meetings. (This issue appears to have been resolved by the introduction of a daily diary by 3 August 1999.)

9.102 On 7 July 1999 City of Nottingham social services wrote to Direct Health to reduce VS's night-time support by six hours. He subsequently had no carers between 1am and 7am.

9.103 On 17 August a CPA meeting was held. VS was reported to be leaving his domestic chores to his carers rather than attempting them himself. He was experiencing repeated episodes of depression. He was occasionally damaging property, and was noted to be sexually and racially abusive at times when taken out by his carers. He had attended a day centre on only three occasions. By this time, his support package had been reduced to two carers for 15-hours a day, and one for three hours.

9.104 Consultant forensic psychiatrist 1 saw VS as an outpatient on 24 September 1999. VS said he wanted to be more independent, and the number of carers to be reduced from two to one. This was discussed at a meeting on Thurland Ward and it was agreed that VS was likely to respond favourably to the reduction in level of support.

9.105 On 2 November 1999 VS threw a plate of food across the room at home. A few days later he smashed his living room door and head butted it.

9.106 As from 8 November 1999, VS's support was reduced to one carer at any one time.

9.107 VS's continued angry outbursts were discussed at a clinical team meeting on 1 December. It was reported that VS might have had a seizure (his eyelids had fluttered and he lost tone in his body for 30-40 seconds). Consultant forensic psychiatrist 1 wrote to consultant neurologist 3 on 3 December asking for VS to be re-assessed.

9.108 Separately VS was seen by the consultant clinical neuropsychologist at The Nottingham Traumatic Brain Injury Service. The consultant clinical neuropsychologist had earlier (April 1998) expressed his view that VS's immature and antisocial personality traits predated any head injury.

9.109 On 24 December the case manager for The Nottingham Traumatic Brain Injury Service, wrote to consultant forensic psychiatrist 1 to tell him that one of VS's knives has been returned (with the understanding that it was stored out of reach); and that VS's care hours had been changed to start at 9am (because another one of his carers had left).

9.110 On 27 December 1999 VS threatened his carer with a hammer after he refused to take VS to see his mother (because he knew she did not want to see him as VS had been abusive to her earlier that day). VS said: *"You've had this f..... coming to you for a long time."* The carer felt that his life was in danger, pushed VS over and left the house. He resigned shortly after. Direct Health, the carer's employer, did not inform the police.

Finding

Our opinion is that this was an extremely serious incident that Direct Health should have reported to the police (see section 11).

9.111 The multi-disciplinary team met on 5 and 7 January 2000 to discuss the incident and its implications for the risks posed by VS to carers, the public and VS himself. It was agreed that the care package provided by Direct Health should be

reduced to one to two hours a day for three to five days a week because VS was considered to be able to cope with activities of daily living. The reduction in support was also thought important to avoid VS becoming over involved with carers and to stop him developing unrealistic expectations of them. The shorter, more practically focused visits were also thought likely to reduce the risk to carers to an acceptably low level. The notes of the meeting indicate that no consideration was given to reporting the incident to the police or assessing VS under the Mental Health Act. However, they do conclude that *"in the event of a breakdown in the care package, there may be a need to terminate [VS's] community placement."*

Finding

In our opinion, VS threatening his career with a hammer should have prompted consideration of whether he should be assessed under the Mental Health Act.

9.112 The multi-disciplinary team also agreed to stop the anger management sessions because *"it was clear that (VS) has not been able to change or benefit from them."* VS would be reviewed by the neurologist at the Queen's Medical Centre *"in the next few months".* Consultant forensic psychiatrist 1 agreed to remain in contact with VS until the new arrangements had been put in place and tested.

Finding

This period of time seems to have been a cross roads in VS's care. Having started with a very intensive package of care to facilitate his discharge, there was now a significant reduction being proposed because of VS's aggression and the belief that increasing VS's independence and levels of frustration would help moderate his behaviour.

9.113 The multi-disciplinary team noted that the presence of two carers had not prevented VS acting inappropriately in public (using sexually inappropriate and aggressive behaviour with strangers), and agreed that it would be an acceptable risk to allow VS to go out unsupervised.

9.114 The risks to VS of the reduced care package — in particular loneliness and isolation leading to depression, self-harm and suicidal thoughts — were also thought to be low (although it was agreed that the risks were likely to increase if the care package broke down completely).

9.115 Consultant forensic psychiatrist 1 wrote to VS's GP to inform him of the new care package. In the letter he points out that if it broke down, a residential placement may need to be found.

9.116 At the review meeting on 14 January 2000, one of VS's main carers (who provided three hours support on three week days and five hours a day on Saturdays and Sundays) reported that VS was now managing most tasks on his own. The carer reported that he was confident about managing VS's aggression should it arise. VS's mother noted that VS had noticeably *"quietened down"* and had not subjected her to any verbal abuse (although it was reported that VS had *"trashed"* a bread bin after an unsuccessful attempt to make a sandwich).

9.117 The cognitive behaviour therapist carried out a risk assessment (completed in January 2000) to gauge the impact of reducing VS's level of care. VS was found to be capable of carrying out daily tasks such as shopping, using public transport and making meals and drinks for himself, and that he had *"surpassed the expectations of many".*

9.118 The main risks were identified as VS's poor tolerance of frustration, disinhibition (leading to verbal and physical aggression towards objects and people), and his sexually offensive behaviour towards women. Although some of VS's aggression and disinhibited behaviour was thought to stem from lack of insight and awareness of its consequence, the assessment report states that:

> *"it is clear that a significant feature of his aggression is that it is often purposeful, and is carried out with the intention of dominating and intimidating others in order to get his own way."*

9.119 The report concluded that VS had learned that aggressive behaviour was extremely effective in influencing others, and that he had made little attempt to

modify his behaviour. His carers were reported to be unable to prevent aggressive and disinhibited behaviour, especially in public places. Carers were reported to be the target of verbal abuse and physical aggression at home which made it difficult to recruit and retain staff. The report concluded by asking VS's clinical team to decide whether it was appropriate to continue providing care on the current basis or to explore other arrangements such as some kind of supported, staffed accommodation or unit.

Finding

The presence of two carers had not prevented VS exhibiting aggressive and inappropriate in public, and had seemed to increase his levels of anger and frustration (confirmed in the internal report. Although seemingly counter intuitive, the reduction in the number of carers from two to one, and the decrease in the number of hours spent each day with VS, appeared to have some moderating effect on his behaviour — and increased his independence.

9.120 At the end of January 2000 VS was involved in an incident in the coffee bar at The Wells Road Centre when another patient threatened to throw an ashtray at him. VS responded by throwing a chair at him which missed and hit another person. VS was banned for one month.

9.121 Shortly after, VS was involved in an argument with another patient just outside the coffee bar. After a further aggressive outburst in the coffee bar on 5 April 2000, VS was banned indefinitely.

9.122 On 10 November 2000, the acting forensic social work manager at Wells Road referred VS to the Independent Living Team (part of the City of Nottingham's social services department) for care management support and review. In her letter she stated: *"it is now felt that most of his needs relate to difficulties stemming from (his) brain injury"* and that her own role has become one of monitoring and reviewing his care package and that *"this is not a role which should keep him with the forensic mental health team."* A representative from the Independent Living Team was invited

to the next care programme approach review on 24 November 2000, but no one attended.

9.123 At the meeting it was reported that VS had been banned from his local pub following one of his outbursts. All concerns were reported to relate to his brain injury either directly or indirectly because of how depressed and angry VS felt about his disability. At this time, VS was receiving 20 hours support a week from a single carer. The acting forensic social work manager agreed to follow up VS's referral to the Independent Living Team. Once a care manager (from the Independent Living Team) had been identified, it was agreed that VS could be discharged from the forensic service (VS would continue to see his GP and the consultant neurologist at the Queen's Medical Centre). The case manager from the brain injury service agreed to find a second carer to share the responsibility of supporting VS.

9.124 On 3 December 2000 the Independent Living Team wrote to the acting forensic social work manager to say that it was not able to support people with head injuries.

9.125 On 15 January 2001 Community Care Services was appointed to provide half of VS's care package which enabled Direct Health to reduce its hours from 20 to 10 a week.

9.126 A case conference meeting to discuss the recent changes was held on 12 February 2001. The notes state that consultant forensic psychiatrist 1 had discharged VS.

Finding

Although consultant forensic psychiatrist 1 ceased direct contact with VS during 2000 he continued to attend all the CPA review meetings.

9.127 On 18 January 2001 the nurse manager from Direct Health wrote to say that its only carer prepared to work with VS wished to withdraw. She gave notice of Direct Health's decision to terminate the contract because it could not find anyone to take

his place. Community Care Services was subsequently contracted to provide 20 hours support a week to VS.

