REPORT TO NHS ENGLAND OF THE INDEPENDENT INVESTIGATION INTO THE HEALTH CARE AND TREATMENT OF 'PATIENT P'

COMMISSIONED BY THE FORMER

NORTH EAST STRATEGIC HEALTH AUTHORITY

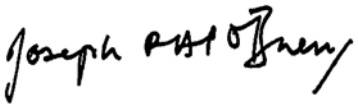
May 2013

CONTENTS

THE INVESTIGATION Panel

The members of the panel were:-

- Mr Joseph O'Brien – Barrister (Chair)
- Mrs Nicola Bailey – then Director Child and Adult Services, Hartlepool Borough Council and subsequently Acting Chief Executive of Hartlepool Borough Council
- Dr Avice Simpson – Consultant Psychiatrist, Cumbria
- Mr Tim Evans – Mental Health Nurse, Cumbria



Mr J O'Brien

Mrs N Bailey

Dr A Simpson

Mr T Evans

- **Commissioning of the Investigation**

1. The Investigation was commissioned by the North East Strategic Health Authority in July 2008 to investigate the health care and treatment of P and to prepare a report and make recommendations to the Authority.

2. The Investigation was established under the terms of the Health Service Guidance HSG (94) 27, following P's conviction on 22 October 2007 of the manslaughter of A.

- **Terms of Reference**

3. Our terms of reference were:

- To examine the circumstances surrounding the health care and treatment of P, in particular:

- The quality and scope of his health care and treatment, in particular the assessment and management of risk;

- The appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary care programme approach and the assessment of risk in terms of the harm to himself or others;

- The standard of record keeping and communication between all interested parties;

- The quality of the interface between the forensic and general mental health services, Mental Health Matters (MHM) and other agencies;

- The extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health;

- To prepare a report of the findings of that examination for, and make recommendations to, the North East Strategic Health Authority.

- **Overview**

4. P was born on 3 February 1972. At the time of the unlawful killing of A, both of P's parents had died. P was the youngest of three children. P was reported to have disliked school and is reported to have been bullied. P was described as a loner, who often truanted and mixed with the "wrong crowd". P left school in June 1988 without passing any examinations. P enrolled at Monkwearmouth College in September 1994 to study mathematics, physics, politics and information systems at GCSE level. P did not complete these studies. P's employment was limited. P, on leaving school, enrolled on a Youth Training Scheme for two years and then worked for a tool firm for a further two years. Following a further period of unemployment P found work in a laundry for a period of only six months. Between 2003–2004, P worked for five months in the Oasis Café at Cruddas Park in Newcastle upon Tyne.

5. P's first contact with mental health services was in July 1993 (Chapter 2-Treatment in 1993) following P's attendance on his GP. P's next involvement with mental health services was in 1994 as a result of an assault by P on his parents on 11 November 1994 (Chapter 3-P's attack on his parents). Following further concerns expressed by P's parents on 8 January 1997 P again became involved with mental health services which led to P's regular engagement with mental health services, often following petty criminal behaviour by P. However, from 19 June 1998 until November 1999, P was detained under section 3 of the Mental Health Act 1983 (Chapter 4-P's treatment 1997-1999). In September 1999 P became a client of MHM in anticipation of P being discharged. P was provided with accommodation in the Sunderland area until January 2003 when P moved first into the Walker area of Newcastle upon Tyne and then, in February 2005, P moved into the Heaton area of Newcastle upon Tyne. P's Care Co-ordinator post assessment January 2003- to June 2004 OT1, an Occupational Therapist. CPI was part of the care team and was administering P's depot injection. CPN1 became Care –Coordinator in June 2004, later in 2003 Consultant 8 became P's Consultant. (Chapter 5-P's Treatment 2000-2005). In January 2006, P disengaged with community psychiatric services in Newcastle upon Tyne and travelled to

London where, on 16 January 2006, P was detained by the Metropolitan Police outside the gates of Buckingham Palace where he was threatening the kill the Queen who he believed was his mother. P was eventually returned to Newcastle upon Tyne where he was admitted for inpatient treatment until discharged on 15 February 2006. From 15 February 2006 until 19 May 2006, P continued to be managed in the community. Throughout this period CPN1 was P's care co-ordinator and Consultant 7 was P's Consultant.

6. In the period prior to 19 May 2006, P was a patient receiving mental health services from the Northumberland, Tyne and Wear NHS Foundation Trust. These services were provided alongside housing support services commissioned by Newcastle City Council from MHM. At this stage it is helpful to briefly set out the role of MHM in relation to P. MHM is a charity which provides housing related support services to vulnerable adults. In terms of P, MHM's role was to support and assist P to manage and maintain his accommodation, including the provision of practical support such as helping P understand the obligations on him under his tenancy agreement. MHM was not engaged in this case as a care agency supporting P.

7. A was a 22 year old support worker employed by MHM. A was a graduate of Northumbria University where she had read psychology, graduating with BSc (Hons) in 2005. After graduating, A volunteered as a support worker with the Citizen's Advice Bureau in Jarrow. On 20 September 2005 she commenced employment in the records department at the Royal Victoria Infirmary, Newcastle upon Tyne. On 30 November 2005 A was interviewed by MHM for the post of support worker. A commenced employment with MHM on 19 December 2005. A worked at MHM's office based in the West End of Newcastle Upon Tyne. She worked under the supervision of MHM W1 and MHM W2. During A's probationary period she attended a course on non abusive psychological and physical intervention which lasted one day and was delivered by an external provider. The course focused on assessment, prevention and management of confused, unpredictable and aggressive service users, and training employees on assessment of the potential for difficult behaviour and the prevention of confused and unpredictable

behaviour. However, A's last day of her probationary period of employment with MHM was 19 May 2006.

8. On 19 May 2006, A's appointments included visiting P at his home address in the Heaton area of Newcastle upon Tyne. This was one of three visits each week made by employees from MHM, and in the weeks prior to 19 May 2006, A had made a number of visits to P's home. The purpose of each visit, as already identified, was to offer P support.

9. Prior to leaving her place of work on 19 May 2006, A was asked by MHM W2 to hand deliver a letter to P. This letter was from MHM and drafted by MHM W2. The contents of this letter are important, as is the background to the letter. On 18 April 2006, at a joint visit between CPN1 and MHM W1 (the key worker assigned to P by MHM), P disclosed that he had "smashed up" a payphone in his flat. P said that he had smashed the payphone up in order to obtain money to buy cigarettes. On 15 May 2006, MHM W2 drafted a letter which confirmed that the cost of the damage to the phone was £236 and was to be paid off in instalments of £2.50 per week. The letter recorded that P had previously agreed to pay for the damage to the telephone, the letter thereby confirming that P in fact had knowledge that he was to be charged £236 for the damage to the phone.

10. A left the office of MHM shortly after 9.30 am on 19 May 2006. A intended to visit other clients of MHM in Heaton, Newcastle upon Tyne. It was planned that all the visits to be made by A on 19 May 2006 were to be made on her own. During the course of A's visit to P, P unlawfully killed A, using a knife to inflict the fatal injuries. P then left his home address and walked to Byker police station in Newcastle upon Tyne. This is a relatively short walk from P's home address. On attending at the reception area of the police station P informed the police that there was a dead body in his flat. Police attended his flat and found the body of A. P told officers that the person he had killed was A and that he had blood on his hands because the 'knives kept snapping'.

11. During the course of P's interviews with Northumbria Police, P answered all questions with 'King'.

12. On 22 October 2007, at the Crown Court at Newcastle upon Tyne, P pleaded guilty to the manslaughter of A on the grounds of diminished responsibility. The plea of manslaughter on the grounds of diminished responsibility was accepted by the Crown. P was sentenced to be detained under section 37 (Hospital Order) and section 41 (Restriction Order) of the Mental Health Act 1983.

13. The investigation into the unlawful killing of A revealed that MHM had breached health and safety at work duties owed to employees of the charity including A. Whilst the issues surrounding compliance with the relevant policies and procedures are set out in some detail later in this report, MHM pleaded guilty to one count of breaching section 2(1) of the Health and Safety at Work Act 1974. This provides:

"It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees."

14. A basis of plea was agreed between the Crown and MHM. In summary the Crown accepted that:

(a) On or about 15 February 2008 MHM breached section 2(1) of the Health and Safety at Work Act 1974, in that it failed to carry out individual risk assessments of P after discharge from section 2 Mental Health Act 1983; and
(b) MHM breached section 2(1) Health and Safety at Work Act 1974 in failing to carry out an individual risk assessment at some point before 19 May 2006;
(c) In the course of completing those risk assessments arrangements for visiting P would, and should, have been reviewed.

15. On 31 January 2010, at the Crown Court at Newcastle upon Tyne, MHM was fined £30,000 and ordered to pay costs of £20,000 in relation to its plea of guilty to the one count of a breach of section 2(1) of the Health and Safety at Work Act 1974.

- **Extent of the Investigation**

16. In order to complete the investigation the Panel have had to consider 15 lever arch files of records. These records and the relevant documentation can be divided into the following categories:

    (a) P's medical and social care records from 1993 to the date of the incident;
    (b) Policies and procedures supplied to us from the Northumberland, Tyne & Wear Trust, MHM, Newcastle City Council and Northumbria Police.
    (c) Internal reports compiled after the incident.

17. The Panel has interviewed 16 witnesses. The Panel is grateful to those who co-operated. All witnesses who gave evidence were informed that, should they wish, a person could attend to support them. Some witnesses chose to have such support. In addition all the witnesses who gave evidence were given the opportunity to amend and approve transcripts of their evidence.

18. The Panel found the great majority of witnesses who gave evidence before us to be honest and trying to do the very best they could in their recollection of events. In some cases witnesses were being asked about consultation and events going back over 10 years ago. An investigation such as this relies upon the honesty of those called to give evidence and, from the organisations that they work for, a genuine willingness to provide full and frank disclosure of all relevant matters and documentation. This report is prepared and delivered on the basis that we have had full and frank disclosure, where relevant.

19. The Panel has already noted the co-operation received from the majority of witnesses. Three persons, however, refused to co-operate with the investigation. P did not co-operate. On a number of occasions the Panel co-ordinator invited P to be interviewed by the Panel. Two employees (at the time of the incident) of MHM also refused to co-operate (referred to in the report as MHM W1 and MHM W2). These employees were manifestly significant witnesses in terms of their knowledge of the events leading up to the tragic killing of A by P. The Panel was of the view that so significant was their evidence that special arrangements could be made to facilitate their evidence, including the Chair hearing them alone. Both MHM W1 and MHM W2 refused to co-operate. However, they were called to give evidence at the inquest into the death of A, heard by the City of Newcastle upon Tyne coroner, Mr David Mitford, in November 2011. Their evidence was given in public and transcripts of their evidence have been provided to the Panel. Both witnesses had been made aware that the transcripts of their evidence would be made available to the Panel. In the light of this evidence, these two witnesses were invited to give evidence to the Panel. Yet again they declined. Whilst this is a source of regret to the Panel, it has not hindered us greatly in our task and the report is no less credible as a result.

20. It is easy for judgments and conclusions to be reached with the benefit of hindsight and in the knowledge that a serious untoward incident has occurred, The Panel has tried to ensure that in reaching criticisms we have done so on the evidence which those responsible for P's care had available to them and not on subsequent events. It should be remembered by that what may appear clear cut with the benefit of hindsight will be far removed from events which unfold on a day to day service and in the context the pressures of providing a service.

21. It is equally important that the Panel stresses that our firm impression of those responsible for the care and treatment of P have worked conscientiously at all times and diligently sought to perform their duties and responsibilities generally and to P.

1. P'S CONTACT WITH SERVICES IN 1993

1. P's first contact with psychiatric services was in 1993. This was a very limited contact. However, it is necessary to address this limited contact with mental health services in 1993. Firstly, given the overall criticism that has been levelled at mental health services by those who represented P in P's criminal proceedings and secondly, because of P's own criticism of the clinician who treated him in July 1993.

2. It is useful to set out the full entry in the medical records in relation to this contact.

3. The entry of 6 July 1993 records as follows:

   "Claims he is "depressed" for years … nothing to do … sleeping most of the time … does not socialise … low self-esteem … no girlfriend … socially frustrated … history of drug abuse, marijuana, acid trips, ecstasy, speed … stopped two years ago … past history … anti-social behaviour - truanting … disruptive … mental state … preoccupied with his physical health, vague somatic complaints, wants some investigation … diagnosis? anxiety, unable to attend AM1"

4. On 11 August 1993 , Consultant 1 sent a letter to the general practitioner stating:

   "I do not think he is suffering from any psychiatric disorder and I am therefore discharging him from the outpatient clinic."

5. The Panel did not interview Consultant 1.

6. After P attacked his parents in 1994, he was seen by Consultant 2. P complained during his interview with Consultant 2 that he felt "fobbed off" by the psychiatrist (Consultant 1) in July 1993 and that no one was interested in his problems. The Panel notes that, whilst P was stating that he wanted his

concerns investigated, he is recorded as being unwilling, in July 1993, to attend anger management treatment.

- ***Commentary***

7. *The Panel is satisfied that at the time of P's presentation in July 1993, it was reasonable for Consultant 1 to discharge P and to conclude that P was not suffering from any psychiatric illness at that stage. The Panel is equally satisfied that P's presenting complaints in July 1993 were vague and ill defined. There was no clear evidence on which Consultant 1 could or should have made a diagnosis of schizophrenia. Whilst P stated in his interview with Consultant 2 that these symptoms continued for a period of 18 months prior to the assault on his parents (thereby covering the whole period from the date of consultation in July 1993 through to the date of the assault on his parents), there is no evidence to suggest that during this period P sought the advice of his general practitioner or any mental health service in relation to these alleged on going symptoms. The first time that P complained about the quality of his treatment in July 1993 was when he was seen by Consultant 2 in relation to the preparation of a medical report for submission to the Crown Court in relation to the very serious attack by P on his parents.*

8. *However, the Panel is also satisfied that this episode, seen with the benefit of hindsight, was an exhibition of an early prodrome of schizophrenia. It is a feature of the assessment and treatment of P that at no stage during P's lengthy engagement with mental health services was there any comprehensive longitudinal assessment of P's presentation over the relevant period of his mental illness, including any consideration of the presentation in July 1993. The Panel will return to this later in the report.*

3. P'S ATTACK ON HIS PARENTS IN NOVEMBER 1994

- **The Assault and Criminal Proceedings**

1. The involvement with mental health services in 1994 was as a result of an assault by P on his parents on 11 November 1994. P gave a history that he had been "nagged" by his mother for not going to work. P consumed a two litre bottle of cider, which he drank between 9-30 pm and 12-30 am.

2. P went to bed about 1 am. P attempted to sleep but failed. P claimed that he was concerned that his father was forgetting things and this began to irritate P.

3. P went downstairs, picked up a hammer and went into his parents' bedroom. His intention was to attack his father, but his mother woke up and he attacked her. Both parents were attacked with blows to the head.

4. P ran out of the house, wearing only a t-shirt and underwear. P ran to the local police station. P was interviewed but it appears that little emerged during the course of this interview to identify why P had attacked his parents.

5. P denied that he had tried to hit and kill his mother and that his intention was to attack his father, not his mother.

6. As a result of the assault on his parents, P faced two counts of offences under section 18 of the Offences Against the Person Act 1867.

7. The Panel were able to review the evidence obtained by Consultant 2, Consultant forensic psychiatrist, which was contained in a report dated 2 February 1995. The report was prepared whilst P was on remand at HMP Holme House and based on two interviews with P; 21 November 1994 and 1 February 1995. P informed Consultant 2 of the following:

(a) P had, until just a few weeks before the assault on 11 November 1994, hardly drunk alcohol at all. For a number of weeks before the offence, he had developed the habit of drinking a bottle of cider at weekends.

(b) P described an array of psychiatric symptoms. P stated that these symptoms had been going on for over three years and appeared to have been gradually increasing in severity. These symptoms included:

• A period of high anxiety (panic attacks, accompanied by palpitations and apparently a nervous twitch of the neck). P described an electric shock feeling. He was prone to such attacks when under pressure or mixing with large groups of people.

• A feeling which he called paranoia. P said that when talking with people he felt self-conscious and lacking in confidence. P explained that he would get the feeling that other people were talking about him but this paranoia had never been accompanied by actual hallucinatory activity.

• Feelings of depression which occurred when he was socially isolated. When in these moods, P said he would stay in bed all day and stay up all night. He said that he would suffer from bad headaches and that his appetite would diminish.

• In relation to his previous contact with psychiatric services in July 1993, P stated that this referral was at a time when he was sexually frustrated, depressed, paranoid and anxious. P saw the psychiatrist (assumed to be a reference to Consultant 1) on one occasion and no medication was prescribed. No follow up appointment was made. P said that he felt “fobbed off” by the psychiatrist and no one was interested in his problems.

• Although P stated that his psychiatric symptoms had been on going right up to the time of the offence, he had not been seen by his general

practitioner or any other doctor for his problems in the 18 months preceding the offence. In this period of time before the offence, P was living at home with his parents and he was continuously suffering from the type of psychiatric symptoms described previously.

• The circumstances of the offence were described by P. P stated he had not gone to work but had stayed in bed. His mother had apparently nagged him about not going to work and he spent the day at home apart from going out for a short time to buy a computer disc. In the evening P consumed a two litre bottle of cider. He drank the cider between 9.30 pm and 12.30 am. P told Consultant 2 that he thought his parents went to bed at about 10.30 pm or 11 pm. P thought he went to bed at about 1 am. Whilst in bed, P stated that he had tried to get to sleep but was thinking about his problems. He was focussed in on the fact that his father was forgetting things. P stated he just went downstairs, picked up a hammer, went into his parents room and hit them. His intention was to hit his father but his mother woke up and he hit her as well. Both parents were hit on the head although P was unsure how many times he hit his parents. He recalls hitting his father twice on the head and his mother once on the head. He ran downstairs and out of the house. P was wearing only a t-shirt and a pair of underpants. He ran to S police station. He told the police “I’ve killed my father … I have hit him with a hammer … I went into the room, he woke up and I just hit him”.

• Consultant 2 had spent some time talking to P about the offences in an endeavour to achieve some understanding as to why these offences had occurred. P stated that he had not involved himself in any earlier planning to assault his parents. He said the offences were committed purely on impulse. There was no suggestion that P was responding to hallucinatory or other psychotic phenomena which made him attack his parents. His initial response as to why he had attacked his parents was that he did not know. In a further discussion, however, he stated that his parents had always treated him well but had always appeared very

distant to him. P had never had a “heart to heart” conversation with them in his life. P went on to say that he had a lot of problems which kept worrying him including his inability to get a girlfriend and his impotency. Nobody had appeared to take these problems seriously. He stated that he had no social life. His father’s forgetfulness had been getting on his nerves and he felt frustrated, depressed, angry and desperate. P wanted someone to take notice of the fact that things were going wrong for him and he thought that by attacking his father with a hammer, he would be showing that all was not well. It would be an expression of his anger.

• Consultant 2 recorded that although P’s parents had visited him regularly in prison it was of note that P had still not discussed with them the problems that had been worrying him or attempted to explain why he attacked them.

• In discussions with Consultant 2, P’s mother had stated that her son was a loner, that he had no friends and no social life, that he was not working and that both her and her husband had remained mystified as to why their son had attacked them.

• Consultant 2 stated that P did not suffer from any formal type of mental illness although he was an individual with a history of psychological difficulties. These difficulties were on going neurotic and personality problems, as opposed to being symptomatic of mental illness.

• P’s offences arose from a background of anxieties including adolescent sexual anxieties which he felt unable to cope with or share with others. The motivation behind his offence appeared to be an expression of frustration and anger coupled with grossly abnormal cries for help.

8. Consultant 2 concluded that P suffered from neurotic and personality difficulties although he was not mentally ill. Consultant 2 recommended a probation order as this would allow for regular counselling sessions and guidance in the context of which P would be able to explore some of his problems and difficulties. Consultant 2 also concluded that P would benefit from psychiatric supervision and help. Attendance on a psychiatrist could be made a condition of his probation. Consultant 2 stated he would be happy to see P at the Hutton Unit, St Luke's Hospital, Middlesbrough. Alternatively he could be seen by a psychiatrist at Cherry Knowle Hospital, Sunderland and it would be a condition of any probation order that P should not reside with his parents.

9. Consultant 2 recommended that P's engagement with psychiatric services should be through supervision under a probation order.

10. However, Consultant 3 wrote to Consultant 2 on 10 April 1995. Consultant 3 stated that supervision through forensic psychiatry mental health services was appropriate. Consultant 3 confirmed that he would be willing to see P but his own preference with patients where there was no clear mental illness was to offer voluntary attendance at an outpatient psychiatric facility. Consultant 3 stated that he was reluctant to take P's care on as a condition of treatment when he had not had the opportunity of interviewing P himself.

11. Prior to P being sentenced at the Crown Court at Durham on 1 May 1995, P was bailed to reside at Ozanam House. This was to assess his suitability to reside at this probation hostel as a condition of residence. In an undated letter, but before 1 May 1995 (the date of sentence at the Crown Court), the project worker noted that P had:

(a) Claimed that he had tried to gain professional help before he committed the assault on his parents. He maintained that he did not receive this help and still required psychiatric help.

(b) P discussed the offences and his feelings in an intelligent, open manner and showed deep remorse for what happened.

(c) Since his arrival at the probation hostel, P had no longer felt the need to take antidepressants, there being no obvious signs of depression. He was able to engage with the staff appropriately and the hostel had given him a stable supportive place from which he could explore his feelings and anxieties.

(d) P had shown an interest in art and design and started attending art classes at a local probation centre.

(e) P had expressed a wish to settle in Newcastle upon Tyne and make a new start. To this end a facility would be available for him through the probation hostel which would give guidance and advice on budgeting skills and help P prepare for independent living.

(f) During the period of his assessment, P had shown that he was a likeable young man who was undoubtedly ashamed of the offences he had committed and determined to accept the “help he knows he needs”. The staff at the probation hostel had been impressed by P’s commitment to change and that they would welcome the opportunity to continue the progress that had been made with P. A 12 month residence order at the probation hostel was suggested.

12. On 1 May 1995 at Durham Crown Court a two year probation order was made. As already pointed out, there was a condition of residence at Ozanam House but in the light of the recommendation of Consultant 3, psychiatric treatment was on a strictly voluntary basis.

- ***Commentary***

13. From the history obtained by Consultant 2 a number of features of P's behaviour are regarded by the Panel as significant:

(a) Prior to the assault on his parents P had been drinking alcohol.

(b) P appeared to be describing a continuation of symptoms from the time he was referred in July 1993, which referral was made against a background of P being sexually frustrated, depressed, paranoid and anxious. P informed Consultant 2 that he had many problems in his life including his inability to get a girlfriend and his impotency.

(c) P's attack on his parents was impulsive.

(d) P wanted someone to take notice of the fact that things were wrong with him, and that by attacking his father with a hammer he would be showing that all was not well. The assault was an expression of his anger.

14. The Panel accepts that in retrospect P was developing symptoms of schizophrenia. The Panel notes that during the continuance of the Crown Court proceedings, no direct link was made between any underlying mental illness and the assault. The Panel believes that in this regard Consultant 2 cannot be criticised for his diagnosis. At the time Consultant 2 saw P, it is likely that P was developing very early symptoms of schizophrenia and P was unable to describe the symptoms to Consultant 2.

15. However, another relevant and possible explanation was that P was experiencing frank symptoms of schizophrenia but was hiding them from Consultant 2. The Panel are of the view that this explanation has, in retrospect, considerable merit to it, given that the subsequent history shows P was frequently capable and did hide symptoms of his mental illness from

clinicians.

16. *Consultant 2 cannot be criticised given the information that he had at the time of his investigation into P's mental state. Furthermore, given the information that was available to Consultant 2, it was entirely reasonable not to recommend detention under section 37 of the Mental Health Act 1983. The Panel is satisfied that there was no clear basis for deciding that P was suffering from a mental illness within the terms of the Mental Health Act 1983 and no basis whatsoever for concluding at that stage that P suffered from a psychopathic disorder.*

17. *However, the Panel are of the view that the significance of the assault on his parents must be seen within the context of the subsequent diagnosis that P was suffering from schizophrenia. Once it had been established that P suffered from schizophrenia, it was highly likely that his developing illness in 1994 was related to the attack upon his parents.*

- **Post Sentence Contact with Mental Health Services**

18. By 7 June 1995, Consultant 3 was offering a further appointment to P after he had failed to attend the first one. A further appointment was offered to P on 2 August 1995. P did not attend a further appointment was offered on 11 August 1995. Further appointments were offered on 5 February 1996, 14 February 1996, 18 April 1996 and 10 May 1996.

19. On 25 May 1996, Consultant 3 wrote to P's general practitioner. Consultant 3 noted that in discussions with P, he had talked particularly of social difficulties, anxiety, girlfriends and impotency. It was noted that P's attendance at the clinic was intermittent although Consultant 3 was of the view that at least for some of the appointments P had missed he had good excuses. P had become heavily involved in work with local voluntary groups. Consultant 3 noted that P had hoped for a place on Operation Raleigh, admitted to occasionally continuing to use illicit drugs and used amphetamines as an attempted self treatment for depression. Consultant 3 noted that exploring P's mood disorder it was appropriate to describe him as suffering from cyclothymic condition as the mood swings which he had experienced cannot be appropriately described as a manic illness. There were periods when "my head positively explodes with ideas" and he said there weretimes when he feels "on a high" and amongst his activities are his overspending. Much more commonly, he felt really "down" for a day or two at a time and during such a period he would experience impaired sleep, poor concentration and much more anxiety. Consultant 3 discussed the possibility of the prescription of lithium and proceeded as far as routine screening tests in terms of urea and electrolytes and thyroid function. These were normal but at the next meeting P said he was against drug treatment.

- ***Commentary***

20. The Panel accepts that throughout the period that Consultant 3 had been seeing P there was still no clear evidence of symptoms of schizophrenia although there was emerging evidence suggestive of an affective illness which, subsequently, was identified as part of a schizoaffective disorder.

21. In a letter dated 30 April 1996, P's general practitioner wrote to a Consultant psychiatrist stating that in 1994, after taking amphetamines, P attacked and badly injured both parents with a hammer.

- ***Commentary***

22. The Panel has scrutinised the criminal file of papers disclosed with the probation service records. Furthermore, the Panel has sought to identify whether this assertion is confirmed or verified by any records of the interviews with clinicians at the time that P was involved in the criminal justice system or thereafter. The Panel was unable to find any evidence in the records that confirmed that P had taken amphetamines or indeed any drug, other than alcohol, at the time of the attack upon his parents.

23. During the currency of P's probation order, P wished to participate on a 10 week visit with Operation Raleigh to Belize. In a letter from Consultant 3 to the medical advisor of Ocean Youth Club and dated 24 October 1996 Consultant 3 stated that:

"My opinion is that P still has unresolved emotional and personality problems which led to him carrying out acts of extreme violence on his parents and which resulted in a criminal conviction for which he is currently under a probation order. He has engaged actively on a number of projects which have undoubtedly improved his confidence and are likely to be in many ways beneficial. However, another interpretation of his behaviour is that by such enthusiastic participation he is avoiding in depth assessment of his psyche."

