VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr P

A report for

NHS South of England (formerly NHS South East Coast)

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1. Introduction

1.1 On the evening of 26 June 2005 Mr P, Mr Q (the victim) and another man went to Pewley Down, Guildford. Mr P reportedly pushed Mr Q to the ground before picking up a stick and battering Mr Q to death with it.

1.2 All three men were living at a shelter for homeless people at the time of the killing.

1.3 Mr P was known to Surrey and Borders Partnership NHS Trust[1] from September 1999. He had been admitted to hospital in December 2000, January 2003 and October 2003. During the January 2003 admission, Mr P was detained under Section 2[2] and subsequently Section 3[3] of the Mental Health Act 1983.

1.4 Mr P has a history of drug use with varying diagnoses of personality disorder, schizophrenia, and acute psychotic ideation. Mr P was difficult to engage with mainly because he was homeless. He was not open about his whereabouts and often gave false addresses.

1.5 The trust's internal investigation report states that Mr P had numerous contacts with the police and several episodes in prison. The nature of his offences indicate that he had a propensity towards violence.

1.6 In May 2005 Mr P's GP referred him to Guildford Community Mental Health Team (CMHT). Mr P failed to take up offers of appointments and was therefore discharged.

1.7 In September 2005 the chief executive of Surrey and Borders Partnership NHS Trust commissioned an internal investigation into the care and management of Mr P. The investigation was carried out by five trust staff, a service user representative and an external consultant psychiatrist. The internal investigation panel did not meet with Mr P or his family, nor did they meet with the family of the victim.

[1] The trust was formed on 1 April 2005 following the merger of Surrey Hampshire Borders NHS Trust, Surrey Oaklands NHS Trust and North West Surrey Partnership NHS Trust. It achieved foundation trust status on 1 May 2008.
[2] Section 2 of the Mental Health Act is an assessment order and allows compulsory admission for assessment, or for assessment followed by medical treatment, for up to 28 days.
[3] Section 3 is similar to section 2, only the detention is for treatment and may be for a duration of up to six months, although this can be extended.

1.8 The internal investigation report was completed in January 2006 and made seven recommendations which were directed at managerial and operational matters. Its findings were not shared with Mr P, his family or the family of Mr Q.

1.9 Mr P pleaded guilty to manslaughter on 19 February 2007 at the Old Bailey. He was detained indefinitely under the Mental Health Act and admitted to Broadmoor Hospital.

1.10 In 2011 NHS South East Coast, the responsible strategic health authority, commissioned Verita to carry out this independent investigation into the care and treatment of Mr P.

1.11 Amber Sargent, senior investigator for Verita has carried out the investigation supported by Ed Marsden, managing partner. Expert advice was provided by Dr Douglas Gee, consultant psychiatrist and medical director of Humber NHS Foundation Trust.

1.12 Derek Mechen, partner, peer-reviewed this report.

2. Terms of reference

2.1 This independent investigation is commissioned by NHS South East Coast (now part of NHS South of England) with the full cooperation of Surrey and Borders Partnership NHS Foundation Trust (the trust). It is commissioned in accordance with guidance published by the Department of Health in HSG 94(27), *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-6 issued in June 2005. It also takes into account the good practice guidance issued by the National Patient Safety Agency in February 2008.

2.2 The investigation will provide independent scrutiny of the care of Mr P largely by means of a documentary review. The investigation will be conducted by a single investigator, supported by a peer reviewer. The work will be conducted in private and take as its starting point the trust's internal investigation.

2.3 The documentary review will examine the following areas.

- The internal investigation, including the methodology, appropriateness of the panel members, the interviewees and the evidence considered.

- The extent to which care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies, in particular:

    - the adequacy of any risk assessments and risk management plans carried out for Mr P, specifically any relating to his long forensic history and the potential for him to harm others

    - any relevant gaps or issues found which were not investigated as part of the internal investigation in relation to the care and treatment provided to Mr P, from his last episode of care with services to the time of the offence on 26 June 2005

    - the care programme approach and how it was carried out in relation to Mr P's care and trust policy

- the progress made against the recommendations from the trust's internal investigation

- any new developments or improvements in services since Mr P's engagement with mental health services.

2.4 A report will be written for NHS South East Coast that includes:

- a general overview of the care and treatment of Mr P from his first contact with services. This will be followed by a detailed chronology of events of the last episode of care leading up to the offence[1]

- an analysis highlighting any missed opportunities and findings based on the evidence received

- any areas of notable good practice, new developments or improvements put in place since this incident which are relevant to this case

- measurable, achievable recommendations for action to address the learning points to improve systems and services.

[1] We have taken his last episode of care from January 2003 as he was never discharged from the care of mental health services between this time and the offence in June 2005.

3. Executive summary and lessons to be learnt

Executive summary

3.1 On the evening of 26 June 2005 Mr P, Mr Q (the victim) and another man went to Pewley Down, Guildford. Mr P reportedly pushed Mr Q to the ground before picking up a stick and battering Mr Q to death with it.

3.2 Mr P had been known to mental health services since 1997. He was under the care of consultant psychiatrist 1 and social worker 1 at the time of the offence. Mr P had not seen either of them since January 2005, three months before the offence.

3.3 In September 1999 consultant psychiatrist 2 reviewed Mr P at the Abraham Cowley Unit[1] following an accident and emergency (A&E) presentation. Possible diagnoses were recorded as mild depressive disorder and personality disorder. Longstanding coping problems, cannabis use and heavy alcohol consumption were identified. Mr P was treated with antidepressant medication and discharged.

3.4 In October 2000 Mr P was remanded in HMP Youth Offending Institute (YOI) Feltham for breaching his bail conditions following charges of burglary, robbery and affray.

3.5 Throughout October and November, while in prison, Mr P reported persistent and intrusive auditory hallucinations. On 4 December 2000 Mr P was assessed by locum psychiatrist 1, locum consultant in forensic psychiatry. Locum psychiatrist 1 was of the view that Mr P was suffering from paranoid schizophrenia and recommended that Mr P was placed under a hospital order using Section 37 of the Mental Health Act 1983. Mr P was subsequently transferred to the Abraham Cowley Unit.

3.6 On 4 January 2001 Mr P absconded from the Abraham Cowley Unit. He was arrested the next day and returned to prison. Consultant psychiatrist 2 considered that Mr P had suffered a brief but real psychotic episode characterised by paranoid experiences, depressive feelings and auditory hallucinations. Mr P made a quick recovery after he was

[1] A specialist mental health unit based at St Peter's Hospital in Chertsey, providing treatment and support to inpatients. It is run by Surrey and Borders Partnership NHS Foundation Trust.

given sedative antipsychotic medication. He served the remainder of his sentence in prison and was released on licence[1] on 10 July 2002.

3.7 Between 4 January 2003 and the end of August 2003 Mr P was an inpatient at the Abraham Cowley Unit. During his eight month inpatient stay Mr P was, at various times, subject to Sections 2, 3 and 5(2)[2] of the Mental Health Act. Throughout this period Mr P was assessed as suffering from schizophrenia.

3.8 On 21 January 2003 Mr P was put on a Section 5(2) as he was threatening to discharge himself and carry out his "*mission*" (which involved visiting his parents in Essex and "*healing them*" by cutting out and eating their hearts). Later that day he was transferred to Laureate Ward[3] under Section 2 of the Mental Health Act.

3.9 On 31 January 2003 Mr P was seen for the first time by psychologist 1, counselling psychologist for the forensic service. He was seen on a weekly basis thereafter, until July 2003.

3.10 On 24 February 2003 the Abraham Cowley Unit referred Mr P to the Windmill Community Drug and Alcohol Team[4]. The referral form stated that Mr P recognised his mental state deteriorated when he was under the influence of drugs but he needed assistance in abstaining from future drug use.

3.11 On 2 March 2003 Mr P absconded, having been given leave to eat in the hospital restaurant. He later told consultant psychiatrist 2 that a thought came into his head whilst eating lunch that it was poisoned. At that point he decided to murder his parents. He took

[1] If an offender is sentenced to more than 12 months in prison, they may be released early on licence. Being on licence means that the offender is still serving a prison sentence but they can live in the community instead of being in prison. Whilst on licence, there are rules that must be followed (such as maintaining regular contact with a probation officer). If the rules are broken the offender may be recalled to prison.
[2] Section 5(2) is a doctor's holding power. It can only be used to detain a person in hospital who has agreed to informal admission but then changed his mind and wishes to leave. It can be implemented following an assessment by a hospital doctor, including psychiatrists, but also those based on medical or surgical wards. It lasts up to 72 hours, during which time a further assessment may result in either discharge from the section or detention under a Section 2 assessment order or Section 3 treatment order.
[3] Psychiatric Intensive Care Unit with seven beds serving Surrey Heath and North East Hampshire.
[4] Windmill house is a drug and alcohol inpatient service providing detoxification and stabilisation, residential rehabilitation or residential crisis intervention. It has 12 beds and provides a 24-hour inpatient detoxification service.

a train to Essex where his father and step-mother lived. He knocked on the door but there was no answer. He then returned to the Abraham Cowley Unit.

3.12 On 10 March 2003, consultant psychiatrist 2 completed a medical report for a mental health review tribunal[1]. Consultant psychiatrist 2 recorded that Mr P suffered from brief paranoid psychotic episodes in which he exhibited delusions of a violent nature including passivity phenomenon. This made him dangerous. Mr P lacked insight during these episodes and declined medication.

3.13 On 30 June 2003, consultant psychiatrist 1 completed a medical report for the mental health tribunal review of Mr P. In the report consultant psychiatrist 1 stated that he had concerns with regard to Mr P's risk to the public. Mr P had recently used cannabis which he admitted made him paranoid. Consultant psychiatrist 1 reported that Mr P was feeling less impulsive and that he had been able to control his desire to abscond. He remained free of psychotic symptoms. Mr P went on leave at the end of August and did not return.

3.14 On 25 October 2003 Mr P presented at the A&E department at St Peter's Hospital, Chertsey, asking to see a psychiatrist. He appeared anxious and said that he was hearing voices and feeling suicidal.

3.15 Mr P had been living with his pregnant partner and reported having thoughts of cutting the baby out of her stomach. He said that he stopped taking quetiapine around three weeks ago. He was admitted informally to Blake Ward[2] and was re-started on quetiapine.

3.16 On 27 October 2003 Mr P was discharged from the Windmill Drug and Alcohol Service as he failed to attend appointments.

3.17 On 16 December 2003 Mr P was discharged from Blake Ward after other patients alleged that Mr P was bringing cannabis onto the ward. He denied the allegations but refused to give a urine sample. Mr P was given two weeks' medication and discharged.

[1] The tribunal is the 'court' which convenes at the hospital at which the patient is detained and which determines whether the grounds for detention under the Act continue to exist. The panel consists of three members: the medical member, usually a consultant psychiatrist; the legal member; and a lay member.

[2] Blake ward is an inpatient mental health ward serving adults aged between 18 and 65 in the Woking - Runnymede - West Elmbridge and Spelthorne areas.