9.128 On 6 April 2001 VS had a fight with a service user at the Friary Drop-in Centre. A care worker tried to intervene and was hit. VS was banned from using the centre. There is no indication that the managers of the drop-in centre informed the police.

9.129 On 14 May 2001, VS's mother told the acting forensic social work manager that VS visited the cafe at a local children's adventure playground where he sometimes volunteered to clear up and wash up. The acting forensic social work manager subsequently challenged VS about working at the playground. He told her that he would never hurt a child.

Finding

We did not interview the acting forensic social manager. Although she spoke to VS, we do not know whether or not she informed the managers of the playground of the potential risk VS posed to children so that they could decide whether to stop using his voluntary services (or take any other action to safeguard children). VS's case notes state that VS continued working at the playground until at least 22 January 2002. See section 12 for more comment on this issue.

9.130 On 29 June 2001 VS grabbed one of his carers by the throat and punched him. The police were notified. Face-to-face support was withdrawn and replaced with daily phone calls.

9.131 At an enhanced CPA meeting on 30 July 2001 Community Care Services confirmed that it was no longer willing to support VS because of the risks he represented.

9.132 The police arrested VS on 31 July for the assault on his care worker in June. VS denied the assault and no further action was taken because the police thought that there was insufficient evidence.

9.133 Case notes dated 13 August indicate that VS had thrown plastic fruit in the presence of the acting forensic social work manager and that the police had expressed concerns about VS making inappropriate sexual comments about her.

9.134 According to the chronology given in the internal report, VS was arrested on 16 August 2001 for false imprisonment, indecent assault and assault. It was alleged that on 7 August VS had invited a male friend back to his house after a night in the pub. Once in the house, VS is alleged to have locked the door and at one point to have removed his clothes and grabbed his friend by the testicles. VS eventually apologised and let the man go. VS denied the charges and was bailed to return to the police station in September. However, the charges were dropped due to lack of evidence.

9.135 Social services supervision notes dated 16 November raised concerns about VS's social isolation and his ability to look after himself. Although the notes stated that *"there is some evidence that he has improved"*, the author (the acting forensic social work manager) concluded that his is "*not really a forensic case"* and that VS needed to be referred to another service and his housing needs re-considered.

9.136 On 20 November 2001 VS was robbed of £115.

9.137 At the CPA meeting on 3 December it was noted that VS was coping better than expected without support. His main problem was reported to be social isolation. VS asked for some kind of carer support to be reinstated and to be allowed to return to the Beeston Day Centre.

9.138 The note reported a discussion about how VS appears to fall between two stools:

> *"On the one hand VS has a high degree of need because of his disability but his aggressive, and potentially aggressive behaviour, has made it difficult to access resources that other people with his high level of need would be able to access. It was generally acknowledged that the forensic service is not the appropriate one for (VS) and in the past referrals have been made to assessment and care management teams and the Independent Living Team,*

both of whom felt they could not take on (VS's) case mainly because of issues around risk."

9.139 An occupational therapy assessment report dated 22 January 2002 stated that VS was still helping in the cafe at the local adventure playground.

9.140 At the CPA meeting held on 26 April it was reported that VS continued to live independently without carers or day care, but that he and his mother had asked for help in the home and to be able to re-attend day centres. VS was reported to have good relations with his neighbours (despite periodic disagreements), and to visit his local pub once or twice a week where he interacted with other customers and the landlord. He regularly used public transport and shopped by himself. He was sometimes subjected to verbal abuse by children. The notes indicate that VS had recently been diagnosed with diabetes which he reportedly was managing adequately.

9.141 On 30 May the Friary Drop-In Centre wrote to VS to tell him that he could not use the centre unless he agreed to be accompanied by a dedicated carer.

9.142 A forensic social worker visited VS on 20 September 2002. He was concerned about his physical health. He wrote to VS's GP detailing his concerns on 24 September.

9.143 On 2 October 2002, the case manager for The Nottingham Traumatic Brain Injury Service wrote to VS's forensic social worker to let him know that he was discharging VS from his caseload.

9.144 On 4 October the forensic social worker re-referred VS for outreach services.

9.145 Another care programme approach review meeting was held on 8 November 2002. It was noted that a number of agencies had refused to offer VS support on account of his aggression and violence towards staff. VS reported that he was being harassed by local youths.

9.146 On 15 November 2002 VS's forensic social worker wrote to Nottingham City Housing Department's 'floating support co-ordinators' to ask for support for VS.

9.147 On 3 June 2003 the police interviewed VS about accusations that he had destroyed a friend's video. VS was not charged.

9.148 On 11 June, following a break-in at VS's home, neighbours reported that he was running up and down the street brandishing a stick and shouting abuse. VS became distressed to the point that an ambulance was called. (Between January and June 2003 VS's bungalow was reportedly broken into and/or vandalised four times.)

9.149 On 16 June, VS and his forensic social worker met with a worker from Town B Housing to discuss the possibility of moving to another area. VS became verbally abusive when asked about his broken internal doors.

Town A

9.150 On 12 July, VS moved to a new home in Town A. During the move, VS became agitated and threatened to hurt himself. He was also verbally abusive to his mother and stepfather and threatened them with a kitchen knife. He reportedly smashed several items of his own furniture and was verbally abusive to the people with whom he was exchanging homes.

9.151 Consultant forensic psychiatrist 1 reviewed VS following a request from the forensic social worker. This request was prompted by an apparent increase in the number of aggressive outbursts at home. Consultant forensic psychiatrist 1 wrote to VS's GP on 31 July with the outcome of the review. In his letter he stated that VS *"presents as physically well with no new features or evidence of mental illness."* He concluded by saying that he did not believe there was any further input he could make at that time.

9.152 On 11 August VS visited his mother's house. He is reported to have thrown himself at the windows of her house and kicked the garden fence when he could not

get the key to the front door to work. Later he told his mother he would return and set fire to her house. Police were called. VS head butted a large hole in a double-glazed window. He was taken to the local accident and emergency department but discharged the same day.

9.153 VS returned to his mother's house on 16 August. He threatened to break the windows when she refused to let him in. The police were called but the situation was diffused by VS's brother-in-law. After this incident, VS's mother is reported to have said that she wanted *"reduced/no contact"* with her son.

9.154 On 2 September the forensic social worker wrote to consultant forensic psychiatrist 1 to let him know that the case manager for The Nottingham Traumatic Brain Injury Service (although reluctant to re-engage with VS formally) had agreed to identify residential accommodation that may be able to accommodate VS's complex needs. However, the case manager from the brain injury service was reported to share the concerns of the forensic social worker and consultant forensic psychiatrist 1 that the vast majority of residential options would be inappropriate.

9.155 The risk assessment and risk management plan completed on 5 September 2003 stated that VS's diagnosis and cognitive damage meant that there was an ongoing likelihood of him becoming angry and frustrated, and that these factors would worsen over time as a consequence of ageing and declining physical health.

9.156 VS is noted as being caught in a cycle of becoming frustrated, acting out verbally/physically, experiencing adverse consequences, and becoming more isolated which in turn made him more angry and frustrated. The resulting downward spiral of behaviour had led to VS being consider unsuitable for or banned from Emmanuel House, the Friary Drop-in Centre, Beeston Day Centre, several pubs, his local KwikSave and Co-op, and the Oaks Outreach Service.

9.157 VS's conversation and conduct are reported as sometimes being racist, sexist and sexually lewd. VS is also reported to lack insight into this behaviour, be unable to face the consequences of his actions, and have difficulty coming to terms with his disability (which further affects his mood and level of frustration).

9.158 The report noted that although he had multiple needs he had either refused to engage with or been considered suitable by all relevant services except those provided by the Nottingham City forensic social work team and consultant forensic psychiatrist 1.

9.159 A new risk management plan was put in place on 5 September 2003. The risk VS posed to his mother and stepfather was assessed as 'medium'; to professionals as 'low to medium', to the general public 'low to medium'; to property 'medium to high' and to himself 'low'. The seriousness or severity of harm should it occur was assessed as 'medium' for his mother and stepfather, and 'low to medium' for professionals, property and VS. The plan stated:

> *"VS's outbursts are very predictable, in that they occur if frustrated with a task or thwarted by a person, and thus should be manageable. However, the sheer frequency of such incidents, coupled with VS's imposing physical strength, propensity towards machismo and limited insight, all work against this rationale. Thus there is this collective cognisance amongst all those working with VS of this individual being a 'walking time bomb' in the community.*
>
> *The likelihood of all of these risks could increase in VS's level of isolation and thus sense of frustration increases.*
>
> *There is also the continual possibility of something going terribly wrong during one of (VS's) outbursts."*

9.160 VS's forensic social worker explained to us that VS was described as *"a walking time bomb"* because he was so unpredictable and impulsive and not because anyone thought that he would kill.