24. On 8 November 1996, Consultant 3 wrote to the probation service. Consultant 3 noted that once the Ocean Youth Club had been made aware of P's personality problems and relatively recent substance misuse, it was thought that the medical advisor would be recommending that he would not be accepted for this expedition. P was noted to be disappointed at this and Consultant 3 noted that P had difficulty in expressing his emotional response which almost certainly included a degree of anger towards Consultant 3 about the amount of detail that had been divulged to the medical advisor. Consultant 3 felt that P should try to engage in some sort of psychotherapeutic work with himself or, if more appropriate, another person in order to deal with his difficulties. P said he believed otherwise and thought that although he had perhaps not gained an understanding of past issues, he felt that he had recently gained confidence. P stated that he had enjoyed a reduction in social anxieties and that it was not appropriate for him to engage in such work. Consultant 3 reminded P that psychiatric treatment was entirely voluntary and was not linked to the probation order. Consultant 3 stated to P that he had been giving coded and more recently explicit messages, that he did not see any point in psychiatric attendance and P accepted that this was the case. P was asked if he wished for a further appointment so that P could give feedback after reflecting on the options for the future. P stated that he had made his mind up and at this stage did not see any need for psychiatric assistance. Consultant 3 noted:

"I would be willing to see P again, as I do fear that his past conflicts are far from resolved, and I believe he is someone who will be vulnerable to stress, and will present with neurotic symptomatology and/or substance misuse in the future."

25. On 22 November 1996, the probation service applied to the Crown Court for a revocation of the probation order on the basis that P had shown good progress. The application for discharge identified the following:

(a) That P had remained at Oznaman House for four months prior to a programmed move to supported living at the Nomad accommodation project in Benwell and following a successful six month period of residence he had gained a tenancy at a property in Heaton on 1 March 1996.

(b) Following his disappointment at being refused a place on the trip to Belize with Operation Raleigh, P was now pursuing the possibility of doing voluntary work in South Africa.

(c) The probation officer had visited P's parents at their home in Sunderland. The parents confirmed that they had visited P over the past year or so and were obviously very proud of his achievements during that period. It was noted that, like P, they seemed to have put the incident of the assaults, which took place two years ago, behind them. They indicated no concerns about early discharge of the probation order.

(d) P had indicated that he did not wish to have any further contact with Consultant 3, though it had been suggested by the probation officer that he seriously consider the options that Consultant 3 had placed before him. It was noted that P's contact with Consultant 3 was on a voluntary basis and not a requirement of the probation orders. The application for early discharge was on the basis of P's co-operation with the requirements of the order and the continued good response to it.

26. It appears that the application for revocation of the probation order was never dealt with by the Crown Court.

- ***Commentary***

27. *The Panel did not interview Consultant 3. The Panel noted that the psychiatric treatment had not been made a condition of the probation order. This was in accordance with the recommendations of Consultant 3, although contrary to the recommendations of Consultant 2. There was no possibility of requiring P to continue with this psychiatric treatment.*

28. *The Panel is agreed that the records do not disclose any evidence to suggest that Consultant 3 was on notice that P was by then showing frank symptoms of any serious mental illness. It is likely that P was still in the "prodrome" stage of developing schizophrenia albeit there was no evidence of significant affective symptoms emerging. Consultant 3 recognised the severity of the attack upon P's parents. Furthermore, any other clinician considering the letter of the 8 November 1996 could have been under little doubt that P's past conflicts were far from resolved and that P was somebody who would be vulnerable to stress in the future.*

4. P'S CONTACT WITH MENTAL HEALTH SERVICES AND HIS TREATMENT IN THE PERIOD 1997-1999

- **Parental Concern in January 1997**

1. On 8 January 1997 P was visiting his parents. The medical records state that it was evident that during this visit that P's parents had become worried about P drinking excessively and talking about good and evil spirits. It is equally clear from the records that the parents were concerned about P's behaviour and in view of his past history, the parents called the police.

2. P was taken to the Accident and Emergency department at the Sunderland Royal Hospital. Here P claimed that there were good and evil spirits in his head which had infested him during a trip to Zimbabwe three to six months previously. P was claiming that many voices were talking to him directly and telling him things to do. P refused to elaborate as to what he was being told. P was sitting handling a wooden figurine which he claimed he had obtained in Zimbabwe but which had some links to the spirits. P expressed a variety of paranoid persecutory ideas. P was afraid of strangers and even his parents. P believed that most people were going to kill him. He claimed that he was so tired he could not think straight and certainly had difficulty answering questions. He denied any recent drug abuse. A mental state examination revealed that P was unkempt, looked tired, was guarded, suspicious, hesitant, furtively glancing around the room, his speech was slow and occasionally stumbling. P claimed that his mood was low and he was constantly sad. He appeared objectively low with little sign of reactivity. It was noted that there were definite signs of paranoid persecutory delusions, perception, hallucinations, insight was lacking. The plan was to admit him to Field House acute mental health unit with close observations. P was to receive medication as prescribed and be transferred to Newcastle the following morning. It was queried whether this was a drug or an alcohol induced psychosis and there was a query as to whether P had an underlying schizophrenic illness.

3. On 9 January 1997 P was described as more settled, less agitated, very amenable. He still thought he was possessed by evil and good spirits from Zimbabwe and believed he was infested by drinking water. He said that he had drunk the water only once when intoxicated with alcohol. He believed he could only get rid of the spirits by changing his religion and planned to go back to Africa as a Christian missionary in order to get rid of the spirits. He was clear that he wanted to get back to his flat in Heaton. The plan was to keep P in hospital for a few more days. The differential diagnosis was:

(a) A drug induced psychosis having smoked cannabis in Africa. P denied smoking any cannabis since returning to the UK in September 1996.

(b) Alcohol induced psychosis. P was drinking 125 units per week over Christmas but denied consuming alcohol since New Year's Eve.

(c) Schizophrenia - the plan was to transfer P to West Willows, another acute admission unit, commence haloperidol 5 mgs bd and to commence diazepam detox.

4. P was transferred to West Willows. By 14 January 1997 P was saying that he was bored on the ward. P was not exhibiting any psychotic symptomatology. He attributed his deterioration to the fact that Consultant 3 had not provided a positive report for him in relation to Operation Raleigh. He intended to return to Africa with some missionary group, although he was not a practising Christian. The diagnosis was of a schizophrenic psychosis, the precipitants being alcohol and illicit drug use, interacting with his underlying personality make up. It was noted that P was not at all keen on any input from psychiatric services and complained that Consultant 3 had failed to engage in examining P's psychological difficulties. It was planned to discharge P later in the week to the Jesmond Project. P was in fact discharged on 17 January 1997.

5. On 5 February 1997 P was seen in the outpatient clinic at Cherry Knowle Hospital. The discharge letter to P's general practitioner recorded no past medical history of note, although P had been under the care of Consultant 3 after the attack on his parents. The letter recorded P's mental state on admission in January 1997. P appeared unkempt, tired, guarded, suspicious

and hesitant. P's speech was slow, stumbling and limited in content. P's mood was noted to be sad and he described definite persecutory delusions. The senior house officer in psychiatry who saw P on 5 February 2007 diagnosed a schizophreniform psychosis precipitated by alcohol and illicit drug use. P had remained well at home since his discharge and he was to be followed up at the 'Jesmond Project'.

- ***Commentary***

6 *The Panel noted that on this occasion P had presented with clear symptoms of psychosis. P had a severe mental illness involving loss of touch with reality, as well as delusional and hallucinatory experiences. It should be noted that there is no evidence whatsoever that P had travelled to Africa in the previous three to six months as he claimed. P was then the subject of a probation order and during the relevant period had been in contact with the probation service. The Panel also accepts that it was difficult to regard the presenting episode as schizophrenia. It should be noted that the symptoms were reported by P to have resolved rapidly. It was, in the circumstances, reasonable to determine that it was premature to diagnose schizophrenia but that a schizophreniform psychosis was reasonable. In retrospect, however, this was the first presentation when P was displaying schizophrenia. Indeed, at the subsequent outpatient appointment the Consultant noted that P was blank and concluded that it was not possible to rule out underlying schizophrenia. At this appointment the Consultant offered a referral to the Jesmond mental health unit to see whether a therapeutic relationship could be developed by a case worker. The Panel accepts that this was a reasonable treatment course at this time. P was not suffering symptoms such that he should have been detained under Part 1 of the Mental Health Act 1983.*

7. *The Panel are equally of the view that this was an opportunity for those treating P to reflect upon the assault upon his parents. The circumstances in which this assault had taken place had, in January 1997, not been properly resolved. It is the Panel's view that any clinician considering P's presentation could now properly have viewed the serious assaults upon P's parents in the*

past as having occurred in association with P having developing schizophrenia.

- **P's Criminality September 1997 – March 1998**

8. On 17 September 1997 P was arrested for breach of the peace. The police were called to P's house because of noise and disturbance. P threatened the police and was arrested by the police for breach of the peace. P claimed his name was Robert Windsor, son of King Edward. He is reported to have said "Get the fucking Queen Elizabeth on the telephone at Buckingham Palace, fought at the Falklands (aged 12) years for you bastards." P was seen by the police surgeon. It was noted that P had been aggressive to neighbours and noises from his flat suggested that P may have been smashing his flat up. The records noted that P had hit his father over the head with a hammer. It is recorded in the notes that P had a diagnosis of severe personality disorder, drug abuse, amphetamine use and alcohol abuse. P gave a history that he had had half a bottle of vodka in his flat the day he was arrested, he became angry and started shouting but that he could not remember what he was angry about and was rude to police because he was drunk. P denied any involvement with drugs in the previous few days and denied any relationship with the royal family.

9. On the morning of the 18 September 1997, and whilst at the police station, P was seen by Consultant 4. P was noted to be hostile and rude. There was, apparently, no evidence of mental disorder. Throughout the interview P kept telling Consultant 4 that he did not want to talk anymore. Consultant 4 noted that P presented to the police surgeon with a psychotic presentation but when seen there was no evidence of mental disorder. Consultant 4 noted that there was no evidence of mental disorder. Throughout the interview P kept telling Consultant 4 that he did not want to talk any more. P refused to discuss the details of his previous forensic history. Consultant 4 concluded that P presented at the police station on the 17 September 2006 with a psychotic presentation but when he (Consultant 4) saw P there was no evidence of mental disorder. P's previous history suggested that P may suffer short lasting psychotic episodes, precipitated by alcohol or it may well be that he was still

taking amphetamines and was dissembling. P required further help and Consultant 4 was happy for a referral to be made to him if the general practitioner could persuade P.

- ***Commentary***

10. *The Panel is of the view that this incident is the first occasion when there was clear association between severe mental illness in P and aggression. There was also an association between the manifestation of his symptoms and alcohol use. The Panel is of the view that the association between severe mental illness, aggression and the use of alcohol could have laid the foundation for clinicians seeing P as at risk of aggression to others when first showing symptoms of mental illness and secondly taking alcohol.*

11. *The Panel is also of the view that the change in P's presentation in a relatively short period of time is of significance. It will be noted that the police surgeon had identified psychotic symptoms, yet when Consultant 4 interviewed P at the police station he could find no psychotic symptoms. This disparity could have two explanations:*

(a) That P's mental state changed suddenly, or

(b) That P was capable of hiding symptoms which he had initially disclosed. In the longitudinal assessment of P's mental illness, this explanation becomes highly relevant.

12. *Consultant 4 offered a follow-up appointment which P did not attend. The Panel is satisfied that Consultant 4 cannot be criticised in any way for the findings he made based upon the short examination at the police station on 17 September 1997.*

13. In the period from November 1997 until January 1998 P was arrested for a number of offences of shoplifting.

14. On the 23 January 1998, P was seen by two members of the Sunderland mental health team at Houghton le Spring Magistrates' Court.

15. The community psychiatric nurse who saw P wrote to Consultant 4 on 28 January 1998. The letter noted:

(a) P was charged with shoplifting a £3.90 sandwich. P had over recent months been charged with a number of similar offences involving food or alcohol. There was concern, at the time, from both the police and the probation officer over P's behaviour. There had been numerous complaints by neighbour's reporting that P was screaming and shouting at night. The conditions in which P was living caused concern; the police reported only a mattress and a bottle of whisky in the house.

(b) On interview P's presentation was odd and his response to questions somewhat guarded and defensive. P denied any auditory or visual hallucinations. The CPN had been informed that P believed himself to be descended from royalty but P himself denied this. P admitted to drinking large quantities of alcohol and also admitted to spending his benefits on alcohol.

(c) P stated that he had experienced detention in prison and would be able to cope if remanded in custody. However, P was subsequently dealt with by the Court and remanded on conditional bail to Ozanam House in Newcastle upon Tyne.

16. Whilst at Ozanam House, P was noted to be cold and guarded and not happy at being at the hostel.

- ***Commentary***

17. *The Panel regards this contact (in January 1998) with mental health services as a missed opportunity to organise further assessments in the community by mainstream mental health services. However, the events set out below meant that the impact of this lost opportunity was of no significant consequence.*

18. On the 6 February 1998, P committed an offence of criminal damage by smashing a TV and other property. A detailed account of this incident is contained within the section headed “Provisional Risk Assessment in Respect of P”. The following information is important from this risk assessment.

(a) P was noted to admit to drinking five pints of beer and two whiskies each day. P confirmed that he had lost money through gambling - £40. P admitted to being angry but there did not appear to be a rational account of the outburst.

(b) Staff who were interviewed noted that P, immediately upon his return, was hostile. The records confirm that P was screaming at the TV and said “I want to see the fucking colonel, bring the fucking marines … you know about Star Wars.” P then went on to shout “I could have killed you both. Princess Anne is not my mother and I want her dead. I want this out of my head.” P then proceeded to damage various articles of furniture at the hostel. When the police arrived P told them “I am Ron Windsor, son of Queen Elizabeth and George III, and I want my mother dead.”

(c) P continued to deny mental health problems. The risk assessment recorded that there was an increased risk factor equating to episodes when P’s behaviour could be bizarre and aggressive. P’s use of alcohol was not clearly understood and required further assessment.

(d) P denied that he was taking illicit drugs.

(e) P was isolated and had no support networks.

(f) P had personality and emotional difficulties including inappropriate responses to problems, stealing for food, disputes with neighbours.

(g) There was a lack of co-operation or motivation to address issues surrounding risk areas.

(h) Living with his parents was an increased risk factor. It was noted that in the short lasting psychotic episode P had said that he wished to kill his mother.

(i) P's co-operation and motivation to change remained questionable. A condition to reside at a specified place could provide some control if P wished to move into accommodation where there would be a demonstrable increase in the risk.

(j) The assessment recorded:

> "P, if released, would be returning to a flat which is virtually bare of furniture. He will be reliant on Job Seekers' Allowance and the lack of money he perceives is a major problem for him. He knows he will be evicted in the next couple of months and in such circumstances he says he may return to live with his parents. Whilst it is hoped that the Court will make him subject to a probation order, evidence suggests it will be very much on his terms. He continues to deny mental health problems although he has accepted that his drinking can be problematic at times. There is already antagonism between himself and neighbour's and I would conclude that the risk of a violent or aggressive incident is high, particularly if a neighbour tries to confront him after he has been drinking. The risk would also be high if he returned to live with his parents.
>
> …
>
> "If alcohol does precipitate his psychotic episode or brings to the surface a mental illness then he can act violently. He used a billiard ball to throw at a TV in the hostel and he has used a hammer to hit his parents when they were in bed. I would suggest therefore that whilst in a psychotic state he could cause significant harm to others."

19. On 11 February 1998, Consultant 4 was written to by the probation officer for P in relation to the incident on 6 February 1998.

20. On 19 February 1998, the clinical assistant from the area forensic service wrote to the Consultant forensic psychiatrist at HMP Durham. It was noted that P was currently remanded in custody until the 5 March 1998 when he was due to appear at Houghton Magistrates' Court on two charges of theft and one of criminal damage. An application for bail was to be heard by the Crown Court Judge on the 24 February 1998. The letter to the forensic psychiatrist noted;

(a) That P stated that he 'could have killed you both', meaning the probation hostel workers. Furthermore, the threat to the mother was also noted. The clinical assistant stated that in view of P's past section 18 assault on both his parents in 1994 the staff at the bail hostel were understandably concerned about the statements and threats made.

(b) It was noted that whilst in the police cells at Houghton Magistrates' Court, P appeared cold and guarded. He denied any symptoms of mental illness and stated that he had no mental health problems. He placed the episode of criminal damage down to being drunk and denied having made any of the statements quoted before. The clinical assistant felt that P required a full forensic psychiatric assessment. It was noted that Consultant 3 appeared to have been of the opinion that P's level of dangerousness was greatly reduced with him no longer living with his parents but in view of the associated violence of his most recent charge a reassessment of his level of dangerousness would be valued.

- ***Commentary***

21. *The Panel is of the view that the events of January to March 1998 are of some significance in the longitudinal assessment of P's mental illness.*

(a) The clinical assistant noted that P had a history of probable severe mental illness in conjunction with violence. However, this was clearly not now restricted to his parents and threats were being made beyond his parents (whom he had previously seriously assaulted). The Panel also notes that it would be reasonable here

to consider that P was capable of violence in association with symptoms of mental illness to victims beyond his family, albeit alcohol would play a significant role.

(b) A pattern was now developing of P's initial presentation being with apparent symptoms of severe mental illness which were then subsequently denied by him in a relatively short period. A consistent history was developing of P being capable of hiding his symptoms that he was, in fact, experiencing.

22. On the 20 February 1998, Consultant 5 assessed P. Consultant 5 found no evidence of psychotic symptomology. Consultant 4 was to be informed.

23. On the 11 March 1998, P was seen in the police cells at Houghton le Spring Magistrates' Court and was noted not to be making sense. P was claiming he was Royalty and "the fucking colonel would get him out". P was noted to snap out of this state quickly and seemed to understand the proceedings. He told the magistrates that he was royalty and when he was remanded in order to obtain a pre-sentence report and a psychiatric report, P said he would kill them. Consultant 5 was to be re-approached for a psychiatric assessment.

24. When seen on 18 March 1998, P completely denied the behavior at Court saying that false information had been given and everybody was lying about him.

- ***Commentary***

25. *The Panel again notes that P was presenting with psychotic symptoms and almost immediately denying them.*

- **Admission under section 3 of the Mental Health Act 1983: 19 June 1998-November 1999**

26. On 19 June 1998, P was held in a police station for questioning about another offence of stealing bread from a baker's shop. He was assessed by Consultant 4. He was then admitted to hospital pursuant to section 3 of the Mental Health Act 1983. Yet again, P was claiming to be the King of England that his surname was Windsor and he was crowned by the Church of England and his mother was Queen Elizabeth II. P claimed that doctors in the palace did a lobectomy on his brain which made him forget the past. P denied auditory and visual hallucinations and denied being depressed. Mental state examination revealed that he was casually dressed, had a mask-like face, well orientated, speech was normal, memory good, no feature of depression, no delusions of grandeur, no hallucinations, no idea of reference, no feeling of passivity, his insight was poor. The impression formed was that P had delusions of grandeur. The cause was masquerading or a psychosis and the plan was to observe.

27. On 23 June 1998, P was again reviewed. P repeated his claim that he was the King of England, that his mother was the Queen, that his father was King Edward VIII. When asked about the assault on his father in 1994, P claimed that the assault was on his adopted father not his real father. P claimed that the doctor worked for Princess Anne or Princess Margaret. P claimed that he was crowned the King of England in the 1950's. P claimed to have slept with several women, and that he had too many sons and daughters to count. P denied hearing voices. P claimed that his mother had a plate put in his head which brings thoughts up on a screen. P claimed that doctors had given him a frontal lobectomy so that he cannot remember his past. On mental state examination he was incongruous, exhibited grandiose delusions and persecutory delusions. The impression was that P had a psycho-effective presentation with a possible polymorphic psychotic disorder.

28. On 3 July 1998, a violence risk assessment was carried out by a junior doctor. The following matters were noted:

(a) Previous violence, charged with wounding with intent in 1995 for assaulting father with a hammer.

(b) Social restlessness has no contact with mother.

(c) Poor compliance with treatment and refuses medication.

(d) Denies drug misuse for the last two years, used to use cannabis, amphetamines, opiates, LSD and Ecstasy.

(e) No evidence of precipitants or changes in mental state prior to violence.

(f) No access to victims; has no specific victims.

(g) Thought broadcasting, believes the Queen had a plate placed in his head so that people could read his thoughts, the plate enables thoughts to be transmitted to a screen.

(h) Some irritability and threats to kick off when medication was discussed, otherwise pleasant and compliant on the ward.

(i) No specific threats made.

(j) Factors increasing the risk of violence included previous violence, social restlessness, non-compliance with medication, previous drug abuse, irritability and threats to kick off when medication discussed.

(k) Factors reducing the risk of violence, no current drug misuse, no recent stresses, no evidence of precipitance or changes in mental state, no specific victims, no access to victims, no persecutory delusions or delusions of passivity, no specific threats made.

(l) The risk was assessed as “low to moderate risk of violence, non-specific, general risk, no immediate risk, moderately volatile risk, given no evidence of precipitance to assault on father and no change in P’s mental state.

Management: given likelihood that current mental state unchanged for many years and given P's strong aversion to taking medication it was probably best not to enforce medication or enforce hospital stay.

- ***Commentary***

29. *It is the Panel's view that by this time there was a clear association between the attack on P's parents and his developing mental illness. The Panel's view of this risk assessment is:*

(a) That it was a comprehensive assessment of the factors which increased the risk of violence and those reducing the risk of violence. Consultant 5 confirmed to the Panel that this form of risk assessment was something which his department was very particular about and that junior doctors were taught the Royal College guidance.

(b) This attempt at collating information and assessing risk was incomplete and drew the wrong conclusions. It was incomplete in that there was a limited longitudinal formulation. P's mental health had been different over the previous 18 months. His presentation changed in that there were incidents of criminal behavior at the same time that he was portraying mental illness and his alcohol use escalated.

(c) *The junior doctor's assertion that P should not be medicated against his will was misconceived. The very purpose of detention under section 3 of the Mental Health Act 1983 is the treatment of a person's mental disorder. P's treatment should not have been determined by his wishes and feelings but by his assessed clinical needs and within the powers given to clinicians under Part IV of the Mental Health Act 1983.*

30. On 9 July 1998, Consultant 4 referred P to Consultant 5. In his evidence to the Panel, Consultant 4 stated that he felt that there was a need for a forensic

opinion given the question of violence and risk to others. Consultant 4 noted that P had been involved in a serious episode of violence, he definitely had a psychosis and it had been necessary for P to see 3 forensic psychiatrists previously. All these factors seemed to suggest to Consultant 4 that it would be unwise to treat P without their opinion. Consultant 4 stated that he would have been very unhappy to "just discharge P" and continue to treat him without forensic advice. The purpose of the forensic opinion was to seek a greater understanding of, for example, the attack by P on his father. Consultant 4 told the Panel that the assault on the parents was "a different order of dangerousness" in his limited experience. He noted that the literature suggested that such people were dangerous, and that attacks on members of the family were things which clinicians had to be careful about especially given the fact that a hammer was used.

31. Accordingly, Consultant 4 referred P to Consultant 5. Consultant 5 saw P and recorded his findings in a letter dated the 23 July 1998 to Consultant 4. Consultant 5 noted:

(a) That P decided that he was not going to spend any time talking to Consultant 5. No meaningful background information from P was obtained. The information relied upon was from the notes available from Cherry Knowle Hospital.

(b) P's delusional beliefs were, however, repeated to Consultant 5. P announced that he was not P but rather Ronald Windsor. He repeated that he was the son of Queen Elizabeth and King Edward VIII. He stated that he had been sent to the North East in 1972 by the Queen. He suggested that the Queen was deliberately trying to keep his existence secret. He alleged that Princes Charles, Prince Andrew, Prince Edward and Princess Anne were not the Queen's children. He confirmed the Queen had arranged to have a plate surgically implanted in his head. Consultant 5 tried to get P to elaborate on the purpose of the plate but P became a little angry at this point stating "You know what it's there for".

Then P said “King … that is all I am saying … King”.

(c) Consultant 5 concluded that P was exhibiting gross psychotic symptomology and presented with marked grandiose delusions. These were persecutory delusions. Consultant 5 noted that P may have experienced symptoms when interviewed by psychiatrists in the past but had had sufficient “insight” to deny them when asked. Equally, it was possible that the episodes had, in reality, been short-lived. Consultant 5 diagnosed that P was between schizophrenia and mania. Consultant 5 thought that the most likely diagnosis was probably one of schizophrenia, albeit with a marked affective component. It was not possible to entirely rule out a psychotic state induced by illicit substance.

(d) Consultant 5 noticed that there appeared to be two episodes of major violence in the past; the assault on his parents in 1995 and a criminal damage conviction in 1998. The most recent offending had been petty in nature involving sandwich thefts from local bakers. Consultant 5 noted that P could be angered by probing in detail into his symptomology. He also noted that staff on P’s ward were more wary of P than some of their other patients.

(e) In relation to management of P’s symptoms, these had to be treated but if P refuses medication then the only reasonable course of action would be giving P depot injections. It was clear that the staff on the ward would have felt uncomfortable at the prospect of forcing medication on P. It was suggested that it may be possible to have P’s medication enforced on a more secure ward.

32. The Panel probed the letter dated 23 July 1998 with Consultant 5. Consultant 5 pointed out that assessing dangerousness is not a one dimensional process and that individuals are not dangerous to everybody in equal measure. Any risk assessment would seek to identify who the potential victims might be. Consultant 5 noted that there had not been a great deal of history of violence in P’s case and the main violence seems to have been

directed towards the father and mother, but again primarily against the father but the mother had got in the way of P's attempt to assault the father.

33. In the light of Consultant 5's opinion, P was moved to a low secure ward and then later transferred to a ward for patients with challenging behavior. However, prior to this move, and in an entry dated the 13 July 1998, it was recorded that nursing staff on the ward felt that the ward was not sufficiently secure to cope with managing P if medication was forced. There was concern about the risk of violence, not so much when any medication was given but afterwards when "he has had time to plan an assault."

34. On 6 November 1998, Consultant 4 again wrote to Consultant 5. The purpose of this letter was an invitation to Consultant 5 to provide a further opinion given that P's detention under the Mental Health Act 1983 was due for renewal on the 18 December 1998 and Consultant 4 "wondered if he should renew his section as it could be argued it would be more in his interest to be discharged."

35. Consultant 5 saw P on the 26 November 1998. It is important that we set out in some detail the summary of the findings made by Consultant 5:

(a) P informed Consultant 5 that he was not too good and that he was hoping to come "off section". P stated that he never believed that there had been anything wrong with him and did not believe that he needed to be an inpatient. He asserted that he was not mentally ill. When the diagnosis of schizophrenia was discussed, P stated that he did not accept that he suffered from it.

(b) When P was asked about his family, his delusional beliefs became readily apparent. P told Consultant 5 that his real mother was the Queen of England. He had known this for many years and remembered living in London with the royal family up until the early 1970's at which point he moved to Sunderland. When asked about the assault that P had committed on his mother and father P told Consultant 5 that he hit his father with a hammer. P did not intend to hit his mother but his mother jumped on top of his father to try to protect him.

P told Consultant 5 that he and his father were not getting on at the time. There had been no specific argument. P asserted that he did not wish to talk about this as it was in the past. When P was asked by Consultant 5 whether the assault upon the father was in any way bound up with him being the son of Queen Elizabeth, he admitted that the assault was connected to these ideas. He would not elaborate, however, on the connection.