3.18 On 25 December 2003 and 9 February 2004 Mr P was seen in the A&E department of St Peter's Hospital. On the first occasion Mr P said that he had run out of medication and that he was hearing voices. Temporary accommodation and a quetiapine prescription were arranged. On the latter occasion, Mr P refused all assistance. Consultant psychiatrist 1 considered that Mr P's presentation was his way of reengaging with trust services and the offer of a follow-up appointment and assistance was left open to him.

3.19 On 23 February 2004, consultant psychiatrist 1 wrote to Mr P's GP having seen Mr P on 9 February 2004 along with CPN 1. Consultant psychiatrist 1 was of the view that Mr P "*malingers*" symptoms of psychosis in the hope that he would be detained in hospital. Consultant psychiatrist 1 did not think it would be helpful to admit Mr P again at that stage.

3.20 On 8 March 2004 consultant psychiatrist 1 interviewed Mr P at HMP Highdown (Mr P had been arrested and remanded in custody for breaching his bail conditions). Consultant psychiatrist 1 did not consider Mr P to be suffering from schizophrenia but instead that he had brief transient psychotic reactions to drug misuse. It was also reported that Mr P refused to reengage with mental health services.

3.21 On 24 September 2004 social worker 1 was contacted by police from Farnham Domestic Violence Unit. Mr P's pregnant partner had made a statement that Mr P had threatened to kill her and her unborn baby if she left him.

3.22 On 20 December 2004 Mr P presented at the A&E department of the Royal Surrey County Hospital and was seen by the crisis team. Mr P described a history of intermittently hearing voices with the voices becoming more intense. Over the past two days they were continuous and aggressive. The voices had been telling him to kill his family and rip their hearts out. The previous week Mr P assaulted a stranger at the train station because voices told him he was going to push him onto the tracks. He was assessed by a CMHT nurse, who reported the outcome to the A&E doctor. Mr P was subsequently discharged and encouraged to register with a GP.

3.23 On 13 January 2005 Mr P was seen by consultant psychiatrist 1 and social worker 1. Mr P was described as having been free of symptoms for several months and no longer on psychiatric medication. There were no signs of mental illness.

3.24 On 6 May 2005 Mr P's GP referred Mr P to Guildford CMHT. The referral was marked as 'routine' (response required within 10 working days). Mr P's risk to others was considered to be low. The referral documentation stated that Mr P had a history of schizophrenia and had originally been taking quetiapine. It also recorded that Mr P is worried that people are controlling him. The form indicated that the GP had no information about Mr P's past convictions, drug use or involvement with other agencies.

3.25 On 31 May 2005 Mr P failed to attend an appointment with social worker 2 from Guildford CMHT. Social worker 2 subsequently discussed Mr P's case with a member of staff at No. 5 Project[1], where Mr P was living. Housing staff had no concerns but social worker 2 offered Mr P a further appointment for 7 June. Mr P failed to attend this appointment.

3.26 On 20 June 2005 Mr P was discharged from Guildford CMHT by social worker 2 due to his non engagement. A letter confirming this was sent to Mr P's GP, and staff at the No. 5 Project were also informed.

3.27 One week later, on 27 June 2005, a member of the public found Mr Q's body at Pewley Down, near Guildford.

3.28 Later that week Mr P and another man were arrested and Mr P was charged with murder at Guildford Magistrates' Court.

3.29 On 19 February 2007 Mr P pleaded guilty at the Old Bailey to the manslaughter of Mr Q. He was detained at Broadmoor Hospital indefinitely under the Mental Health Act.

The trust internal investigation

3.30 In September 2005 the chief executive of Surrey and Borders Partnership NHS Trust commissioned an internal investigation into the circumstances leading up to the incident on 26 June 2005. The investigation was carried out by five trust staff, a service user

[1] No.5 Project is an emergency accommodation night shelter with beds available for 14 men and 2 women in Guildford, Surrey.

representative and an external consultant psychiatrist. The internal investigation panel did not meet with Mr P or his family, nor did they meet with the family of the victim.

3.31 The scope of the review was limited because it was done during the criminal proceedings, but it still contained helpful insights into the care and treatment of Mr P.

3.32 The review found deficiencies in risk assessment and risk management, record keeping, communication, use of Section 117[1] of the mental Health Act, management of non-engagement, and the involvement of drug and alcohol services in Mr P's care. Despite these shortcomings, the review team concluded that the incident itself would probably not have been prevented by the actions or omissions of the team and services involved in Mr P's care and treatment.

3.33 The internal review report was completed in January 2006 and made seven recommendations that were directed at managerial and operational matters. Its findings were not shared with Mr P, his family or the family of Mr Q.

3.34 The trust compiled an action plan to address the seven recommendations and supplied evidence to show progress on completion.

Lessons

3.35 Given the incident took place in 2005, the comprehensiveness of the trust's internal action plans and the evidence provided to demonstrate changes in practice, we have chosen not to make any recommendations in this case. Instead we have identified seven areas in which the trust should continue to focus its efforts on improving and evaluating practice.

Risk assessment and management

L1 The trust should continue to ensure, through personal development plans and supervision, that all staff in direct contact with patients receive training in the

[1] Section 117 states that aftercare services must be provided to patients who have been detained in hospital for treatment under Section 3, under a hospital order pursuant to Section 37 (with or without a restriction order), following transfer from prison under Section 47 or 48.

assessment, planning and management of risk. The trust should ensure that staff receive risk assessment training and are declared competent before conducting any risk assessments. Compliance should be audited no less than every three months by the clinical governance team. Findings should then be reported to the trust board at appropriate times, as defined by the trust's governance processes.

L2 The trust should assure itself that the current process for Care Programme Approach (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report its findings to the board.

L3 The trust should ensure that all staff adhere to its policy and procedure for managing formal and informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments.

Partnership working

L4 The trust should continue to develop relationships with partnership agencies. This should include reviewing the protocols with partnership agencies to ensure effective communication and information sharing for the safety of patients and the general public e.g. information to service providers such as housing associations and hostels. This should take place within the next three months.

L5 The trust should continue to encourage risk panel meetings. In circumstances where there is significant uncertainty about an individual patient's diagnosis and/or treatment plan, these cases should automatically be discussed in an appropriate forum, with other clinical colleagues, to assist in developing an appropriate care and risk management plan.

Personality disorder service

L6 The trust should monitor and review the newly-developed personality disorder initiatives to ensure that all staff, medical and otherwise, are aware of what personality disorder services are available, how to refer, and the waiting time for referral. This should

include knowledge of the referral process and criteria for referring service users to the personality disorder service for assessment.

Internal investigation finding

L7 Point 4 of the trust's action plan states that the trust has delivered Historical, Clinical, Risk Management – 20 (HCR-20)training in response to the need to ensure that formalised risk assessment and management processes, including assessment of longitudinal risk over longer time periods, are in place and effectively used. However, HCR-20 is one tool for assessing risk and the trust needs to ensure that robust mechanisms are in place to support the actual management of risk.

4. Approach and structure

Approach to the investigation

4.1 The investigation was undertaken in private. It comprised a review of documents related to Mr P's care and an interview with the medical director, the deputy medical director and the director of quality and performance about the progress against recommendations made in the internal report. We did not interview any staff directly involved in Mr P's care and treatment, as Mr P's records were comprehensive and we considered the internal investigation reports and supporting papers to be of a good standard.

4.2 The chronology of the report is based largely upon information shared with trust psychiatrists by Mr P throughout his care and treatment. We have not sought to establish the accuracy of the information provided.

4.3 We had full access to the trust's papers produced at the time of the internal investigation. The trust prepared an up-to-date action plan. This included the original recommendations and the supporting documents to show what has changed in the intervening years.

4.4 We met Mr P at the outset of the investigation and explained the nature of our work. He gave us an account of his engagement with mental health services leading up to the offence. Mr P gave his written consent for us to access his medical and other records for the purposes of the investigation. We told him that the SHA was likely to publish the report in some form. Mr P was given the opportunity to comment on a draft of this report before it was finalised.

4.5 As the terms of reference specify that this investigation should be a documentary review with interviews taking place with senior trust managers only to assess the progress of implementing recommendations from the internal report, we have not met with the perpetrator's or victim's families.

4.6 Within the main body of the report our findings from interviews and documents are in ordinary text and our comments and opinions are in ***bold italics***. This does not apply in section 6 as this analysis section largely consists of comment and opinion.

Structure of this report

4.7 Section 5 sets out the details of the care and treatment of Mr P. Whilst the terms of reference state that this investigation will primarily focus on Mr P's last episode of care before committing the offence in June 2005, we have included a full chronology of his care in order to provide the context in which he was known to trust services.

4.8 Section 6 examines, in greater detail, the themes arising from Mr P's care and treatment.

4.9 Section 7 reviews the trust's internal investigation and reports on the progress made in tackling the organisational and operational matters it identified.

4.10 Section 8 sets out our overall analysis and learning points.

5. The care and treatment of Mr P

1981 to 1995: family background

5.1 Mr P was born in 1981 in Chertsey, Surrey to an English mother and an Asian father. His mother left the family home when Mr P was two years old. He was raised by his father in Woking with his younger brother.

5.2 When Mr P was nine years old he moved from Woking to London with his father. Mr P's father remarried when he was 11. Mr P had a poor relationship with his step-mother. He felt neglected by his father and reported suffering verbal and physical abuse from him. Mr P had three step-sisters and three step-brothers.

5.3 Mr P displayed signs of behavioural problems including refusal to go to school. At 12 years old he was expelled from school for setting fires, abusive behaviour and assaulting a teacher.

5.4 In 1993, Mr P ran away from home and went to stay with his birth mother but she asked him to leave after a short time and he returned to his father's address.

5.5 At the age of 14, after a period of escalating family tension, Mr P packed his bags to leave and following an argument threw his father down the stairs and hit his step-mother over the head. His father suffered minor fractures and his step-mother needed 18 stitches[1].

12 November 1997: first contact with mental health services, London

5.6 On 12 November 1997 Mr P presented at St George's Hospital[2], London, after taking an overdose of 56 antihistamine tablets. He was 16 years old. Mr P had been feeling low in mood for two weeks due to being unemployed, having difficulty obtaining benefits and long-standing problems with his family. He was living rough, drinking a large number of cans of strong lager a day and occasionally taking amphetamines. He described this

[1] A list of Mr P's violent behaviour can be found at Appendix A
[2] St George's Hospital is part of St George's Healthcare Trust and is an acute hospital.

episode as an impulsive suicide attempt. He had his stomach pumped in the A&E department. Mr P subsequently discharged himself.

5.7 Three days later a psychiatric liaison nurse at Clare House, St George's Hospital, referred Mr P to the adolescent service. Adolescent psychotherapist 1 was due to meet with Mr P at Clare House on 18 November but Mr P presented again at the A&E department before the meeting could take place.

18 November 1997: first inpatient episode of care, London

5.8 On 18 November 1997, six days after his first contact, Mr P presented at the A&E department of St George's Hospital saying that he would kill himself if he was discharged. He was admitted to Crocus Ward[1] at Springfield Hospital which is run by South West London and St George's Mental Health NHS Trust.

5.9 Mr P remained in hospital for two weeks. He did not display any abnormal behaviour on the ward and there was no evidence of psychosis or clinical depression. He said that he felt as though he would kill himself if he had to leave hospital but did not know why.