9.161 The risk management plan focused on managing risks to staff, for example by not visiting VS alone and what to do if present during one of VS's outbursts. Only one element of the plan related to the wider public – a risk strategy meeting that would

include the police from the *"Dangerous Persons Management Unit"* (DPMU) which had been planned for 20 October 2003. In the event this meeting did not occur as this was the same day VS killed LW.

Finding

We believe that there should have been much earlier engagement with the police in managing the risks posed by VS. The police had a **"Dangerous Persons Management Unit"** *which we understand to be a forerunner to the emerging MAPPA services (Multi Agency Public Protection Arrangements).*

9.162 Around this time (early September 2003) VS is reported to have started a relationship with AW (although this was not made known to health professionals until 23 September). VS referred to AW as his girlfriend. We have not been able to ask AW about how she viewed the relationship. AW was reported to be in her seventies and had a son — LW — thought to be in his mid-thirties. LW was living with his mother at the time of the incident.

9.163 On 23 September 2003 VS and LW argued. LW told VS to jump in front of a car. VS laid down in the road and said he wanted to be run over. An ambulance was called and VS was taken to the accident and emergency department where he was jointly assessed by a mental health liaison nurse and a social worker from the forensic team at Wells Road. They found no evidence of suicidal thoughts. It was during this interview that VS first talked about his relationship with AW. VS was discharged with follow up from the forensic team.

9.164 A police report dated 23 September 2003 indicates that AW requested assistance to remove LW from her home because he was drunk and causing distress.

9.165 On 24 September the forensic social worker was due to see VS at his home when he saw him coming out of AW's house a few doors away. A young girl, aged approximately three to five years old, was standing in the doorway of AW's house. VS confirmed that the young girl was one of AW's grandchildren whom she regularly looked after. Child protection services were informed.

Finding

The forensic social worker acted quickly to identify the risk VS posed to AW's grandchildren and to inform child protection services.

9.166 On 25 September AW telephoned the police to say that VS had hit LW with a hammer. LW was apparently drunk. A neighbour also rang to report that VS had head butted LW. Later LW rang the police to report that his mother was being targeted by a drunken male.

9.167 On 26 September VS phoned his forensic social worker to say that LW had threatened him with a hammer. VS had retaliated by head butting him. VS also phoned the police to say that he had had a fit and fallen through his bathroom door destroying it.

9.168 On the same day the case manager for The Nottingham Traumatic Brain Injury Service wrote to the forensic social worker to decline a formal request (made on 18 September 2003) to resume providing care to VS on the basis that VS had *"no identifiable rehabilitation needs relating to his brain injury."*

9.169 On 1 October VS telephoned his forensic social worker to tell him that he was going to marry AW. LW had stamped on VS's hand and he was advised by his GP to get it x-rayed.

9.170 A CPA review meeting was held on 8 October. VS's relationship with AW and the incidents between VS and LW were discussed. VS's mother expressed her concern about VS's ability to cope with the relationship and was worried about how he might react. VS's contact with AW's grandchildren was also raised and plans to prevent VS coming into contact with them discussed.

9.171 All those present felt that VS's behaviour indicated that he was struggling to cope with the situation in which he found himself. However, it was noted that previous attempts to engage VS in anger management and in cognitive behaviour therapy had not been successful in altering his behaviour. Consultant forensic

psychiatrist 1 remained of the opinion that VS had a personality disorder that was untreatable both informally and within the meaning of the Mental Health Act 1983.

9.172 A new enhanced level CPA care plan was produced following the review meeting to reflect the increased risks posed by VS as a result of his relationship with AW (the typed care plan was dated 27 October 2003 but was clearly developed before VS killed LW). The plan stated that the multi-disciplinary team would continue to advise VS to avoid contact with LW and explain the reasons why, and support him in *"coping with his relationship with AW".*

Finding

Despite recognising that VS was struggling to cope with his relationship with AW and his hostile relationship with LW, the multi-disciplinary team appeared powerless to manage the ensuing risks beyond advising VS to avoid LW and helping him cope with AW.

9.173 On the same day as the review meeting VS took an overdose of 14 Nurofen. He was taken to accident and emergency, but discharged that night.

9.174 On 10 October the children's social worker and a colleague visited AW to discuss concerns about the appropriateness of her looking after her grandchildren when VS was present. Unknown to them, VS was in the bungalow at time. He became very angry and abusive. The children's social worker called the police, and left the house with her colleague and AW. When the police arrived, they escorted VS back to his home.

9.175 Once VS had left, the children's social worker continued the meeting with AW. Despite numerous attempts to explain the risk VS posed to her grandchildren, AW misunderstood and later told members of her family that he was a paedophile. The children's social worker was able to contact several family members the next day to set the record straight, but not before LW had been to VS's house. VS was not at home at the time.

9.176 She noticed some bruising on AW's arm and thought that AW may be frightened of VS, and questioned whether she would be able to finish the relationship safely. As a result of this conversation, the forensic social worker and consultant forensic psychiatrist 1 requested a multi-agency meeting with Nottinghamshire Police's Dangerous Persons Management Unit. The meeting was arranged for 20 October 2003 (the day VS killed LW).

9.177 On 15 October, AW telephoned the police to report that VS had stolen a necklace.

9.178 At 7.50 am on 20 October 2003 an ambulance was called to the home of AW. LW was found dead having been stabbed by VS once in the abdomen with a kitchen knife. In VS's signed statement to the police, he said that LW had told him to get out of his house and then punched him in the face *"and that was when I stabbed him".*

10. VS's challenging and destructive behaviour

10.1 The narrative summary describes the challenges VS presented to those involved in his care and management. Although the terms 'multiple and complex needs' and 'challenging behaviour' are often used in association with people with brain injury and/or personality disorders, VS's case appears to be particularly complex and challenging.

10.2 Even before his first head injury in March 1989, he had been prone to aggressive and violent outbursts. In 1992, four years before the third and most serious brain injury, VS's mother is quoted as saying that living with VS was like *"living with a time bomb"*.

10.3 VS's third motorcycle accident in September 1996 left him with serious brain injuries, physical disabilities, slurred speech, a drooping left eye, significant cognitive impairment, and volatile moods.

10.4 VS's behaviour while an inpatient was typified by numerous attempts of deliberate self harm, disinhibited and sexually inappropriate behaviour, destruction of property, verbal hostility, and verbal threats and physical violence towards other patients and staff (particularly women).

10.5 Consultant neuropsychiatrist 1 at Grafton Manor was of the view that although VS's explosive outbursts were initially beyond his control, he learned to use them to get his own way:

> *"he skilfully deploys aggression, gross destructiveness and threatening behaviour in order to dominate and try to control both our other residents and staff."*

10.6 The cognitive behaviour therapist from The Nottingham Traumatic Brain Injury Service told us that VS's behaviour at Grafton Manor became worse as his physical condition improved: *"he became more mobile and more aggressive, more able to express his aggression*". The fact that that a specialist centre like Grafton Manor was

unable to manage VS without resorting to antipsychotic medication is indicative of the unique challenge VS posed.

10.7 VS continued to display aggressive and violent behaviour after he was discharged. VS's case describe VS as being:

> *"caught in a cycle of becoming frustrated (because of his disabilities), acting out verbally/physically, experiencing adverse consequences, becoming increasingly isolated and thus more likely to be frustrated and angry."*

10.8 Notes of a risk management meeting in September 2003 just a few weeks before VS killed LW state:

> *"There is this collective cognisance amongst all those working with (VS) of this individual being a 'walking time bomb' in the community. ... There is also the continual possibility of something going terribly wrong during one of (his) outbursts."*

10.9 Regardless of whether VS's behaviour was the result of his three head injuries or an existing personality disorder (a theme we explore in section 11), it is clear that VS's case was particularly complex and challenging. Indeed, the cognitive behaviour therapist told us that VS's case was unique:

> *"This was unchartered territory for us ... because we had somebody who's had a brain injury and, by the look of it, lots of premorbid personality issues going on as well that hadn't settled as part of his injury rehabilitation, that was very volatile and aggressive. ... We hadn't had (a case like his) in my time in the service before and we haven't had somebody like it since, so he's incredibly atypical in terms of somebody who has a brain injury. Irritability and aggression is reasonably common but not to that degree and not to that longevity."*

10.10 The multi-disciplinary team responsible for VS's care at the time that he was sectioned for the second time (May 1998) is quoted in the internal report as not having seen before "*symptoms of the nature and degree with which VS was now presenting".*

11. The internal review

General comments

11.1 We, the independent investigation team, have considered the internal review carried out by the trust in the context of attitudes and practices that prevailed between 1989 to 2003 when VS was under the care of Nottinghamshire Healthcare NHS Trust and its predecessor, Nottingham Healthcare NHS Trust, and at the time the review was conducted (October 2004). As already discussed in section 6, attitudes to people with a personality disorder have changed significantly since then. In addition the national service framework for mental health was at a very early stage of implementation, and services that are today taken for granted such as crisis resolution and home treatment did not exist.