(c) P described an incestuous relationship with the royal family. He stated that King Edward VIII was the Queen's father and he was the product of a sexual union between the Queen and his father King Edward VIII. He claimed that he had children by doctors working at one of the hospitals. P asserted that he was in his 40s and that he was in the Vietnam war. He continued to assert that he had a plate in his head and if he (the Consultant) wanted to know the reason for the plate's existence he would have to ask the Queen. P claimed that the Queen had been attempting to keep his identity secret. P was confident that when the Queen died he would accede to the throne.

(d) P told Consultant 5 that there was a colonel who looked after him. He stated that he usually sees the colonel when he is in some form of difficulty. The colonel had confirmed that P was the Queen's son. P last saw the colonel on the Operation Raleigh expedition that he went on.

(e) P noted that it was Consultant 3 who prevented P from going on a previously proposed Operation Raleigh trip.

(f) P had re-established contact with his mother. P had visited his mother on a number of occasions when he was on leave and had visited his mother's house and had spent time with her. Staff however were not aware that the mother had ever visited the hospital. They were not aware that P was spending any time at his mother's house when he was on leave.

(g) Consultant 5 concluded that P was suffering from a severe mental illness characterised by complex delusional system, possibly in association with other psychiatric symptoms such as auditory hallucinations. It was evident that P's

illness has proved largely unresponsive to medication. P had been on antipsychotic medication in the form of Haloperidol and Olanzapine. P disclosed that the assault upon his parents was in some way related to his belief but refused to elaborate on the relationship. There was a marked sexual element in P's delusional system.

(h) Consultant 5 was unsure as to what to make of this situation in relation to contact between P and his mother. P was adamant that he harbored no ill-feeling towards his mother. He maintained that he did not intend to hit her but, for reasons which were not clear, his violence was directed towards the father and he insisted that his mother simply got in the way. In the light of the death of his father it could be argued that P did not pose any significant risk to other persons. Consultant 6 cautioned that he would not rush to that conclusion whilst P was reluctant to talk about the reasons for the original assault. It now appeared that the assault on his parents was related to the illness. P remained severely ill. Any risk of violence that P posed could be reduced if his symptoms were brought under control.

(i) P should continue to be detained under the Mental Health Act 1983 primarily on the issue of his own health. P did not perceive himself to be ill and Consultant 5 doubted that P would comply with medication were he to be discharged. P appeared to have got himself into a chaotic life situation prior to admission with him being reduced to stealing food from the baker's.

(j) Consultant 5 thought there were a number of outstanding issues that needed to be dealt with. An alternative treatment strategy should be developed. A trial of a different neuroleptic treatment for a reasonable period of time at a reasonable dose should be instituted. There were a large number of areas about P's life about which little was known and there were outstanding issues regarding P's sexuality.

(k) It was noted that P was reluctant to discuss his symptomology in any detail. However, although P was reluctant to engage in discussing his symptoms, Consultant 5 noted that he had made significant progress in this regard at the

visit on the 24 November 1998. He noted that there was a limit as to how much can be achieved in one interview. It was essential that P's mental state should be continuously examined in order that the best possible understanding of his delusional system could be achieved.

(l) P was suffering from a severe mental illness and he should not be discharged from the hospital on health grounds. P's behavior on the ward, what he said at interview and the current family situation suggested that P was at a low risk of committing acts of violence but that this could not be entirely ruled out.

36. On the 26 November 1998 Consultant 4 wrote to Consultant 5 querying whether Consultant 5 thought that P should be detained with a view to the protection of other persons or whether Consultant 5 thought that P could go on leave. Consultant 4 expressed concerns about Consultant 5's comments that P was at a low risk of committing further acts of violence but that this could not be ruled out. Consultant 4 also noted that P's psychotic thinking related to his life threatening assault on his parents and that this must change the view of this offence especially when previous psychiatrists had not elicited this.

37. Consultant 5 wrote back to Consultant 4 on the 14 December 1998. Consultant 5 noted that P had admitted at the last interview that the earlier assaults on his parents were in some way related to the mental illness and acknowledged that this was the first time that the assault and the mental illness appeared to have been linked. Consultant 5 suggested that P may now be in a position where he was more willing to talk about this issue. He added that until such time as the precise relationship between the earlier assaults and the illness was elucidated, there was some potential risk to other persons. Consultant 5 declined to be drawn into the question of whether P should be granted leave and indicated that the responsible medical officer was in a more comprehensively informed position to take such decisions. However, by 20 December 1998 all unescorted leave out of the hospital was cancelled due to the past history of violence towards P's mother. P had repeated the belief several times to staff since the interview with Consultant 5, although he had

stated that he had made them up to get out of prison.

- ***Commentary***

38. *It is clear to the Panel that this was a significant period of inpatient treatment for P. It was an opportunity for seeking to formulate a comprehensive determination of P's risk of violence to others, including his mother. In particular, the Panel notes the following as being significant facts which emerged during this time:*

(a) Ward staff had expressed concerns that P may be violent if forced to receive medication.

(b) Anti-psychotic medication had not had any significant effect on P.

(c) There was now a direct link between P's psychosis and the assault on his parents in 1994 and this was the first time that this link had been made by the clinicians and acknowledged by P.

(d) The interview with Consultant 5 on 26 November 1998 was revealing. In this interview it became apparent that P was capable of hiding his symptoms most of the time, even from those treating him and being responsible for his care on a daily basis. Significantly P was also capable of hiding his symptoms such that he was allowed unescorted leave at a time when, in fact, he had a significant mental illness and claimed to be having contact with his mother during this period.

(e) P still refused to accept that he had any mental illness.

39. *However, the letter from Consultant 5 to Consultant 4 dated 26 November 1998 stated that P was at low risk of committing further acts of violence. In the Panel's view Consultant 4 correctly questioned this assessment with Consultant 5. However, Consultant 5 stated only that, "Until such time as the precise relationship between the earlier assaults and illness is elucidated, there is some potential risk to other persons".*

40. *The Panel probed the issue of the assessment of P's risk with Consultant 5. Consultant 5, when interviewed by the Panel, emphasised that his report was being prepared for the purposes of a mental health review tribunal. He emphasised that the most compelling argument for keeping P in hospital was that his illness had been detrimental to P's own health and that this was therefore a more persuasive argument to the tribunal than one on the grounds of P's dangerousness.*

41. *However, the Panel is of the clear view that the letter from Consultant 4 to Consultant 5 was not just focussing on the issue of the forthcoming mental health review tribunal. Consultant 4 was requesting clarification of Consultant 5's assessment that P was at low risk of committing further acts of violence. The letter of 14 December 1998 still left ambiguity as to the nature, degree and management of the risk. The Panel is fortified in its view that there remained ambiguity in the assessment of the risk having regard to a letter received by the Panel after Consultant 5 had been interviewed by the Panel. In a letter dated 28 April 2011, Consultant 5 stated that "In reading the transcript I am anxious to dispel any impression that this meant that I did not think P was potentially dangerous. I want to make it absolutely clear that this is not the case." The reference to dispelling the impression relates to P's detention under the Mental Health Act 1983 on the grounds of his own health alone and that this would be sufficient to justify detention. Consultant 5 pointed out that the hospital notes record (1 December 1998) that Consultant 5 suggested P was still perhaps a danger to society and his parents. Although this was struck out by a person unknown, it appears to reflect a conversation between Consultant 5 and a member of the ward staff. Furthermore, it is also clear that as a result of Consultant 5's consultation with*

P on 26 November 1998, all unescorted leave out of the hospital was cancelled due to P's past history of violence towards his mother.

42. *The Panel has considered this evidence and we are of the view that Consultant 5 did emphasise in the letter of 26 November 1998 that P's detention under the Mental Health Act 1983 could be justified on the grounds of his own health alone. There was no suggestion in the letter of 26 November 1998 that Consultant 5 was of the view that P was dangerous. On the contrary, the letter of 26 November 1998 emphasised that he was at low risk of committing further acts of violence. Furthermore, Consultant 5 did not suggest that P should not be having unescorted leave outside the hospital. He emphasised that he was not suggesting that leave should be withdrawn, simply that it was essential that clarification should be obtained as to where P was going during leave. The letter of 14 December 1998 did no more than emphasise that until such time as the precise relationship between the earlier assaults and the illness was elucidated, there was some potential risk to other persons. The Panel, when considering the letters, did not consider that Consultant 5 was highlighting in any way that P was potentially dangerous. In his interview with the Panel, Consultant 5 did not suggest that his view was that P was potentially dangerous. It was only the letter of 21 April 2011 that emphasised this. The Panel's view is that the time for emphasising that P was potentially dangerous was in the letters of 24 November 1998 and 14 December 1998.*

43. *Consultant 5 did, however, emphasise in his letters of 26 November 1998 and 14 December 1998 the need for P's mental state to be continually examined so that clinicians had the best possible understanding of P's delusional system and that P's explanation for the assault on his parents required further investigation by the responsible medical officer. At this time (November 1998) P's clinical management was passing from Consultant 4 to Consultant 6.*

44. At a case conference review on 28 January 1999, P was noted to have presented no management problems on the ward and had made no attempt to abscond in spite of restricted leave. He displayed no signs of mental illness

and tended to “clam up” when the topic of conversation was not to his suiting. P had told staff that previous references to his being a member of the royal family were “made up” in order to avoid prison. It was generally agreed that this cannot be accepted. P had become involved in occupational therapy activities; seemingly his co-operation was in order to secure his discharge. It was noted that P had a tendency to isolate himself. P’s mother advised that when P was visiting her home P would telephone in advance, which enabled her to ensure that other family members could be present during his visit. The mother said that she felt uncomfortable when alone with P. It was agreed that P could go home to visit his mother with advance notice and plans were made to this end. P maintained that he was not ill, made up his delusionary statements but accepted to take his medication prescribed. It was noted that there was little in his attitude to suggest that P would continue with his medication once discharged.

45. On 12 February 1999, P was visited by a forensic psychiatrist instructed by P’s solicitors. During the course of this discussion it appears that P discussed the incident when he attacked his family. P stated that his parents used to nag him about daily things and on the night of the attack he took a hammer to his parents’ room, went to strike his father and the hammer top fell off and there was not the force to inflict serious injury. He confirmed that his mother stepped in the way to save the father.
46. On 25 February 1999, during a review on the ward, Consultant 6 engaged P in a discussion about the assault by P on his parents. P stated that he had an argument with this father, having had a lot to drink. The assault was unplanned and impulsive. P said that he did not intend to kill or seriously injure his father and had no intention to harm his mother but that she had ‘got in the way’. P stated that he regretted the assault. The plan was to discuss with the social worker and P’s mother at a meeting the following week, including the question of unescorted leave. The key worker and medics were to continue trying to establish a rapport with P.

47. In preparation for a Mental Health Review Tribunal in March 1999, Consultant 6 wrote to P’s solicitors on 25 February 1999. Consultant 6 noted that P

minimised his symptoms and had a lack of insight into his condition. It was suspected that P was also good at hiding his symptoms. Although his symptoms appeared to settle quickly, in February 1998 there was a likelihood that he was indeed suffering from severe mental illness between February and June 1998. Although he had little actual psychiatric contact between February and June 1998 reports indicated that P had not been looking after himself properly, living in poorly maintained accommodation and being reduced to stealing for food.

48. On 11 March 1999, at another review, P was noted to be enjoying unescorted leave in the hospital grounds without problems. There were no behavioural problems although P at one point had been seen making derogatory remarks to other 'ill' patients. P remained fairly reserved but would initiate conversations. Although P was accepting medication without complaint, when he was asked, P stated that he did not need the medication, he was not ill and would not take the medication if he was not on 'section'. The plan was to start a programme of unescorted leave, maximum was twice weekly and initially three hours increasing to six hours. P's mother was to be informed. Mental Health Matters (MHM) was to be contacted in order to consider accommodation for P.

49. P thereafter enjoyed considerable leave. By 15 April 1999 P was being considered for a move to independent supported accommodation at Hill Crest. The review dated 15 April 1999 noted that P had not enjoyed overnight leave as he had nowhere to go and that P's mother felt intimidated to some extent. P was noted to have limited rapport, giving short answers. P was eager to be discharged and wanted to 'get a job'. It was noted that P had problems with managing his budget, spending too much money on alcohol and betting on horses. P was told that he would have to do some planning regarding his money. P was to stay on section even if discharged to Hill Crest.

50. At review on 20 May 1999, P was again stating that he would not take medication when he was 'taken off section'.

51. P was again reviewed on 27 May 1999. P was noted to be cooperative, there was no psychotic symptoms present and it was difficult to establish a rapport. P agreed to the plan to remain on 'section' with a possibility of a discharge at the end of June 1999. P agreed to take medication if he was accommodated at Hill Crest.

52. On 17 June 1999, a case conference was convened. P was enjoying overnight stays at Hill Crest which were reported to be going very well and P was looking forward to staying there permanently. P was to stay on section because he was reluctant to take medication. P's rapport was noted to be limited. The plan was to arrange for a community psychiatric nurse (CPN) and a key worker to be allocated. There was the possibility that P would have his depot injection whilst on the ward.

53. On 26 June 1999, P had a one month trial at Hill Crest, which was reported (15 July 1999) as having gone very well. P was noted to be complying with medication, though P stated that 'once his section had been lifted he would stop taking his medication'. There were no psychotic symptoms evident.

54. When P's case was reviewed on 17 August 1999, progress was noted, again, to be good. P was seeing his mother weekly and there were no problems reported. P was now stating that he would continue to take his medication even if not on 'section'.

55. On 23 September 1999, there was a further review meeting held at Hill Crest. The overall picture was that 'things continue to improve'. P was more relaxed and his social skills had improved. There was no evidence of psychosis. P was agreeing to take the depot and again confirmed that he would continue to do so even if not on 'section'. The plan was to take P off his section, arrange with MHM a move and continue with P's medication It was noted that there was a risk of self neglect, partly alcohol related. There was also a risk of violence to others.

56. P remained at Hill Crest and on 4 November 1999 it was noted that P was ready for a move into accommodation, where he would receive support from MHM. P's care was then to pass over to a social worker from the "south sector".

57. The care programme approach documentation shows that it was anticipated that P would continue to be on his medication, the CPN was to visit on a monthly basis to monitor P's mental health, to supervise his medication regime, administer IMI and to offer supportive counselling.

- ***Commentary***

58. *From November 1998 through to November 1999, the Panel notes that there were attempts by those responsible for P's treatment to follow the advice of Consultant 5. However, these attempts were not systematic and did not result in a clear formulation of P's delusional system and associated levels of risk. There appears to have been no serious attempt to follow the advice of Consultant 5 to continuously examine P's mental state so as to achieve the best possible understanding of P's delusional system. Furthermore, there appears to have been no attempt to make further probing enquiries as to the explanation for the assault by P on his father. It is worth noting that on 12 February 1999 it was recorded in the notes that the hammer top fell off during the attack by P on his father. The Panel regards this as confirming the potential seriousness of the assault upon P's father. Although on 25 February 1999 an attempt was made to revisit the circumstances in which P's father was assaulted, this appeared not to be focussed and no attempt was apparently made on this occasion or subsequent occasions to follow up the significant information revealed by P on 12 February 1999 that if the hammer head had not come off the assault could have been all the more serious, if not fatal.*

59. *Furthermore, despite a consistent concern expressed by the clinicians that P was capable of hiding his symptoms, the records constantly refer to no evidence of psychosis and/or mental illness, yet no analysis was made of these findings against the background of P's known ability to successfully hide*

his symptoms from those clinically responsible for his treatment.

60. *The Panel notes that from 19 June 1998 P was detained under section 3 of the Mental Health Act 1983 and effectively detained until his move to accommodation in November 1999. This represented P's longest period of detention under the Mental Health Act 1983. During this period a body of evidence came to light which assisted in the determination of P's underlying illness and from which a more systematic assessment and formulation of P's potential risk to others could and should have been made. There were failings:*

(a) In communication, including proper record keeping.

(b) In the clarity of communications between Consultant 4 and Consultant 5.

(c) In the level of enquiry into risk, which was not sufficiently robust.

5. P'S CONTACT WITH MENTAL HEALTH SERVICES AND HIS TREATMENT IN THE PERIOD 2000-2005

1. In 2000, P's care was reviewed every month. Medical records during this period show that P was displaying no signs of mental illness and there was no evidence of psychotic symptoms. P had apparently bought a season ticket for Sunderland Football Club and was saving up to buy a car. P stated that he was spending time with his mother, attending day services and that he was no longer consuming alcohol. Throughout the whole of 2000 P was noted to be compliant with his medication.

2. On 10 August 2001 P was recorded as well but that he had declined all offers of day care, "drop-ins" and support work. The social worker had apparently closed his file.

3. In On 30 October 2001,MHM assessed P as requiring minimal assistance, receiving two hours care a week from his key worker. P was noted to otherwise live independently.

4. Throughout 2002, the records confirmed that P was compliant with his medication and no further problems had been identified in relation to his mental health.

5. On 6 January 2003 P moved to another MHM property in the Walker area of Newcastle upon Tyne. Because of P's transfer, his clinical treatment and care was also transferred to a new trust. On 14 January 2003, MHM contacted P's then community psychiatric nurse (CPN). There had been a meeting with a locum Consultant. This locum Consultant probed into P's past and discussed his attack on his father in great depth. The locum Consultant told P that the assault could have resulted in him murdering his father and he was lucky. P stated that the interview concentrated on this incident and some other negatives. No positives were identified. The MHM worker noted that P was very

upset and tearful and she was worried about his wellbeing. The CPN contacted P and provided positive support with good effect.

6. In January 2003, P's care was transferred to the community health team at the Walkergate Centre.

7. P was seen on 1 April 2003, when it was noted that he had no psychotic symptoms, that he kept himself tidy and clean but not his flat. A further review was arranged for 15 July 2003. This was the first occasion that he was seen by Consultant 7. P was noted to be slightly anxious during interview and had two main worries. The first was in relation to his Disability Living Allowance (DLA) form and the second was in relation to a lump in his testicle. No symptoms of psychosis were identified and it was noted that P had no suicidal ideas. The plan at that stage was to advise the general practitioner to reduce P's Temazepam.

8. P was again seen on 4 November 2003 by Consultant 7. It was noted that P had started work at a café. His tenancy was going well. He reported lumps at the site of the depot injection. This was a recent problem. He wanted to change to tablets. Consultant 7 advised against this given that whilst P was on the depot he had "stayed out of hospital for six years", had made progress and was now doing voluntary work. The request to change to oral medication was discussed with Consultant 7 who noted that there was a risk of non-compliance and relapse. This was despite P saying that he would take the medication. The plan was for P to stay on long term depot, to ask the CPN to organise a care plan review and for a further review in three months' time.

9. On 26 January 2004, P was again reviewed by Consultant 7. He was upset because he no longer received £10 for working at the café. P was noted to be reluctantly willing to continue on his medication but wanted the dose reduced. At this stage Consultant 7 reduced P's depot to 125 mg four weekly. In his interview with the Panel, Consultant 7 confirmed that ideally he would have preferred P to stay on 150 mg, however, he was considering the long term position in relation to the depot.

10. P was then seen on 8 July 2004. His mental state was again noted to be stable. P was again complaining that the lumps at the site of the depot injection were painful. On this occasion Consultant 7 noted that the warning signs of relapse of P's mental health were paranoia, depression and panic attacks. P felt that people passing by were talking about him saying "he's ugly, he's psycho". In his interview with the Panel, Consultant 7 confirmed that this was not a current symptom but symptoms that P had identified. Consultant 7 informed the Panel that part of the process of seeing P at this stage was to devise a plan for the possibility of relapse. However, the plan was to reduce the frequency of the depot to every five weeks.

11. P was again seen on 28 September 2004. On this occasion the risks were identified within the context of P having attacked his parents when unwell in 1994, taking drugs and with a chaotic lifestyle. There was no evidence of any suicidal ideation and there was a risk of relapse with the reduction in the depot. A crisis plan was noted to be in place. At this stage the plan was to review P in six months' time. If there was any sign of earlier relapse then an appointment should be arranged and consideration was to be given to an increase in the depot injection.

12. A further review took place on 20 December 2004. P was noted to be not sleeping well. The Temazepam was noted not to be working. P's mood was down and P was noted to have less motivation to wash and shave. However, there were no signs of paranoia. There were no suicidal ideations. The plan was to stop the Temazepam and Trazodone (an antidepressant) was to be added to the Haldol injections. In his interview with the Panel Consultant 7 confirmed that there was no suggestion of any psychosis and this was more a mood change. It was not a situation where he thought someone was just clinically severely depressed. Consultant 7 did confirm in a letter of 23 December 2004 that there had been a slight deterioration in P's mental state.

13. P was again reviewed by Consultant 7 on 22 March 2005. At this stage P's sleep and mood had improved. The change from Trazodone was beneficial. In addition, P had moved to a new flat in the Heaton area of Newcastle upon Tyne.

P planned to stay in Newcastle. The plan at this stage was to review P in six months' time.

14. In May of 2005, P's mother died.

15. P was seen on 20 September 2005. There had been no problems since his mother's death. P had run up an £800 catalogue debt. His mental state was noted to be stable, he had no suicidal ideas. Consultant 7 noted that the early warnings of relapse were of P having a more anxious and low mood, he would be more paranoid, his self-care would reduce or he had suicidal thoughts. However, the plan was to reduce the dose of depot to 100 mg but maintain five weekly administration cycles. The risk of relapse was further discussed and it was planned to review P on 16 November 2005.

16. On 16 November 2005, the date of the review, P did not attend. In discussions with CPN1, Consultant 7 was told that P was a bit cool and withdrawn when she had last seen him. P was then asking for the depot to be stopped. It was noted that there was no current evidence of drug and alcohol abuse. It was unlike P not to attend. It was noted that the serious assault occurred when P was paranoid in the past. The plan was for CPN 1 to contact P and give the depot, which was due on 1 December, and then arrange another appointment. If P was non-compliant then it would be necessary to arrange a review with P earlier.

17. In his interview with the Panel, Consultant 7 stated that this was the time when he decided to obtain the notes in relation to P's previous admission. This was prompted essentially by P stating that he was going to stop his depot and Consultant 7 and CPN1 wished to get as much information as possible about P's history.

18. On reading those notes, Consultant 7 told us at interview that the contents confirmed to him that "we needed to be taking this seriously" in reference to P's case. Consultant 7 confirmed that one of the concerns was that P may be relapsing. Essentially this was based on P's disengagement from services, even though there were no psychotic symptoms. In terms of the risk of violence, Consultant 7 confirmed that there remained a risk of him attacking

somebody. He stated, “Absolutely, that was from the word go the primary reason why he’s got this care plan in place because of that attack in 1994”.

19. On 13 December 2005, there was a home visit with Consultant 7 and CPN 1 in attendance. P was slightly guarded but spoke with them both for some time. He denied any current psychotic symptoms and denied ever having any hallucinations. He agreed to having had delusions in the past, in that he talked about royalty and being the son of the King. These assertions were in order to help him get psychiatric treatment rather than a custodial disposal. P claimed that he no longer required the medication and said that he took it because he was told too by staff and that it would help with the award of Disability Living Allowance (DLA). If he deteriorated he agreed to re-start oral Haloperidol. Three risks were identified as relapse indicators:

(a) Debt. That was an issue at this stage but P was trying to resolve it.

(b) Alcohol. It was noted that P’s relapses had been associated with alcohol. It was noted that in the past P was consuming as much as 120 units per week. However, P was currently drinking but not as much.

(c) Self neglect and neglect of flat. That was currently not the case. P’s mental state was regarded as being broadly stable, although he was guarded.

20. P was to keep in touch with the CPN. If he deteriorated then he would be offered oral Haloperidol of 1-2 mgs daily and home based treatment. If he refused then consideration was to be given to an assessment under the Mental Health Act. The plan was:

(a) For P to contact the Citizen’s Advice Bureau regarding his debts.

(b) CPN 1 was to continue visits.

(c) The next appointment was to be on 16 March 2006.

In his interview with the Panel, Consultant 7 confirmed that he did not identify in the records that if P was not taking his medication, this was a relapse

indicator. His reference to the Mental Health Act 1983 was, in effect, to start planning for any potential admission. Whilst Consultant 7 noted that P was slightly guarded, he did not believe that P was paranoid, there was no evidence of major mood disturbance, he was not neglecting himself and P was not behaving in a disturbed way. Consultant 7 stated that broadly speaking he was seeing the same person as he had seen on the first occasion in 2003. He was communicating in a normal fashion particularly in relation to his desire not to take his depot injection. Consultant 7 was clear that P was not detainable under the Mental Health Act 1983. Consultant 7 confirmed that P would have been detainable if he had started to talk about any of his symptoms such as the ones about 'the King', or if he had refused to continue treatment, or talked about wanting to harm somebody else, or there were reports of him being aggressive or he had been going out and stealing and ending up in confrontations with others. Consultant 7 did agree, however, that the three monthly assessment review was on the understanding that at that time P did not want to see Consultant 7 and CPN1. He stated that, "he (P) did not want really to see me that much and we were sort of saying well we need to stay involved." Consultant 7 accepted that P was trying to disengage.

21. The care programme approach (CPA) review was also undertaken on 13 December 2005. It recorded P was currently not wishing to take his medication, though he would consider this if he felt unwell. P agreed that he would have contact to monitor this. In the section 'Professionals Perception' it was noted that P was ''at risk of relapse", as he had suddenly stopped all psychotrophic (mental health medication). P was to be monitored and reviewed. No change to previous risk assessments was noted.

- ***Commentary***

22. *A significant feature of the assessment of P by Consultant 7 and CPN 1 was the absence of obvious symptoms of P suffering psychosis. However, the Panel notes that there was no evidence of consideration by Consultant 7 and CPN 1 as to whether, in December 2005, P was yet again concealing those symptoms. The records, which Consultant 7 had by now received and considered, showed clear evidence that P was very capable of concealing his*

symptoms from clinicians. In the Panel's view, Consultant 7 and CPN 1 had clear knowledge that P was capable of hiding his symptoms. In addition, they knew from the meeting on 14 December 2005 that P thought that he was also capable of making his symptoms up in the hope of avoiding a prison sentence.

23. *The Panel is of the view that there were other factors which indicated the probability that P was relapsing into his psychotic illness. First of all, he was noted to be guarded which needed to be considered within the context of the history of his ability to hide psychotic symptoms. Secondly, a significant risk factor was that P was stopping his medication. Thirdly, P was in significant debt relative to his income. It is clear that Consultant 7 recognised the risk of relapse but concluded that the risk factors did not currently indicate relapse or necessitate a review and or a change to P's then care plan. It is the Panel's view that there was ample evidence at this stage to indicate that P was at significant risk of relapse if, in fact, he had not already relapsed into his psychotic illness.*

24. *The Panel is of the view that the CPA review of 13 December 2005 was not adequate. There was, at this time, a significant change in P's presentation; P was guarded, he was stopping his medication and remained in debt. The review should have considered robustly increased monitoring by CPN1 as P's care co-ordinator or earlier review by Consultant 7. Further, this was a missed opportunity to focus in and, possibly clarify, inter agency roles and the support offered to P.*

25. *The Panel is of the view that the events of January 2006 confirmed that in December 2005 P was probably in relapse.*

6. P'S CONTACT WITH MENTAL HEALTH SERVICES AND HIS TREATMENT IN 2006

1. This period of P's engagement with mental health and other services is, in view of the Panel, a critical period.

- **January 2006-15 February 2006**

2. In January 2006, P had not engaged with psychiatric services as he had agreed previously and in particular he had not kept in touch with community psychiatric nurse (CPN) 1. Visits made to P's home by CPN 1 revealed that P was not there.