5.10 On 24 November 1997 adolescent psychotherapist 1 wrote to the duty manager at Wandsworth social services stating that, in his opinion, Mr P should not be on an adult psychiatric ward. He stated that there was no clinical evidence of the presence of a psychiatric illness. He said that the adolescent service was happy to offer therapeutic support, but that Mr P's primary need was accommodation.

5.11 On 27 November 1997, towards the end of Mr P's admission and while negotiating new accommodation, he absconded from the ward. He told friends that he was going to the railway station to commit suicide. He briefly returned to the ward the next day but then left to spend the night with a friend. Mr P did not return to the ward. Ward staff were informed the next day by the social service team that Mr P had accepted a hostel placement.

[1] Crocus ward treats people with schizophrenia, depression, anxiety, bi-polar diosorder, eating disorders, substance abuse, psychosis, personality disorder, self-harm and organic disorders. Treatments involve assessment as well as psychological and pharmacological methods.

5.12 A registrar completed a discharge summary on 27 November 1997. It stated that Mr P's care had been taken over by consultant psychiatrist 3's adolescent psychiatric team. A copy of the discharge summary was sent to Mr P's GP, consultant psychiatrist 3, the CMHT and social services.

5.13 Mr P was treated briefly with fluoxetine whilst in Springfield Hospital but stopped taking it upon discharge.

Comment

Mr P spent two weeks in hospital as an informal patient. He was only 16 years old but was treated by adult services. However, the plan was for Mr P to be followed up by the adolescent service on discharge. We have not sought to explore any potential safeguarding issues as this episode of care occurred outside of Surrey and Borders Partnership NHS Trust's services.

The psychiatric team did not consider that Mr P was suffering from a significant mental illness at that time, but, rather that his presentation was a manifestation of long-standing behavioural problems exacerbated by a difficult upbringing. Despite the lack of psychotic or depressive symptoms, Mr P was treated with fluoxetine which may have given Mr P a mixed message about his diagnosis and treatment needs.

Late November 1997 to September 1999

5.14 Shortly after being discharged from Springfield Hospital, Mr P was involved in two separate violent altercations. On both occasions he stabbed young men in the leg with a knife. Mr P was arrested for possession of a knife and was placed in a children's home. He remained in the children's home for approximately three months before being placed with a foster family.

5.15 Between January and April 1998 Mr P received cautions for two counts of theft, one for possession of a knife, and a further caution for burglary.

5.16 Mr P had a poor relationship with his foster father and became physically violent towards him on at least one occasion. Mr P also burgled his foster parents' house.

5.17 Mr P went to live in bed and breakfast accommodation where he frequently became involved in fights. He then had a brief period of living on the streets before going to his birth mother's address in Woking, Surrey. He reported that things were going well until his mother's boyfriend no longer wanted him there. When he was told to leave he hit his mother's boyfriend in the face with a cricket bat resulting in a fractured jaw, cheek bone and broken nose.

5.18 In Woking, Mr P began a relationship with a female friend of his mother who was 23 years his senior. She was known to mental health services.

5.19 In February 1998 Mr P secured accommodation at the Woking Close Family Resource (Wandsworth social services). He agreed to have weekly psychotherapy sessions with adolescent psychotherapist 1, adolescent psychotherapist.

5.20 In April 1999 Mr P went to a psychiatric unit in south west London to see his girlfriend. The doors were locked and Mr P broke the glass of the door to gain entry.

Comment

Between November 1997 and September 1999 Mr P was often of no fixed abode and his propensity for violence was increasing.

Despite Mr P disclosing heavy alcohol and drug use during his first A&E admission on 12 November 1997 there was no consideration of the impact continued drug and alcohol use would have on his mental health or risk. Nor was there a plan put in place to manage this risk.

2 September 1999 to 9 September 1999: second episode of care and first presentation to services provided by Surrey and Borders Partnership NHS Trust

5.21 On 2 September 1999, aged 18, Mr P was seen in the A&E department of St Richard's Hospital, the Royal West Sussex NHS Trust, and was transferred to the Abraham Cowley Unit, Chertsey, for assessment.

5.22 Mr P was expressing ideas of harming himself and others. He was assessed by psychiatric specialist 1 and consultant psychiatrist 2. They recorded that Mr P was paranoid and that he heard his name in strangers' conversations. He was anxious about life in general and experienced panic attacks. Mr P had difficulty controlling his aggression and disclosed that he had been physically aggressive towards others in the past.

5.23 Mr P told the assessing doctors that he had had no contact with either of his parents for some time and was drinking three bottles of whisky a week. He disclosed that he used to take crack cocaine but had stopped 18 months ago.

5.24 He was reported as saying "*I know I'm ill*" and asking for help. At this point the possible diagnoses were recorded as:

> *"1) Depression with psychotic symptoms*
> *2) ? Personality disorder"*

5.25 After assessment on Blake Ward Mr P was admitted to Laureate Ward as an informal patient. He was given properidol and lorazepan. He also started on sertraline, an antidepressant. He settled quickly on the ward and consultant psychiatrist 2's team made a primary diagnosis of a mild depressive episode.

5.26 Mr P was considered by consultant psychiatrist 2's team to have an adjustment disorder resulting from his life difficulties superimposed on personality disorder of an unstable type with impulsive aggression. Longstanding coping problems were identified as well as cannabis use and consumption of approximately 26 units of alcohol a week. The team assessed that Mr P had poor coping abilities and was vulnerable to stress as a result of personality disorder.

5.27 There is no documentary evidence to suggest that Mr P was considered as needing to be managed under the Care Programme Approach (CPA) at this time.

5.28 On 9 September 1999 Mr P was discharged. The senior house officer (SHO) to consultant psychiatrist 2 completed a discharge summary. The plan for follow up was for Mr P to be seen by psychiatric specialist 1 in his outpatient clinic. As Mr P did not have anywhere to live, he was given a letter to take to Woking Borough Council asking for help in finding accommodation. Due to the short notice, the council was unable to accommodate him for 28 days. Mr P subsequently found temporary accommodation with a friend.

Comment

The clinical staff did not act upon the fact that Mr P had longstanding coping problems and had misused cannabis and alcohol. No formal arrangements were put in place to help Mr P reduce his drug and alcohol use or to manage the risk of his mental health deteriorating again in the future.

This was potentially a toxic combination of personality disorder, forensic history, drug misuse and current risk indicators.

It is relatively easy for a clinical team to engage in treatment of mild depression but hard to treat the above combination. Even so a valuable opportunity to intervene was missed.

There is nothing to suggest that the team tried to engage Mr P's family with his care and treatment or sought to clarify information. Discussions with Mr P's family may have provided the team with an opportunity to better understand Mr P and his treatment needs.

Despite expressing his desire to kill himself and others and disclosing his use of cannabis and alcohol, no risk management plan was completed. Some care plan documentation was completed; however there was no clear treatment plan in place in the event of Mr P deteriorating.

Follow-up arrangements were put in place but given that Mr P had nowhere to live more consideration should have been given to how contact could be maintained.

October 1999 to September 2000

5.29 On 5 October 1999 psychiatric specialist 1 wrote to Mr P's GP. He reported that since Mr P had left the Abraham Cowley Unit there had been no recurrence of his depressive episode despite Mr P not being given a supply of antidepressant medication upon discharge (Mr P's discharge summary stated that he was discharged with sertaline 50mg daily).

5.30 Psychiatric specialist 1 reported that Mr P continued to suffer dysthymia[1] associated with personality difficulties. Psychiatric specialist 1 recommended to Mr P's GP that Mr P start a trial of venlafaxine, starting with 37.5mg twice a day.

5.31 On 15 December 1999 psychiatric specialist 1 wrote to the Central Referral Body[2] coordinator to try to secure accommodation for Mr P. He stated that Mr P was:

> *"Considered to have an adjustment disorder resulting from his life difficulties, and superimposed on personality disorder of an unstable type with impulsive aggression."*

5.32 On 7 January 2000 Mr P appeared at Kingston Crown Court charged with affray. The case was adjourned for pre-sentence and psychiatric reports. Psychiatric specialist 1 completed a psychiatric report for the court on 21 January 2000 in which he stated:

> *"I do think that the violence of the offence is part of severe adolescent disturbance of personality, partially resulting from early experiences of emotional deprivation, and verbal and physical abuse... In view of Mr P's age... it may be too early to categorise him as having a fixed personality disorder, in this case, with emotionally unstable and sociopathic traits. However, it seems clear that unless*

[1] Dysthymia is a chronic type of depression in which a person's moods are regularly low.

[2] A multiagency project, managed by Welmede Housing Association, funded and supported by Surrey Social Services, West Surrey Health Authority, Bournewood NHS Trust and the borough councils of Woking, Runnymede and Elmbridge.

there is change in personality factors he remains capable of further acts of violence, since his threshold to provocations is low and such are likely to recur."

5.33 On 1 February 2000 a pre-sentence report was completed by a probation officer from Surrey probation service for the same offence. It concludes:

"Once he again resumes control of his own life there is in my mind a concern that he will find extreme difficulty in coping. If my concerns are justified, there will be both a high risk of re-offending and of harm to the public."

5.34 On 29 February 2000 a psychological report was compiled by a clinical psychologist at the Shaftsbury Clinic. He reported that tests placed Mr P's level of intellectual functioning at below average. He also reported that Mr P could be considered to have had a diagnostic label either of 'conduct disorder' or 'oppositional defiant disorder' when he was younger. He said that Mr P's behavioural patterns might become fixed as 'antisocial personality disorder'. He also described the presence of signs significant of psychopathology.

5.35 On 15 September 2000 Mr P found his girlfriend hanged in her kitchen. Mr P believed that she had committed suicide because she was fearful of the prospect of him returning to prison and her being alone.

Comment

Psychiatric specialist 1 acknowledged that Mr P had personality disorder of an unstable type with impulsive aggression. However, there is no documentary evidence to suggest that his team had considered the triggers for Mr P's violent behaviour or formulated a plan to try to manage his risk which you would expect as part of a treatment package for personality disorder.

There is no information to suggest that the pre-sentence report or the views of the probation service regarding the risk that Mr P posed to the public were shared with mental health services. It is not clear from the policies provided by the trust whether this type of information should have been routinely shared between the services,

although it would have been good practice and would have provided a good insight into Mr P's behaviour.

10 October 2000 to 10 July 2002: first prison episode

5.36 On 10 October 2000 Mr P, aged 19, was remanded in HMP YOI Feltham for breaching his bail conditions following charges of burglary, robbery and affray. He had originally been bailed to his late girlfriend's address but because of her death he was not able to continue living there and was subsequently arrested.

5.37 During the initial health screen in HMP YOI Feltham Mr P complained of general mental health problems and said that he had previously been diagnosed as suffering from paranoid schizophrenia. He also expressed ideas of self harm. He was admitted to the healthcare centre and a suicide awareness form was completed.

5.38 On 17 October 2000 Mr P was started on antipsychotic medication (sulpiride 200mg twice a day). Throughout October Mr P remained troubled by persistent and intrusive auditory hallucinations. This primarily consisted of one voice that he called *"Mr Man"*. This was outside of his head, made threatening comments, called him names and told him "*we're going to kill you*".

5.39 In light of his floridly psychotic presentation his antipsychotic medication was changed to olanzapine, 10mg daily. This was increased to 15mg at the beginning of November 2000. Mr P's mental state improved following the change in medication and dose.