11.2 In this respect, the internal investigation was very much 'of its time'. However, the chronology is largely accurate and comprehensive, and makes reference to its source material throughout. Although only a relatively small number of staff were interviewed, the work of all staff was considered.

11.3 In this section we comment only on issues covered by the trust's internal review where we have further comment to make. This includes VS's diagnosis where we believe that a different classification of personality disorder may have changed the therapeutic emphasis for those involved in his care; and risk assessment and management which we believe to have been weak particularly in relation to safeguarding and child protection issues.

11.4 Section 12 goes on to comment on issues that were not covered by the internal review or are required of us to fulfil the terms of reference of this independent investigation.

Diagnosis

11.5 The internal report accepts VS's diagnosis as personality disorder exacerbated by head injuries sustained in three motorcycle accidents (the third being the most serious). It quotes the report produced on 19 November 1998 by consultant forensic psychiatrist 3 in preparation for VS's appearance at Nottingham Magistrates' Court to face charges of arson and criminal damage:

> *"[VS had] some organic brain damage, and this appears to have exacerbated some of his previous antisocial behaviour. It is certainly clear that he does have full control of his mood and actions and this is characterised by his impulsive aggression and acts of violence with little regard for consequences."*

11.6 The internal report notes that the care package for VS once he was discharged was said to have been designed to help manage some of the risks that he posed and not to treat his personality disorder. The clinical team was said to feel under an obligation to manage some of the risks posed by VS's behaviour even though they did not believe that they were making any progress in treating his personality disorder.

11.7 The internal review notes that it interviewed a number of mental health professionals involved at various stages of VS's care and that they all thought that he was untreatable. It comments:

> *"The issue of whether or not a particular personality disorder is likely to respond to psychiatric or psychological intervention, thereby warranting such detention, is often a source of disagreement amongst mental health professionals. We interviewed a number of individuals who were involved at different stages of VS's inpatient and outpatient care. It was notable that we could find no areas of dissent amongst professionals regarding the issue of whether or not VS was treatable. One of the professionals we interviewed (forensic social worker) told us that there was* 'no evidence that VS had benefited from previous inpatient treatment – his time at Wells Road (had been) a nightmare'. *Another (specialist registrar to consultant psychiatrist 1)*

said that VS's case was one where it was 'as clear as it can be' that (VS was) untreatable."

11.8 The internal review team found no reason to doubt VS's diagnosis of personality disorder.

Conclusion

We consider that, under the International Classification of Diseases (ICD), diagnostic category F07.0 (organic personality disorder) or F07.8 (other organic personality and behavioural disorders due to brain disease, damage and dysfunction) might have been a more accurate fit for VS.

VS may well have displayed antisocial personality traits before his first significant head injury in 1989 at the age of 16. However, his behaviour worsened after both this head injury and the further head injury in 1996. Therefore the diagnosis of ICD F07.0 or ICD F07.8 might have better reflected the true picture in VS's case and would have recognised VS's condition as a mental illness rather than a psychopathic disorder.

We stress that this may have had no material effect on the eventual outcome but could have freed up the professionals involved to consider assessment under the Mental Health Act when violent incidents occurred.

Although we asked to see VS, he told his responsible clinician at Rampton that he did not want to see us. We acknowledge that our assessment of his case has been somewhat limited by this, although we do not believe that interviewing him would have significantly altered our conclusions.

Detention under the Mental Health Act 1983

11.9 VS was detained under the Mental Health Act 1983 on two occasions both using section 2, which allowed 28 days for assessment. The first time, on 30 January 1998, was after VS had made several attempts to leave Thurland Ward shortly after he was admitted.

11.10 According to consultant forensic psychiatrist 1, VS was a "*relatively unknown quantity*" at the time, and the team was assessing whether or not VS's personality disorder was such that it merited further detention for treatment under section 3 of the Mental Health Act 1983.

11.11 The second use of section 2 occurred on 15 May 1998 and resulted in VS being transferred to Trent Ward, a locked unit, because of the risk he presented to himself and others. At this time, the clinical team was still not sure whether his symptoms were related to mental illness or a direct consequence of the separation from his wife.

11.12 There are occasions when assessment under the Mental Health Act would have seemed appropriate. In particular, on 1 June 1999 when VS threatened his carer with a knife and, on 27 December 1999 when he threatened another carer with a hammer.

Conclusion

We conclude that if VS had been given a diagnosis of F07.0 (organic personality disorder) or F07.8 (other organic personality and behavioural disorders due to brain disease, damage and dysfunction) as described earlier, resistance to use the Mental Health Act might have been removed. This may have had no material effect on the eventual outcome but may have changed the therapeutic emphasis for those involved in considering his care needs.

Seclusion and assessment

11.13 The original internal trust investigation carried out by the trust highlighted a particular issue relating to the use of seclusion whilst VS was an inpatient. There were concerns that as an informal patient, not subject to the Mental Health Act, the authority of staff to seclude may not be legal. For an informal patient, a mental health act assessment should be carried out as soon as practicable after seclusion is implemented.

11.14 The internal inquiry panel did not find any evidence that such an assessment had taken place on the two occasions that VS was secluded (for three hours on 27 August 1998 and for 35 minutes on 23 September 1998). However, we found evidence that a mental state examination was carried out by the duty senior house officer on 27 August 1998.

11.15 The duty senior house officer concluded that there was no evidence of *"exacerbation of mental illness"* and that VS was not detainable under the Mental Health Act 1983.

11.16 Although it is clear that seclusion of an informal patient can be justified under common law in certain circumstances, the seclusion policy at the time gave no guidance on this. Consequently, the internal review panel recommended that the trust should amend its seclusion policy. We were able to see evidence that the revised seclusion policy dated November 2008 includes guidance on the seclusion of informal patients.

11.17 Although seclusion was only used twice there were many occasions when staff had to restrain VS. On 3 March 1998 the specialist registrar to consultant psychiatrist 1 consulted the trust solicitor about VS being restrained several times a week even though he was not 'sectionable'. The trust solicitor is reported as saying that staff could continue to restrain VS when necessary in order to protect others even though he was considered not to be 'sectionable' and this action would be covered by common law.

Conclusion

We conclude that VS was treated appropriately in respect of restraint and seclusion and that the trust was right to seek legal advice from the trust solicitor. Staff could have used section 5.2 (doctors holding order) or section 5.4 (nurses holding order) of the Mental Health Act 1983 to ensure the legality of their actions.

A mental state examination should have been carried out after VS was secluded for the second time in September 1998.

However, the trust's seclusion policy at the time gave no guidance on the seclusion of informal patients. The trust revised its seclusion policy in November 2008 to include guidance on the seclusion of informal patients.

Police liaison

11.18 The trust's internal investigation made comment that staff felt that the police were not always prepared to take appropriate action for acts that were considered by the staff to be criminal. This particularly related to VS's time as an inpatient where his key worker is quoted as saying: *"The team saw it as an attempted assault* (referring to a violent incident), *the police felt it was normal behaviour for here".*

11.19 However, as stated in the internal review report, on 24 November 1998 VS was convicted of criminal damages in relation to the fires that he set at The Wells Road Centre in May 1998. He received a six-month conditional discharge.

11.20 Once in the community there were occasions when incidents should have been referred to the police but were not. For example, on 1 June 1999 VS picked up a knife from the kitchen and threatened to kill a care worker. Also, VS threatened his care worker with a hammer on 27 December 1999. Neither of these two incidents was reported to the police.

11.21 In contrast, incidents of criminal damage to property were reported to the police, although charges were generally dropped.

11.22 Although the risk assessment and management plan dated 5 September 2003 mentions the possibility of referring VS to the MAPPA panel, a referral was never made.