3. On 16 January 2006, P was detained by the Metropolitan Police pursuant to the provisions of section 136 of the Mental Health Act 1983. Section 136 of the 1983 Act provides that if a constable finds in a place to which the public have access a person who appears to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety. The records from the relevant NHS trust in London reveal that P was standing at the gates of Buckingham Palace staring at the police and would not move when requested by three armed police officers. He told them he was "the King" and he had come to see his "mother" who "needed to be killed". P had in his possession a rail ticket from Newcastle. It appears that he had travelled down earlier that day. P had brought his dog with him. P was assessed by two clinicians approved under section 12 of the Mental Health Act 1983. Both felt that P was suffering from mental disorder requiring further assessments to prevent deterioration in his mental state and possible risk to others. P was interviewed in the presence of two police officers. The records reveal that these interviews possibly had a compliant effect upon P. He was relatively calm and contained in his behaviour. There were occasional outbursts of frustration and verbal

aggression. P was unwilling to provide much information as to his background. He reasserted that he was “the King” and that he had come to Buckingham Palace to visit his mother and to have her killed. The reason for this appeared to be that she (his mother the Queen) had placed an electronic crown on his head some years ago. This seems to have caused him some distress and he requested that his head be x-rayed. P presented as clean and well-groomed. There was not much variance in mood although he did laugh somewhat inappropriately on one occasion. He maintained that he was “King Ronald” and his mother was the Queen. He answered very few questions and often replied “King”. An application for an assessment under section 2 of the Mental Health Act 1983 was made. It was noted that there was a risk of deterioration in P’s mental state and it was felt that he presented a risk to himself and a possible risk to others.

4. It appears very little information was forthcoming from P during his assessment. On the 18 January 2006 at 16:20 the relevant records reveal that the ward on which P was being assessed received a telephone call from Battersea Dogs’ Home. They had scanned the dog for a microchip and came up with P name, address and the telephone number.

5. On 19 January 2006 CPN 1 visited the home of P but there was no reply. She contacted Mental Health Matters (MHM) worker 2 who confirmed to CPN 1 that MHM staff had not seen P since 6 January 2006, although telephone contact had been made with P on 13 January 2006. The situation was discussed between CPN1 and Consultant 7 and it was agreed that CPN1 would seek to make contact with P on 20 January 2006. If contact was not made the plan was for CPN1 to contact the Police. MHM WW was advised by CPN1 that joint visits might be appropriate due to the change in P’s behaviour.

6. On 19 January 2006, a telephone call from Northumbria Police to the NHS trust in London resulted in the identification of P.

7. By 21 January 2006, contact was made with the clinical team for P in the north east. Confirmation was made that P was under the care of Consultant 7

and CPN1. At that stage a provisional transfer back to the North East was being recommended.

8. On 25 January 2006, P was transferred back to Newcastle upon Tyne. The discharge summary dated 8 February 2006 confirmed the legal basis for his admission to the ward and also the factual circumstances of his detention in London. P was noted to have been at times irritable, abusive and hostile. He refused to divulge any information whatsoever. The clinical impression was that P had suffered an episode of psychotic symptoms which could be due to acute and transient psychosis, schizophrenia or drug induced. Further information and an assessment was required to ascertain a firm diagnosis.

9. During his interview with the Panel, Consultant 8 confirmed that P was almost certainly in a psychotic state at the time of his detention and admission for assessment in London in January 2006. Consultant 8's assessment was that P was probably an experienced patient in terms of P having psychiatric interviews. He was referred back to the North East of England because P was an established patient in the north east. Consultant 8 confirmed that there were great pressures in London to discharge patients. Consultant 8 did express concern that having reviewed the records there could have been a more detailed analysis about the ideas that P was expressing and an assessment of those ideas in terms of his overall clinical picture. Consultant 8 also confirmed that there was little evidence that P posed a risk to himself and there was no evidence that he was a risk to other individuals apart from the Queen. Because of the threats he had made, the risk to the Queen could be regarded as high.

- ***Commentary***

10. *It appears reasonable to the Panel for P to have been placed on section 2 Mental Health Act 1983 for assessment during this period. At the time of admission on the 16 January 2006, the hospital in London to which P was conveyed under section 136 of the Mental Health Act 1983 did not know P's*

medical history. The period of admission in London was nine days. During this period the Panel notes that there is little by way of clinical analysis of the ideas that P was expressing or any real assessment of those ideas. Further, the Panel were concerned that on P's immediate transfer back to Newcastle upon Tyne there appears to be sparse evidence of any detailed communication between the London hospital and the receiving hospital in the north east as to P's presentation, especially surrounding the provisional diagnosis of the clinicians in London. CPN 1, in her interview with the Panel, stated that she contacted the ward by telephone but communication with ward staff was difficult because of language issues. The Panel is of the view that this was a missed opportunity to assess P at a time when he was displaying psychotic symptoms.

11. At 19:00hrs on 25 January 2006, P arrived at a hospital in Newcastle upon Tyne and was admitted to G ward. It was noted that he was detained under section 2 of the Mental Health Act 1983. He settled well, was pleasant towards staff and fellow patients and was said to understand the reason for his admission into hospital. He was said to be insightful into the circumstances leading up to his admission. P stated that he was becoming fed up with his daily routine and felt that he could not cope with the amount of debt he had. P was concerned that he was sleeping for only one hour during the night. P requested leave to go home to bring some of his belongings.

12. On 26 January 2006, CPN 1 visited P on the ward. CPN 1 spoke to P and felt that P should be kept in hospital for a longer assessment. She explained that P had been receiving depot injections in the community on a "maintenance dose" every five weeks. However, P had been refusing this since November 2005. CPN1 noticed a change in P leading up to his admission and described P as being "cold". She also described that P going to London was out of character. P at this stage was stating that he had no delusion ideas and blamed the psychosis on the drugs and alcohol. P was given unescorted leave to his home to collect some belongings. CPN1 drove P home and P returned using a taxi. CPN1 accepted in her evidence that no written risk assessment was made in relation to lone working with P and whether joint

visits were still desirable. CPN1 did not regard P as a risk to herself at this time.

13. The records from 26 January 2006 to 30 January 2006 merely record that P was settled throughout this period and regularly taking leave. On the 30 January 2006 it was recorded that P remained quite guarded about his thoughts and feelings and did not discuss “much” except to say that he was fine and communicated largely to “get needs met”. There were no direct signs of psychosis, agitation or anxiety noted.

14. On 30 January 2006, P was transferred from G ward to C ward. The history taken on transfer from G ward to C ward was that P had been on a depot injection but that his last depot injection was November 2005. P had stopped the depot injection because “he didn’t need it”. The record shows P had missed his appointment with his care worker CPN1. P stated that he went to London for a break having felt stressed about his debts. He had a £2,000 debt since March 2005 including credit cards, catalogues and TV. The notes record that when in London P had taken alcohol and cannabis. His symptoms came on very acutely after this. P confirmed that at the time of his detention under section 136 of the Mental Health Act 1983 he believed he was “the King”. He was said to now feel completely well and attributed the whole event to drug use. He had not accepted any depot since but would be prepared to take oral medications. It was noted that he was having day leave whilst on G ward. The assessment recorded that:

(a) P was relaxed, and his speech was spontaneous.

(b) He wanted to be discharged. There were no thoughts of self-harm or harm to others or the Queen. There was no evidence of delusions or odd ideas.

(c) P had insight and he realised the relationship between drug use and the symptoms, and identified this as the cause. He did not really understand the previous diagnosis of schizophrenia.

(d) The impression was of a drug induced psychosis in someone with a background of schizophrenia. The plan was to discharge soon if P's mental state continued to be stable. He was to continue without medication at that time.

15. From 31 January 2006 until 7 February 2006 the records state that P was settled but that he was keen to be discharged. He emphasised that his psychotic symptoms were due to excessive alcohol and cannabis.

16. On 7 February 2006, P was seen by his treating clinical team. It was noted that his detention under section 2 Mental Health Act 1983 expired on 12 February 2006. P had six hours leave daily which was used appropriately. P was noted to have been asymptomatic despite no anti-psychotic medication. It was suggested that the psychosis may only arise when using illicit drugs. P said that he was feeling fine and stated that he had been feeling fine since he had stopped taking the drugs. P stated that he had never really considered he was "a King" and said this in order to get "sectioned" and then receive further help. He was denying all psychotic symptoms. P stated that he had "never heard voices". He was only on "psychotics" because he had attacked his parents with a hammer when he was high at the time. P claimed that he did not use illicit drugs anymore except for the one off episode whilst in London. He stopped using illicit drugs in 1997. He denied being alcohol dependent because he could not afford alcohol. P wanted to be discharged from his section. This was denied and P was then requesting more leave. This request was denied and P was noted not to be hostile on hearing this. It was noted that there was a need to liaise with CPN 1 and Consultant 7 for further information. Importantly, the impression was that P was very guarded and could be hiding psychotic symptoms or he could be manifesting manipulative behaviour. His full notes were required.

17. On 9 February 2006, there was a Consultant review at which Consultant 7 attended with P's treating clinician. There was a discussion with P as to the events in London. It was noted that P had claimed to be the son of King Edward VIII and the Queen was his mother. P continued to say that he went to London because his debt was mounting and he was feeling stressed. On

discussion P could see that he was more impulsive after his depot injection was stopped in November 2005. There was a discussion about the merits and demerits of oral depot versus depot antipsychotics. P agreed to take anti-psychotics.

18. On 13 February 2006, P was seen again by the treating Consultant clinician and CPN1 and MHM W1. There is a lengthy entry in the records of this meeting and it is important to set out what P was asserting on this occasion and also to record some concerns that CPN1 had. P noted that he was fine. He was reasonably kempt, calm and coherent. P stated that he accepted that he was suffering from a mental health illness and was happy to continue with his medication. CPN1 mentioned concerns about P's insight and P's failure to accept his diagnosis and medication. The records state, however, that at "present" P seems to have good insight. MHM were to continue to support him in the community. The indicators of relapse were increased impulsivity (i.e. going to London) and decreased engagement. In addition, the use of substances, cannabis and increased alcohol intake were said to be indicators of relapse. It was noted that these had been well contained on medication but came back once P defaulted with other stresses. The loss of support of his mother who died in May 2005 was also regarded as an indicator of a relapse. The plan was:

    (a) Overnight leave from hospital to return on Wednesday for depot and discharge.

    (b) For the CPN to review P on Monday, 20 February and seven days thereafter.

    (c) For MHM to visit.

    (d) For the CPN to arrange outpatient department review by Consultant 7.

19. The care programme approach (CPA) care plan discharge is dated 14 February 2006. The Panel notes the following significant entries in this care plan:

(a) The care co-ordinator was to be CPN1 but in the event that the care co- coordinator was not available P was to contact MHM worker 1.

(b) The care plan provided that there was a need to continue to risk assess P, to regularly complete the FACE risk and that the long term plan had been to identify indicators of relapse.

(c) P was to enjoy leave following risk assessments.

(d) The plan provided for CPN 1 to visit P at his home and that by the next review there would be regular visits and the regular administration of depot injections.

(e) The care plan also provided that support upon discharge would be by regular visits from MHM and it was anticipated that P would comply with visit, support, and P's recognition of stress and early intervention with MHM.

(f) The contingency plan highlighted the circumstances in which P would require extra help. This included increased consumption of alcohol and substances, increased stress levels, withdrawal from support services (e.g. MHM and CPN 1), thoughts about stopping the depot injection and thoughts about the royal family and possible travel to London.

(g) The plan identified that in the event of a crisis P was to contact, and in this order, MHM, CPN 1 and the general practitioner and/or A&E.

(h) The risk management plan identified the history of P having attacked his parents "with an axe" whilst they were sleeping, no charges brought against P, which had been documented in old notes "but unclear". At the side of this entry and in handwriting it states: *"Served prison sentence"*. It was noted that in September 1997 P had threatened the police when they had arrived. The risk management plan also identified that P had problems with managing finances in the past. P had run up debts with catalogues, credit cards and TV amounting to £2,000.

(i) Under the section "The event, behaviours, thought and other signs that are around when things are difficult that gives us clues that there might be more risk" it was noted that increased alcohol and drug misuse, refusal of prescribed medication, disengaging from services, voicing bizarre, delusional

and grandiose ideas – believes that he is King and related to the royal family, were all risk factors.

(j) The action plan if "things start to happen" was as follows and in this order: (i) time with keyworker or allocated nurse, (ii) review of mental state by medical staff, (iii) review medication and offer supportive medication, (iv) access increased level of support and observation if felt necessary.

(k) Under the section "the things that reduce the risk to yourself or others" it was recorded that regular (i) sessions with nursing staff, (ii) support from care co-ordinator, (iii) supportive medication, (iv) hospital admission – detained under section 2 of the Mental Health Act, were all identified.

(l) The care plan was agreed and signed by P on 15 February 2006 and by CPN 1 on 20 February 2006.

(m) The FACE risk profile was dated 13 February 2006. It stated that P's Mental Health Act status upon assessment was "informal". The following is noted and significant from this risk profile:

(i) In response to the question "any evidence of a history of significant risk/behaviour", the box is ticked "Yes". The risk of violence or harm to others was scored as 1, which is low apparent risk. The narrative states "No current behaviour indicative of risk but patient's history and/or warning signs indicate possible present of risk. Necessary level of screening/vigilance covered by a standard care plan, i.e. no special risk prevention measures or plan are required."

(ii) The risk of suicide was scored as 1 (as above).

(iii) The risk of adult abuse was scored as 1.

(iv) The risk to children was scored as 0, as was the risk of exploitation.

(v) There was no potential risk to staff.

20. The FACE risk profile identified the following:

(a) Clinical symptoms indicative of risk: Indicative risk history was identified in relation to early warning signs of relapse as, ideas of self-harming, ideas of self-harm/suicidal ideation and impulsive/lack of impulsive control but, in relation to each of these there were no current warning signs. Insofar as P had delusions, the risk profile recorded that there were current warning signs.

(b) Behaviour indicative of risk: In relation to physical harm to others, threats, intimidation, preparation to harm others, targeting children/males/females, drug/alcohol abuse, domestic risk, severe self-neglect and wandering rootlessness, a positive risk history was identified. However, in relation to each of these indicative risks, there was no current warning sign. Alcohol abuse: there was a possible risk history, with current warning signs.

(c) In relation to treatment related indicators: Discontinuation of medication and failure to attend appointments were all identified as positive risk indicators but there were no current warning signs. Insofar as compulsory admissions were an indicator, this had a positive risk history but no current warning signs.

(d) Forensic history: Conviction for violent offences and other involvement (e.g. stalking, injunctions) were identified as positive risk factors but with no current warning signs.

(e) Personal circumstances indicative of risk: Recent severe stress, concern expressed by others of circumstances associated with risk behaviour, and risk of homelessness were identified as positive risk factors but with no current warning signs. Social isolation and financial vulnerability were identified as positive risk factors with current warning signs.

(f) In the section “further action” two overnight leaves were planned for the 13 and 14 February, and if successful P, was to be discharged on the 15 February. P was to be followed up in the community by CPN 1 and MHM. P was to continue with his depot upon discharge.

(g) The risk profile also identified risk history. Under the section “current warning signs” the following significant factors were noted:

(i) P reportedly suffered from low mood, anxiety and suicidal thoughts in the past.

(ii) P had limited insight into mental health problems was difficult and sometimes reluctant to engage with clinical staff at times in the past.

(iii) P was described as isolated and not very outgoing.

(iv) P had poor compliance with prescribed medication two to three months prior to the current admission. There were problems with P managing his finances in the past and following his mother's death he had run up debts with catalogues, credit cards and TV amounting to £2,000.

(v) P's early warning signs of relapse were identified in previous outpatient notes as becoming more anxious, low mood, increased paranoia, reduced self-care and suicidal thoughts. It was stated "there was a higher risk of assaultive behaviour with increased paranoia."

(vi) Under the section "current warning signs" it was noted that P appeared to be gaining some insight, states prior to relapse was drinking excessively and using illicit substances, mainly cannabis. P denied any current or planned use of cannabis and stated that he would continue to drink but only small amounts.

(vii) P was concerned about his sleep pattern as he was finding it difficult to sleep.

(viii) P was reluctant to discuss thoughts/feelings with ward staff, he appeared quite guarded at times, denies any delusions, however unsure if present or not.

(ix) P continued to be in debt from credit cards, catalogues etc.

(x) P denied any suicidal/self-harm thoughts.

(xi) P states recent deterioration was due to alcohol and substance misuse. He agreed that medication was beneficial to him.

21. P was discharged on 15 February 2006. The discharge letter dated 16 February 2006 is also important. Another section "risk assessment" confirms the circumstances of P's admission under section 2 of the Mental Health Act 1983, emphasising his delusions that he was the King and the Queen was his mother Edward VIII being his father It noted that P wanted to kill the Queen as he felt she had placed an electronic crown on his head, which was causing his distress. The previous offences including the serious assaults on his parents are also noted. The summary continues, and we set this out in full:

> "Initially P was guarded and unwilling to share information with the staff, however, by the time he was transferred to Newcastle the psychotic symptoms had completely disappeared. P himself attributed the episode to a binge of cannabis and whisky. Since his time of transfer to C ward there were no further psychotic symptoms elicited. However, at times P could be somewhat prickly if his demands were not met. We are not sure this represents his usual personality or whether it is a feature of becoming unwell again. Of note, P had missed a depot and had also missed an appointment with the community mental health team (CMHT) prior to going to London. However, he adamantly denies that his initial reason for going to London was to confront the Queen. He said that this was because he felt stressed out and wanted a break. Apparently, since March 2005, he has accrued £2,000 of worth of debt on credit card, catalogue and Telewest television. He has not been started on anti-psychotic medication. He will be prepared to take oral anti-psychotics but not depot, due to the induration at injection sites. It was felt that oral medication could be a problem for P so with agreement his depot was changed to Clopixol, which he has taken without any problems at the time of discharge and this needs to be continued within the community. At the time of discharge planning P appeared reasonably kempt, he was calm and coherent and reported his mood as being fine. There continues to be some evidence of delusional thinking and he did state that he intended to continue drinking alcohol in moderation. However, he agreed with the discharge plan and seemed to have some insight into the

acceptance of the diagnosis of schizophrenia. Risk assessment at the time of discharge: P was felt to have no apparent risk of suicide or violence to others. He was also felt to have no apparent risk of severe self-neglect and felt to be at no apparent risk of self-harm, risk to children or risk of exploitation. He continues to be financially vulnerable and at risk of social isolation."

- ***Commentary***

22. *In relation to this period of admission the Panel have a number of concerns.*

23. *At the time of P's transfer from London back to the North East of England, detention under section 3 of the Mental Health Act 1983 could have been an appropriate medical and legal framework in which to detain P. On 21 January 2006, CPN1 was recorded as expressing the view that P should have been kept in hospital longer for assessment. The Panel notes that in interview with the Panel CPN1 and Consultant 7 were both of the view that P should have been the subject of a longer period of assessment and treatment when admitted in January 2006 and that consideration should have been given to the use of section 3 of the Mental Health Act 1983. These views appear to have been strongly held by CPN1 and Consultant 7. The Panel notes that within the medical records, save for the recording on 21 January 2006, these concerns were not recorded. Whatever views were expressed by Consultant 7 and CPN1 the views of the clinical team prevailed. Within the medical records there is no evidence to confirm whether serious consideration had been given to treatment under section 3 of the Mental Health Act 1983. In the absence of any such analysis the Panel can only speculate as to why such a course was not followed. From the records it could be that the absence of symptoms, the willingness of P to engage with community based treatment (including medication) and the general requirement to adopt the least restrictive approach all could objectively justify discharge on 15 February 2006. The Panel regrets that the notes did not record any analysis.*

24. *The Panel's primary concern relates to risk formulation. Records and the interviews with those responsible for P's treatment in this period show no clear risk formulation specifically relation to longitudinal data. We note that*

standardised best practice guidance around risk identification, formulation and management was not published until mid-2007 (Department of Health Guidance: Best Practice in Risk Management). However, health and social care providers treating P relied on locally determined models of risk management. The model utilised was in line with similar models in use at the time. Nonetheless, the lack of a clear risk formulation during the period in the January/February 2006 admission is apparent from the records and also from the evidence received by the Panel. A clear example of this, and not insignificant within the context of P's longitudinal assessment of risk, was that the previous history of a very serious assault upon his parents when psychotic and the clear causal connection between those offences and his illness which had been established by Consultant 5, did not feature in any analysis of the risk assessment which led to the conclusion that P was a low risk of violence to others. In this context P had threatened to kill the Queen and given very clear delusional reasons for this. The risk assessment dated 13 February 2006 is in our view flawed. As already pointed out this assessed the risk of violence or harm to others as low. Under the section current warning signs, there was a failure to indicate "yes" to early warning signs of relapse, ideas of harming others, threats and intimidation and absconding. There was a failure to refer to discontinuation of medication as a clear recent risk factor. This, in the Panel's view, cannot be explained away on the basis of current warning signs. Practice at this stage would have been to consider and interpret into a clear risk management plan, all relevant information relating to current and past risk behaviours (in particular in relation to the events covering the period from November 2005 to January 2006).

25. *It is also a concern to the Panel that during this period of assessment under section 2 of the Mental Health Act 1983, no analysis was given to the question of whether P was in fact hiding symptoms. By 2006, P had a well-established history of psychotic symptoms. The clear pattern was developing of P presenting with such symptoms but then rapidly denying those symptoms. We note that the Senior House Officer seeing P on 7 February 2006, gained the impression that P was very guarded and potentially hiding psychotic symptoms or that he had manipulative behaviour. Having been flagged up as*

an issue, it was not subsequently analysed against the background of the established history of presenting with psychotic symptoms and then rapidly denying them, a pattern of presentation which occurred during the admission and which was entirely similar to previous occasions.

26. *The Panel note that the Care Programme Approach care plan dated the 15 February 2006 is a comprehensive summary narrative of P's past history and warning signs. However, there was no analysis of formulation to support a robust management plan. The Panel notes that, for example, P's early warning signs of relapse are identified in previous outpatient notes as P becoming more anxious, low mood, increased paranoia, reduced self-care and suicidal thoughts. P was assessed as being "at higher risk of assaultive behaviour and increased paranoia". However, there was a lack of bringing such information together to form a robust management plan. For example, the contingency plan failed to identify what steps or actions would be taken at the time of any crisis.*

27. *The Panel's view is that this period of admission from 25 January 2006 (P's date of transfer from the hospital in London) to 15 February 2006 was a missed opportunity to make an exhaustive investigation of P's current mental state having regard to his longitudinal history. The Panel's view is a more focused approach to P's assessment would, at the very least, have informed the care plan for his discharge into the community.*

- **15 February 2006-19 May 2006**

28. In accordance with the discharge plan, P was visited by Community Psychiatric Nurse 1 on 20 February 2006. On this occasion, P was referred to MM (a debt agency) because of debts he had incurred. At the same time P was to make an application for disability living allowance. During this visit, P confirmed to CPN1 that he had met a woman over the weekend, but was unsure if he would see this lady again.

29. On 21 February 2006, P's dog was returned by social services following P's discharge from hospital.

30. On 6 March 2006, P was again visited by CPN1. P was noted to be subdued but had settled back into his normal routine. He had made contact with MM. He was noted to be "mildly aloof", but there were no other reported indications of mental illness at the time. P was noted to have made further contact with the woman he mentioned on the visit on 20 February 2006.

31. On 15 March 2006, P was again visited at home by CPN1. P was given his depot injection, this being the last injection prior to the incident on 19 May 2006. P felt that all was well other than the fact that he did not have enough money. P refused on this occasion to attend the outpatient appointment to see the psychiatrist. Following discussion between Consultant 7 and CPN1, it was agreed that P would be jointly assessed at Walkergate on 16 March 2006 (the following day).

32. On 16 March 2006, P was seen by Consultant 7 and CPN1 at Walkergate. P was reported to be showing no signs of psychotic symptoms; he appeared slightly irritable and demanded that Consultant 7 "get his disability living allowance back for him". The flat appeared to be looked after and P seemed to be coping reasonably well. P remained in debt, however, and admitted to drinking alcohol regularly. It was noted that he was drinking approximately three cans of beer a day when he could afford it. P did not feel this was excessive. The follow up plan agreed was that CPN1 would continue to administer the depot injection and monitor P's mental health and deal with the application for Disability Living Allowance. Mental Health Matters would continue to offer P support during home visits 3 times a week.

33. The outpatient letter of 17 March 2006, from Consultant 7, records that P was discharged approximately six weeks previously. The letter stated "At interview today he was well kempt, he was more guarded, irritable and demanding than normal. There was a lack of warmth. He demanded that we help him get the disability living allowance back and it was difficult to enter into a collaborative discussion regarding this. Two significant risk factors remain in place. These are that he is in significant debt and that he continues to drink alcohol.

Protective factors include the fact that he has agreed to restart Depot medication as above (it is worth noting that the dose of Clopixol that he is currently taking is roughly equivalent to half a dose of Haldol that he was previously on). The other protective factor is that he is looking after the flat and the dog. His insight is quite variable; at one point today he did agree that he had delusions in the past that he is the King. On other occasions he has said that he has made these statements so as to get psychiatric disposal rather than a custodial sentence." Consultant 7 describes the care plan as including continued Depot medication (Zuclopenthixol Decanoate 200 mgs four weekly) and for contact to continue with CPN1. During his interview with the Panel, Consultant 7 vigorously asserted that there was nothing, other than the matters recorded in the discharge letter and in the records of P's attendance, to cause him any concern as to P's mental presentation. Furthermore, he was equally vigorous in his defence of the care plan put in place.

- ***Commentary***

34. It is clear to the Panel that at this stage P was manifesting signs of relapse. The description of P as guarded, irritable and demanding with a lack of warmth was not consistent with any previous prolonged period of time when P was assessed as being fully well.

35. P was visited on 11 April by CPN1. P was found to be intoxicated with alcohol, having consumed a bottle of wine and two cans of lager. He refused his depot injection and insisted that nothing was wrong with him and he did not need medication. He said that he was not violent and that the injections made him drowsy. P was observed to have a bottle of whisky in the flat. He remained concerned about his disability living allowance but at the same time insisted that he did not have an illness. P telephoned CPN1 later that day to say that he would have his depot injection after all, but when she returned to his flat, P again refused it. CPN1 informed Consultant 7 and MHM W1 of the situation.

- ***Commentary***

36. The Panel is of the view that a Care Programme Approach review should have been undertaken on 11 April 2006.

(a) P was in relapse. The warning factors of relapse were present.

(b) It was reasonable to assume that P would start to disengage from services, which increased the risk of impulsivity and an increased risk of violence.

(c) A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage.

(d) At the same time that a Care Programme Approach (CPA) care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including Mental Health Matters in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have led to lone working with P being terminated and joint working implemented. The risk to staff from the Mental Health Trust and Mental Health Matters was increased when P was consuming alcohol.

(e) At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the multi agency public protection arrangements (MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have

been referred because under MAPPA Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the head of public protection (HPP1) for the Northumbria Probation Trust, who confirmed that P, if referred, would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

37. On 18 April 2006, a joint visit was then undertaken as planned between CPN1 and MHM1. P had broken a pay phone belonging to Mental Health Matters (MHM) in order to get money out of the phone for personal use. P did not appear to take personal responsibility for the damage caused. P was reported to be settled and calm and did not display any evidence of any major mental illness. He remained adamant that he did not want his depot injection and saw his only problem as a lack of finance. P was asked not to drink alcohol when expecting home visits in the future. It was agreed that P would be fully reviewed by Consultant 7 and Community Psychiatric Nurse 1(CPN1) at the next planned appointment. CPN1 arranged weekly monitoring visits for

the next three weeks and MHM agreed to continue visiting three times per week.