5.40 On 20 November 2000 consultant psychiatrist 1 visited Mr P. In his psychiatric report dated 5 December 2000 he reported that Mr P was complaining of symptoms of a psychotic illness, including auditory hallucinations and paranoid delusions.

5.41 Consultant psychiatrist 1 reported that given Mr P's presentation at the time of the meeting in HMP YOI Feltham he required an assessment in hospital with a possible future

Section 37[1] disposal under the Mental Health Act. Given his compliance with medication in the hospital wing and his willingness to remain in hospital consultant psychiatrist 1 recommended that Mr P be assessed on an open ward under a Section 35 for a period of 28 days.

5.42 On 4 December 2000 locum psychiatrist 1 compiled a medical report at the request of Kingston Crown Court to assist with sentencing for offences of burglary, robbery and affray. Locum psychiatrist 1 concluded that he was:

> *"Firmly of the opinion that... [Mr P] is suffering from paranoid schizophrenia."*

5.43 Locum psychiatrist 1 recommended that the court made Mr P the subject of a hospital order under Section 37 of the Mental Health Act 1983. He suggested that this be under consultant psychiatrist 1's care at the Abraham Cowley Unit.

Comment

Mr P reported during the initial health screening at HMP YOI Feltham that he had previously been diagnosed as suffering from paranoid schizophrenia. However there is nothing in his clinical notes to indicate that this diagnosis had been suggested before.

On 20 November 2000 consultant psychiatrist 1 assessed Mr P as suffering from a 'psychotic illness' although he did not appear to reach any definitive conclusion about its nature.

The following week locum psychiatrist 1 informed the court that his view was that Mr P was suffering from paranoid schizophrenia. This is the first time that a clinician had made the diagnosis of paranoid schizophrenia.

Mr P's presenting symptoms had remained consistent since his first engagement with mental health services: he continued to report auditory hallucinations and paranoid

[1] This section of the Mental Health Act (1983) is also known as a Hospital Order and is sometimes used by the courts to send a person to hospital for treatment instead of prison. Patients will eventually be discharged from hospital to the community when they are well enough.

delusions. But by this time locum psychiatrist 1 considered that Mr P's presentation warranted a diagnosis of paranoid schizophrenia.

5.44 In a letter to consultant psychiatrist 1, locum psychiatrist 1 reported that Mr P may now be presenting with psychotic symptoms as part of a schizophrenic illness. He considered that Mr P could be managed in a local psychiatric intensive care unit and he would try to arrange a bed for him. Mr P was subsequently placed on a Hospital Order and moved to the Abraham Cowley Unit.

5.45 Throughout December Mr P's antipsychotic medication was altered in response to his symptoms. Mr P reported that he had not used cannabis for two and a half months.

5.46 On 4 January 2001 Mr P absconded from the ward. The next day he was arrested and returned to prison. He was considered to have experienced a brief psychotic reaction.

5.47 After Mr P returned to prison consultant psychiatrist 2 completed a psychiatric medical report on 9 January 2001. The purpose of the report was to consider whether Mr P needed to be returned to hospital for treatment or whether he was able to remain in prison. The report stated:

> *"I formed the impression that he was suffering from a schizo-affective disorder, but alternative diagnosis including hysterical psychosis with personality disorder."*

5.48 Consultant psychiatrist 2 reported that by 2 January 2001 there was no apparent evidence of psychosis. He considered that Mr P almost certainly suffered a brief but real psychotic episode characterised by paranoid experiences, depressive feelings and auditory hallucinations (which he reported was not entirely characteristic of schizophrenia). Mr P was given sedative antipsychotic medication and made a quick recovery.

5.49 Consultant psychiatrist 2 concluded that in due course Mr P should receive treatment for his personality disorder at the Henderson Hospital[1]. He did not believe that

[1] The Henderson Hospital was a residential therapeutic community and outreach service that offered treatment to up to 29 people aged between18-60 who had been diagnosed with personality disorder. It was run by South West London & St George's Mental Health NHS Trust. This service is no longer available.

at that time Mr P fulfilled the criteria for a Section 37 to be returned to hospital for treatment. He therefore served the remainder of his sentence in prison.

Comment

Mr P was first considered to be suffering from paranoid schizophrenia by locum psychiatrist 1 on 4 December 2000. On 9 January 2001, consultant psychiatrist 2 formed the view that Mr P was suffering from a schizo-affective disorder, but suggested that alternative diagnosis could include hysterical psychosis with personality disorder.

Consultant psychiatrist 2 concluded that Mr P should receive treatment at the Henderson Hospital for his personality disorder. This suggests that personality disorder continued to be considered the likely diagnosis and that a firm diagnosis had not been reached. There is no documentary evidence to suggest that a treatment plan was formulated to manage Mr P's suspected personality disorder.

Before Mr P absconded, and while he was subject to a hospital order, his risks should have been assessed and care planning arrangements put in place. There is no evidence that this was done. Irrespective of diagnosis, Mr P's risk should have been assessed to reflect his presenting symptoms and behaviour at that time.

5.50 In February 2001 Mr P was sentenced to 42 months imprisonment for robbery, burglary and affray.

5.51 On 30 March 2001 consultant psychiatrist 2's SHO completed a discharge summary as Mr P was in custody.

5.52 On 1 May 2002 a probation officer from Surrey Probation Service, wrote to psychiatric specialist 1 to inform him that Mr P was due to be released into the community on 10 July 2002. Given his past pattern of "*violent and irrational behaviour*" the probation officer asked for the opportunity to discuss any treatment or support that could be offered to Mr P as part of his release plan.

5.53 Consultant psychiatrist 2 asked consultant psychiatrist 1 to take forward this request. It is not documented in the notes whether this request was acted upon.

5.54 Mr P was released into the community on licence on 10 July 2002. It is not clear from Mr P's clinical notes what arrangements were put in place with mental health services upon his release from prison.

July 2002 to January 2003: community

5.55 Following a referral from Mr P's GP Mr P was offered an outpatient appointment with consultant psychiatrist 2's SHO on 31 July 2002. Mr P failed to attend. The plan was for consultant psychiatrist 2 to ask a member of the CMHT to make sure Mr P continued to take his antipsychotic medication.

5.56 Consultant psychiatrist 2 saw Mr P on 2 October 2002, nine weeks after Mr P was released from prison. In a letter to Mr P's GP on 4 October 2002, consultant psychiatrist 2 recorded that Mr P had told him that he was well and for the first time in his life he felt happy. He said that he had a job and was moving from a bail hostel into a flat. He had not experienced any auditory hallucinations for about a year (since he reportedly stopped smoking cannabis) and was convinced that his psychosis was due to the large quantities of cannabis he had been taking. He found olanzapine to be helpful. Consultant psychiatrist 2 subsequently discharged him from the clinic.

5.57 On 7 January 2003 Mr P was referred to the community forensic service by his probation officer for an assessment with a view to ascertain his suitability for psychological therapy.

5.58 On 13 January 2003 Mr P was seen by a duty practitioner at Woking CMHT. Mr P had been referred to the crisis response team at the Abraham Cowley Unit by his probation officer. She was concerned about his mental state as he was expressing the urge to carry out a "*mission*" which involved visiting his father and step-mother in Essex and "*healing them"* by cutting out and eating their hearts.

5.59 The plan was for the police to bring Mr P into the Abraham Cowley Unit under a Section 136[1].

Comment

It is unclear whether plans were put in place while Mr P was in prison for him to be assessed by mental health services on his release despite his probation officer's attempts to establish contact with mental health services.

When Mr P failed to attend his appointment with consultant psychiatrist 2 on 31 July 2002, consultant psychiatrist 2 informed the CMHT that it was important that Mr P continued with antipsychotic medication. However, it is not clear from Mr P's clinical notes whether he was released from prison with antipsychotic medication.

Mr P informed clinical staff that his mental health deteriorated when he was using excessive amounts of cannabis which could provide an alternative explanation for his psychotic presentation. There is no suggestion that this was explored.

There is no evidence to suggest a treatment plan was drawn up that recognised cannabis as a trigger for deterioration. Nor was Mr P referred to drug and alcohol services. In fact Mr P was discharged from the trust's services as he was deemed to be doing well. There was seemingly no recognition that if Mr P returned to cannabis use, lost his job or became homeless that his mental health had the potential to deteriorate.

Mr P was discharged from mental health services by consultant psychiatrist 2 on 2 October 2002. There is no evidence to suggest that this was a multidisciplinary decision or that there was any ongoing community support in place for Mr P should he need it. This is an example of the lack of long-term planning in Mr P's care and treatment. When he reported to be well he was discharged from services. When he presented in crisis staff involved in his care reacted by treating his presenting symptoms without gaining a full understanding of the reasons that lead to the deterioration in his mental health or considering the risk that he posed.

[1] Section 136 of the Mental Health Act 1983 covers removing a mentally ill person from a public place to a place of safety. It details police powers and the rights of someone in this position.

Sometime between October 2002 and January 2003 Mr P's mental health deteriorated to the point where his probation officer thought it appropriate to refer him to the crisis team at the Abraham Cowley Unit. By this time there had been an escalation in the severity of violent thoughts he was disclosing.

It was unclear at that point whether Mr P had returned to cannabis use, but given that his psychotic symptoms often presented after cannabis use it should have been considered.

13 January 2003 to 11 September 2003: third episode of inpatient care

5.60 On 13 January 2003 Mr P was brought into the Abraham Cowley Unit by police and he agreed to stay as an informal patient. He was re-admitted to Blake Ward, re-started on antipsychotic medication, and placed on Section 2 and subsequently on Section 3 of the Mental Health Act. Mr P initially made poor progress on olanzapine 20mg daily. A change to quetiapine 450mg daily led to the disappearance of psychotic symptoms. A urine sample on admission tested positive for cannabis. Mr P was at that time on police bail. He had recently been evicted by his landlord due to unacceptable behaviour, although the nature of this behaviour was not recorded in Mr P's clinical notes.

5.61 A risk assessment form was completed on the day of admission by a staff nurse. Mr P scored highly for the risk of suicide and violence/aggression with all boxes being highlighted as 'severe' except in relation to sexual behaviour. His triggers for violent behaviour were marked as 'unknown'. In the 'summary of risk status and care programme approach level' Mr P was regarded as presenting a high level of risk in all categories (suicide, self harm, neglect, violence to others, abuse by others and risk to property). The level of CPA for Mr P's management was not recorded.

Comment

Mr P's admission to the Abraham Cowley Unit in January was an opportunity to reassess Mr P and review his longitudinal diagnosis and treatment plan. Instead, he was restarted on antipsychotic medication and treated in line with past presentations.

Given that Mr P had now been diagnosed with a serious mental illness and had been identified as being at risk of suicide and violence with a history of drug and alcohol use he should have been identified as needing to be managed under CPA.

In relation to the presence of co-morbid substance misuse the assessing staff nurse documented that Mr P had a history of drug and alcohol abuse and it was noted that he was a forensic patient. However, there is little evidence to suggest that the link between excessive cannabis use and deterioration in mental health was drawn.

Mr P's triggers for violence were apparently 'unknown'. Given his history and his past presentations, clinical staff should have had greater insight into his triggers.