11.23 The medical director described to us that there were now formal and structured arrangements in place between the trust and the police. He also described how the addition of a local security management specialist within the trust had facilitated stronger working arrangements with the police. However, the medical director describes in his interview with us that there are still on-going issues to be resolved:

> *"There is an intermittent, once a year, meeting (with the police), at the sort of chief executive/constable level* (and) a variety of other operational meetings. *Relationships can vary across the trust. We're quite geographically spread and so you have different relationships. But they are not without difficulties, even now."*

11.24 Describing recent incidents of violence and assaults on staff, the medical director stated:

> *"That still remains an issue occasionally — the police and CPS not prosecuting people when they are on psychiatric wards for violent offences, when we want them to be prosecuted."*

Conclusion

It was a missed opportunity not to have formally reported incidents of criminal damage and assault to the police, and to have supported care staff in pressing charges. The inconsistency of reporting to the police would have made it difficult for the police to build up a picture of the risk VS posed in the community. Equally, repeated police inaction may have dissuaded people to report serious

incidents. There appears to have been a lack of understanding on both sides as to how and when police and criminal procedures should have been followed.

The trust has told us that it has made strenuous efforts over several years to gain the support of the police and CPS in prosecuting people with mental health problems who commit serious offences but with little success. We have in our recommendations suggested a possible way forward for the trust to raise this issue with the police and to engage them in a joint approach to managing risks to the wider public.

Risk assessment

11.25 The internal review comments on risks associated with fire setting in its chronology. The chronology also includes reference to incidents that indicated that VS was a risk to himself, his mother, wife and stepchildren, fellow patients and staff.

11.26 The internal review made no specific comment on the standard of risk assessment carried out on VS – or how the risks were managed. It made no comment on issues relating to safeguarding and child protection.

Conclusion

VS clearly challenged the services with his unique combination of problems, and risk assessment and management were central to his care. However, the internal review did not comment on the standard of assessment and management. We consider the failure to comment on safeguarding and child protection to be a major omission.

We cover risk assessment in section 12.

Recommendations made in the internal review

11.27 The recommendations in the internal review were consistent with the report, but not all the issues were identified (for example, diagnosis and child protection issues). Recommendations 3, 4 and 5 relate to the management of violence and the relationship with the police. Although the action plan is signed off as completed there still remains fundamental difficulties that need further action (see section 13 for our comments on the quality of the action plan and its implementation).

12. Issues arising from VS's care and treatment

12.1 In this section we give our findings on issues that were not covered by the internal review and those required of us to fulfil the terms of reference of the independent investigation.

Care programme approach: policy

12.2 We received copies of the trust's CPA policy and procedures that were in place at the time of VS's care and treatment (1999 to 2003). The trust had a short over-arching CPA policy that outlined the aim of the policy, the responsibilities and a statement on training and communication. The directorates of the trust then had much more detailed procedures about how the CPA policy would be carried out locally. In particular, the forensic services had its own procedure in place which would have applied to VS's care and treatment. We also received the procedure for the adult mental health services.

12.3 The forensic services' CPA document is in our view comprehensive and clear and should be commended. Nationally, at this time (1999 to 2003) most forensic services would have followed the CPA policy for adult mental health services which often did not reflect the complexities of community treatment for patients being managed by the forensic services. For example, 12 minuted multi-disciplinary meetings took place in 1999, four in 2000, three in 2001, two in 2002 and one in 2003.

12.4 There is clear evidence in the clinical notes that CPA reviews were occurring frequently and in line with the procedure. There was comprehensive preparation for the reviews, they were well attended by the multi-disciplinary team members and documentation was of a good standard.

12.5 In our interview with the medical director, he described the implementation and performance management of CPA in 2003 as less rigorous than today. Although the trust has not yet moved to an electronic care records system, the medical director stated that he would today be able to tell us how many people had a care coordinator,

and who had had seven-day and two-day follow-ups. However, within the forensic services in 2003 we have been satisfied that the spirit of CPA was being applied and followed.

Conclusion

We conclude that the trust's CPA policy had been followed in respect to VS.

Record keeping

12.6 We were able to review all of the clinical files associated with VS. Clinical records were recorded in sections according to the professions involved. For example, there is a section relating to medical notes, one for nursing records and another for the forensic social workers. This was normal practice for the time (1999-2003) in most of the United Kingdom and is therefore what we would have expected to see. In recent years many trusts have moved to a contemporaneous note taking which makes it easier for clinicians to follow what is occurring on a day-to-day basis. Many mental health trusts have now also implemented electronic care records giving an even more comprehensive record.

12.7 In the year leading up to the offence (October 2003) there are very well documented notes made by VS's care manager, his forensic social worker. Telephone contact with VS and his family was particularly important at this time and there is strong evidence that calls were recorded comprehensively.

12.8 Some reports written for CPA reviews were not dated making it very difficult to understand them in context. However, these are the exception and generally most entries are clearly dated and signed.

Conclusion

The records in relation to VS's care and treatment are detailed and comprehensive. There were only a few occasions when we were unable to source documents relating to his care, for example the initial service level agreement with Direct Health.

Risk assessment

12.9 Risk assessment and management were central to VS's care. With the exception of the risks VS posed to children, we believe that staff fully understood the risks that were present but often had no effective strategies to minimise those risks.

Self harm and risk to others

12.10 There was broad agreement and understanding that VS presented a considerable risk to others and a risk to himself. The case files do not show a clear direction on how such risk was to be managed. This resulted in inconsistent practice and confusing messages. Violence and bullying towards staff and service users did not result in any particular sanctions. Actions that should have resulted in arrest by the police were not reported. VS's abusive outbursts in the community were tolerated and did not affect his very active programme of community activity after discharge.

12.11 We believe that staff were doing their best to manage the very considerable risks that were evident, but that the focus was on advising carers on how to react before or during one of VS's outbursts. However, because the behaviours that would not be tolerated were not described, and the lack of understanding between care services and the police on what constituted criminal behaviour, we believe that the public was put at unnecessary risk.

12.12 The notes of the risk assessment and risk management plan that took place on 5 September 2003 describe VS as a *"'walking time bomb' in the community"* and that there was *"the continual possibility of something going terribly wrong during one of*

VS's outbursts with a concomitant increase in the seriousness of the severity of the incident". Despite these comments, the agreed action plan focused on advice to staff on avoiding or diffusing VS's outbursts and continued to only *consider* referring the case to MAPPA. However, given that MAPPA was only just getting started – and the lack of meaningful engagement with the police on VS to date – it is unlikely that the referral would have prevented VS killing LW just six weeks later.

Fire setting

12.13 The internal review team noted that the clinical team did not assess VS as being a serious fire risk. The internal review team defended this position, explaining that consultant forensic psychiatrist 1 was of the view that VS set fires because he was frustrated and that these episodes would diminish once he was discharged; and pointing out that this assessment had proved correct. There were only two minor incidents of possible fire setting in the years after he was discharged and one alleged incident of making a false call to the fire brigade.

Child protection

12.14 We found that there were inconsistencies in approach regarding child protection. For example, on 17 March 1998 VS's stepchildren were put on the child protection register, and at the child protection meeting it was made clear that VS should have no contact with either of them. Yet on 14 April 1998 VS's wife visited VS with his stepdaughter.

12.15 VS was allowed to continue helping out in the café at a children's local adventure playground even though there were concerns based on factual evidence that VS had been violent to children in the past.

12.16 However, VS's forensic social worker is to be commended for his quick action in identifying the risk VS posed to AW's grandchildren in September 2003, and for notifying children's services straight away.

Conclusion

We conclude that although the risks that VS posed to himself, property and others were well known and carefully documented, staff had no effective strategies to manage those risks. Risk management plans tended to be reactive and focused on advising staff on how to protect themselves with little mention of protecting the wider public.

Risk assessment and management in relation to safeguarding and child protection was generally poor and inconsistent. Consequently we have been left with the impression that many professionals working with VS did not see child protection as a priority and did not take it seriously enough.

Care package provided to VS in the community

12.17 Prior to VS's discharge from Thurland Ward in March 1999, a comprehensive package of care was put together to support him in the community. This is well documented. The package was jointly funded by social services and health which reflected the complexity of his needs and the *"considerable risks to the public"* posed by VS. The main responsibility for community support was given to a secondary provider called Direct Health. Unfortunately, we, like the internal review panel, were not able to locate a copy of the actual contract made with Direct Health, and the company itself has since been merged with another provider.

12.18 Carers from Direct Health were introduced to VS while he was an inpatient. A varied programme of activity (involving shopping, cooking, swimming, horse riding, trips to the cinema and even water skiing) was also initiated from Thurland Ward to enable the carers to get to know him. The package of care after discharge initially consisted of two staff for 18 hours a day. In addition, VS attended a day centre in Beeston which his care staff would drive him to. It was agreed that the care package should be reviewed after one month with the view to scaling it down.

12.19 The staff employed by Direct Health to deliver VS's care package were given training and on-going support by the health and social care team as it was recognised that VS would be likely to present a particular challenge.