- ***Commentary***

38. The Panel is of the view that a CPA review should have been undertaken on 11 April 2006.

(a) P was in relapse. The warning factors of relapse were present, including his inability to cope financially.

(b) It was reasonable to assume that P would start to disengage from services, which increased the risk of impulsivity risk of violence.

(c) A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage.

(d) At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have led to lone working

with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol.

(e) At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

39. On 19 April 2006, the Metropolitan Police rang CPN 1 to request information on P's whereabouts. This was because a royal visit was due in the area and there was concern about P following the incident at Buckingham Palace in January 2006. CPN1 indicated that there were difficulties with treatment compliance and although P was being closely monitored, he was said to be "unpredictable" at this point.

- ***Commentary***

40. The Panel's conclusion that P was in relapse at this stage must also lead to a conclusion that on receiving this telephone call from the Metropolitan Police, P should have been referred under the then existing MAPPA arrangements for the reasons outlined in paragraph 36 (e) above.

41. On 24 April 2006, Consultant 7 was updated on the situation. A joint visit with CPN1 was arranged for 2 May 2006.

42. On 2 May 2006, Consultant 7 visited P at his home. On this occasion, CPN1 was in fact unable to attend because of cover duty commitments. It was noted that P had been refusing his depot medication for some four weeks by this time. P indicated that he had been successful in obtaining higher level disability living allowance. However, because of the damage to the telephone, P was now required to pay £236. P said he had not been drinking for five days, although he admitted to drinking prior to this. He denied using any illicit drugs. There was no indication that P was experiencing psychotic symptoms during the visit and he appeared to be calm and friendly when interviewed. His eye contact was good. It was agreed that P would be closely monitored by CPN1 and MHM staff who were still to continue visiting at home three times a week. The overall impression was that P appeared to be reasonably well.

43. During his interview with the Panel, Consultant 7 was adamant that on this occasion P had shown no psychotic symptoms. Consultant 7 did not believe that any of the risk factors associated with P's mental illness had increased by this time. Consultant 7 stated that this was 'the best that he had seen P'.

- ***Commentary***

44. It is the Panel's view that by this stage P was presenting with significant changes in his presentation, with increased risk factors and relapse triggers apparent. At this stage, P was consuming alcohol such that on the visit on 11 April 2006 he was found to be intoxicated. P was yet again refusing his depot injection. P had also broken a pay phone belonging to MHM in order to get money out for personal use. A risk factor previously identified was P's

indebtedness which caused him stress, leading to an increased risk of impulsivity. The significance is not in the damage to the pay phone but P's admission that he wished to get money from the pay phone for personal use. Indeed, at the meeting on 18 April 2006, P focussed on his lack of finance as being his only problem.

45. *At the meeting with P on 2 May 2006 with Consultant 7, the Panel notes that Consultant 7 had a genuinely held view that P's mental state was then stable. However, the Panel notes the letter of 3 May 2006 which states as follows:*

> *"I visited P at home on 2 May 2006. He had stopped taking the depot antipsychotic medication because it made him sleep too much. He is refusing to take any neuroleptic medication. At interview he was calm and friendly. He sat on the sofa and his eye contact was appropriate. He smiled once when talking about alcohol, saying that he liked to drink it. He was not guarded. There was no evidence of any psychotic symptoms and his mood was euthymic. He related previous psychotic episodes to the use of mefloquine or illicit drugs. He says he is not currently using these so does not need antipsychotics. Overall he thinks "things are looking up". He had no thoughts of harming others nor of harming himself. My impression is that his mental state is stable. However there is a risk that he will experience another relapse as he is not on an antipsychotic. I strongly advised him to restart oral antipsychotic medication but he clearly is against this. The plan is:*
>
> *(1) We will continue to support P and monitor his mental state. Staff from MHM will visit him a few times a week and CPN1 is in regular contact.*
>
> *(2) A further appointment will be sent for two months' time."*

46. *Given the lack of any previous attempts by those who were treating P to assess his tendency to hide his symptoms, the Panel feel that no great weight can be given to the findings of Consultant 7 on 2 May 2006. Indeed, if anything, post-discharge on the 15 February 2006, P's continued non-compliance with medication, resorting to alcohol, damaging the telephone and his financial pressures were all indicators that a full multi-disciplinary review of*

P's risk management plan should have been made at this stage. Furthermore, by this time there was a clear demand for CPN1 to undertake a formal review of care following what were, unquestionably, significant changes in P's presentation. At this time;

(a) P was in relapse.

(b) The warning factors of relapse were present.

(c) It was reasonable to assume that P would start to disengage from services, which increased the risk of impulsivity and an increased risk of violence.

(d) A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage.

(e) At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol.

(f) At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel

is of the view that P could have been referred because under Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

47. *The Panel is also of the view that CPN1, as the care co-ordinator, should have attended the meeting on 2 May 2006. She had agreed to attend at this meeting and even though in her interview with the Panel she stated that she was required on 2 May 2006 to deal with another service user, the Panel is of the view that seeing P should have been regarded as a priority.*

48. On 5 May 2006, A visited P. She noted that P said that he was well and looking forward to going out that day given the nice weather. P asked A what Consultant 7 had said regarding his medication. He stated that that he was not receiving his depot nor taking medication orally and that Consultant 7 was planning to visit in a few months.

49. On 9 May 2006, CPN1 visited P but there was no reply. A message was left and a further visit was planned on 10 May 2006. CPN1 made contact with MHM W1 to update him on the situation. MHM W1 said that staff reported that they had no particular concerns about P's mental health at that point in time.

50. On 10 May 2006, CPN1 again visited P but there was no reply. A message was left saying that CPN1 would call again on the morning of 12 May, which had been suggested by MHM staff.

- ***Commentary***

51. The Panel is of the view that by 10 May 2006 there was a clear demand for CPN1 to undertake a formal review of care following what were, unquestionably, significant changes in P's presentation.

(a) P was in relapse.

(b) The warning factors of relapse were present.

(c) P had disengaged with services, which increased the risk of impulsivity and an increased risk of violence.

(d) A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage. However, by now P was not compliant with his treatment in the

community. P had disengaged from services. There was clear evidence that P could not be managed in the community. The Panel is of the view that by 10 May 2006 P could and should have been detained under the Mental Health Act 1983.

(e) At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol.

(f) At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who

confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

52. CPN1 visited again on 12 May 2006 but there was no reply. A further message was left asking P to make contact with CPN1 or to leave a message with MHM. On further discussions with MHM W1 it was agreed that one of the support workers would visit later that day and confirm with CPN1 whether P had been seen. At the time of the visit in the afternoon, P was again not present at the property. However, it appears that MHM W1 did visit later that day and saw P and noted that P did not wish to engage in conversation.

- ***Commentary***

53. *The Panel is of the view that by 12 May 2006 there was a clear demand for CPN1 to undertake a formal review of care following what were, unquestionably, significant changes in P's presentation.*

(a) P was in relapse.

(b) The warning factors of relapse were present.

(c) P had disengaged with services, which increased the risk of impulsivity and an increased risk of violence.

(d) A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely,

however, that P would have been detained under the Mental Health Act 1983 at this stage. However, by now P was not compliant with his treatment in the community. P had disengaged from services. There was clear evidence that P could not be managed in the community. The Panel is of the view that by 10 May 2006 P could and should have been detained under the Mental Health Act 1983.

(e) At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol.

(f) At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation

victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

54. On 14 May 2006, a saw P in the street. P was holding a bottle of vodka and seemed unsteady on his feet. P said that he was "pissed".

55. On 16 May 2006, a further visit was made by CPN1, but again there was no reply. MHM staff called CPN1 on the telephone to report that P had been seen, in what appeared to be, an intoxicated state. CPN1 agreed to continue to try to make contact with P and a letter was sent to P to inform him of the situation. Consultant 7 and MHM 1 were again updated as to the situation.

56. On 16 May 2006 CPN1 telephoned MHM and was told that P had been seen and was very intoxicated. It was noted that he had not been seen as planned but that there would be continued attempts to see P.

- ***Commentary***

57. The Panel is of the view that by 16 May 2006 there was a compelling need for CPN1 to undertake a formal review of care following what were, unquestionably, significant changes in RD's presentation.

(a) P was in relapse.

(b) The warning factors of relapse were present, including by this time clear evidence was again abusing alcohol.

(c) P had disengaged with services, which increased the risk of impulsivity and an increased risk of violence.

(d) A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the

possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage. However, by now P was not compliant with his treatment in the community. P had disengaged from services. There was clear evidence that P could not be managed in the community. The Panel is of the view that by 10 May 2006 P could and should have been detained under the Mental Health Act 1983.

(e) *At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol.*

(f) *At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious*

risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

- **19 May 2006**

58. On 19 May 2006, a left her home address in order to travel to work at MHM, which is situated at Granger Park Avenue, Newcastle upon Tyne. A arrived at MHM shortly before 9.00 am. A had a number of appointments with other clients of MHM who lived in the Heaton area. Her second appointment on 19 May 2006 was with P. A's appointment with P was scheduled for around about 10.40 am. It appears that P was aware of the fact that the visit was scheduled. As A left the office she was seen by her boss, MHM W2, to pick up a letter addressed to the accused P. This letter was typed on the afternoon of the 15 May. It was intended that another support worker MHM W1 would deliver the letter to P on the 16 May. MHM W1 had been unable to deliver the letter as P had not kept his appointment that day. The letter referred to a verbal agreement that had been made that P would repay the cost of replacing a telephone that he had damaged at the flat. The letter outlined the repayment terms and the amount to be repaid. A left the office alone. At some time shortly after 10.30am, A attended P's flat. Another client of MHM heard screams at between 5 and 15 minutes later. He heard a person shouting "get off" or "stop it". He assumed this was A. He then heard screams coming from the living room at P's home and he rang A but got no reply. He subsequently rang A's supervisor MHM W2. At about 10.45am another witness heard a long hysterical screech which lasted for more than a minute

but less than two. At about 10.56am on the 19 May, P was seen on police CCTV on Shields Road walking towards Clifford Street police station with his dog. At 10.58am the CCTV evidence showed P entering the premises. The duty officer at Clifford Street police station encounters P who states "I've murdered someone". He explained where the body was, handed the keys over and was subsequently detained. P was noted to have cut his hands and was bleeding. P was asked the name of the person he had murdered and stated she was called A. P had blood on his hands as "the knives kept snapping". Police attended at P's flats and found A dead in the kitchen. A had received 39 separate stab wounds including clusters situated in the neck, chest, left arm, right arm, right hand and left hand.

59. Whilst P was booked into the custody suite, he constantly answered questions with "King". Following an assessment ,he was deemed to be fit for interview and during the course of an interview which lasted approximately an hour, he answered all questions with the word ''King''.

- **Ancillary Issues**

60. During the course of the Panel's investigation of events during this period, we focused on some issues which, for completeness, are addressed below.

- ***The Role of Mental Health Matters (MMH)***

61. The role of MHM in assessing P's mental state requires some critical analysis. In the context of the provision of services to P, MHM was essentially a housing support charity. As a charity providing housing related support for vulnerable adults, MHM had a contract with Newcastle City Council's supporting peoples services. The aim of this provision was to support and assist people to manage and maintain their accommodation. This often requires practical support such as helping service users understand the obligations under their tenancy agreements, helping people to be good neighbours and general practical advice on maintaining property. MHM was not engaged in this case as a care agency supporting P.

62. From the documentation the Panel has received and furthermore from the interviews of CPN1 and Consultant 7, the Panel has formed the clear view

that there was a misplaced but substantial over reliance, by Consultant 7 and CPN 1, upon MHM staff reporting to CPN1, in particular, on the issue of P's clinical signs. The core role of MHM was to support P to maintain his housing status. Examples of this over and inappropriate reliance are found in the CPA care plan dated 14 February 2006. The care co-ordinator is named as CPN1 but in the event that CPN1 was not available, P was directed to contact MHM W1. The Panel is of the view that P should have been directed to contact another person at the Trust or his general practitioner. In the care plan, P's support on discharge was from MHM. In the section of the care plan 'Persons or service who will take action in a crisis", the first named organisation was MHM.

63. *The reliance on MHM staff to report on P led to a situation where P's mental state was never properly established or assessed on a regular basis. It was, in our view, wholly inappropriate to rely upon MHM as the conduit for reporting on P's mental state and clinical signs. On any analysis P's mental presentation was complex and, in any event, P was more than capable of hiding this. MHM staff did not have the training or the skills to assess and reliably report to CPN1 on P's mental stability. Having decided that there was a need for P to be assessed four times a week, it was inappropriate that on three of those occasions P was being assessed by people who were simply not trained in reporting on a person's mental health presentation.*

- ***Allegation of bullying by CPN2 Against Clinicians and Management at Newcastle East Community Mental Health Team***

64. *During the course of our investigations we were made aware by CPN2 of the grievance that he had raised in relation to bullying. His allegations were levelled at senior clinicians and an administrator in the Newcastle East community mental health team. CPN2 named Consultant 7 as one of those who had bullied him. These allegations were investigated and the grievance dismissed. During the course of the grievance investigation, however, the investigating officer reported that there had been a breakdown of confidence within the team about managing patients that had resulted in some problematic discussions.*

65. *This information required further investigation by the Panel particularly in the light of a suggestion that this could have impacted upon the quality of care provided to patients. Given that one of the individuals against whom this complaint was made was Consultant 7, the Panel probed this at some length with him, the complainant (CPN 2) and also CPN1. Despite the nature of this complaint we are entirely satisfied that this did not impact upon the level of care afforded to P. The Panel has concluded this for two reasons:*

(a) *The panel found no evidence, despite our detailed analysis of this issue including analysing the chronological events in relation to P's treatment, that P's care and treatment was in any way adversely affected.*

(b) *CPN2, who made the grievance complaint, was keen to point out that in his view patient care was not adversely affected by the personnel issues which arose in 2006. The Panel, of course, has been cautious not just to accept this this exculpatory assertion by CPN2 at face value. Nonetheless, the Panel's view is reinforced by the uncontroverted evidence in this case that the person most closely responsible for P's treatment and care, CPN1, was not embroiled at all in any dispute and was an individual who carried out her work without being involved in the issues which lead to the grievance.*

- ***P's Applications for Disability living allowance***

66. *During the course of our investigation the Panel has had sight of the applications that P made for disability living allowance.*

67. *One application was dated 8 June 2005. It is necessary to set out what P said his problems were (using P's exact words and spellings in the applications):*

Question

''Describe in your own words the problems you have and the help you need.

I am unable to concentrate outdoors as I hear voices in my head. These voices tell me to do things like attack my enemies, they make me feel paranoid and I have panic attacks. I have breathing problems when I walk outdoors alone because of the anxiety. When I need to do my shopping,

collect me benefits, doctors appointments etc my support worker calms me down by talking to me and distracts me from the voices in my head.

When my schiztaphreania is at its worst I cannot concentrate outdoors in my own, I think people are going to attack me and always think people are talking about me. I cannot concentrate on the car traffic because the voices are telling me to walk in front of cars.

Describe in your own words the problems you have and the help you need when you are outdoors.
I hear voices in my head telling me that people are going to attack me, therefor I will defend myself…. If I was in a place I did not know I would breakdown and lash out at people.

Do you need someone to keep an eye on you.
I need supervision and support during the day. I receive this from a support worker without support I would neglect myself and would be at significant risk of a relapse. I get confused I do not recognise a worsening in my condition. I could be destructive or cause danger. I would be at risk to myself and others."

68. *This application was signed by CPN1. She signed this as 'Statement from the person who knows you best.'*

69. *Another application was made on 20 February 2006. Again it is important to set out some of the answers that P gave to certain questions.*

Describe in your own words the problems you have and the help you need with medical treatment. And tell us what would happen if you did not take your medication.
My support worker makes sure I take my medication in the morning. If I did not take my medication I would become phycotic and attack anyone I would become depressed and kill myself.

Describe in your own words the things you do or cannot do, or the experiences you have had, because of your mental health
I suffer from panic attacks, paranioa and I hear voices in my head. I have

dellusions. I suffer from hallucianatons. I am paranoid throughout the day thinking and believing that people are going to hurt me. I do not relize when I become violent and aggressive.''

70. *This application was signed by CPN1. She signed this as 'Statement from the person who knows you best.'*

71. *CPN1 was subjected to some adverse criticism in the press after the criminal proceedings against P were concluded. The gist of this criticism was that she signed the disability application form knowing that P was claiming to be a danger to others. Indeed, the Panel too was concerned about CPN1 signing this form. P was claiming to be a danger to others when out in the community. This assessment had not been made by the clinical team. On the contrary, the assessment from the community mental health team was that P was a low risk to others. Accordingly, if CPN 1 had seen the content of either document, an explanation from CPN1 would have been warranted.*

72. *These two disability application form were addressed in CPN1's interview with the panel. Our attention was drawn to the following under section 12 of the form 'Statement from the person who knows you best' and the section 'Notes for people filling in this statement'. This states 'Please fill in this statement straight away and give the form back to the person who asked you to fill it in. Please fill it in from your own knowledge-you do not need to look at their answers on this form'. When CPN 1 signed this form on 8 June 2005, she was certain that she had not seen any of the boxes in the questionnaire which had been completed by P.*

73. *The DLA form completed in 2006 did not contain the same section 'Notes for people filling in this statement.' However, there is no direction that the person filing in the form should read and comment on the answers given by the claimant. When CPN1 signed this form on 20 February 2006, she was certain that she had not seen any of the boxes in the questionnaire which had been completed by P. She had not noticed any change in the form either. We accept that CPN1 did not see the content of the questionnaire filled in by P. We also accept that if she had seen it, she would have been concerned about what P was claiming his problems were. Either such claims by P were*

misleading or they revealed a level of mental illness which had not been previously identified or, possibly, both. In this case, it cannot be ruled out that P was giving an honest account of his mental health presentation, a presentation which he had hidden from his treating clinicians. We have enquired of the Department for Work and Pensions of the reason for the change in section 12 and the erasure of the 'Notes for people filling in this statement'. The Department for Work and Pensions was not able to give a reason for the change.

74. *The nature of this form has caused the Panel to reflect on whether we should recommend a change such that there is a requirement that the person who signs section 12 (or its equivalent) should have sight of the whole application and furthermore confirm that they have had sight of the same. The reason for such a requirement is obvious from the facts of this case. However, we feel that we are ill equipped to make such a recommendation. These forms come into use often after consultation with relevant interest and user groups. There may be compelling reasons why those signing section 12 are not obliged to read the whole form. In addition, we note that the current benefit system is changing and it is reasonable to anticipate that there will also be a change to how applications are made and the forms that are used.*

7. SERIOUS AND UNTOWARD INCIDENT INTERNAL INVESTIGATION

1. The relevant Mental Health Trust policy was 3NTW(A)05, Issue 3 “Policy and Procedure on the Handling of Serious and Untoward Incidents” issued in February 2005.

2. This policy defined a serious and untoward incident as:

> “An accident or incident (including near misses) when a patient, member of staff or a member of the public suffers injury or unexpected death, or the risk of death or injury in hospital, other health service premises where health care is provided or where actions of health services are likely to cause significant public concern”. (Paragraph 2.1)

3. This policy stated that it was a priority of the Trust, within its clinical governance framework, that adverse events and near misses were identified and openly investigated. To achieve this end:

> “Incidents are reviewed and analysed through Root Cause Analysis (RCA) to reassure stakeholders in the service that any problems can be identified and resolved and that good practice can be shared and supported, within a learning culture; to ensure that lessons are learned throughout the organisation; prompt action taken ensuring dependable local delivery and the maintenance of public confidence and patient safety”. (Paragraph 4.2)

4. The policy identified the stages of the procedures:

(a) Stage 1 was the initial reporting procedure. In the event of a serious or untoward incident during working hours, the person reporting to corporate

services should complete the initial report, telephone the corporate services department and obtain an incident number. The initial reporting form requested information, for example, the name, address and date of birth of the patient, the nature of the incident and action taken, the staff involved, the mental health status of the individual, an assessment of risk at the time of the incident, who had been involved, Consultant/care co-ordinator and name of reporting officer. (Paragraph 12)

(b) The second stage was the investigation of the incident. If the reported incident was considered to be of sufficient concern to warrant further investigation then such investigation would be management led. All clinical records are collected by the general manager, the general manager on call will inform the professional lead, the professional lead will supply appropriate clinical professional advice to the general manager. Requests for information can be made. A contemporaneous record of events and decisions taken should be made by the general manager investigating. Within 14 days the general manager is to provide a root cause analysis. The aim and purpose of root cause analysis is to ensure; in-depth analysis of the incident, to ensure approach experience and expertise is fully applied to the review process, to ensure that all the events leading up to an adverse outcome are considered, a structured and systematic approach is applied to the review aiding mapping of events, a comprehensive investigation and a production of a formal report, a climate of openness and blame-free approach, that learning takes place, a reduction in subsequent and similar risks; all findings are applied at the clinical level. The clinical review should take place within 6 weeks. (Paragraph 13).

(c) Stage three of the review should be held, whenever possible, within four weeks of the general manager completing his investigation of the incident. At this stage a record of the review in the format of a report and action would be completed.

(d) At the review meeting, a presentation of the incident report is made by the general manager. This includes a summary of what happened, the chronology and outcome, how did it happen, identifying the care problems,

why did it happen, identifying the contributory factors and what the Trust can learn from the root cause analysis.

(e) Each incident review is presented to the mental health trust's clinical risk management group which reviews all incidents and takes responsibility for overall issues and themes from reviews.

5. In accordance with the Trust policy set out above, an internal investigation was commenced almost immediately upon notification of the death of A. The investigation was carried out by DvM, who was at that stage the divisional manager for the working age adult mental health services in Newcastle. During the course of the investigation, a review was undertaken of all available case records and reports. In his interview with the Panel, DvM confirmed that most of the records in this case relating to P's contemporaneous treatment were seized almost immediately.

6. In the body of DvM's investigation report there is no reference to 3NTW(A)05, Issue 3 "Policy and Procedure on the Handling of Serious and Untoward Incidents" or indeed the purpose of the investigation and report. In his interview with the Panel DvM confirmed that no specific terms of reference were given in relation to this serious untoward incident but that the investigation and report were pursuant to this trust policy.

7. It appears to the Panel that in accordance with the procedures set out in the policy, records were secured as soon as the incident came to the attention of the organisation. The records were reviewed and there was a series of interviews with the staff. In this case, as part of the analysis of the events leading up to the death of A, there was a review of the clinical records by the Associate Medical Director and also a Nurse Consultant.

8. The report comprehensively records P's background from 1993 through until the 19 May 2006. Furthermore, a time line of significant events in P's life was also compiled. A further section of the report entitled "Time line documented referral, assessment, care planning and review activities since December 2002" was also compiled.

9. The interim findings of the internal review were:

(a) The risks and care needs presented by P appear to have been reviewed regularly by Consultant 7 and CPN1.

(b) There appeared to have been good liaison with other agencies and services involved with P's care since his transfer to Newcastle.

(c) Records show clinical risk assessment and risk management planning for P during the time he was receiving care from mental health services in Newcastle.

(d) Practice has been in accordance with the requirements of the Trust care co-ordination policy.

(e) P's Sunderland records were requested by Consultant 7 in November 2005 and this was helpful in enabling a full and informed assessment of P's mental state and risk factors.

(f) It was evident from the records available and from interviews with the health care staff involved that there had been regular communication between agencies on care/risk management plans put in place for P.

(g) It was difficult to ascertain from the records specifically what information had been shared with other agencies involved in P's care, as this was not consistently documented. Subsequent statements from Consultant 7 and CPN1 helped to clarify this.

(h) When reading through P's records it took a considerable amount of time to piece together his risk history and to link up the risk management plans that had been put in place over the years. This was because information was recorded in numerous different reports and records and in several different case files.

(i) Prior to P's transfer to the Newcastle service in January 2003, his clinical records indicated that mental health monitoring arrangements put in place for him had broken down on several occasions.

(j) P's mental health presentation was complex and since 1994 he had been diagnosed as possibly suffering from psychological problems, psychotic illness (precipitated by the consumption of alcohol or illicit drugs), schizophrenia psychosis, personality disorder, bipolar effective disorder, stress related problems and depression. This, combined with P's often speedy recovery from what appeared to be significant psychotic symptoms, appears to have made the accurate assessment of the level of risk he presented all the more difficult.

(k) It was evident from records that risk indicators were present prior to the 19 May incident, these being that P had stopped his medication and was consuming alcohol. His mental state and risk level was, however, being monitored closely by all staff involved in his care at this time, as is shown by the proactive and assertive follow-up provided by Consultant 7, CPN1, Mental Health Matters and other inpatient services.

10. The following interim conclusions were reached:

(a) There was nothing to suggest from the internal review that the events from the 19 May could have in any way been predicted.

(b) It proved difficult for the professionals involved to offer consistent input.

(c) This was because of P's periodic lack of willingness to comply with medicinal treatment and his ability to be seen to be coping on these occasions.

(d) It would also appear that P's Consultant psychiatrist and CPN did all that could reasonably be have been expected of them to ensure that he received the care and support in the community that he needed.

(e) A joint agency review of the current care co-ordination documentation and practice with the aim of developing and agreeing a unified system between agencies was required. This would clarify joint agency working arrangements and cross-examination role expectations when providing shared care packages. It would also provide a clear framework for implementation and monitoring of joint agency practice standards.

11. Under the section “This Incident” it was stated that the Mental HealthTrust, in accordance with good practice, was seeking assurances that the practice standard set out in Trust policy guidance was being met in all services. A review of current practice in the following areas was being undertaken:

(a) Compliance with the effectiveness of lone worker safety procedures.

(b) The quality of risk assessment and management plans in place for all patients with a forensic history and/or who presented a potential risk to others. Are they clear, up to date, jointly agreed and understood by all service providers involved? Are there contingency plans in place?

(c) The effectiveness of communication systems and joint working arrangements in place between agencies involved in care provision.

(d) The policy guidance available to support the clinical decision making process when making contact with patients who present a possible risk to others.

(e) The possible guidance available to support the clinical decision making process when following up on no reply visits or failure to attend appointments.

(f) Compliance with trust-wide training available on the management of aggression and violence.

- ***Commentary***

12. The Panel have a number of concerns in relation to this investigation report leading us to conclude that many of its findings and conclusions are unreliable:

(a) The Panel is of the view that the investigation report did not undertake a robust root cause analysis of the events leading up to the death of A on the 19 May 2006. Root cause analysis was and is an essential feature of the Trust’s policy. Incidents were to be reviewed and analysed through root cause analysis to reassure stakeholders that any learning points are identified and resolved and that good practice can be shared and supported within a ‘fair-blame’ learning culture; to ensure that lessons are learned throughout the

organisation; that prompt action was taken ensuring dependable local delivery and the maintenance of public confidence and patient safety.