5.62 On 14 January 2003 Mr P was referred to Woking CMHT by a locum psychiatrist at the Abraham Cowley Unit. On the referral form Mr P's diagnosis was given as:

> *"Schizo-affective disorder, relapse of psychotic behaviour".*

5.63 The next day Mr P was referred to specialist psychology services by his probation officer.

5.64 On 20 January 2003 Mr P's dose of olanzapine was increased to 15mg at night. The next day Mr P was put on a Section 5(2) as he was threatening to discharge himself and carry out his "*mission*". Mr P also described visual hallucinations. Later that day Mr P was put on Section 2 and transferred to Laureate Ward.

5.65 Mr P was seen by a community psychiatric nurse from Woking CMHT on 27 January 2003. Mr P's presentation was recorded as having changed considerably. He reported that he was not experiencing any psychotic symptoms and that he was unable to recall anything since Christmas day. Besides his mental health, Mr P's homelessness remained a problem. If he remained homeless it was likely that he would return to prison as it was a breach of his bail conditions.

5.66 It was recorded on the decision of mental health review tribunal form, completed on 28 January 2003, that there was a high risk that Mr P will act upon commands and delusions, especially as he said he would stop taking his medication and leave hospital immediately upon discharge of the section.

5.67 On 31 January 2003 Mr P was seen for the first time by psychologist 1. He was seen on a weekly basis thereafter, certainly until July 2003.

5.68 On 2 February 2003 Mr P expressed a desire to leave the ward, insisting that he needed to go to Essex to visit his family who had been made ill by *"wombats"*. He reported that he needed to heal them by *"ripping their hearts out"*. Haloperidol and lorazepam were prescribed on an as needed basis. The following day Mr P was noted as experiencing auditory and visual hallucinations. He was non-compliant with his medication and documented as having no insight into his condition. The assessing doctor recommended that Mr P remain under Section 2 of the Mental Health Act.

5.69 The following day a 'summary of risk status and care programme approach' form was completed but the level of CPA was not recorded.

5.70 On 4 February 2003 consultant psychiatrist 2 wrote a medical report for a mental health review tribunal in which he stated that Mr P admitted to using large doses of cannabis from time to time. He denied having used cannabis since before his prison admission in October 2001. However his urine test on this admission proved positive. Consultant psychiatrist 2 recommended that Mr P should continue under Section 2. This advice was followed by the tribunal panel.

5.71 It is unclear at what point Mr P was transferred to Blake Ward, but on 6 February 2003 he was transferred (still on a Section 2) back to Laureate Ward as a result of psychologist 1 informing ward staff of Mr P's unpredictable nature. The section was later changed to a Section 3.

5.72 On 9 February 2003 a risk assessment form was completed on Laureate Ward. Again Mr P's risk was scored as 'severe' in all areas relating to violence/aggression indicators, except in relation to sexual offences. On 15 February 2003 he was recorded by a staff nurse as needing to be managed under enhanced CPA.

5.73 By 18 February 2003 Mr P was considered to present a low risk of harm to others.

5.74 On 24 February 2003 the Abraham Cowley Unit referred Mr P to the Windmill Community Drug and Alcohol Team. The referral form stated that Mr P recognised his mental state deteriorated when he was under the influence of drugs but he needed assistance in abstaining from future drug use.

5.75 On 2 March 2003 Mr P absconded, having been given leave to eat in the hospital restaurant. He later told consultant psychiatrist 2 that he had been feeling well, but a thought came into his head whilst eating lunch that it was poisoned. At that point he decided to murder his parents. He took a train to Essex where his father and step-mother lived. He knocked on the door but there was no answer. He returned to the Abraham Cowley Unit later that day.

5.76 The following day Mr P was seen by a member of the Windmill Community Drug and Alcohol Team. He was noted as being ambivalent about stopping using cannabis but that he engaged in a conversation about the benefits of going into a rehabilitation unit versus continuing with his current lifestyle.

Comment

On 15 February 2003 Mr P was recorded as needing to be managed under enhanced CPA. This is the first reference to CPA. By this point Mr P had been an inpatient for just over a month and had been admitted to hospital twice before. Given Mr P had previously been diagnosed with a serious mental illness he should have been identified as needing to be managed under CPA much earlier.

On 24 February 2003 (while on section) Mr P was referred to Windmill Drug and Alcohol Team. This was the first time that it was acknowledged that Mr P needed help to abstain from drug use and the potential impact excessive cannabis use had on his mental state. This is despite drugs and/or alcohol featuring in every presentation to mental health services since November 1997.

On 2 March 2003 Mr P absconded from the ward. His account of travelling from Chertsey to his parents' home in Essex and his intentions when he got there are extremely concerning. There is nothing to suggest that, following this incident, that his risk or care management plan were reviewed. Given the potential harm Mr P could have caused, this incident should have been treated as a 'near miss' and investigated accordingly.

5.77 On 4 March 2003 a Blue Light Information Process (BLIP) form was completed by a member of staff on Laureate Ward and sent to Windmill House Drug and Alcohol Inpatient Service, Chertsey. The purpose of the form is to ensure that organisations share information on high risk individuals with relevant partners. On the form the following warnings were ticked:

> "*Homicide (when psychotic), threats to kill, serious violence, domestic violence (parents), mental disorder, drugs/alcohol. He is also noted as being a risk to strangers and his parents.*"

5.78 On 4 March 2003 Mr P was recorded as being managed under enhanced CPA. His risk of violence towards others was recorded as high.

Comment

It was good practice to alert other agencies to Mr P's potential risk. It demonstrated that staff understood the risk that Mr P posed and the need to share information.

5.79 On 10 March 2003 a Section 117 meeting was attended by consultant psychiatrist 2, a doctor from the drug and alcohol team, and a community psychiatric nurse for the forensic service. They agreed that Mr P should continue to be seen by the drug and alcohol team who would encourage and support Mr P to abstain from cannabis use. Psychologist 1 was to continue to provide Mr P with weekly psychological treatment.

5.80 Consultant psychiatrist 2 completed a medical report for a mental health review tribunal on 10 March 2003. In the report he stated that Mr P suffered from brief paranoid psychotic episodes in which he exhibited delusions of a violent nature including passivity phenomenon[1]. This made him dangerous. Mr P lacked insight during these episodes and declined medication, and he should not be released from Laureate Ward. It was agreed by the tribunal that Mr P was to remain an inpatient under Section 3.

[1] A delusional belief that some aspects of themselves are being externally controlled by another/others.

Comment

Despite being assessed as 'dangerous' and declining to comply with medication there is nothing to suggest that Mr P's treatment plan was reviewed to reflect his status as 'high risk'. This is not to say that it needed to be altered, but documenting that this had been considered would have been good practice.

5.81 The psychology clinical notes, completed by psychologist 1, indicate that on 25 March 2003 Mr P described flashbacks about finding his ex-partner after she had committed suicide. Mr P also expressed thoughts of putting billiard balls in one of his socks and hitting out at members of staff with it.

5.82 On 1 April 2003 psychologist 1 reviewed Mr P. She recorded that Mr P's mental state was very variable. Mr P reported that he had a particularly bad night on 31 March. He said that he had been hearing a 'good' voice but instead of being benign it had been aggressive and frightening. He reported that it had been:

> *"instructing him to commit violent acts e.g. kill members of staff, slit patients' throats and drink their blood, hang himself."*

5.83 Mr P said that the voice had been telling him not to take his medication and that it was beginning to sound like the "*Mr Man*" (bad) voice.

Comment

There is nothing in the clinical notes to suggest that Mr P's risk of harm (particularly the risk posed to staff) was reviewed after he made the comments about his flashbacks and violent thoughts. Given the fact that Mr P had previously been described as impulsively aggressive, this would have been a good opportunity to review the risk posed by Mr P.

5.84 The mental health review tribunal documentation completed on 9 April 2003 recorded a diagnosis of schizophrenia. The tribunal considered that the delusional symptoms persisted on a daily basis and Mr P remained a danger and that the section should therefore continue.

5.85 On 11 April 2003 Mr P was transferred from consultant psychiatrist 2 to the care of consultant psychiatrist 1's team. The notes of 7 April record this decision but do not explain the reasons for it.

Comment

It is likely that Mr P was transferred because consultant psychiatrist 1 specialised in forensic psychiatry, however this is not explicitly stated.

5.86 On 17 April 2003 Mr P's antipsychotic medication was changed from chlorpromazine to quetiapine, but he was to continue with olanzapine.

5.87 On 12 and 19 April 2003 a staff nurse completed a 'summary of risk status and care programme approach level' form. It noted that Mr P continued to present a high risk of violence/harm to others. No CPA level was recorded.

5.88 On 24 April 2003 Mr P informed consultant psychiatrist 1's team that he was feeling more relaxed and was no longer hearing voices. The plan was recorded as: increase quetiapine dose, reduce olanzapine dose, continue with psychology input and to review again next week.

5.89 Over the following week Mr P reported that his delusional beliefs and auditory hallucinations were gradually disappearing. Mr P was also recorded as showing insight into his illness and recognised that 'healing' his parents would result in harming them which he acknowledged was not a good idea.

5.90 On 12 May 2003 Mr P absconded from the ward. Mr P's description was faxed to the police. It stated that Mr P posed a high risk to his parents, and that he had a history of paranoid schizophrenia and convictions for violence. He was described as impulsive, with

the propensity to act at short/no notice. The fax also indicated that Mr P's probation officer had been told that Mr P had absconded.

5.91 Mr P returned to the ward the same evening having handed himself into the police. He had been drinking alcohol.

5.92 Mr P was reviewed by consultant psychiatrist 1 and his team during a ward round on 15 May 2003. They discussed Mr P absconding from the ward and he said that he had no regrets and would abscond again if he had the opportunity. The plan was for Mr P's quetiapine dose to be increased from 450mg to 600mg a day and for Mr P's suitability for depot[1] to be discussed. Mr P was also to be restricted to the ward for the time being.

Comment

Given Mr P's previous desire to harm his parents it would have been good practice to review Mr P's risk and his risk management plan on his return to the ward. This does not appear to have been done, although Mr P's medication was changed. There is no evidence to suggest that the Windmill Drug and Alcohol Team were alerted to the fact that Mr P had absconded and then returned to the ward under the influence of alcohol.

There was clearly a disconnection between addiction and mental health services. Mr P's use of drugs and alcohol generally preceded deterioration in his mental health and an increase in his offending behaviour. This trigger should have been recognised and acted upon. Drug and alcohol use could have also provided an alternative explanation to Mr P's primary mental illness, causing psychosis, which in turn caused offending behaviour.

[1] Depot antipsychotic medication is a special preparation of the medication which is given by injection. The medication is slowly released into the body over a number of weeks.

5.93 On 19 June 2003 care coordinator 1 from Woking CMHT agreed to act as Mr P's care coordinator. CPN 1 and social worker 1, approved social worker from CREST[1], also agreed to provide input.

5.94 On 26 June 2003 Mr P took escorted leave to Woking town centre for two hours. No problems were reported.

5.95 On 23 and 29 June 2003 a staff nurse assessed Mr P's risk of violence/harm to others as 'medium' and recorded that Mr P was to continue to be managed under enhanced CPA.