12.20 The cognitive behaviour therapist described the support to VS as *"uncharted territory".* The complexity of VS's aggression, his diagnosis of personality disorders and the impact of his head injuries made this a unique case for Nottingham: the cognitive behaviour therapist told us that *"we hadn't had* (a case like VS's) *in the service before that and we haven't had somebody like that since, so he's incredibly atypical in terms of somebody who has a brain injury".*

12.21 There was a significant incident in June 1999 when VS threatened one of his care staff with a knife. Readmission to hospital was considered on the day but the decision taken was to remove sharp knives from his flat and that if his care staff refused to continue supporting him admission would be inevitable.

12.22 By 17 August 1999 his support package had been reduced to two carers for 15-hours a day, and one for three hours. By November 1999 the care package was reduced to one-to-one support with less cover at night time. This reduction was first because VS was not responding well to having two people with him at all times, and secondly because it was a very costly and was not intended to be sustained long term.

12.23 In December 1999 there was another serious incident when a member of care staff was threatened with a hammer. The member of staff did not return to work with VS as a result. There were various meetings to discuss this incident which led to *"significant change in the carer/support arrangements for VS"* and *"a review of the health and safety of carers, the public and VS himself".* As a result the care package provided by Direct Health was reduced to one to two hours a day for three to five days a week in January 2000, and the anger management sessions terminated because "*it was clear that (VS) has not been able to benefit from them"*. It was also agreed that it would be an acceptable risk to place VS unsupervised in public situations as the presence of two carers had not prevented VS acting inappropriately in the past. Consultant forensic psychiatrist 1 agreed to remain in contact with VS until the new arrangements had been put in place and tested.

12.24 VS's behaviour eventually led to all community care services being withdrawn in July 2001 and an indefinite ban from day centres. Despite this it was felt that he was managing somewhat better than had been expected. He continued to live in the community; formed some positive relationships; sustained his diet; and, didn't get into serious trouble with the police.

12.25 In his final year in the community (2003) VS's support consisted of regular telephone contact and some visits by his forensic social worker. His family, particularly his mother also continued to support him. Consultant forensic psychiatrist 1 continued to attend CPA meetings, despite having discharged VS from forensic services in 2001.

12.26 VS's forensic social worker arranged for VS to move home in July 2003 because he had become the target of considerable abuse from local youths and his bungalow had been broken into on four occasions. It was hoped that the move to a quieter neighbourhood would defuse the situation.

Conclusion

We consider that the care that VS received during his time in the community between 1999 and 2003 was well planned and considered given the complexity of his case. The initial support package was very intensive, and VS responded adversely to such close supervision. Reducing the level of supervision helped reduce his frustration levels and moderate his behaviour. However, when the care package support ceased in 2001 there seems to have been few options open to the forensic team. The shared clinical view was that VS did not warrant admission to hospital and did not fulfil the criteria for compulsory admission under the Mental Health Act. Attempts by VS's forensic social worker to have VS accepted by other support services, including the trust's adult mental health services, all failed.

There is no reason to believe that VS would have responded well to the re-introduction of a care package – even if new carers prepared to work with VS

could have been found – or that this would have made any difference to his behaviour and the eventual outcome of this case.

Multi-agency working

Health and social services

12.27 The forensic mental health services were fully integrated between health and social services. Staff worked as a single multi-disciplinary team but with their line management held within each separate profession. There is strong evidence that care was discussed regularly and risks assessed as a team. VS's care in the community was jointly funded between social services and health, and was an innovative attempt to make things work.

12.28 Health professionals failed to inform children's services when VS's wife visited VS on Thurland Ward with her daughter, and when they knew that he was volunteering at a children's adventure playground.

Conclusion

The health and social care staff of the forensic team were working in a positive and proactive way throughout their involvement with VS. The care programme approach was proactively used to enhance the multi-agency working arrangements.

Health professionals should have worked with child protection services to prevent VS coming into contact with his stepchildren while they were on the child protection register, and with other children.

The police

12.29 The case occurred at a time when Multi Agency Public Protection Arrangements (MAPPA) were just forming for high risk offenders. However, we heard from the forensic social worker that there was a team within the Nottingham police called the

'Dangerous Persons Management Unit (DPMU)' that appeared to be a forerunner to MAPPA and may have been able to support the health and social care agencies with VS's management. Contact with this team occurred very close to the date of the offence with the first meeting planned for the actual day VS was arrested.

Conclusion

At the time of the incident the working relationship between the trust and the police could be characterised as one of misunderstanding and confusion on both sides. There were times when it would have been helpful if the police had charged VS following his violent actions whilst an inpatient. However, there were occasions when violent and threatening behaviour in the community was not reported to the police when it should have been. VS was not referred to the DPMU (the precursor of MAPPA) until October 2003 even though it was considered as a possibility much earlier.

We believe the trust still has work to do with the police and the CPS to address long-standing difficulties.

The Nottingham Traumatic Brain Injury Service

12.30 The service first became involved with VS at Grafton Manor in its role of assessor for out of area placements.

12.31 The traumatic brain injury service is situated and managed within the acute trust (now named Nottingham University Hospitals NHS Trust). Although it is primarily a case management service, it worked very closely with the forensic team during VS's time as an inpatient, planning his discharge from hospital and until nine months after his discharge. It was involved in selecting appropriate care staff to support VS and provided ongoing supervision to them.

Conclusion

We have been impressed at the role the traumatic brain injury service took in helping with VS's care package. It demonstrated an ability to work alongside the forensic mental health services which greatly enhanced VS's assessment and care package in the community.

Grafton Manor

12.32 This is a private hospital (run by the Partnerships in Care organisation) in Northamptonshire. It advertises itself as providing:

> *"highly specialised services for people with the complex physical, cognitive, functional and behaviour difficulties that typically follow a brain injury. Our expert care includes the management of people with challenging behaviour."*

12.33 VS was transferred from Linden Lodge (NHS) to Grafton Manor on 21 October 1996 because of his challenging behaviour. VS remained at Grafton Manor until his transfer to Thurland Ward on 27 January 1998. Although progress was made in respect of his physical recovery, staff had great difficulty in managing his aggressive and unpredictable behaviour.

12.34 The cognitive behaviour therapist told us that when he visited VS at Grafton Manor he was being heavily sedated to manage his behaviour and it was made clear to him that Grafton Manor wished to terminate its involvement in his care. Given that Grafton Manor is one of the few places in the country that specialised in brain injury and difficult behaviour, the cognitive behaviour therapist told us that he was very concerned as to where else would accept VS.

12.35 When consultant forensic psychiatrist 1 assessed VS on 26 January 1998 and arranged for his transfer into the forensic services the next day he reports the following.

"He (VS) has managed to alienate himself from all the staff and patients and is effectively being contained using antipsychotic medication and one to one nursing. His therapy programme has entirely broken down and he lives largely as a recluse."

Conclusion

The fact that Grafton Manor, a specialist unit for brain injury and behavioural problems, was unable to cope with VS when his behaviour got worse gives an indication of the unique challenge that he presented.

St Andrew's Hospital

12.36 This is a privately run psychiatric hospital in Northampton that has a brain injury service used almost exclusively by the NHS. We found some confusion in the care records as to whether VS was referred and assessed by St Andrew's Hospital.

12.37 St Andrew's Hospital confirmed to us that it had no record of an assessment taking place during the period covered by this review.

Conclusion

St Andrew's Hospital may have offered an alternative solution for VS had he been assessed and accepted by them. However, this would have placed him some considerable distance from his family. It would have also been an expensive option with the full cost of care being met by the NHS.

Probation service

12.38 On 15 November 1998, consultant forensic psychiatrist 3 recommended a probation order for VS in the report prepared for VS's appearance on 24 November at

Nottingham Magistrates' Court to face charges of arson and criminal damage. He argued that this would allow ongoing supervision once he was discharged into the community in addition to the ongoing supervision from psychiatric services.

12.39 The report stated that consultant forensic psychiatrist 3 and consultant forensic psychiatrist 1 were willing to work with the probation service. The suggestion of a probation order was not taken up so there was no involvement from the probation services.

Conclusion

The recommendation of subjecting VS to a Probation Order was an innovative approach to managing the risks posed by VS.

13. Trust action plan

Trust's system for follow up of action plans

13.1 The trust's internal review was completed in October 2004 and the first action plan with progress notes was produced by consultant forensic psychiatrist 1 on 18 April 2005.