(b) *The failure to carry out a root cause analysis led to a number of sweeping but unsustainable interim findings.*

(c) *By way of example, the report asserted that records showed clear evidence of on-going clinical risk assessment and risk management planning for P during the time he was receiving care from mental health services in Newcastle. In the Panel's findings in previous sections in this report, and in the critical period from January 2006 until 16 May 2006, the Panel have identified no less than six occasions when P's on-going clinical risk should have been reassessed in order to update his care plan in accordance with the Care Programme Approach, to update P's risk assessment, to formulate an updated risk management plan.*

(d) *The findings asserted that when Consultant 7 obtained P's records from Sunderland in November 2005 this was helpful in enabling a full and informed assessment of P's mental state and risk factors to be undertaken. In the Panel's view this interim finding was inconsistent with a further interim finding which was that P's mental health picture was complex and that since 1994 there had been a number of diagnoses and this, combined with P's often speedy recovery from what appeared to be significant psychotic symptoms, made the accurate assessment of the level of risk P presented all the more difficult.*

(e) *The interim findings included an assertion that it was evident from records available and from interviews with health care staff involved that there had been regular communication between agencies on the care risk management plans put in place for P. The Panel is of the view that in at least one area, that of lone working, such an assertion was unsustainable. On 19 January 2006, CPN1 visited P's house but there was no reply. CPN1 contacted MHM 1 who confirmed that MHM's staff had not seen P since 6 January 2006 although phone contact had been made with him on 13 January 2006. The situation was discussed between CPN 1 and Consultant 7 and it was agreed that CPN1 would try and make phone contact and again call on the 20 January*

2006. If contact could not be made then, the police would have to be informed. MHM 1 was advised by CPN1 that joint visits should take place, due to the change in P's pattern of behaviour. However, during P's in-patient admission in January 2006, CPN1 subsequently conveyed P to his home on her own. There is no evidence that any updated risk assessment on the issue of lone working had been communicated to MHM. Furthermore, it is of concern to the Panel that DvM, at the date of his interview with the Panel was still under the impression that CPN1 and clinical staff had still been embarking upon joint visits to P at his home up to the date of the unlawful killing of A on 19 May 2006. This impression was incorrect.

13. *The Panel is also concerned as to the adequacy of the enquiries that were made by DvM in compiling his report. The Panel has the following concerns:*

(a) *No detailed analysis of the relevant applicable Trust policies was set out in the report. Chapter 10 of this report sets out those policies in detail and the failings made to follow those policies in relation to the treatment of P.*

(b) *As set out above, DvM was under the mistaken impression that staff were jointly visiting P in the months and weeks up to 19 May 2006.*

(c) *DvM was not aware that CPN1 and Consultant 7 were both of the view that P should have been the subject of a longer period of assessment and treated when admitted in January 2006. DvM, in his interview with the Panel, stated that he was not told this by Consultant 7. DvM accepted that if this had been mentioned by Consultant 7 it would have been addressed in his report. However, regardless of what Consultant 7 told DvM, his review of the notes would have revealed that on the 21 January 2006 CPN 1 is recorded as suggesting that P should be kept in hospital longer for assessment. DvM was, accordingly, on notice that this issue was raised by CPN1. However, this issue received no mention in his report and accordingly there was no analysis of it.*

14. *The Panel is also concerned that the failings in this report were not subsequently identified at the review meeting and also at the Trust clinical risk management group.*

8. COMPARISON OF NATIONAL AND LOCAL POLICIES

1. The Panel have primarily focused in its consideration of a comparison of national and local policies to those issued post 2000. Save for the Care Programme Approach which was introduced in England and Wales in 1991 by the Department of Health, the Panel have not been supplied with either national policies or local policies in force prior to this date.

- **Strategic Overview**

2. When this event occurred in 2006, the strategic document underpinning mental health service and development for adults up to the age of 65 was the National Service Framework for Mental Health (NSFMH) Department of Health (DH) September 1999. The purpose of this framework was to deliver the Government's agenda by driving up the quality and reducing unacceptable variations in health and social services. The document sets seven separate standards and defines service models for promoting mental health and treating mental illness. The NSFMH was developed through the work of the external reference group (DH December 1998) *Modernising Mental Health Services: Safe Sound and Supportive,* from which 10 guiding principles that underpin the NSFMH were identified. These stated that people with mental health problems should be able to expect that services will:

    - Involve service users and their carers in planning and delivery of care
    - Deliver high quality treatment and care which is known to be effective and acceptable
    - Be well suited to those who run them and non-discriminatory
    - Be accessible so that help can be obtained when and where it is needed
    - Promote their safety and that of their carers, staff and the wider public

- Offer choices which promote independence
- Be well co-ordinated between all staff and agencies
- Deliver continuity of care for as long as it is needed
- Empower and support their staff
- Be properly accountable to the public, service users and carers.

- **Care Programme Approach**

3. The Care Programme Approach (CPA) in England is a system of delivering community mental health services to individuals diagnosed with mental illness. It was introduced in England in 1991 and in 1996 had become a key component of the mental health system in England. The approach requires that health and social services assess need, provide a written care plan, allocate a care co-ordinator and then regularly view the plan with key stakeholders, in keeping with the National Health Service and Community Care Act 1990. The CPA framework required the Trust to prepare a Care Co-ordination Plan and FACE risk profile assessment. The CPA introduced in 1991 under HC(90)23/LASSL(90)11 comprised four main elements:

(a) Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services.

(b) The formation of a care plan which identifies the health and social care required from a variety of providers.

(c) The appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care.

(d) Regular reviews, and where necessary, agreed changes to the care plan.

4. In 1998, a further review of the Care Programme Approach resulted in the publication of "*Modernising the Care Programme Approach*". A review of the CPA model, still regarded in 1998 as a model for good practice which remained applicable, was required because:

(a) The Mental Health National Service Framework set out a challenging agenda for reform. The review of the care co-ordination process was required to ensure that it matched the approach of a modern mental health and social care system.

(b) Practitioners had been able to learn from lessons about the operation of the CPA.

(c) Professionals have found some aspects of the CPA over bureaucratic.

(d) Managers and service users alike had found the lack of consistency confusing.

5. There were a number of key changes:

(a) The CPA was to be integrated with care management in all areas to form a single care co-ordination approach for adults of working age with mental health problems.

(b) Each health and social services mental health provider should jointly identify a lead officer with authority to work across all agencies to deliver an integrated approach to the CPA in care management.

6. In order to achieve consistency two levels of the CPA were to be introduced:

   (a) Standard

   (b) Enhanced.

7. The key worker was to be known as a care co-ordinator.

8. In order to achieve a more streamlined approach a number of recommendations were made. Review and evaluation of care planning should be regarded as an on-going process and the requirement for a nationally determined review period, i.e. six monthly, was removed. However, at each review meeting the date of the next review was to be set and recorded. Any member of the care team or the user or carer was also able to ask for a review at any time. In order to achieve a proper focus, it was noted that risk

assessment was an essential and on-going part of the CPA process (paragraph 31).

9. A seamless service was to be achieved through an integrated approach to care co-ordination which provides for:

(a) A single point of referral

(b) A unified health and social care assessment process

(c) Co-ordination of the respective roles and responsibilities of each agency in the system and

(d) Access through a single process, to the support and resources of both health and social care.

10. The features of a truly integrated system of the CPA in care management included:

(a) A single operational policy

(b) Joint training for health and social care staff

(c) One lead officer for care co-ordination across health and social care

(d) Common and agreed risk assessment and risk management processes

(e) A shared information system across health and social care

(f) A single complaints procedure

(g) Agreements on the allocation of resources and, where possible, devolved budgets

(h) A joint serious incident process

(i) One point of access for health and social care assessments.

12. Characteristics of people on the standard CPA would include some of the following:

(a) They require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline

(b) They are more able to self-manage their mental health problems

(c) They have an active informal support network

(d) They pose little danger to themselves or others

(e) They are more likely to maintain appropriate contact with services. (See paragraph 57)

13. People on enhanced CPA are more likely to have some of the following characteristics:

(a) They have multiple care needs including housing, employment, requiring inter-agency co-ordination

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

(c) They may be in contact with a number of agencies (including the Criminal Justice System)

(d) They are likely to require more frequent and intensive interventions, perhaps with medication management

(e) They are more likely to have mental health problems co-existing with other problems such as substance misuse

(f) They are more likely to be at risk of harming themselves or others

(g) They are more likely to disengage with services.

14. Paragraph 63 recommended that for those requiring standard CPA, it was only necessary for professionals to maintain adequate clinical/practice records which recalled the assessment of the service user's needs, the agreed care

plan and the date of the next review of the care plan. Elements of risk and how the care plan managed the identified risk should always be recorded.

15. Insofar as the review of care plans was concerned, it was not necessary for a nationally determined review period of six months. Review and evaluation of the service user's care plan should be on-going. At each review meeting the date of the next review must be set and recorded. Any member of the care team or the user or carer would be able to ask for a review at any time. All requests for a review of the care plan must be considered by the care team. If the team decide that a review is not necessary the reasons for this must be recorded.

16. Paragraph 67 provided that it was particularly important to review a service user's care plan upon discharge from hospital. Hospital discharge was not the point of discharge from care, but a transfer in the location of the delivery of care. Both hospital and community based staff should be trained in discharging care planning. The implementation of the care plan should be assessed within the first month of discharge.

17. Achieving a proper focus (paragraph 73) provided that the primary focus of the CPA is to ensure that the needs of all mental health service users are assessed and that the appropriate care is delivered to meet those needs. It is important that we set out the section on risk assessment and risk management.

    74. "Risk assessment is an essential and on-going element of good mental health practice. Risk assessment is not, however, a simple mechanical process of completing a pro forma. Risk assessment is an on-going and essential part of the CPA process. All members of the team, when in contact with service users, have a responsibility to consider risk assessment and risk management as a vital part of their involvement, and to record those considerations.

    75. Risks cannot simply be considered as an assessment of the danger an individual service user poses to themselves or others.

Consideration also needs to be given to the user's social, family and welfare circumstances as well as the need for positive risk taking. The outcome of such consideration will be one of the determinants of the level of multi-agency involvement.

76. Risk management is at the heart of effective mental health practice and needs to be central to any training developed around the CPA. Staff must also consider the extent to which they might need support from colleagues, other services or agencies especially when someone's circumstances or behaviour changes unexpectedly".

18. Paragraph 77 provides that service users on enhanced CPA will require, as part of their care plans, crisis and contingency plans. These plans form a key element of the care plan and must be based on the individual circumstances of the service user. Paragraph 78 provides that contingency planning prevents a crisis developing by detailing the arrangements to be used where, at short notice, either the care co-ordinator is not available or part of the care plan cannot be provided. The contingency plan should include the information necessary to continue implementing the care plan in the interim, for example, telephone numbers of service providers and the name and contact details of substitutes who have agreed to provide interim support.

Trust Policy: 3NTW(C)06, Issue 3 "Policy and Procedure on Care Co-Ordination"

Date of Issue February 2005

19. This Policy sought to implement "Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach". (Paragraph 1.4)

20. Under the section "Assessment" it was stated systematic assessment of health and social care needs as they impact on a particular individual is the cornerstone of care co-ordination. The individual service user should be at the centre of assessment, engaged in the process and its scope. (Paragraph 9.1)

21. Integral to all initial assessments is the assessment of risk using a research based validated tool. The minimum requirement was a completed FACE risk profile which can be supplemented by use of other specific risk assessment tools as clinically indicated. (Paragraph 9.3)

22. Decisions following assessment cannot be made collectively by team meetings. This responsibility rests with the professional carrying out the assessment. They should seek support and advice from their supervisor if necessary. However, team meetings are essential to good team practice in supporting colleagues and guiding and informing practice. Team members have a responsibility to give sound advice, particularly where there are risk issues. (Paragraph 10)

23. Risk assessment and risk management was regarded as a multi-disciplinary responsibility and is required:

(a) As part of the initial assessment.

(b) When admitting/discharging from hospital and as part of planning and agreeing leave.

(c) As part of review considerations.

(d) When there are major changes/incidents.

(e) When alerted by carers.

(f) When transferring service users to other teams/service providers. (Paragraph 11.1)

24. Risk management plans are an integral part of the care plan and will be developed when the level of risk is significant, serious or serious and imminent. (FACE risk profile rating scale 2, 3 or 4) The management of risk issues that are rated 1 do not require a specific management plan and should be covered by the care plan.

25. Care planning, crisis and contingency planning was specifically addressed. The care plan must meet laid down standards and include the necessary help with housing, financial benefits, support towards employment as well as health services and services under the Community Care Act, 1990. (Paragraph 12.1) It will identify the services, resources, actions and targets set by the service user and the team to meet the service user's needs. It will be the responsibility of the care co-ordinator to assist the service user and the team in reaching the identified goals. (Paragraph 12.2)

26. All care plans will have a contingency plan agreed with the service user and relevant others that clearly sets out. (Paragraph 12.4)

27. The circumstances in which the service users may need urgent extra help including, if relevant, warning signs which are indicators of worsening problems should be identified. (Paragraph 12.5)

28. The actions to be taken by whom/which services should be identified.(Paragraph 12.6)

29. The requirement for reviews is specifically addressed. The care plan must be reviewed regularly in line with the risk management plan, and planned review dates. The review will be undertaken by the care co-ordinator involving the service user, any identified carer and all those providing care. This may involve a meeting of all concerned in a setting where the service user feels comfortable or to be undertaken by the care co-ordinator's meeting the service user and any identified carer, with other members of the care team contributing to the process through the care co-ordinator e.g. through written or verbal reports. (Paragraph 13.11)

30. The frequency of reviews should be determined by the needs of the service users but should be at least six monthly. (Paragraph 13.2).

31. In-patient, admission and discharge arrangements is also addressed. It is noted that all patients admitted to a mental health in-patient facility will be registered under care co-ordination. (Paragraph 15.1) The person referring would be expected to supply the admitting nurse on the ward with the following, completed, care co-ordination documents:

(a) Initial admission/assessment form.

(b) Risk profile (FACE and risk management plan).

32. The admitting nurse and referrer, in conjunction with the patient and carer (where appropriate), will collectively update the risk profile as appropriate and use this as a basis to develop the initial risk management plan, which will incorporate the following:

(a) Planned or agreed leave.

(b) Observation levels.

(c) Action to be taken in the event of increased clinical risk e.g. abscontion risk.

(d) Any medication the patient requires.

(e) Details of risk history. (Paragraph 15.3)

33. In relation to the “Inpatient Multi-Disciplinary Team Meeting” - the team will hold a formal care co-ordination review, and with, the care co-ordinator, will complete a full review of the patient’s care needs for the duration of their in-patient admission, including where, appropriate, referral :

(a) For housing.

(b) To assertive outreach of other specialist service(s).

(c) To see Mental Health Team for allocation of care co-ordinator (if not already allocated). (Paragraph 15.8)

34. The review will be informed by the care co-ordination assessment, the risk profile and other appropriate clinical assessments (health and social care). (Paragraph 15.9)

35. At the pre-discharge meeting or final patient review (multi-disciplinary team meeting) prior to the patient’s actual discharge, the team would hold a formal care co-ordination review. With the care co-ordinator, a discharge care plan, identifying the patient’s care needs for their immediate discharge and successful reintegration into the community will be completed, with particular

reference to immediate needs, support in the first week of discharge and the subsequent three months including:

(a) Financial issues.

(b) Medication changes, monitoring, depot clinic, Clozaril clinic, follow-up.

(c) Outpatient appointments.

(d) Social requirements.

(e) Risk management plan.

(f) Contingency and crisis plans.

(g) Seven day follow-up (in accordance with the relevant locality protocol) and action to be taken if the service user does not attend. (Paragraph 15.13)

36. For services users registered at enhanced level the discharge care plan will be recorded using the care co-ordination care plan document. Service users registered at standard level will have their care plan recorded using the care co-ordination standardised letter document. (Paragraph 15.4)

37. The care co-ordinator will be responsible for completing the care co-ordination care plan arrangement (if relevant) and ensuring copies of the care plan are sent to all relevant parties.

38. The care co-ordination levels are identified:

Level 1 – Standard – this level will usually receive their care co-ordination from the person they receive services from to meet their assessed needs. For example people receiving psychiatric out-patient appointment or help from a community psychiatric nurse or provider of social services.

Level 2 – Enhanced – people on this level were likely to have more complex needs and require intensive help for a range of services combining health and social care. They will receive their care co-ordination from a specialist mental health worker – most often a community psychiatric nurse (CPN), a social worker or during long in-patient admissions, a senior member of ward staff. (Paragraph 16.1)

39. The care co-ordinator's responsibilities set out as.

(a) Ensuring full details of the new service user are entered into the care co-ordination data base, or to enter the change of care co-ordinator when receiving a transfer.

(b) Making contact with the service user at agreed intervals and, if they cease contact, informing others as necessary.

(c) Providing assessment, care plans and review arrangements with the service user in accordance with the standards set out in the procedural document. Communicating effectively with all those involved with the service user's care.

(d) Completing a FACE risk assessment and updating the risk history record.

(e) Identifying when a service user needs advocacy help to participate in the planning of care and ensuring the user has access to the care identified.

(f) Making arrangements for their inclusion in the care planning arrangements and supporting their role, identifying carers who meet the criteria set out in the procedural document.

(g) Ensuring that the service user's entry into the care co-ordination data base is accurate and up to date at all times and is removed when they no longer meet the criteria of the registration.

(h) Receiving information from others providing a service to the service user and using, as appropriate, this information in the care arrangements.

(i) Informing the person responsible for the care co-ordination system where difficulties arise, either because the system is not being adhered to or because the system itself is not meeting the best interests of the service user.

(j) Undertaking appropriate care co-ordination training as required. (Paragraph 17)

40. The care co-ordination system would be reviewed on a regular basis to ensure national standards have been met. This was to be done in three ways for the audit by:

(a) Monitoring the activity in the system.

(b) Clinically auditing the standards of service which had been delivered involving service users and carers.

(c) Performance indicators and performance targets. Attached to this policy are the relevant pro forma documents used.

- ***Commentary***

41. The Panel is of the view that Trust's care co-ordination policy (3NTW)(c) 06 (Issue 2) reflected the good practice envisaged in the guidance given in "Modernising the Care Programme Approach" of 1998. The Trust's policy follows all the recommendations of the national guidance.

42. However, no matter how good a local policy reflects national guidance, it is the implementation of the policy on a day to day basis where failings often occur, and in the treatment and management of P, this is very apparent to the Panel. In many respects the implementation of the national and local guidance did not occur:

(a) There was little evidence of the co-ordination of the respective roles and responsibilities of the Trust and Mental Health Matters.

(b) There was little evidence of the features of a truly integrated system of care programme approach and case management. The Panel saw no evidence of joint training involving MHM staff. There was no evidence of any common and agreed risk assessment and risk management procedures between the Trust and MHM, particularly on the issue of lone worker policies (to which the Panel returns to later). There was no joint serious incident process.

(c) *Risk assessment is an essential and on-going element of good mental health practice. As the guidance points out, risk assessment is not a simple mechanical process of completing a pro forma. Risk assessment is an on-going and essential part of the CPA process. All members of the team, when in contact with the service users, have a responsibility to consider risk assessment and risk management as a vital part of their involvement and to record their considerations. The Panel is satisfied that in this case the on-going risk assessment of the dangers P potentially presented to himself and to others did not feature as a high priority particularly in the period from January 2006 until the unlawful killing of A on 19 May 2006. In this regard, the Panel have a number of concerns. In particular, at the time of P's discharge from hospital on the 15 February 2006, there was no clear risk formulation specifically in relation to longitudinal data. The quality of this risk assessment raises concerns for the Panel. There was no analysis whatsoever of P's previous history of the serious assault upon his parents when psychotic. Under the section 'current warning signs', there was a failure to indicate "yes" to early warning signs of relapse, ideas of harming others, threats and intimidation and absconding. There was a failure to refer to discontinuation of medication as a clear recent risk factor. Reviews should have also taken place on 17 March 2006, 11 April 2006, 18 April 2006, 2 May 2006, 10 May 2006, 12 May 2006 and 16 May 2006 .*

(d) *The Panel found no evidence of any effective crisis and contingency plan in the event of deterioration in P's condition or the manifestation of any of the known risk factors which may have led to psychotic episodes.*

- **LONE WORKING: NATIONAL GUIDANCE: NOT ALONE**

43. On 2 May 2005 the Department of Health published a document "*Not Alone*" – *a guide for the better protection of lone workers in the NHS*. The executive summary states that the document was designed to provide guidance to NHS health bodies and their staff to help them develop, communicate and

implement procedures that address the need to minimise the risks faced by the very many different groups of staff that may have to work alone in a diverse range of environments. The guidance was directed to Local Security Management Specialists, risk managers, human resource departments and, importantly, the managers of lone workers and lone workers themselves. The document emphasises the need for:

(a) Good risk assessment processes for managers and staff

(b) Clear and robust management procedures that put in place measures to address identified and potential risks, and to deal with incidents when they occur.

(c) Sharing of information from within and outside the NHS on identified and potential risks.

44. Under the section “risk assessment prior to visit” it states:

(a) Where it is practicable, a log of known risks should be kept, updated and reviewed regularly – in respect of the location and details of patients/service users/other people that may be visited by their staff, where such a risk may be present.

(b) Such information should, where legally permissible, be communicated with other agencies who may work with the same patients/service users, as part of an overall local risk management process.

(c) If there are known risks for the particular location or patient/service user, lone workers and their managers should reschedule this visit to a particular time, place or location where they can be accompanied.

(d) Lone workers should remain alert to the risk presented from those who were under the influence of drink, drugs, are confused, or where animals may be present. Being alert to these warning signs will allow the lone worker to consider all the facts at their disposal, allowing them to make a personal risk assessment and, therefore, assess the best possible course of action.

- **TRUST'S POLICY 'LONE WORKING' NTW(A)24 ISSUED IN APRIL 2005**

45. The Panel has considered the Trust's policy 'Lone Working' NTW(A)24 issued in April 2005. This essentially mirrors *Not Alone*. There is a significant emphasis in the policy on risk assessment (Paragraph 3) and that the process of risk assessment should take into account the identification of hazards from means of access and or egress, equipment, substances, environment, travel, communication. Particular consideration should be given to:

    (a) The remoteness or isolation of workplaces.

    (b) Any problems of communication.

    (c) The possibility of interference, such as violence or criminal activity, from other persons.

    (d) The nature of injury or damage to health and anticipated 'worse case' scenario.

- ***Commentary***

46. Any assessment of risk may change as circumstances change. It is vital, therefore, that risk is continually reviewed, particularly in the area of the provision of mental health services. The Panel does not believe that this general statement of principle should be controversial. However, the Panel has concluded P's change in presentation did not result in any formal reassessment of his risk within the context of lone/joint working. Indeed, the Panel is of the view is that there is no evidence at all to show that throughout the whole of the period from January 2006 until 19 May 2006 was any consideration given by any employee of the Trust and , in particular CPN1, to a robust and written risk assessment of lone working with P.

47. The Panel has already drawn out that on 19 January 2006, CPN1 advised MHM 1 that joint visits might be appropriate due to a change in P's pattern of behaviour. The Panel is of the view that CPN1 did in fact believe that P was a risk and joint visits would be appropriate due to a change in P's pattern of behaviour. Although she had not seen him at this stage, the changed pattern of behaviour was a combination of his non-engagement with services and his

continued refusal to have the depot injection. At the date of CPN1 contacting MHM 1 she was not aware that P had absconded to London. Her assessment, therefore, of the change in risk was correct. However, at this stage CPN1 did not undertake any formal risk assessment herself, nor was any formal risk assessment undertaken by any other person in the Trust. It may be that events overtook the need for such an assessment because shortly after 19 January 2006 CPN1 became aware of P's admission to hospital in London. However, the lax approach to the question of lone policy working and joint visits, is apparent from the events of 26 January 2006. On this occasion CPN1 visited P on the ward. P was given escorted leave to his home to collect belongings and CPN1 drove P home on her own. Whilst at that stage CPN1 did not consider P to be a risk to her, yet again there was no formal assessment of this risk, which in the view of the panel was surprising. Only a matter of seven days prior to the 26 January 2006 CPN1 was recommending joint visits to MHM.

48. Furthermore, the need to consider lone visits should have been given a greater priority post-P's discharge on 25 February 2006. It is important to set out the dates when the assessment of risk should have been made:

(a) On 17 March 2006, Consultant 7 noted that P was guarded, irritable and more demanding than normal. There was a lack of warmth and a demand that he received assistance with his Disability Living Allowance application. It was noted that there were two significant risk factors remaining in place, these being P's significant debt and that P continued to drink alcohol. It is clear to the Panel that at this stage P was manifesting signs of relapse. A robust review of his care plan, given his presenting condition, should have led, amongst other things, to a reconsideration of the lone worker policy and whether joint visits should be commenced.

(b) On 11 April 2006, CPN1 visited P and P was found to be intoxicated having consumed a bottle of wine and two cans of lager. P again refused his depot injection and insisted that nothing was wrong. Whilst he was not violent, P's presentation should have been the focus for, amongst other things, a further

review of the lone worker policy and where the joint should have been commenced.

(c) On 18 April 2006, a joint visit was undertaken between CPN1 and MHM 1. By this time P had broken his pay phone in order to obtain money for personal use. Yet again, P refused his depot injection and there continued to be an issue surrounding P's lack of finance and his indebtedness. Debt had been identified as a risk factor and increased likelihood of relapse into a psychotic state. The Panel is of the view that the lone worker policy, amongst other things, should have been reviewed at this stage and a consideration being given to the implementation of joint visits.

(d) After Consultant 7 had visited P on 2 May 2006, the lone worker policy and whether joint visits should be commenced, should have been reviewed. It is the Panel's view that by this stage P was presenting with significant changes in his presentation, with increased risk factors and relapse triggers being present. P was consuming alcohol such that on the visit on 11 April he was found to be intoxicated. He was yet again refusing his depot injection and had also broken a pay phone belonging to MHM. A risk factor previously identified was P's indebtedness which caused him stress and with this came an increased risk of impulsivity. Consultant 7, furthermore, identified that there remained a risk that P would experience another relapse as he was not on any anti psychotic medication. P was strongly advised to restart all anti psychotic medication but he was against this. Given the fact that all the identified relapse risk were now present, the Panel is of the view that the lone worker policy, amongst other things, should have been reviewed at this stage and consideration given to the implementation of joint visits.

(e) On 9 May 2006, 10 May 2006 and 12 May 2006 CPN1 visited P but there was no reply. Given the fact that all the identified relapse risks were now present, the Panel is of the view that the lone worker policy, amongst other things, should have been reviewed at this stage and a consideration being given to the implementation of joint visits.

(f) On the 14 May 2006 A saw P walking along the road with a bottle of vodka seeming to be unsteady and saying he was "pissed". This information was

passed to CPN1 on 16 May 2006. Given the fact that all the identified relapse risk were now present, including P's abuse of alcohol, the Panel is of the view that the lone worker policy, amongst other things, should have been reviewed at this stage and a consideration being given to the implementation of joint visits

49. The Panel is of the view that if a robust assessment of the risks of lone working with P had been undertaken, then on the balance of probability, we are satisfied that by 12 May 2006, at the latest, joint visits would have been commenced by the Trust. The Panel would have expected that this information would then have been relayed to MHM to ensure that staff employed by MHM would have also commenced joint visits.

- **TRUST POLICY : 3NTW(C)/(09), ISSUE 4 "RECOGNITION, PREVENTION AND MANAGEMENT OF AGGRESSION AND VIOLENCE" DATE OF ISSUE SEPTEMBER 2005**

50. The policy accords with the Zero Tolerance (DH 1999) guidance. The policy defined aggression and violence from the guidance given in the British Psychologist Society report "Prevention and Management of Violence at Work, February 1992". The following definitions are used:

    (a) Physical aggression: a physical expression of anger directed towards the body (including pushing and punching) or towards property (e.g. overturning furniture).