5.96 On 30 June 2003 consultant psychiatrist 1 completed a medical report for the mental health tribunal review of Mr P who continued to be detained under Section 3 of the Mental Health Act on Laureate Ward.

5.97 In the report consultant psychiatrist 1 stated that he had concerns about Mr P's risk to the public given his previous history of absconding, carrying a knife and the nature of his psychotic symptoms on admission. He recorded that Mr P had recently used cannabis which he admitted made him paranoid and would be difficult to stop. Over the last few weeks Mr P's mental state had improved. Mr P reported feeling less impulsive and that he had been able to control his desire to abscond. He remained free of any current psychotic symptoms. The plan was documented as a slow rehabilitation programme with Mr P having increasing periods off the ward. The diagnosis was recorded as paranoid schizophrenia. It was agreed that Mr P should remain under section.

5.98 On 8 July 2003 psychologist 1 compiled a report for the mental health tribunal review. In the report she states that she met with Mr P for the first time on 31 January 2003 and has been seeing him every week since then. She reported that despite a positive start, over the following weeks his condition fluctuated markedly and he became delusional. He disclosed information relating to risk, such as the desire to attack a man who had been violent towards his ex-partner.

5.99 On 10 July 2003 an enhanced CPA meeting was held on Laureate Ward. Mr P said that he would like to be transferred to Blake Ward. It was agreed that the nursing staff

[1] CREST provides intensive long-term help for a small group of people with very high ongoing support needs. The service can be accessed through Woking CMHT.

would enquire about bed availability and Mr P would begin overnight stays. Mr P said that on discharge he did not want to live in the Woking area. It was recorded that Dr R (from the drug and alcohol team) would allocate a member of staff to work with Mr P regarding his drug use. Mr P's identified needs were recorded as:

- accommodation
- psychotic symptoms
- psychological distress
- drugs
- engagement in community activities.

5.100 The potential features of Mr P relapsing were recorded as:

- homelessness and loss of contact with services
- when Mr P stops taking his medication
- when Mr P gets paranoid and suspicious or states that he cannot cope
- when Mr P starts smoking excessive amounts of cannabis.

Comment

This is the first time that the care plan documentation records that Mr P's mental state has the potential to deteriorate when he uses excessive amounts of cannabis. At this point he had been an inpatient for almost seven months and drug use had been a feature in his presentations to mental health services since November 1997.

Mr P had limited support in the community. He was often out of touch with family and friends. This was not seen as a risk factor.

Mr P was frequently homeless and this was recognised as a risk factor. We asked the trust whether they have a homeless strategy; this is discussed in section 6.

5.101 On 28 July 2003 Mr P was referred by CPN 1 to a day hospital. Mr P's mental state was described as "*currently stable"* and his level of risk was described as "*generally low*". He was considered to be "*progressing well with his treatment*".

5.102 On 10 August 2003 Mr P's future accommodation needs were discussed at a CPA meeting. Accommodation was subsequently arranged for Mr P at Croft House[1]. Mr P did not think that he would fit in at Croft House as he preferred independent living. He went on leave at the end of August and did not return.

Comment

By this time, Mr P had been an inpatient for eight months. His presentation and willingness to engage fluctuated markedly during this time.

When he was first admitted on 13 January 2003 he was diagnosed with a schizo-affective disorder with a relapse of psychotic behaviour. He was assessed as posing a high risk to himself and others but his triggers for violent behaviour were recorded as unknown. He was admitted under the care of consultant psychiatrist 2's team but was moved under the care of consultant psychiatrist 1 on 11 April 2003 (although the reason for this is not clear from Mr P's clinical notes).

By the time Mr P went on leave at the end of August and failed to return, his diagnosis was recorded as paranoid schizophrenia and his risk had been assessed as 'generally low'. At a CPA meeting in July 2003 there was recognition that drug use was a potential feature of relapse. However, there is no documented plan of how the risk would be managed.

Given the length of Mr P's inpatient stay, more could have been done to get a real understanding of the reasons behind his deteriorating mental health and the triggers which lead to it. When Mr P left the Abraham Cowley Unit in August 2003 there was little consideration given to aftercare arrangements and the prevention of further presentations in crisis. This was significant as Mr P did not have family support in the community. This should have been identified as a potential risk factor by those working with him.

[1] Croft House is a shared supported housing service for people who have experienced mental health problems. Staff support is based on site Monday to Friday with an emergency out-of-hours on call service.

Mr P was under a Section 3 whilst he was an inpatient. Health and social services were therefore obliged to provide aftercare services to him, through a Section 117. Although Mr P discharged himself, services should have ensured Section 117 discharge arrangements were in place as the decision to discharge him had already been made and suitable accommodation had been found.

5.103 At some point between the CPA meeting on 10 July and the end of August 2003 Mr P was transferred to Blake Ward. Mr P did not attend an enhanced CPA meeting on 11 September 2003. In his absence, it was decided that he should be discharged from Blake Ward. The plan was to keep access to all team members open to Mr P, and for consultant psychiatrist 1 to be informed immediately if he presented to the Abraham Cowley Unit so that he could be assessed. The discharge summary records that Mr P would be monitored in the community but the notes do not indicate how.

5.104 On 19 September 2003 consultant psychiatrist 1 wrote to Mr P's GP expressing concern that Mr P had discharged himself two weeks ago giving a false address. Consultant psychiatrist 1 asked the GP to find out whether Mr P was willing to re-engage with mental health services if he saw him.

5.105 On 24 September 2003 Mr P presented on Blake Ward with the intention of re-engaging in order to get support with his application for accommodation. Mr P reported that he was living in Virginia Water. Consultant psychiatrist 1 assessed Mr P and he was restarted on quetiapine. He was found temporary accommodation in Woking.

5.106 On 2 October 2003 an enhanced CPA meeting took place during which Mr P acknowledged his mental health needs and said that he was taking his medication. Mr P was documented as being homeless and in need of somewhere to live. He was considering moving to Essex where his father lived. His medication was documented as quetiapine, 300mg twice a day. The warning signs of deterioration were recorded as:

- if Mr P stops taking his medication, becomes paranoid or hostile
- if Mr P disengages with the services and becomes homeless.

5.107 On 13 October 2003 the council stated that it would not be able to house Mr P because of his violent behaviour. Mr P was deemed unsuitable for bed and breakfast accommodation and had been evicted from York Road and St Catherine's[1] for fighting. Later that week Mr P informed CPN 1, consultant psychiatrist 1 and his care coordinator that his girlfriend was pregnant and he therefore needed two bedroom accommodation.

5.108 On 17 October 2003 CPN 1 completed a clinical risk management form in which Mr P was recorded as presenting a medium risk of violence/harm to others. The following risk accelerators were recorded:

- homelessness
- disengaging with services
- non-compliance with medication
- cannabis.

Comment

Given that Mr P had a history of poor compliance with his medication in the community and that he was frequently homeless and regularly disengaged with services there was a risk that his mental health would deteriorate. There was no mention in the CPA documentation of the risk associated with Mr P using cannabis despite his previous presentations preceding drug use. Since his disengagement with drug and alcohol services on 2 September 2003 no further attempts were made to manage or review this risk.

Despite Mr P's previous desire to kill his parents (when he was acutely unwell), concerns were not raised about his desire to relocate to Essex. There did not appear to be any consideration of the risk Mr P could pose if his mental health deteriorated again.

There is no evidence to suggest that concerns were raised about Mr P's partner being pregnant, nor was a further risk assessment completed to consider whether Mr P

[1] York Road Project and St Catherine's provide a variety of support services for homeless people.

posed any direct risk to his partner or the baby. The potential stress of the pregnancy and the impact on Mr P's ability to cope do not appear to have been considered at this time either.

25 October 2003 to 16 December 2003: fourth inpatient episode of care

5.109 On 25 October 2003 Mr P presented at the A&E department of St Peter's Hospital, Chertsey, asking to see a psychiatrist. He appeared anxious and said that he was hearing voices and feeling suicidal. Mr P reported that he had auditory hallucinations telling him to kill a former girlfriend (who committed suicide in September 2000).

5.110 Mr P had been living with his pregnant partner and reported having thoughts of cutting the baby out of her stomach. He said that he stopped taking quetiapine around three weeks ago. He was admitted informally to Blake Ward and was restarted on quetiapine.

Comment

Mr P's presentation on this occasion was less than two months after he was discharged from the Abraham Cowley Unit (following an eight month inpatient stay). This is a very short time to have deteriorated so considerably without any services recognising signs of deterioration. This may be because Mr P refused to engage with services whilst in the community but may well demonstrate a lack of long-term planning and support for Mr P outside of an inpatient setting.

Mr P's presenting symptoms were the same as on previous occasions, however, his violent thoughts were becoming more graphic.

There is nothing in Mr P's clinical notes to suggest that a risk assessment was completed following these comments. His risk to his pregnant partner and her unborn child was largely unknown at this time. There is nothing to suggest that Mr P's risk was discussed in a multidisciplinary setting, and there is no evidence that the police were told about Mr P's graphically violent thoughts towards his pregnant partner.

5.111 On 27 October 2003 it was recorded that Mr P had been discharged from the Windmill Drug and Alcohol Service as he failed to attend appointments. It is not clear from Mr P's clinical records what attempts had been made to engage him.

5.112 Two days after admission to Blake Ward Mr P reported that he was feeling well and the voices had stopped. He reported that he had decided to end the relationship with his pregnant partner.

5.113 On 30 October 2003 consultant psychiatrist 1 saw Mr P on the ward. He said that he thought he was suffering from post-traumatic stress disorder associated with the suicide of his girlfriend in 2000 and planned to restart Mr P's psychology sessions with psychologist 1.

5.114 Within three weeks on the ward, Mr P had obtained a job as a hod carrier. On 19 November 2003 it was recorded that Mr P was compliant with medication and that he remained in regular contact with services and had stopped using cannabis. The following day consultant psychiatrist 1 expressed the need for Mr P to be accommodated somewhere where he could be monitored by services. It is not documented why consultant psychiatrist 1 considered this to be necessary.

5.115 On 4 December 2003 staff on Blake Ward completed a summary of 'risk status and care programme approach level' form. Mr P's risk was recorded as 'low' in all categories (including risk of violence/harm to others). He was noted as being "*mentally stable at present*". No CPA management level was recorded.

5.116 On 16 December 2003 Mr P was discharged from Blake Ward after other patients alleged that he was bringing cannabis onto the ward. Mr P denied this but refused to give a urine sample. Consultant psychiatrist 1 informed Mr P of the decision to discharge him and Mr P was provided with two weeks' medication.

5.117 On 6 January 2004 consultant psychiatrist 1's SHO sent a discharge summary to Mr P's GP. The following plan was recorded:

- follow up from Mr P's CPN in the next two weeks
- a CPA meeting to be held in the New Year
- CPN 1 to liaise with Mr P regarding accommodation.

Comment

No CPA management level was recorded on 4 December, shortly before Mr P was discharged. But, given there was no documentation to suggest otherwise, he should have continued to be managed under enhanced CPA.