13.2 In our view the 2005 action plan was inadequate. Actions were not clearly defined and did not always specifically relate to the recommendations made by the internal review panel. For example, the action in response to the recommendation that the trust should encourage and support staff in taking appropriate action when they have been the victim of crime by service users reads:

> *"The Trust Police Liaison group is addressing numerous unresolved issues relating to the prosecution of our patients following assaults.*
>
> *Trust IR forms record all assaults and confirm that police have been advised. A local data base is maintained that is used to monitor progress of assault investigations."*

Similar vague wording was used for the action drafted in response to the recommendation that the trust improves liaison with the police:

> *"Meetings have now been established at WRC between police and managers. A Trust Police Liaison forum has been established."*

No mention is given to the frequency and purpose of the meetings and who should attend.

13.3 The 2005 action plan states that four of the 14 recommendations were completed, four would be completed within three months, four were on-going, one was long-term and the timescale for one not specified. We would have expected more

progress to have been made in implementing the action plan six months after the completion of the internal review and 18 months after the incident.

13.4 We later received a more recent version of the action plan dated June 2007. On this version the actions had been signed off as "*actioned*". In our opinion, this action plan was still not sufficiently robust and we are not convinced that much had changed as a result. Some of the responses seem inappropriate. For example, in response to the recommendation that a safer environment should be provided for people who work at the coffee bar at The Wells Road Centre the action plan states that:

> *"Controlled access to The Wells Road Centre using iris recognition software will be introduced in June 2007 as part of general improvements to the security of the centre."*

13.5 We have been assured by the medical director at Nottinghamshire Healthcare NHS Trust, and the trust's risk manager that the governance systems now ensure that recommendations and action plans are followed up routinely. The medical director told us:

> *"Most of them (action plans) are monitored at the Serious Clinical Incident Review Group. That was not the case when I started in 2006. We were looking at the reports. We were looking at the action plans. But we did not have a closing of the loop issue in that group, and what we were doing was passing them into the directorate where they stayed. I was unhappy about that. I could not get assurance and ... I did a brief audit myself of 50 consecutive SUIs to see if I could track the paperwork and track anything in relation to what happened after the action plans had been generated, and I found it quite tricky. I tracked nine out of 50 to completion."*

Conclusion

We have concluded that the trust did not have robust systems in place between 2004 and 2007 to ensure the quality of action plans and monitor progress against them.

It is outside of our remit to review the current governance arrangements of the trust. However, given that there were previous difficulties it is particularly important to maintain the trust's new robust process for tracking action plans described to us by the medical director and the trust's risk manager.

14. Conclusions

14.1 This section summarises our conclusions relating to:

- issues covered by the internal review in section 11
- issues that we identified in section 12 which were not covered in the internal review but required by the terms of reference for this independent investigation
- the trust's action plan to address the recommendations made in the internal review covered in section 13.

Diagnosis

14.2 We consider that, under the International Classification of Diseases (ICD), diagnostic category F07.0 (organic personality disorder) or F07.8 (other organic personality and behavioural disorders due to brain disease, damage and dysfunction) might have been a more accurate fit for VS.

14.3 VS may well have displayed antisocial personality traits before his first significant head injury in 1989 at the age of 16. However, his behaviour worsened after both this head injury and the further head injury in 1996. Therefore the diagnosis of ICD F07.0 or ICD F07.8 might have better reflected the true picture in VS's case and would have recognised VS's condition as a mental illness rather than a psychopathic disorder. This may have freed up the professionals involved to consider assessment under the Mental Health Act when violent incidents occurred.

Detention under the Mental Health Act 1983

14.4 We conclude that if VS had been given a diagnosis of F07.0 (organic personality disorder) or F07.8 (other organic personality and behavioural disorders due to brain disease, damage and dysfunction), resistance to use of the Mental Health Act might have been removed. This may have had no material effect on the eventual outcome

but may have changed the therapeutic emphasis for those involved in considering his care needs.

Seclusion and assessment

14.5 We conclude that VS was treated appropriately in respect of restraint and seclusion and that the trust was right to seek legal advice from the trust solicitor. Staff could have used section 5.2 (doctors holding order) or section 5.4 (nurses holding order) of the Mental Health Act 1983 to ensure the legality of their actions.

14.6 However, when VS was secluded for the second time in September 1998, we could find no evidence that a formal assessment under the Mental Health Act 1983 was carried out. Although we accept that such an examination would in all likelihood have concluded that VS was not detainable, we agree with the internal report that the deprivation of an individual's liberty, especially in the case of an informal patient, demands formal process and this should have been carried out.

14.7 The trust's seclusion policy at the time gave no guidance on the seclusion of informal patients. The trust revised its seclusion policy in November 2008 to include such guidance.

Care programme approach and record keeping

14.8 The forensic services' CPA document is in our view comprehensive and clear and should be commended. Nationally, at this time (1999 to 2003) most forensic services would have followed the CPA policy for adult mental health services which often did not reflect the complexities of community treatment for patients being managed by the forensic services.

14.9 We conclude that the trust's CPA policy had been followed in respect to VS. Meetings were regular and well attended.

14.10 The records in relation to VS's care and treatment are detailed and comprehensive. There were only a few occasions when we were unable to source documents relating to his care, for example the initial service level agreement with Direct Health.

Risk assessment and management

14.11 We conclude that although the risks that VS posed to himself, property and others were well known and carefully documented, staff had no effective strategies to manage those risks. Risk management plans focused on advising staff on how to protect themselves with little mention of protecting the wider public beyond the possibility of referring the case to MAPPA.

14.12 Risk assessment and management in relation to safeguarding and child protection was inconsistent. Consequently we have been left with the impression that many professionals working with VS did not see child protection as a priority and did not take it seriously enough.

14.13 The internal review did not comment on the standard of risk assessment and management, other than to note that consultant forensic psychiatrist 1's view that VS would cease to pose a fire risk after he was discharged had been vindicated. We consider the failure to comment on safeguarding and child protection to be a major omission.

Multi-agency working

14.14 The health and social care staff of the forensic team were working in a positive and effective way throughout their involvement with VS. The care programme approach was proactively used to enhance the multi-agency working arrangements. Similarly the Nottingham Traumatic Brain Injury Service worked well alongside forensic services and played an important part in VS's assessment and care package in the community.

14.15 Attempts by forensic services to engage other support services, including the trust's adult mental health services, all failed. Similarly, for various reasons, attempts to refer VS to more specialist services such as St Andrew's Hospital, also failed. We conclude that other services and agencies were reluctant to get involved in such a complex and challenging case.

14.16 However, we believe that forensic services should have worked better with child protection services to identify and manage the risks that VS presented to his stepchildren, nieces and the children at the adventure playground where he worked as a volunteer.

14.17 We also conclude that forensic services should have reported all incidents of criminal damage and assaults of staff and other patients to the police. This would have made it possible for the police to build up a more accurate picture of the risks VS presented and made it more likely that they would have worked with forensic services to manage those risks.

Care package provided to VS in the community

14.18 We consider that the care that VS received during his time in the community between 1999 and 2003 was well planned and considered given the complexity of his case. The initial support package was very intensive. VS responded adversely to such close supervision. Reducing the level of supervision helped reduce his frustration levels and moderate his behaviour. However, when the care package support ceased in 2001 there seems to have been few options open to the forensic team. The shared clinical view was that VS did not warrant admission to hospital and did not fulfil the criteria for compulsory admission under the Mental Health Act. Attempts to have VS accepted by other support services, including the trust's adult mental health services, all failed.

14.19 There is no reason to believe that VS would have responded well to the re-introduction of a care package – even if new carers prepared to work with VS could

have been found – or that this would have made any difference to his behaviour and the eventual outcome of this case.

The internal review's recommendations and the trust's action plan

14.20 The recommendations in the internal review were consistent with the report, but not all the issues were identified (for example, diagnosis and child protection issues).

14.21 Although the resulting action plan is signed off as completed, fundamental issues – such as working with the police to jointly manage risks – still need to be addressed.

14.22 We have concluded that there were not robust systems in place at the trust between 2004 and 2007 to ensure the quality of action plans and monitor progress against them.

Preventability of VS killing LW

14.23 We have considered a number of important factors when reviewing VS's care and treatment:

- the attitudes that prevailed at the time towards personality disorder
- the lack of specialised provision
- the reluctance of other services and agencies – with the notable exception of The Nottingham Traumatic Brain Injury Service - to take on such a complex and challenging case
- and the fact that clinicians felt powerless to detain VS under the Mental Health Act.

14.24 In this context, we conclude that the staff who did engage with VS did their best to manage the challenges that he presented.