    (b) Verbal abuse: a verbal outburst expressing anger towards the recipient causing a sense of alarm or arousal.

    (c) Threats or menaces: a threat of attack which may or may not involve the use of a weapon.

    (d) Fear of attack: a personal sense of threat not identified by any of the above.

The policy concerned the following people:

(a) All staff.

(b) Lone workers.

(c) Community staff.

(d) Agency staff.

(e) Visitors, including contractors.

51. The employee's responsibilities were identified. (Paragraph 4.2) All staff had a responsibility to ensure their own safety and that of others who may be affected by their work activities. Staff had a responsibility to report all incidents of aggression and violence, be it actual or threatened, on the Trust's untoward incident form depending on the severity of the incident.

52. The policy noted that "aggression and violence can often be predicted and is often preventable." In the past, greater emphasis had been placed on skills development relating to the physical management of aggression and violence rather than skills development in:

(a) Recognition, prevention de-escalation.

(b) Organisational, environmental and clinical risk assessment.

(c) Risk management.

(d) Care programme approach and care co-ordination.

(e) The use of advance directives or negotiated care plans. (Paragraph 6.1)

53. The policy stated that injuries to staff and service users following exposure to aggression, violence and the process of restraining, are well documented. In the most serious cases death has occurred. It is only through a multi-dimensional approach that mental health service providers can address the problems of aggression and violence in in-patient services. The policy was

aimed at minimising its occurrence and promoting a safe and therapeutic environment for people to work in, live in and visit.

54. The policy stated that assessment of the management of risk is an essential part of the care and treatment provided for service users and is an integral part of the care programme approach, care co-ordination and the single assessment process. It is essential that on admission a clinical risk assessment of all individuals is carried out and a risk management plan is put in place. This should be conducted in collaboration with the service user and their carer wherever possible. (Paragraph 6.9)

55. Risk assessments and management plans should be regularly reviewed from the service user and their carer wherever possible. Plans should record known triggers to aggressive/violent behaviour based on previous history and discussion with service users and their carer's families. Changes in levels of risk should be recorded, communicated and risk managements plans changed accordingly. (Paragraph 6.10)

- ***Commentary***

56. The local policy 3NTW(C)/(09), Issue 4 "Recognition, Prevention and Management Of Aggression And Violence" was entirely consistent with national policy. Furthermore, Panel is of the view that this policy was clear in the guidance it gave on the issues of aggression and violence.

57. The Panel saw no evidence that during the period January 2006 to 19 May 2006 any consideration was given to the reassessment of P's risk of aggression and violence. A clear example of when this should have taken place is after the visit on 11 April 2006 when P was noted to be intoxicated with alcohol and also on 18 April 2006 when P informed CPN1 and MHN W1 that he had smashed up a pay phone. The damage to the pay phone clearly engaged the definition of aggression; a physical expression of anger directed towards property. Furthermore, on 16 May 2006 CPN1 was informed that P had been seen by A drunk in the street. On each of these occasions P's risk of aggression and violence should have been robustly re- assessed.

- **TRUST POLICY: 3NTW(C), ISSUE 2 "DIFFICULT TO ENGAGE SERVICE USERS (INCLUDING NON-COMPLIANCE WITH TREATMENT)" DATE OF ISSUE MARCH 2005**

58. This policy notes that users of mental health services may choose to discontinue contact with a proportion of all of the services provided. In the vast majority of cases this is not problematic. However, there will be occasions when this situation may give rise for concern. (Paragraph 1.1)

59. The policy noted that the report of the *National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (Safer Services) 1999*, found that non-attendance and loss of contact with services were frequent findings in inquiries into suicide and homicide. The report recommended that Trusts had written policies regarding non-compliance and disengagement from services.

60. "Difficult to engage" and "non-compliant with treatment" patients were defined. It was noted that the service user must already be receiving services from specialist mental health services and continue to meet the eligibility criteria. The reasons for monitoring and managing service users who were difficult to engage is to minimise the risk they could present for themselves and others. A difficult to engage patient was one where there was a history of disengagement from services (usually leading to hospital admission) and a sufficient risk to tell others to negate the option of case closure. Non-compliance with treatment referred to (non) receipt of proposed treatment. (Paragraph 3).

61. The Policy provided that a Care Co-ordination review/case review meeting should be called to determine the reasons for disengagement and to see whether any changes could be made to the care plan in order to re-engage the service user. However, where the situation warrants prompt intervention, assessments under the Mental Health Act 1983 should be considered. (Paragraph 4.2) In the event that these strategies proved unsuccessful, the

following approaches to facilitating engagement and management of risk were to be considered:

(a) Who is to visit/contact and how often?

(b) Communication plan between all involved agencies and parties.

(c) Consideration of involvement of relatives and/or carers.

(d) Consideration of involvement of police and/or other agencies.

(e) Consideration of involvement of statutory mechanisms.

(f) Plan review with multi-disciplinary team.

(Paragraph 4.3)

62. The care co-ordinator, in discussion with the multi-disciplinary team, should consider whether the service user met the criteria for assertive outreach services, where these are available. (Paragraph 4.6)

63. The care co-ordinator should also consider requesting either a conference under Multi-Agency Public Protection Arrangements (MAPPA) or a vulnerable adult multi-agency conference if indicated.(Paragraph 4.7)

64. The Care Co-ordinator, in discussion with the MDT, may decide that the referred person represents a significant risk (e.g. violence to others), that this is not as a result of mental illness and so does not require follow-up within the mental health services. Such a decision should be clearly documented and information should be shared with the other agencies e.g. police, on a need to know basis following information sharing procedures. Consideration should be given to requesting a MAPPA conference. (Paragraph 4.8)

65. Where there has been non-compliance with treatment or the service user has not engaged in the care plan to the extent that they are considered non-compliant with treatment as defined in the policy, the steps outlined above should be followed. (Paragraph 5.1)

66. Where the service user has discontinued taking his/her medication, then the responsible medical officer should consider undertaking a medicine review in order to try to agree a medication plan that is acceptable to the service user.

Where such a plan cannot be agreed, then the steps outlined above should be followed (Paragraph 5.1). (Paragraph 5.2).

- ***Commentary***

67. *The Panel is of the view that from 11 April 2006 onwards the definition of difficult to engage and non-compliant with treatment was engaged. The occasions when P fell into this category are:*

    (a) 11 April 2006 - P refused his depot injection.

    (b) 18 April 2006- P refused his depot injection.

    (c) 2 May 2006 – P continued to say he was not taking his depot injection.

    (d) 9 May 2006, 10 May 2006 and 12 May 2006-P had failed to engage with CPN1.

68. *The Panel saw no evidence that CPN1 or Consultant 7 had given consideration to neither this policy nor the procedure to be followed where the definition of difficult to engage and non-compliant with treatment was satisfied. This policy was easy to understand and gave clear guidance on the procedures to be followed in the event that P was either difficult to engage or non-compliant with treatment.*

69. *The Panel is of the view that a focussed assessment of P's presentation particularly in the period from 11 April 2006, whether as part of the Care Programme Approach care plan review, or in accordance with this policy, would have led to a more robust management of P in the community, as set out in Chapter 7 of this report.*

- **Trust Policy: 3NTW(A)21, Issue 2 "Record Management Policy" Date of Issue January 2005**

70. This Policy reflected HSE 1999/053 "For the Record". It noted that a systematic and planned approach to the management of records within the organisation, from the moment they are created to their ultimate disposal, ensures that the organisation can control both the quality and quantity of the information that it generates. It can maintain the information in a manner that effectively services its needs, those of Government and the citizen and it can

dispose of the information efficiently when it is no longer require. (Paragraph 4.1)

71. Records are valuable because of the information they contain and information is only useable if it is correct and legibly recorded in the first place, is then kept up to date, and is easily accessible when needed. (Paragraph 4.4)

72. Good record keeping ensures that:

    (a) Employees work with maximum efficiency without having to waste time hunting for information.

    (b) There is an audit trail, this enables any record entry to be traced to a named individual at a given date/time with the secure knowledge that all alternations can be similarly traced.

    (c) Staff can see what has been done, or not done and why, any decision made can be justified or reconsidered at a later date. (Paragraph 4.3)

73. It was important to ensure:

    (a) Important and relevant information is recorded and completed

    (b) Information is legible and can be easily read and reproduced when required

    (c) Information records are easily accessible and kept up to date

    (d) Information is shared, rather than copied, in order to reduce risks to confidentiality

    (e) Records are disposed of as soon as possible subject to national and local retention periods. (Paragraph 4.5).

- ***Commentary***

74. The Panel is of the view that the local policy on record keeping was consistent with national guidance. Furthermore, the policy set out clearly the real benefits of good record keeping.

75. *Overall the standard of record keeping was satisfactory throughout P's engagement with psychiatric services. However, there were some notable lapses. In the Panel's view there are two examples of this in the period from January 2006 19 May 2006*

    (a) When CPN1 contacted MHM 1 on 19 January 2006, there is a clear record that CPN1 advised that joint visits might be appropriate due to the change in P's behaviour. However, there was no recording of what the risks were to lone workers and or why the risk had increased (apart from the assertion that P's behaviour had changed).,

    (b) There was a failure to record, analyse and properly consider CPN1's clear view expressed on 13 February 2006 that P should have been detained longer for a more extensive period of assessment. It was unsatisfactory that CPN1's concerns were not properly recorded in the records.

- **MULTI AGENCY PUBLIC PROTECTION ARRANGEMENTS: MAPPA**

76. Multi Agency Public Protection Arrangements (MAPPA) is the name given to arrangements in England and Wales for a number of authorities who are tasked with the management of registered sex offenders, violent and other types of sexual offenders and offenders who pose a serious risk of harm to the public.

77. MAPPA was first introduced by the Criminal Justice and Court Services Act 2000 and was strengthened under the Criminal Justice Act 2003. The guidance issued under the 2003 Act and applicable in 2005-2006 (pursuant to section 67(6)) identified that there was a lack of consistency in the MAPPA between areas. It stated that the guidance did not seek to argue for a slavish uniformity of process but for a commonality of approach and practice, a consistent definition of risks and the means of managing them and a framework common to all areas would enable a consistent approach to risk identification, assessment and management. The framework was said to be important in supporting:

(a) greater professional confidence in the multi-agency management of risk
(b) the work done to establish national standards to underpin and support the development of good practice
(c) the more effective and efficient management of cases across areas
(d) consistency in the communication of public protection work to the public
(e) the effective development and sharing of good practice and
(f) Effective links with other agencies both within MAPPA areas.

78. The guidance also identified three phases towards the development of national standards. Phase 1 (April 2001 to Autumn 2002) involved the setting up of the MAPPA; phase 2 (Autumn 2002 to January 2004) involved the distilling and learning from the first year's operation and the first annual reports, preparing and implementing the guidance; phase 3 (January 2004 to annual reports 2005) preparing and then implementing the duty to co-operate and lay adviser provisions contained in the Criminal Justice bill.

79. The guidance also referred to the work of Professor Hazel Kemshall (2003) "The Community Management of High Risk Offenders Prison Service Journal, March 2003. She clarified that public protection depended upon:

(a) defensible decisions

(b) rigorous risk assessments

(c) the delivery of risk management plans which matched the identified public protection need; and

(d) the evaluation of performance to improve delivery.

80. The MAPPA guidance drew down on this evaluation by Professor Kemshall and stated that the idea of defensible decisions was not about defensiveness. It intended to embed risk assessment and risk management with robustness. Professor Kemshall identified the following criteria:

(a) That all reasonable steps had been taken.

(b) Reliable assessment methods had been used.

(c) Information had been collated and thoroughly evaluated.

(d) Decisions were recorded (and subsequently carried out).

(e) Policies and procedures had been followed.

(f) Practitioners and their managers adopt an investigative approach and were proactive.

81. The guidance asserted that no risk assessment method was fully protective, yet good risk assessment practice was dependent upon those undertaking it having all the relevant information and time to consider it. The guidance therefore placed great emphasis upon the identification of risk and information sharing to assess risk.

82. In relation to robust risk management it was noted that this began with planning how the assessed risks were to be managed. Risk management was dynamic and depended upon changes in risk and in the circumstances likely to affect risk. It was noted that the management of good risk involved ensuring that each case is managed at the lowest appropriate level.

83. The legislation and guidance identified MAPPA offenders. Category 1 covered registered sex offenders (not applicable here), category 2 covered violent and other offenders (summarised as offenders who receive a sentence of imprisonment of 12 months or more, although it was noted that the legislation was considerably more complex including those detained under hospital or guardianship orders and those who committed specific offences against children); this would also not apply here. Category 3, however, included other offenders not in category 1 or 2 but who would be considered by the responsible authority to pose a serious risk of harm to the public. The guidance asserted that the identification of category 3 offenders was challenging and significantly different from categories 1 and 2 in that it is determined by the judgement of the responsible authority rather than automatically by the sentence or other disposal imposed by the Court. That judgement is exercised in respect of two considerations. First it must be

established that the person has a conviction for an offence which indicates that he is capable of causing serious harm to the public. Secondly, the responsible authority must reasonably consider that the offender may cause serious harm to the public.

84. Paragraph 66 of the guidance stated that in those agencies that operate a Care Programme Approach (CPA) the referral would be expected to have been considered and risk assessed in that system first.

85. The guidance set out the categorisation of the levels of risk of harm (paragraph 99).

    (a) Low - no significant, current indicators of risk of harm;

    (b) Medium - identifiable indicators of risk of harm. The offender has the potential to cause harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

    (c) High - there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

    (d) Very high - there is imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be very serious.

86. Paragraph 100 defined the categorisation of risk by reference to those who may be the subject of harm. This included:

    (a) The public, either generally or a specific group such as the elderly, women or minority ethnic groups.

    (b) Prisoners within a custodial sentence.

    (c) A known adult, such as a previous victim or partner.

    (d) Children who may be vulnerable to harm of various kinds, including violent or sexual behaviour, emotional harm or neglect.

(e) Staff, anyone working with the offender whether probation, prison, police or other agency and relates to all forms of abuse, threats and assaults that arise out of their employment.

(f) Self, the possibility that the offender would commit suicide or self harm.

87. The guidance identifies three levels of risk management:

(a) Level 1 – ordinary risk management which is used in cases in which the risks posed by the offender can be managed by one agency without actively or significantly involving other agencies. A person referred under category 3, according to the guidance (paragraph 111) can never be managed under category 1 because by definition category 3 offenders present a risk of serious harm which requires active, inter-agency management.

(b) Level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that their permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management: social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies.

(c) Level 3 – multi-agency public protection panel which is responsible for the management of the critical few. Here the individual is assessed as being high or at a very high risk of causing serious harm and presents

risks that can only be managed by a plan which requires close co-operation at senior level due to the complexities of the case and/or because of the unusual resource commitments or although not assessed as high or very high risk, the case is exceptional because the likelihood of media scrutiny and/or public interest in the management of the case is very high and there is a need to ensure that public confidence in the criminal justice system is maintained.

- **Local Policy**

88. The local policy was set out in a MAPPA guidance by the Northumbria probation area in December 2005. This policy guidance clearly reflects the guidance issued by the Home Office, set out above headed *Multi-Agency Public Protection Arrangements* In addition to collecting the detailed guidance issued nationally, Northumbria probation area also introduced "the non-MAPPA system" into which individuals considered to be dangerous can be referred in circumstances where they do not qualify for inclusion in MAPPA e.g. the individual does not have a conviction or does not have a relevant conviction.

- ***Commentary***

89. The Panel interviewed HPP 1, the Head of Public Protection for the Northumbria Probation Trust. HPP 1 confirmed that P, if referred, would have been managed through MAPPA. The Panel have been cautious in accepting this assertion because, as the national guidance states, there was inconsistency in the approach to MAPPA and even in 2006, the learning and understanding on MAPPA was not at the same level it is today. The Panel was also cautious because paragraph 66 of the guidance stated that in those agencies that operate a Care Programme Approach (CPA) the referral would be expected to have been considered and risk assessed in that system first.

90. The Panel has seen no evidence to confirm that any consideration was given to a MAPPA referral in 2006. At first the Panel was against any potential criticism of the failure to consider a referral to MAPPA, primarily because the operation of MAPPA was not well known in 2006. However, the Panel has

considered this in the light of trust policy 3NTW(C), Issue 2 Difficult to Engage Service Users (Including Non-Compliance with Treatment) (Date of Issue March 2005), which recommended that consideration should be given by the patients Care Co-ordinator to a referral under MAPPA where the patient was difficult to engage or non-compliant with treatment.

91. The Panel is, therefore, of the view that P could have been referred at some point after 11 April 2006 because under category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management: social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts, and probation victim contact teams or appropriate agencies. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

9. Mental Health Matters POLICIES AND PROCEDURES

1. Prior to the incident in May 2006, Mental Health Matters (MHM) had a number or written policies relating to health and safety at work. These included:

   (a) An individual risk assessment policy.

   (b) An individual risk assessment procedure.

   (c) A national lone working policy

   (d) A local lone working policy.

2. The national policy document was not based upon any generic framework or guidance issued by any statutory body or governmental department.

3. The national policy document *Lone Working Policy* is a comprehensive statement which states:

   (a) 'We recognise lone working can be an appropriate and positive means of delivering support. We are also aware of the risks and concerns which lone working and working alone can bring. We provide the following conditions to support staff who work alone:

   - Practice which promotes safety at work.
   - Adequate levels of supervision.
   - On-going training.
   - Team structures which promote professional development.
   - Effective risk assessment/management procedures.
   - Regular monitoring and review of risk assessments, management and control measures.
   - Access to support, including support in the event of an emergency.

   (b) "If you are a lone worker or a staff member who works alone you are responsible for your own safety, health and welfare and that of those

affected by your work. In any situation, you should assure your safety first and foremost and make sure that your next priority is the safety of those you have a duty of care for…. You must also report any problems or omissions with the risk assessments and the risk assessment procedure, as it applies to you."

(c) "If you are a line manager with day to day responsibility for staff you must assure that the appropriate risk assessments for your staff are undertaken. You must identify the policies and procedures which are relevant to each staff members situation and ensure that they have time and support to understand and comply with them. You should also report any problems or omissions with the risk assessments and the risk assessment procedure as it applies to you or your staff".

(d) "If you are a Team/Service Co-ordinator you are responsible for the risk assessment strategy for your area, and for ensuring risk assessments are regularly reviewed and updated. The risk assessment strategy for your service should review specific issues relevant to lone working and working alone in that particular environment. You are responsible for ensuring that risk assessment control measures and a safety protocol are in place".

4. Within this policy framework there is a clear direction that a risk assessment is a key tool to safeguard the health and safety of staff working alone.

'What is a risk assessment?

Risk assessment is a key tool to safeguard the health and safety of staff working alone. We provide a number of policies and practical aids to risk assessment and training as part of Mental Health Matters mandatory training programme. When we develop or review a service, the risk assessment process considers:

- Staff levels
- Staffing rotas/patterns

- Any equipment or procedure needs to ensure the health, safety and welfare of staff.

Risk assessment of a specific task or site enables MHM and the staff member to identify and manage specific risks."

5. The national policy also addresses MHM staff working with specific service users

"Standards for working with service users

MHM existing policies and procedures can be effectively used to promote safe working practice for staff and service users.

These areas can specifically be used to review practice when working alone with service users.

The referral and assessment process

This provides an opportunity to evaluate whether we can appropriately and safely offer support to the applicant within the constraints of the service, which includes when staff are working on their own.

Risk Assessment

This can be used to evaluate the risks of working alone with a particular service user. Where it is appropriate to work alone with a service user, the risk assessment may also affect the choice of key worker/line worker.

MHM has risk assessment procedures for working with service users, which include an initial assessment of risk and periodic reviews of the assessment. Risk assessments are undertaken with service users and their views on their own management of risk should be recorded".

6. In a section headed 'Ideas for developing risk awareness in practice", the policy states;

Task, times, places, people

A simple way to generate understanding of risk is to ask yourself or others

Tasks Do you have some tasks that are more likely to get a difficult or confrontational reaction? For example, are you going to give notice to a service user, or break some bad news?
Places Do some places feel more hazardous than others? For example because of lay out, condition or location?
Times Are there times when a risk is more likely to be presented. For example, when it is dark, when the weather is poor, after the pubs have closed?
People Are some people more likely to pose a threat than others? For example, because of the current state of mind or condition e.g. upset drunk or having a history of violence?

There is another mental checklist that you can run through

Where	Am I going-do I know the environment? Do I know how to get there?
When	What time of day/night?
Who	Am I going to see? Do I have up to date information about them?
Why	Am I going? A routine visit, or to hand them a notice or evict them?
What	Do I expect to find when I get there/ What do I know about recent events or circumstances?
How	Am I going to react if things don't go as expected.

7. The individual risk assessment policy dated September 1999 set out the statutory background upon which the formalised risk assessment was carried out (regulation 3 of the Management of Health & Safety at Work Regulations 1992). It was noted that the policy and its associated procedures addresses the issue of carrying out personal risk assessment of existing and potential new service users. The purpose of a personal risk assessment was the assessment of client needs and their goals, ensuring the continued safety of staff members by having correct, up to date information to allow informed decisions to be made and an awareness of the risks to the service user, others and an awareness of risk factors. The policy stated:

> *'MHM recognise the importance of working with external agencies and will attempt to promote the exchange of relevant information in relation to risk assessment. Where a referral agent produces an up to date risk assessment, MHM will not duplicate the work by carrying out a risk assessment of its own. However, MHM reserves the right to carry out a risk assessment where it feels more detailed information is required".*

- ***<u>Commentary</u>***

8. *These policies, on the face of it, are robust policies in relation to the assessment of the individual service user and also in addressing the question of lone working.*

9. *MHM, by its plea of guilty in the Crown Court, admitted a significant failure in relation to the implementation of these policies. The Panel did not have the benefit of hearing from MHM 1 and MHM 2 as to the circumstances in which these were implemented a local level and, more importantly in this case, why such policies were not followed.*

10. *At the Crown Court, MHM accepted that the period during which risk assessments should have been reviewed was from 15 February 2006 until 19 May 2006. It is the Panel's view, however, that when MHM staff became aware on 19 January 2006 that CPN1 was advising joint visits, a new risk assessment should have been undertaken addressing the risks in relation to visiting P. During the course of our interview with a senior member of staff of*

MHM it was suggested that the telephone call from CPN1 to MHM 1 may not have been made. Of course, we have been deprived of the benefit of interviewing MHM 1 on this issue. Nonetheless, we are satisfied that CPN1 did inform MHM on 19 January 2006 that joint visits should now be considered and that this was as a result of a change in P's presentation. Such information was more than sufficient to trigger a review by MHM of the risks of its employees visiting P on their own.

11. *The Panel notes that at the Crown Court MHM accepted that there was a continuing failure between 15 February 2006 and 19 May 2006 to implement MHM's existing policies. A clear example of when a review should have taken place was on 18 April 2006, when MHM 1 undertook a joint visit to P. In this visit, P disclosed that he had damaged the pay phone in order to obtain money to buy cigarettes. Furthermore, on 14 May 2006, A had seen P in the street holding a bottle of vodka. P said he was "pissed". The damage to the phone and P's intoxicated state on 14 May 2006 were all factors which pointed towards a review of the lone worker policy.*

12. *On 15 May 2006 MHM 2 drafted a letter to P confirming that P would be required to pay off the sum of £236 by way of instalments at £2.50 per week. MHM 1 attempted to visit P on 16 and 17 May but there was no answer. He was therefore unable to give the letter to P on these occasions. On 17 May 2006, a team meeting took place at MHM. This was attended by MHM 1, MHM 2 and A. A took handwritten notes of the meeting. The note of the discussion about P reads:*

> *"Not accepting any medication, refusing depot injection, amassed debts, abusing alcohol, not accessing any support from the community mental health team, they are monitoring from a distance. Recently completed new DLA application for a higher rate. P divulged he had lied about the info on the form and surprisingly was successful in achieving the higher rate award. This was not backed up by his psychiatrist. Staff to monitor P before visits to establish if under the influence of alcohol, if so lone working policy should be adopted, P has*

built up [service charge] and telephone arrears. Repayment plan set up. P has received a written warning regarding wilful damage to MHM."

13. *In the light of the facts known at this meeting, it is abundantly clear to the Panel that, at this review meeting, consideration should have been given to a robust review of lone working with P and also a robust risk assessment should have been carried out. If the question had been asked* ***"Do you have some tasks that are more likely to get a difficult or confrontational reaction? For example, are you going to give notice to a service user, or break some bad news?"*** *ideas for developing risk awareness in practice set out in paragraph 6 above), the answer would have been 'yes'. If the question had been posed* ***"Are some people more likely to pose a threat than others? For example, because of the current state of mind or condition e.g. upset, drunk or having a history of violence?*** *(Ideas for developing risk awareness in practice set out in paragraph 6 above), then the answer would have been 'yes'.*

14. *It is the view of the Panel that if a robust risk assessment had been completed including a consideration of the lone working policy with P, such lone working would have been abandoned and joint visits implemented. Thus, it must follow, that A would not have been attending P's house on her own on 19 May 2006.*

15. *Even if the Panel is wrong in our assessment that the lone worker policy would have been abandoned, it is abundantly clear to us that a robust risk assessment would have considered the seniority of the person delivering the letter to P. It was, in our view, entirely inappropriate for A to have delivered the letter to P. MHM's policies clearly directed those assessing risk to consider the nature of the news or information being imparted to the service user, in this case P. The Panel notes that MHM 1 had made two previous attempts to deliver this letter to P. In our view the assignment of MHM 1 to deliver the letter was entirely appropriate. The Panel is of the view that it should not have been left to A to deliver to P what could have been a provocative letter. Regrettably we are in no position to assess whether in fact*

the delivery of the letter and the contents of that letter were significant in the events of the 19 May 2006.

16. *Whilst the Panel is critical of MHM for not carrying out appropriate risk assessments of both the lone worker policy in relation to visiting P and the general risk assessment of P's risk to staff and others, the Panel accepts that MHM may well have been influenced in the failure to assess risk by the lack of any suggestion by the mental health trust that the risk posed by P had increased or that P should no longer be visited alone. Indeed, we note that in the agreed basis of plea at the Crown Court this was specifically asserted at paragraph 40. This stated that:*

> *"At no time during the period 15 February – 19 May 2006 did trust employees advise MHM that the risk posed by P had increased above level 1 or that P should no longer be visited alone. As at 19 May 2006, the Trust, in common with MHM, were aware of the following matters, which were the significant changes in P's circumstances since the 15 February 2006:*
>
> *(a) P had refused to accept medication.*
>
> *(b) The incident when P damaged the pay phone and thereby incurred a financial penalty.*
>
> *(c) The fact that he had begun to disengage from support services.*
>
> *(d) The fact that he had increased his alcohol consumption."*

17. *Parliament has imposed specific duties on employers in relation to the health and safety of employees. These duties are non-delegable. Whilst it is understandable that some reliance may have been placed upon the trust's assessment of P's risk, such reliance could only be one factor to be taken into account by MHM in assessing risk. It could and should not have been a substitute for its own robust assessment of risk.*

18. *Equally, it is important to focus upon the role of the Trust and in particular the role in the assessment of risk in these situations. It is clear that CPN1 did regard it as important that she communicated to MHM the need for joint visits because of a change in P's presentation. The 1998 changes to the care programme approach, recommended joint risk assessments. The Panel is clear that such joint assessments are an opportunity for each party taking part in the assessment to consider the risks having regard to the service it is contracted to deliver and exchanging information. In this case the Panel saw little evidence to suggest that formal joint risk assessments were ever considered, never mind carried out.*

19. *The panel is satisfied that if risk assessments had been carried out by the mental Health trust and by MHM in the early part of May 2006 and in any event before 19 May 2006, then joint visits to P would have been implemented immediately.*

10. CONCLUSIONS

1. *In this chapter the Panel sets out the conclusions reached, with direct reference to the headings in the terms of reference of this investigation. Prior to setting out the detail of those conclusions, the Panel's primary conclusions are highlighted and drawn together. These should stand separate from the detail of the chapters examining the treatment and care received and also from body of the conclusions.*

- ***Primary Conclusions***

2. *The Panel is of the view that it is impossible to conclude with absolute certainty that the vicious attack on A which resulted in her death could have been predicted or avoided. However, the Panel is compelled to conclude that a more robust approach to the care and treatment of P, particularly from 11 April 2006 and in the days leading up to 19 May 2006, would have resulted in:*

    (a) A reassessment of his risk which would have concluded that P had relapsed.