When we met Mr P in Broadmoor Hospital (in September 2011) he told us that he felt that this was the main occasion when he felt let down by trust services. Mr P was adamant that he had not brought cannabis onto the ward but recognised that the refusal to give a urine sample implied his guilt. He told us that, before being asked to leave the ward, his mental health had improved significantly and he was managing to work consistently and save money. Mr P felt that following discharge he deteriorated rapidly as he did not have anywhere to live.

Although consultant psychiatrist 1 considered Mr P to be making good progress during his inpatient stay, it is unclear from documentation whether he was deemed ready to be discharged or whether he was discharged purely as a result of allegedly bringing cannabis onto the ward.

25 December 2003: A&E presentation

5.118 On 25 December 2003 Mr P was referred from the A&E department of St Peter's Hospital to the Abraham Cowley Unit and was seen by Dr Z (Dr Z's title is unclear from documentation). Mr P told Dr Z that he had run out of medication and was hearing voices. He reported that he had been living in an abandoned car. He had planned to live with his father but he had refused to accommodate him. Temporary accommodation and a quetiapine prescription were arranged. The plan was to inform consultant psychiatrist 1 and his team of Mr P's presentation on Monday 29 December 2003. It is not clear from documentation whether this information was shared with consultant psychiatrist 1.

5.119 On 6 January 2004 CPN 1 was informed that Mr P was in custody and was being charged with possession of an offensive weapon. Mr P was seen by a police doctor and deemed fit for detention and interview. Mr P was held in custody but was subsequently granted conditional bail. Mr P failed to attend court on 14 January 2004 and a warrant for his arrest was issued.

9 February 2004: A&E presentation

5.120 On 9 February 2004 Mr P presented at the A&E department of St Peter's Hospital and was seen by consultant psychiatrist 1 and CPN 1. He refused all assistance and said that he did not believe in medication. He felt that he was suffering from the trauma of his adolescent experiences. Consultant psychiatrist 1 considered that Mr P's presentation was his way of re-engaging with trust services and the offer of a follow-up appointment and assistance was left open to him.

5.121 On 12 February 2004 Mr P surrendered to the police. He appeared at Woking Magistrate's Court the next day and was remanded at HMP Highdown. He was charged with being in possession of a knife. On 14 February Mr P was found not guilty and was released.

5.122 On 20 February 2004 Mr P was discharged by Woking CMHT as he had failed to engage with its services. It is unclear from documentation what attempts had been made by the CMHT to engage Mr P or whether Mr P's consultant psychiatrist was informed of the decision to discharge him.

5.123 Consultant psychiatrist 1 wrote to Mr P's GP on 23 February 2004 having seen Mr P on 9 February 2004 with CPN 1. Consultant psychiatrist 1 was of the view that Mr P "*malingers*" symptoms of psychosis in the hope that he would be detained in hospital. Consultant psychiatrist 1 did not think it would be helpful to admit Mr P to hospital again at that stage.

5.124 Mr P's presenting symptoms were generally the same as on previous occasions. However, consultant psychiatrist 1 no longer considered Mr P to have a serious mental illness. There is no indication in Mr P's clinical notes the reason why consultant psychiatrist 1 reached this conclusion.

5.125 Consultant psychiatrist 1 interviewed Mr P at HMP Highdown on 8 March 2004 (Mr P had been arrested for another offence and remanded in HMP Highdown for breaching his bail conditions). In a letter to Mr P's solicitors consultant psychiatrist 1 stated that Mr P did not suffer from schizophrenia but had brief transient psychotic reactions to drug misuse. Consultant psychiatrist 1 also stated that Mr P refused to re-engage with mental health services.

5.126 At some point in March 2004 Mr P was released from prison. On 23 March 2004 Mr P contacted mental health services asking for help, although from the clinical records it is unclear who reviewed Mr P on this occasion. Mr P reported that he was living in a homeless shelter. No future plan for care and treatment was recorded nor was a risk assessment completed.

Comment

Mr P was unwilling to engage with mental health services when he was seen by consultant psychiatrist 1 and CPN 1 on 9 February 2004 and consultant psychiatrist 1 did not see the benefit of admitting Mr P to hospital at that time. Consultant psychiatrist 1 now considered that Mr P exaggerated symptoms of psychosis in order to be detained in hospital and he no longer considered Mr P to be suffering from schizophrenia. Mr P's refusal to engage with trust services and exaggerated symptoms could have been viewed as symptomatic of personality disorder and managed in such a way. Irrespective of diagnosis, Mr P's risk should have been assessed based on his presenting symptoms.

This was the first time that Mr P's deterioration was directly linked to drug use. Although this link was known, a management plan was not drawn up to reflect this change in diagnosis, nor was his risk reviewed. This clearly demonstrated a disconnection between addiction and mental health services.

Despite no longer being considered to have a serious mental illness, Mr P's CPA status was not reviewed and he therefore should have continued to be managed under enhanced CPA. This should have included regular reviews and clear crisis and contingency plans being in place to recognise early deterioration in Mr P's mental health.

5.127 On 26 March 2004 Mr P was assessed and accepted by Vaughan House[1]. On 7 April Mr P was verbally abusive and threatening towards a member of staff after it was alleged that he was bringing alcohol into the detoxification unit.

[1]Vaughan House provides short term accommodation for 18-65 year olds.

5.128 Mr P was evicted from Vaughan House on 14 April 2004 after he tested positive for cocaine (thereby breaching his tenancy agreement). On 20 April Vaughan House agreed that Mr P could stay after he apologised for taking cocaine and pleaded for help with abstinence. He was subsequently readmitted to the detoxification unit.

5.129 On 10 May 2004 an enhanced CPA meeting took place. During the meeting Mr P expressed his desire to be housed in independent accommodation. However, the team at Vaughan House felt that Mr P would benefit from further rehabilitation before moving into independent accommodation. Mr P acknowledged that he continued to use drugs but did not consider himself to be drug dependent. He stated that he did not need any formal therapy or psychology input from the multidisciplinary team.

5.130 The risks of relapse were recorded as:

- if Mr P becomes paranoid or hostile
- if Mr P disengages with the services and becomes homeless
- if Mr P loses his current tenancy.

5.131 A crisis and contingency plan was completed that stated that if any of the above risks were to occur then Mr P's care coordinator and consultant psychiatrist should be informed.

5.132 It was documented in the clinical notes on 30 July 2004 that psychology input was closed as Mr P was unlikely to engage with the psychologist. However, Mr P could be re-referred should the situation change.

5.133 On 24 August and 2 September 2004 social worker 1 made attempts to visit Mr P but was unsuccessful.

5.134 On 24 September 2004 social worker 1 was contacted by police from Farnham Domestic Violence Unit. Mr P's pregnant partner had made a statement that Mr P had threatened to kill her and her unborn baby if she left him. Mr P disappeared and she returned to her parent's address.

5.135 On 30 November 2004 social worker 1 met with Mr P. He subsequently contacted consultant psychiatrist 1 and informed him that Mr P was *"well but homeless"*.

Comment

Mr P was reported to have brought alcohol into the detoxification unit and to have tested positive for cocaine. However, there was no recognition that this indicated a deterioration in Mr P's mental health or an escalation in risk – despite his last acute presentation being described as a brief transient psychotic reaction to drug misuse.

The crisis and contingency plan agreed at the CPA meeting on 10 May 2004 did not recognise that returning to drug use may result in a deterioration in Mr P's mental state and an increase in the risk of harm he posed to others. However, it did identify that if Mr P disengages with services and becomes homeless then he was at risk of relapsing. By this point, Mr P had a history of being asked to leave his accommodation due to his behaviour and was frequently disengaging with mental health services. This again demonstrated a lack of realistic long-term planning and management of Mr P in the community.

Mr P was living in the community, however no changes were made to his care plan relating to risks and triggers for risk or deterioration. Given his history of drug use and his desire to disengage with mental health services a greater emphasis should have been placed on managing Mr P's risk of relapse and risk of harm.

The enhanced CPA meeting on 10 May 2004 was the final one before the offence in June 2005. Therefore, from this point until the offence (13 months later) Mr P should have continued to have been managed in line with the requirements of enhanced CPA.

Psychology input was closed on 30 July 2004, although the reason for this is not recorded. It is likely that this was a result of Mr P's unwillingness to engage at that time although is not clear what attempts were made to engage Mr P with the psychology service.
On 24 September 2004 social worker 1 was made aware by the police of Mr P's threats towards his pregnant partner. The threats were similar to thoughts he had disclosed to a psychiatrist on 25 September 2003. There is no evidence that his thoughts on 25 September were shared with any other agency (including the police).

Mr P's threatening behaviour could have been interpreted as an indication that his mental health was deteriorating and/or that he had returned to drug use.

It is not clear from documentation what assessment social worker 1 undertook to determine Mr P was* "well but homeless". *Given homelessness had been recorded as a risk factor on his last CPA documentation, staff working with Mr P should have ensured that Mr P's risk of harm and risk of deterioration were reviewed and attempts should have been made to reengage him with trust services.

20 December 2004: final A&E presentation

5.136 On 20 December 2004 Mr P presented at the A&E department of the Royal Surrey County Hospital and was seen by the crisis team. Mr P described a history of intermittently hearing voices with the voices becoming more intense. Over the past two days he described the voices as continuous and aggressive. The voices were telling him to kill his family and rip their hearts out. On 16 December, Mr P assaulted a stranger at a train station because voices told him he was going to push him onto the tracks. He also believed that he had seen friends on the television telling him to hurt people. Mr P reported that he had been walking around in the woods that day trying to clear his head.

5.137 Mr P was noted as having previously been an inpatient at a psychiatric hospital and that he had been discharged on 16 December 2003 from the Abraham Cowley Unit. Mr P reportedly stopped taking his medication a year before because he thought he was able to cope without it. Mr P was experiencing paranoid delusions regarding a government plot to kill him and expressing a desire to self harm. He was recorded in the A&E notes as being a paranoid schizophrenic with thoughts to harm others and was assessed as high risk. Mr P was referred by the A&E department to Guildford and Waverley crisis team.

5.138 On the evening of 20 December 2004, following the referral from the A&E department, Mr P was reviewed by a CMHT nurse. Mr P was noted to be rambling about voices and said that he felt paranoid. Mr P stated that he had been living at Vaughan House, but he had been asked to leave and was subsequently of no fixed abode.

5.139 Mr P felt that he was in need of medication but did not want to register with a GP. Mr P told the nurse that he was asking too many questions and became threatening. He said he did not want to see him as he was not a psychiatrist. The outcome of the assessment was reported to the A&E doctor. According to the CMHT nurse, Mr P did not

appear to be psychotic or at risk of self harm. He was documented as being a cannabis user, having last used cannabis three or four days ago. The plan was to:

- encourage Mr P to register with a GP
- discharge him.

Comment

Mr P presented with violent thoughts similar to those described on previous occasions. However the CMHT nurse did not consider Mr P to be psychotic, at risk of self-harm or in need of an inpatient admission.

Despite the crisis team in the A&E department assessing Mr P as high risk there was no evidence of a risk assessment or risk management plan being considered by the CMHT before discharging him. It is unclear how much information the CMHT nurse had about Mr P's past engagement with trust services as the description of Mr P's involvement with the Abraham Cowley Unit was not entirely accurate. It is possible that the CMHT nurse was unaware of the length of time Mr P had spent as an inpatient at the Abraham Cowley unit or of his ongoing involvement with consultant psychiatrist 1 and his team.