14.25 It is not possible, even with the benefit of hindsight, to have predicted whether the deterioration in VS's behaviour would have led to him killing someone. The only way to have stopped VS killing LW would have been to have detained him under the Mental Health Act earlier - which would have been possible if VS had been given a diagnosis of F07.0 (organic personality disorder) or F07.8 (other organic personality and behavioural disorders due to brain disease, damage and dysfunction). However, given the prevailing attitudes to personality disorders at the time, we conclude that it would be unfair to criticise staff for not doing so.

15. Recommendations

15.1 A great deal has changed since the period covered by this review, most significantly the publication of national guidelines on specialist services in January 2003 and changes in April 2007 to the Mental Health Act 1983 that removed the 'treatability' clause and redefined mental disorder to include personality disorders. Nottinghamshire Healthcare NHS Trust was one of the first trusts to implement national guidance on the provision of specialist services for people with personality disorder, with services effectively getting off the ground in 2004/05.

15.2 As a result of these changes, attitudes to the care and management of people with personality disorder at the trust are today very different from those that prevailed between 1996 and 2003.

15.3 We therefore focus our recommendations on the three main areas where we believe the trust still has work to do.

R1 **Working with the police.** This report has concluded that issues remain about how the trust worked with the police to manage the risks that VS presented. The trust needs to assure itself that it has effective working relations with local police. Attempts by the trust to engage the police in prosecuting mental health patients who commit a criminal offence have been largely unsuccessful. To bring fresh impetus to resolving this issue, we recommend that this report is formally tabled at a meeting between the trust and the police to consider how both agencies handled the individual incidents that occurred, and consider whether similar situations are occurring today. A nominated trust lead should be appointed to identify outstanding issues in relation to multi-agency working and risk assessment and management, and to develop a plan of how they should be addressed within six months of publication of this report.

R2 Safeguarding children. This report has highlighted a number of concerns about the risk presented to children. There are also examples of when these risks were handled well. We recommend that this report is tabled at the local safeguarding children's board to consider these risks and whether similar situations are occurring today. A nominated trust lead should be appointed to identify outstanding issues and develop a plan of how they should be addressed within six months of publication of this report.

R3 Recommendations and action plans from the internal review. This report concludes that the trust's system for ensuring the quality of action plans and their timely implementation was inadequate between 2004 and 2007. The trust has already taken steps to ensure that recommendations of serious untoward incident reviews and action plans are routinely followed up. However, we recommend that this report is tabled at the Serious Clinical Incident Review Group, and that the group is tasked with developing a plan within six months of the publication of this report to improve the quality of action plans and ensure that progress continues to be made in their timely implementation.

Appendix A

Terms of reference for Independent Investigation into the care and treatment of VS under HSG (94) 27

Undertake a systematic review of the care and treatment provided to VS by Nottinghamshire Healthcare Mental Health NHS Trust to identify whether there was any aspect of care and management that could have altered or prevented the events of 20th October 2003.

The investigation team is asked to pay particular attention to the following:

- To review the quality of the health and social care provided by the Trust and whether this adhered to Trust policy and procedure, including:
    - To identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to VS.
    - To identify whether the risk assessments of VS were timely, appropriate and followed by appropriate action;
    - To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;
    - The Mental Health Act assessment process
- Consider the adequacy of liaison, communication and involvement between health professionals and other agencies (particularly the Police, Social Services and Direct Health) relevant to VS's care.
- To consider if the decision not to involve VS and his relatives or the victim's family in the internal investigation process was appropriate.

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

- To identify any learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable.

- To report the findings of this investigation to East Midlands Strategic Health Authority.

Approach

The investigation will not duplicate the earlier internal investigations; this work is being commissioned to build upon the internal investigations.

Should the reviewers identify a serious cause for concern, this should be notified to the SHA and the trust immediately.

Initially there will be an information and fact-finding process incorporating the gathering and review of relevant pieces of information to establish the scope of the second phase of the review.

The second phase will include interviews with key managers and/or staff as required, the families of both the victim and of VS. Interviews will be carried out at a neutral venue within a reasonable distance from Nottinghamshire Healthcare Mental Health NHS Trust or in the case of relatives, at their homes if they prefer this.

It is expected the final report will include recommendations to inform the appropriate commissioning of the service by Nottingham City Commissioning PCT as the lead commissioner of mental health services.

Publication

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

Review team

The review team will comprise of appropriately skilled members, assisted as necessary by expert advisers with nursing, medical or other relevant experience, and be expected to work promptly and effectively, with the full process completed within 6 months following consent being obtained from relevant parties.

The review team will submit monthly progress reports to the commissioners and victims/perpetrators families as agreed.

Appendix B

List of interviewees

- Trust risk manager, Nottinghamshire Healthcare NHS Trust
- Forensic team manager, social worker, Nottingham City Social Services
- Medical director, Nottinghamshire Healthcare NHS Trust
- Brain injury case manager, The Nottingham Traumatic Brain Injury Service
- Consultant forensic psychiatrist, The Wells Road Centre
- Cognitive behavioural therapist, The Nottingham Traumatic Brain Injury Service
- Forensic social worker/case manager, Nottingham City Social Services

Appendix C

List of documents reviewed

Documentation relating to VS

- Serious untoward incident report; the care and treatment of VS, Nottinghamshire Healthcare NHS Trust, October 2004
- Action plans based on the recommendations in the SUI report, April 2005 and June 2007
- Psychiatric report, consultant forensic psychiatrist 3 for the Crown Prosecution Service, 26 February 2007
- Care programme approach review report, VS's responsible clinician, 16 January 2007
- Transcript of sentencing remarks, R v VS, 5 March 2007
- Clinical notes from Nottingham Health Authority and Nottinghamshire Healthcare NHS Trust 1989-2003
- Notes from Queen's Medical Centre Accident and Emergency Department, 1993 and 2003
- Witness statements given to the police, October 2003
- Record of the police interview with VS, 20 and 21 October 2003
- Summary of convictions
- Record of police charges

Policies and procedures

- CPA policy, Nottingham City Council and Nottinghamshire County Council Social Services Departments, June 2002
- Care programme approach, consultant forensic psychiatrist 1 for Nottinghamshire Healthcare NHS Trust June 2004
- CPA policy, Nottinghamshire Healthcare NHS Trust, November 2005
- Care programme approach in partnership with social services departments in Nottinghamshire, consultant forensic psychiatrist 1, Nottinghamshire Healthcare NHS Trust, March 2009
- Nottinghamshire adult mental health services care programme approach (CPA) procedures (undated)

- Policy and procedure for the reporting and management of serious untoward clinical incidents, Nottinghamshire Healthcare NHS Trust, May 2003
- Reporting, management and investigation of serious untoward incidents (clinical and non-clinical), Nottinghamshire Healthcare NHS Trust, November 2008
- Use of seclusion on Thurland Ward, Trent Unit and Darwin Ward, consultant forensic psychiatrist 1, November 2008
- Seclusion, Nottinghamshire Healthcare NHS Trust, August 2009
- Multi-agency public protection arrangements for the risk assessment and risk management of sexual or violent offenders, July 2004
- Risk management strategy 2007-2010, medical director, Nottinghamshire Healthcare NHS Trust, January 2008
- Observation policy, Nottinghamshire Healthcare NHS Trust, 2003

Appendix D

Biographies

Peter Hasler

Peter has worked at director level within the NHS for over 10 years. A former executive director of nursing and modernisation and interim director of operations at Kent and Medway NHS and Social Care Partnership Trust, Peter's areas of expertise include service development and redesign, team building and facilitation and review of professional practice. Before joining the trust he was the commissioner of mental health and secure services for West Kent Health Authority where he led the multi-agency response to the inquiry into the care and treatment of Michael Stone. He has published a book and several articles on mental health and guidance on the care of older people. For Verita, Peter has recently completed a review commissioned by NHS London into the actions of NHS organisations immediately after the death of Baby P.

Lesley Sargeant

Lesley is one of Verita's founding directors. Since joining Verita as an executive director in February 2009, she has taken an active role in a number of high-profile reviews, including an independent management review related to the care of Baby P, an investigation into criminal record bureau checks for a foundation trust and a mental health homicide investigation. She also advises on all aspects of communication relating to investigations including media handling. Before joining Verita, she was a director of Freshwater Healthcare (formerly CLEAR), a consultancy offering specialist communication advice and training to public sector organisations. Between 1984 and 1994 she held senior posts in the NHS at national, regional and local level specialising in issue and crisis management. Before that she worked as an editor for the World Health Organisation in Geneva.

Tim Amor

Tim Amor is a consultant general adult psychiatrist. He now works with a community mental health team in central London and has previously had extensive experience working as a consultant psychiatrist in the forensic division of another London mental health trust. He is a part time medical member of the Mental Health Review Tribunal and an examiner for the Royal College of Psychiatrists.