    (b) The probability that given P's deterioration in his presentation and his relapse, P could and should been detained under the Mental Health Act 1983 and accordingly no longer in the community on 19 May 2006.

    (c) If P was not detained under the Mental Health Act 1983 in the weeks and days leading up to the 19 May 2006, a more robust care plan based on the reassessment of his risk such that by 19 May 2006, visits to P by lone workers would have ceased and only joint visits would have taken place. Whether this would have prevented the vicious attack on A is in many ways a matter of speculation; such conjecture necessarily involves the scenario that the attack on A may not have taken place if another member of staff was present with her.

3. *The Panel is of the view that over a period of 12 years, since the attack by P on his parents on 11 November 1994, there had been no clear risk formulation specifically in relation to longitudinal data, i.e. clear consideration of records of previous significant events, behaviours and influences along with their cumulative effect*

4. *The Panel is of the view that only a superficial investigation of the circumstances of P's attack on his parents was undertaken in the 12 years prior to the unlawful killing of A on 19 May 2006. It is regrettable that no clinician was sufficiently focussed in the care and management of P so as to sustain any significant investigation as to why P did in fact assault his parents and the circumstances leading up to that assault.*

5. *The Panel is of the view that throughout the period from 1994 to 2006 no analysis was undertaken by any clinician as to whether P was capable of successfully hiding symptoms. By 2006, P had a well-established history of psychotic symptoms. The clear pattern was developing of P presenting with symptoms but then rapidly denying those symptoms. On only one occasion, on 7 February 2006, did a clinician identify that P was guarded and potentially hiding psychotic symptoms or that he had a manipulative behaviour. This criticism becomes more important with the passage of time, such that by 2006, and having been flagged up, this should have been subsequently analysed against the background of P's established history of presenting with psychotic symptoms and then rapidly denying them. Such an analysis was likely to have resulted in significantly more caution being given to P's own declarations that he was not suffering psychotic symptoms and also his apparent presentation, which often confirmed that he was not suffering psychotic symptoms.*

6. *In the period since the involvement of MHM, and in particular from January 2006 onwards, there was an over-reliance by CPN1 and Consultant 7 on MHM's reporting and interpretation of P's presentation. In the context of P, MHM's role was extremely limited, providing housing support particularly in relation to the continuation of his tenancy. MHM staff did not have the experience to report upon presenting mental health symptomatology, let alone*

symptoms suggesting that P had relapsed into a psychotic episode. The over-reliance upon MHM may well have been as a result of a lack of understanding and clearly defined boundaries as to what its duties and contractual obligations were.

7. *There was a failure on the part of the care co-ordinator, CPN1, and Consultant 7 to robustly assess P's deterioration of presentation from 11 April 2006 to 19 May 2006. CPN1 and Consultant 7 remained engaged during this period and carried out a number of assessments of P's mental state. The previously identified risk factors indicating a relapse in P's condition were increasingly apparent during this period. P continued to refuse his medication. P disengaged with services towards the end of this period. The financial position, in particular his indebtedness, had not resolved and indeed in order to fund his lifestyle P damaged a telephone in his flat. P was known to be drinking during this period. From 11 April 2006 onwards a care programme approach care plan review was mandatory and this would have included a reassessment of P's risk of a relapse and a consideration of whether P should have been detained under the Mental Health Act 1983. The Panel is left with the clear impression that throughout this period a "light touch" approach was taken when P's presentation demanded a more robust intervention.*

8. *The failure to reassess the risk resulted in a failure to reconsider whether lone working with P was appropriate. Independently of the mental health trust's obligations to reassess the risk in relation to its own staff working with P, MHM were under clear obligations, imposed by statute, to also reassess risk including whether it was appropriate to continue lone working with P. The Panel is of the clear view that if a reassessment of risk had taken place, lone working would have ceased prior to 19 May 2006.*

- ***Assessment and Management of Risk***

9. *The Panel has set out its conclusions, in general terms, in the section above. However, it is necessary address these in accordance with the terms of reference of this independent investigation.*

10. *The Panel is satisfied that no criticisms can be made in relation to P's first engagement with mental health services on 6 July 1993. No obvious risks were apparent at this stage.*

11. *The Panel is satisfied that no criticism can be made as to the assessment and management of P's risks after the assault on his parents which took place on 11 November 1994. The Panel is of the view that during the continuance of the Crown Court proceedings no direct link was made between any underlying mental illness and the assault. Consultant 2 cannot be criticised for his diagnosis. At the time that Consultant 2 saw P it is likely that P was experiencing early symptoms of the onset of schizophrenia. However, it is also a possible explanation that P was experiencing frank symptoms of schizophrenia but was hiding them from Consultant 2.*

12. *P was admitted to hospital in January 1997. The Panel is of the view that P presented with clear symptoms of psychosis. He had a severe mental illness involving a loss of touch with reality, as well as delusional and hallucinatory experiences. The Panel is of the view that this was an opportunity for those treating P to analyse the 1994 assault by P on his parents. The circumstances in which this assault had taken place had, in January 1997, not been adequately investigated. It is the Panel's view that any clinician considering P's presentation could now properly have viewed the serious assault upon P's parents, as having occurred in association at a time when P had developed schizophrenia.*

13. *On 17 September 1997, P was arrested for breach of the peace. P claimed his name was Robert Windsor and he is reported to have said "Get the fucking Queen Elizabeth on the telephone at Buckingham Palace, fought at the Falklands aged 12 years for you bastards." P was noted to have been aggressive to his neighbours, had smashed up his flat and the previous assault on his father was noted. The Panel is of the view that this was the first occasion when there was clear association between severe mental illness in P and aggression. There was also an association between the manifestation of his symptoms and alcohol use. The Panel is of the view that the association between severe mental illness, aggression and the use of*

alcohol could have laid the foundation for clinicians seeing P as at risk of aggression to others when first showing symptoms of mental illness and secondly taking alcohol.

14. *In January to March 1998, P was arrested on a number of occasions for petty offences. The Panel regards the offences committed in January to March 1998 as being of some significance in the longitudinal assessment of P's mental illness. P had a history of probable severe mental illness in conjunction with violence. This was clearly not now restricted to his parents and threats were being made beyond his parents. The Panel notes that it would have been reasonable, at this time, to consider that P was capable of violence in association with symptoms of mental illness to victims beyond his family, albeit alcohol appeared to play a significant role. Furthermore, a pattern was clearly now developing of P's initial presentation with apparent symptoms of severe mental illness, being subsequently denied by P in a relatively short period. A history was also developing of P being capable of hiding his symptoms that he was in fact experiencing.*

15. *On 3 July 1998, a violence risk assessment was carried out. It was nonetheless incomplete in its conclusions. It was incomplete in that there was limited longitudinal formulation. P's mental presentation had changed over the previous 18 months. P's presentation had changed in that there was criminal behaviour at the same time that he was portraying mental illness and that this was related alcohol consumption. The junior doctor's assertion that P should not be medicated against his will was misconceived. The very purpose of detention under section 3 of the Mental Health Act 1983 was the treatment of his mental disorder. P's treatment should not have been determined by his wishes but by his assessed clinical needs and within the powers of the Mental Health Act 1983.*

16. *P's admission and detention under the Mental Health Act 1983 from June 1998 until November 1999 was a significant period of inpatient treatment for P. It was a clear opportunity to seek a comprehensive determination of P's risk of violence to others, including his mother. The Panel notes that a number of significant facts emerged during this time: the ward staff had*

expressed concerns that P may be violent if forced to receive medication; anti-psychotic medication had not had any significant effect on P; there was now a direct link between P's psychosis and the assault on his parents in 1994, it had become apparent that P was capable of hiding his symptoms most of the time and even from those treating him and being responsible for his care on a daily basis. Consultant 5, who had been invited by Consultant 4 to consider P's risk, was not of the view, at this time, that P was potentially dangerous, although in subsequent correspondence with the panel, he claimed that he was of that view. It is regrettable that if Consultant 5 was of the opinion that P was potentially dangerous in 1998, he did not say so in any correspondence or in any records viewed by the Panel. As pointed out, the Panel notes that from 19 June 1998 P was detained under section 3 of the Mental Health Act 1983 and effectively detained until his move to accommodation in November 1999. This represented P's longest period of detention under the Mental Health Act 1983. During this period a body of evidence came to light which assisted in the determination of P's underlying illness and from which a more systematic assessment and formulation of P's potential risk to others could and should have been made. There was a failure on the part of those responsible for P's treatment during this period to adequately investigate the risk that P posed to others including his mother. The failings included:

(a) Failings in communication, including record keeping.

(b) A lack of clarity between Consultant 4 and Consultant 5 as to the formulation of risk. In particular, Consultant 5 failed to express at all his concerns that P was dangerous.

(c) Superficial levels of enquiry into the relationship between P's assault on his parents, his criminality and his underlying mental illness.

17. Following Consultant 7 obtaining P's records in relation to P's previous treatment and admission, there was a home visit by Consultant 7 and CPN1 on 14 December 2005. During the course of this visit P claimed that he no longer required medication and said that he had taken it because he was told

by staff that it would help with the award of Disability Living Allowance. In addition, P asserted that his claim to have delusions was simply a ploy to help him get psychiatric treatment rather than a custodial disposal. In the assessment of risk in December 2005, a significant feature of the assessment of P by Consultant 7 and CPN1 was the absence of obvious symptoms of P suffering a psychosis. However, the panel notes that there was no evidence of any assessment by Consultant 7and CPN1 as to whether P was concealing those symptoms. By this time, Consultant 7 had received and considered the records which showed clear evidence that P was very capable of concealing his symptoms from clinicians. In the Panel's view, Consultant 7 and CPN1 had information from the records which raised the possibility that that P was capable of hiding his symptoms. In addition, Consultant 7 and CPN1 knew from the meeting on 14 December 2005 that P thought that he was also capable of making his symptoms up in the hope of avoiding a prison sentence. It is the Panel's view that the assessment of risk in December 2005 failed to identify the probability that P was relapsing into psychotic illness. P was noted to be guarded which needed to be considered within the context of the history of his ability to hide psychotic symptoms. Further, a known risk factor was that P was stopping his medication. P was in significant debt relative to his income. Whilst Consultant 7 recognised the risk of relapse, he concluded that the risk factors did not currently indicate relapse necessitating a review or a change in the current care plan. However, it is the Panel's view that there was ample evidence at this stage to indicate that P was at significant risk of relapse if in fact he had not already relapsed into his psychotic illness. In fact the events of January 2006 confirmed P's relapse.

18. *P was admitted to hospital in London on 16 January 2006. The period of admission in London was nine days. During this period, the panel notes that there was little by way of clinical assessment or analysis of the ideas that P was expressing. The Panel is the view that, even during this short period of admission, the opportunity was missed to assess P at a time when he was displaying psychotic symptoms.*

19. *P was transferred to Newcastle on 25 January 2006. P was discharged on 15 February 2006. CPN1 and Consultant 7 stated that they had a strongly held*

view that P should have been the subject of a longer period of assessment and treatment. The notes do not record Consultant 7 expressing the view but do record CPN1 as having expressed this view. However, no analysis or serious thought appears to have been given to the concerns expressed by CPN1.

20. *The FACE risk assessment prepared prior to P's discharge on 15 February 2006 showed no clear risk formulation, specifically in relation to longitudinal data. The risk assessment dated 13 February 2006 was flawed. This concluded that the assessed risk of violence or harm to others was low. Under current warning signs, there was a failure to indicate "yes" to early warning signs of relapse, ideas of harming others, threats and intimidation and absconding. There was a failure to refer to discontinuation of medication as a clear recent risk factor.*

21. *During this period of assessment under section 2 of the Mental Health Act 1983 (January – February 2006) no analysis was made as to the significance of P's capabilities to hide symptoms. By 2006 P had a well established history of psychotic symptoms. A clear pattern was developing of P presenting with such symptoms but then rapidly denying the symptoms. The Senior House Officer who examined P on 7 February 2006 gained the impression that P was very guarded and potentially hiding psychotic symptoms or that he had manipulative behaviour. It is regrettable that the possibility of P hiding psychotic symptoms was not subsequently analysed against the background of the established history of P presenting with psychotic symptoms and then rapidly denying them. This pattern of presentation occurred during the admission in January-February 2006 and was entirely similar to previous occasions.*

22. *Overall it is the Panel's view that the period of admission from January-February 2006 was a missed opportunity to make an exhaustive investigation of P's current mental state having regard to his longitudinal history i.e. a clear consideration of records of previous significant events, behaviours, influences and their cumulative effect. The Panel's view is that, at the very least, this would have informed the care plan for P's discharge into the community.*

23. P was seen by Consultant 7 on 16 March 2006. Consultant 7 vigorously asserted that there was nothing, other than the matters recorded in the discharge letter and in the records of P's attendance, to cause him any concern as to P's presentation. However, it is not clear to the Panel how Consultant 7 could have reasonably come to this conclusion. There was no analysis by him of P's presentation. The description of P was that he was guarded, irritable and demanding with a lack of warmth. This was not consistent with any prolonged period of time when P was assessed as being fully well. It is the Panel's view that at this stage P was manifesting signs of relapse but these were not heeded by Consultant 7.

24. On 11 April 2006 P was visited by CPN1. P was found to be intoxicated with alcohol, having consumed a bottle of wine and 2 cans of lager. P refused his depot injection and insisted nothing was wrong with him and that he did not need medication. It is the Panel's view that a review of P's CPA care plan was mandatory at this stage. The known risk factors of relapse were apparent. P had refused his depot injection. P was drunk. His debt situation had not improved. It is likely that a review of the CPA care plan would have opened up reconsideration of P's risk of relapse, the lone worker policy in relation to P and whether P should have been referred into the MAPPA process. It was reasonable at this stage to assume that P may start to disengage with services and with disengagement there was a risk of increased impulsivity and a more likely risk of violence. There should have been a mental health assessment of P. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant

with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage. At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol. At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

25. *By 18 April 2006 it is clear to the Panel that a review of the CPA should have been undertaken. On 18 April 2006 P was visited by CPN1 and MHM W1 and admitted that he had smashed the pay phone in order to get money out for personal use. P remained adamant that he did not want his depot injection and saw his problem as a lack of finance. It is the Panel's view that a review of P's CPA was mandatory at this stage. The known risk factors of relapse were still apparent. It is likely that a review of the CPA care plan would have opened up reconsideration of P's risk of relapse, the lone worker policy in relation to P and whether P should have been referred into the MAPPA process. It was reasonable at this stage to assume that P may start to disengage with services and with disengagement there was a risk of increased impulsivity and a more likely risk of violence. There should have been a mental health assessment of P. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage. At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol. At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the*

MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

26. On 2 May 2006 Consultant 7 visited P at his home. CPN1 was scheduled to attend at this appointment but was unable to attend because of other duty commitments. The Panel finds that CPN 1 should have attended having organised this meeting. It is the Panel's view that by this stage P was presenting with significant changes in presentation with increased risk factors and relapse triggers being apparent. P was consuming alcohol such that on the visit of 11 April 2006 he was found to be intoxicated. P was yet again refusing his depot injection. P had broken a pay phone belonging to MHM in order to get money out for personal use. A risk factor previously identified was P's indebtedness which caused him stress and an increased risk of compulsivity. The Panel finds that no great weight can be given

to P's presentation on 2 May 2006. No previous attempts by those treating P had been made to assess his tendency to hide his symptoms. By 2 May 2006 and post-discharge his admission – February 2006 P had showed continued non compliance with medication, resorted to alcohol, damaged a telephone and had significant financial pressures which were all indicators that a full review of P's risk and P's management plan should have been made. There was now a clear demand for the care co-ordinator, CPN1, to undertake a formal review of care following what were, unquestionably, significant changes in RD's presentation. The review of care should have taken place in late April early May 2006. P was in relapse, the warning factors of relapse were present and it was reasonable to assume that P would start to disengage from services, which increased the risk of impulsivity and an increased risk of violence. A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage. At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol. Further, at the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would be considered

by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

27. *On 9 May 2006, 10 May 2006 and 12 May 2006 CPN1 had visited P but there was no reply. The Panel is of the view that on each of these dates there was a clear demand for CPN1 to undertake a formal review of care following what were, unquestionably, significant changes in RD's presentation.*

    (a) P was in relapse.

    (b) The warning factors of relapse were present.

    (c) P had disengaged with services, which increased the risk of impulsivity and an increased risk of violence.

    (d) A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes. P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A

discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage. However, by now P was not compliant with his treatment in the community. P had disengaged from services. There was clear evidence that P could not be managed in the community. The Panel is of the view that by 10 May 2006 P could and should have been detained under the Mental Health Act 1983.

(e) At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment of the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol.

(f) At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred

under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

28. *On 16 May 2006 CPN1 telephoned MHM. CPN1 was informed that A had seen P was very intoxicated, claiming to be 'pissed'. P was holding a bottle of vodka and seemed unsteady on his feet. P admitted that he was "pissed" but at this stage CPN1 recorded to persevere with attempts to see P.*

    (a) *P was in relapse. The warning factors of relapse were present.*

    (b) *P had disengaged with services, which increased the risk of impulsivity and an increased risk of violence.*

    (c) *A mental health assessment should have been undertaken. The mental health assessment could lead to a variety of outcomes.*

P may have continued to be treated in the community if he agreed to be compliant with his treatment, care and support. A discussion with P may have resulted in his informal admission. Furthermore, the discussion with P could have included the possibility of detention under the Mental Health Act 1983 in the event that P refused to become compliant with his treatment, care and support and in the event that P fulfilled the criteria for detention under the Mental Health Act 1983. The "least restrictive approach" to the management of mental illness would have weighed significantly under the Mental Health Act 1983 in the event that P was compliant with his treatment, care and support. If P remained compliant with his treatment in the community it is unlikely, however, that P would have been detained under the Mental Health Act 1983 at this stage. However, by now P was not compliant with his treatment in the community. P had disengaged from services. There was clear evidence that P could not be managed in the community. The Panel is of the view that by 10 May 2006 P could and should have been detained under the Mental Health Act 1983.

(d) At the same time that a CPA care review was being undertaken, there should have been a review of the lone working policy and co-ordination with MHM on this by either including MHM in such a review or informing MHM of the outcome of the review. The Panel is of the view that a robust assessment the risk of visiting P alone on this occasion would have lead to lone working with P being terminated and joint working implemented. The risk to staff from the Trust and MHM was increased when P was consuming alcohol.

(e) At the same time that a CPA review was being undertaken, there should have been consideration given to whether P should have been processed under the MAPPA arrangements then in existence in the Northumbria area. The Panel is of the view that P could have been referred because under Category 3 P would

be considered by the responsible authority to pose a serious risk of harm to the public. Because P would have been referred under category 3, P could only have been managed under level 2 – local inter-agency risk management. Level 2 risk management should be used where the active involvement of more than one agency is required but where either the level of risk or the complexity of managing the risk is not so great as to require referral to level 3. Level 2 management is an example of managing risks which can and will change. The guidance states that the MAPPA provides the framework which those changes, particularly when they concern the serious risks offenders can present, can be effectively and consistently managed. The essential feature of level 2 arrangements is that the permanent membership should comprise those local agencies which have an active role to play in risk management. The guidance notes that the following agencies routinely play an active role in level 2 management; social services departments, housing authorities, housing providers, young offender teams, the relevant health authority, including the mental health trusts and probation victim contact teams or appropriate agencies. The Panel interviewed the HPP 1 the Head of Public Protection for the Northumbria Probation Trust, who confirmed that P, if referred would have been managed through MAPPA. The Panel is of the view that if a referral had been made a more robust multi agency care plan would have been in place.

- ***Treatment, Care and Implementation of the Care Plan***

29. *There is a close connection between the assessment and management of risk, treatment, care and implementation of the care plan.*

30. *The inevitable consequence of a flawed assessment of risk made over a number of years is that the subsequent treatment, care and risk management plan were less effective in delivering appropriate treatment and care for the*

patient. However, the primary criticism relates to the implementation of the care plan under the CPA which was both defective and ineffective.

31. *The central plank of the Panel's concern, however, is the failure on a number of occasions post 15 February 2006 to review the care plan in the light of changed circumstances. The Panel is very conscious that the judgments and conclusions we have reached are made with the significant benefit of hindsight, in the knowledge of an untoward incident and without the pressures of day to day practice issues limiting the time available for each patient. Nonetheless and even with this caveat the Panel has identified a number of dates when P's presentation was such that P could objectively be regarded as in relapse and which should have triggered more robust intervention.*

32. *In addition, the responsibility for the implementation of P's care plan was significantly, and inappropriately, reliant on MHM's reporting of mental health symptoms. It is the Panel's view that the reliance upon MHM to report and assess the significance of changes in P's mental health presentation, in a case where the case records report that P's presentation was complex, was misguided and inappropriate. The respective roles of the Trust and MHM were not clearly defined in practice. MHM's role should have been limited to ensuring that P maintained his tenancy at his flat in Heaton.*

- ***Standards of Record Keeping and Communication Between All Interested Parties***

33. *On a number of occasions the records do not demonstrate the basis for clinical decision making. In this regard, the Panel notes*

    (a) *That between Consultant 4 and Consultant 5, and during P's extensive period of admission in 1998 to1999, there was a fundamental failure in communication with the result that the analysis of P's dangerousness was never concluded and never properly investigated. In this regard, it is regrettable that Consultant 5 did not clearly state in his correspondence to Consultant 4 that he was of the opinion that P was dangerous. Instead any objective reading of the letters sent by Consultant 5*

to Consultant 4, would result in the reader concluding that Consultant 5 was not satisfied that P was dangerous.

(b) There was no analysis in the records in February 2006 as to the clinical decision making which lead to the rejection of the concerns of CPN1, expressed at this time, that P should be detained for a longer period for the assessment of his underlying mental health.

(c) Record keeping in relation to the assessment of risk with lone worker policy in relation to P is non-existent. At no stage post January 2006 was any written assessment of risk made by either CPN1 or any person at MHM in relation to lone working with P.

(d) The Panel has found only one incident of poor oral communication between teams. When CPN1 became aware that P was detained in London in January 2006 she made contact with the ward. However, because of language barriers, she felt that she was unable to communicate in any meaningful way, P's past history nor was she able to receive, in any meaningful way, any worthwhile information as to P's presentation.

- ***Interface Between Mental Health Services and Other Agencies***

34. The Panel's main focus has been on the relationship between the mental health trust employees, CPN1 and Consultant 7, and Mental Health Matters. In the context of the provision of services to P, MHM was essentially a housing support charity. As a charity providing housing related support for vulnerable adults MHM had a contract with Newcastle City Council's supporting peoples services. The aim of this provision was to support and to assist people to manage and maintain their accommodation. This often requires practical support such as helping service users understand the obligations under their tenancy agreements, helping people to be good neighbours and general practical advice on maintain property. MHM was not

engaged in this case as a care agency supporting P. From the documentation the Panel has received and furthermore from the interviews of CPN1 and Consultant 7, the Panel has formed the clear view that there was a misplaced but substantial over reliance by Consultant 7 and CPN 1 upon MHM staff reporting to CPN1, in particular, on the issue of P's clinical signs. The core role of MHM was to support P to maintain his housing status. The reliance on MHM staff to report on P led to a situation where P's mental state was never properly established or assessed on a regular basis. It was, in our view, wholly inappropriate to rely upon MHM as the conduit for reporting on P's mental state and clinical signs. On any analysis P's mental presentation was complex and, in any event, P was more than capable of hiding this. MHM staff did not have the training or the skills to assess and reliably report to CPN1 on P's mental stability.

35. *Despite the care programme approach (CPA) encouraging joint risk assessments, there was no evidence before Panel that the benefits of such joint working had been implemented or heeded in relation to P. The most obvious area of joint working was the assessment of P's risk to staff of the Trust and MHM. However, no such joint assessment was, in reality, ever undertaken.*

- ***The Extent to which P's care corresponded with Statutory obligations and relevant guidance from the department of health***

36. *The Panel is of the view that the statutory obligations and the guidance issued by the Department of Health was followed in all local policies issued and circulated by the trust.*

37. *There was, however, a significant failure to have regard to those policies in relation to the care and treatment of P, particularly from January to 19 May 2006. A number of changes in P's presentation in this period should have engaged a whole range of guidance and policies, whether under the CPA, lone worker policies, aggression and violence at work, the management of patients who were disengaging from services or non-compliant or the multi agency public protection arrangements (MAPPA) procedures. The national guidance was distilled in clear policies issued by the mental health trust,*

which, if they had been followed, would have led to a more focussed and robust care plan for P in this period.

11. RECOMMENDATIONS

1. *The Panel has found that there was an inconsistent implementation of the care programme approach (CPA) organisational policy at key points in P's care. Although the Panel do not see the need for organisational review of the local CPA policy, the mental health trust should review its assurance arrangements to ensure that all staff consistently follow policy. In this regard the Panel notes that the CPA is underpinned by a multi disciplinary team approach and all professionals involved in the CPA have a responsibility to ensure individual and team compliance.*

2. *The Trust should amend the existing policy framework to provide a clear and measurable assurance system.*

3. *The trust should formally review its risk assessment and management learning framework to ensure the use of longitudinal data as a key component in a systematic model of risk formulation to ensure a clear consideration of records of previous significant events, behaviours and influences along with their cumulative effect. An assurance framework must be established to monitor the impact of this revised learning framework.*

4. *There should be greater inter-agency role clarity. In particular the specific role of outside agencies should be clarified and documented within a patient's records so that there is a clear understanding between a clinical team and outside agencies as to the role each has to play.*

5. *The policy framework issued by corporate management to line managers and staff should be followed consistently. It is of particular importance that trusts monitor and ensure, by way of regular audit, compliance with policy on a continuing and enduring basis.*

6. *There should be a review of the effectiveness of communication systems in place between the Trust and other agencies involved in care provision using the CPA framework.*

7. *There should be a review of the compliance with and the effectiveness of lone worker's safety procedures in particular having regard to the reliance that outside agencies may place upon the assessment of risk by clinical teams.*

8. *That there should be a review of the internal reporting in relation to serious untoward incidents. In particular, the Trust should seek to ensure that root cause analysis remains the focus of such internal investigations, which should be carried out robustly so as to ensure that failures are highlighted as soon as possible.*