During the assessment with the CMHT, Mr P disclosed recent cannabis use. Given his past deterioration following cannabis use, this should have alerted the nurse to a possible deterioration in Mr P's mental state. However, the plan was to encourage Mr P to register with a GP and no reference was made to referring Mr P to drug and alcohol services, arranging a follow-up in the community, or alerting his psychiatrist to his A&E presentation.

5.140 On 13 January 2005 Mr P was seen by consultant psychiatrist 1 and social worker 1. Mr P was described as having been symptom free for several months and no longer on psychiatric medication. There were no signs of mental illness.

Comment

Given this description of Mr P, it would appear that consultant psychiatrist 1 was unaware that he had presented to A&E on 20 December 2004 (three weeks earlier).

5.141 On 18 January consultant psychiatrist 1 wrote to the Crescent Unit[1] in support of Mr P's application for residence there. He stated that he:

> *"Would not consider him [Mr P] to be in any way a dangerous individual and he appears to have matured somewhat over the past few years."*

5.142 Consultant psychiatrist 1 stated that he was sure that a period of stability at the Crescent Unit would consolidate his improvements and lead to further maturation. Consultant psychiatrist 1 said that he would remain involved with Mr P's care and stated that Mr P had agreed to attend outpatient appointments with him every two months. Social worker 1, Mr P's approved social worker, also provided support for Mr P's application for residence at the Crescent Unit.

Comment

It is unclear from the clinical notes whether risk assessment forms and CPA documentation were sent with the housing application – but we would expect Mr P's history of violence to be disclosed with the application.

5.143 On 2 March 2005 a supported housing worker sent an email to social worker 1 saying that Mr P had been living at the Crescent Unit for approximately two weeks and was doing well. Mr P was due to start counselling sessions the following day.

5.144 On 29 March 2005 Mr P appeared at Woking Magistrates' Court charged with assault. He pleaded guilty and was fined £200. He was also issued with notice to leave the Crescent Unit by noon on 1 April. There is no information detailing why Mr P had been

[1] The Crescent Unit in Woking is run by Surrey Community Development Trust. It provides supported housing for 14 people aged 18-30 years.

asked to leave, however it is believed that this request followed a physical assault on another resident.

5.145 Mr P was due to go to the Crescent Unit on 7 April 2005 to return his keys and collect the rest of his belongings. He failed to do so. On 8 April a supported housing worker at the Crescent Unit wrote to social worker 1 to inform him that Mr P was alleged to have assaulted another resident twice in one week and had subsequently been remanded at HMP Highdown. If this was the case, Mr P must have been released before 28 April when he was arrested for theft and damage and for giving a false name and address. The police contacted social worker 1 who told them that Mr P was well enough to be dealt with via the criminal justice system. Social worker 1 asked the police to contact the mentally disordered offenders service should there be any concerns regarding Mr P's mental state.

5.146 At some point between 28 April 2005 and 6 May Mr P was released from HMP Highdown. He was referred by his GP to Guildford CMHT on 6 May. The referral was marked as 'routine' (response required within 10 working days). Risks to others were felt to be 'low at present'. The reason for the referral was recorded as:

> *"History of schizophrenia, originally on quetiapine. Seen by CHMT crisis team in December 2004 but then moved out of area. Is worried that people are controlling him."*

5.147 The form indicated that the GP had no information about Mr P's past convictions, drug use or involvement with other agencies.

Comment

Mr P was sentenced for an assault on 29 March 2005 at Woking Magistrates' Court. There is no evidence to suggest that this information was shared with mental health services. Having such knowledge may have prompted staff to try to reengage with Mr P as the assault might have been an indication that his mental health was again deteriorating. Mr P's previous behaviour demonstrated a link between escalating drug use, deteriorating mental health and deteriorating behaviour.

In April social worker 1 was aware that Mr P was again involved with the criminal justice system, but no steps were taken to try to re-engage him with mental health services.

In relation to Mr P's GP referring him to Guildford CMHT, there is no mention in the referral documentation of Mr P's inpatient episodes or violent past behaviour, his trigger factors or propensity to behave violently and impulsively. The GP did however record that Mr P is **"worried that people are controlling him"** ***which would indicate a return to previous paranoid behaviour typical of previous hospital presentations.***

At this point Mr P was still recorded as being managed under enhanced CPA. Mr P's GP should have been aware of this as documentation following CPA meetings should have been sent to him. Mr P's most recent CPA documentation says to alert consultant psychiatrist 1 and his CPN in the event of deterioration. This did not appear to happen. However if Mr P was newly registered with this GP it is possible that he was not yet in possession of Mr P's full mental health history.

If consultant psychiatrist 1 had been made aware of Mr P's deteriorating mental health, steps could have been made to reengage him with trust services.

5.148 Guildford CMHT acknowledged GP 1's referral on 12 May 2005.

5.149 On 26 May 2005 social worker 2, social worker at Guildford CMHT, wrote to Mr P offering him an assessment appointment for 31 May. Mr P failed to attend. On 1 June social worker 2 discussed Mr P's case with a member of staff at No. 5 Project where Mr P was living. There were no concerns raised by housing staff but social worker 2 offered Mr P a further appointment for 7 June.

5.150 Mr P failed to attend the appointment with social worker 2 on 7 June 2005. He told staff at No. 5 Project that he did not want to see anyone and that he did not feel he needed CMHT support.

5.151 On 20 June 2005 Mr P was discharged from Guildford CMHT by social worker 2 due to non-engagement. A letter confirming this was sent to Mr P's GP and staff at No. 5 were

also informed. The letter from social worker 2 stated that she had regular contact with No. 5 Project so if Mr P's mental health deteriorated or he became willing to engage then a further appointment would be offered.

5.152 One week later (on 27 June 2005) a member of the public found Mr Q's body at Pewley Down, near Guildford.

5.153 Later that week Mr P and another man were arrested and Mr P was charged with murder at Guildford Magistrates' Court.

5.154 On 19 February 2007 Mr P pleaded guilty at the Old Bailey to the manslaughter of Mr Q. He has been detained at Broadmoor Hospital indefinitely under the Mental Health Act.

6. Arising issues, comment and analysis

6.1 In this section we have reviewed the policies and procedures that were in place at the trust at the time Mr P was known to the services. We have also looked at the trust's current policies and procedures and other documentation to establish what improvements have been made since the incident in June 2005. We interviewed senior trust managers who gave us examples of how policies and procedures have been operationalised. A full list of the documents reviewed can be found at appendix B.

6.2 In keeping with our remit we have considered the key issues relating to policies and practice identified by the internal review team in January 2006 and further areas that have emerged during our independent investigation. We have not undertaken an independent audit but have relied on information provided by the trust.

6.3 The trust's internal review highlighted concerns regarding risk assessment and risk management, record keeping and communication, use of Section 117, the management of Mr P's non-engagement and the involvement of drug and alcohol services.

6.4 The terms of reference for this investigation ask that we assess:

- the adequacy of any risk assessments and risk management plans carried out – including specifically any relating to the potential for Mr P to harm others
- the extent to which the trust received and used information sought or supplied from other agencies to shape risk assessment and risk management plans
- whether CPA was carried out in keeping with the trust's policy
- any new developments or improvements in services since Mr P's engagement with mental health services.

Risk assessment and management of Mr P

6.5 The deputy medical director told us that in 2005 trust services used a paper-based system to record risk. This involved extensive hand-written notes. This system did not make it easy for the various teams and services involved in a patient's care to get an instant overview of a patient's risk or his or her previous involvement with services.

6.6 The trust was unable to locate the risk management policy in place at the time Mr P was known to trust services. However, they provided a copy of the *CPA risk assessment and management procedure* which came into effect in June 2007, two years after the offence. This policy says:

> *"For service users in the community, the care co-coordinator or the professional assessing the patient at the point of referral will complete the part I, the initial risk assessment and screening form and part 2, the risk findings and management form… The care co-coordinator is responsible for ensuring that the risks are reviewed on a regular basis and the care plan reflects any changes using part 2, the risk findings and the action plan form."*

6.7 Mr P's greatest contact with trust services was during an inpatient stay between January and August 2003. During this time his risk was regularly reviewed. However, risk documentation was often only partially completed and clinical risk management forms were frequently not filled in. For example although 'summary of risk status and care programme approach level' forms were regularly completed, the level of CPA under which Mr P should be managed was not identified until 15 February 2003. By this point, Mr P had been an inpatient for a month and had been admitted to hospital twice before.

6.8 When Mr P was discharged into the community there is no evidence to suggest that his risk management plan was reviewed or amended.

6.9 Mr P generally presented to mental health when he was in crisis. There were some attempts to engage Mr P following discharge. For example, on one occasion consultant psychiatrist 1 contacted Mr P's GP asking him to ask Mr P to contact him if he sees him. However, overall, there was a lack of long-term planning and recognition of Mr P's needs in order to reduce his risk of harm and of deteriorating mental health while in the community. Instead, he was offered support as and when he presented.

6.10 There was a lack of consistency in recording drug use as a trigger to Mr P's deteriorating mental health. This trigger was first identified on 10 July 2003 despite it being a feature of his presentations since November 1997. The need to take action should Mr P return to drug use was not recognised.

6.11 After 10 July 2003 drug use was not a consistent feature in Mr P's CPA documentation, despite escalating drug use remaining a constant risk for deterioration.

6.12 Mr P had presented to mental health services on a number of occasions over nine years with essentially the same symptoms: auditory hallucinations, violent and paranoid thoughts and the desire to hurt himself and others. His diagnosis altered during this time as did his perceived level of risk. Generally, it appears that Mr P's risk was based on past presentations and did not demonstrate that consideration had been given to the fact that Mr P may act upon his violent thoughts. This is despite Mr P having committed, and been charged with, violent acts on numerous occasions during this time.

6.13 A full assessment of risk is arguably based on a full assessment of the person in a holistic sense and this has to include personality aspects. The account of Mr P's care gives the impression of staff not engaging with the 'whole person' and at time focusing on treating the condition rather than Mr P as a person.

6.14 As part of Mr P's risk assessment, a psychological formulation focusing on personality could have been undertaken. This may have influenced Mr P's risk management by guiding staff in what would help to engage Mr P in appropriate services. It could have also helped define where Mr P's personal responsibility for his actions should start and end.

Findings

Throughout Mr P's involvement with trust services risk assessments were completed but risk documentation was only partially completed. Irrespective of diagnosis, Mr P's risk should have been assessed based on his presenting behaviour. There was a lack of long-term planning and risk management in Mr P's care and treatment.

There was also a lack of consistent recognition of the significant detrimental impact drug use had on Mr P's mental health. Once the link between drug use and deterioration in Mr P's mental health was identified by trust staff no action was taken when Mr P returned to heavy cannabis use. This indicates a disconnection between addiction and mental health services.

Learning points

L1 The trust should continue to ensure, through personal development plans and supervision, that all staff in direct contact with patients receive training in the assessment, planning and management of risk. The trust should ensure that staff receive risk assessment training and are declared competent before conducting any risk assessments. Compliance should be audited no less than every three months by the clinical governance team. Findings should then be reported to the trust board at appropriate times, as defined by the trust's governance processes.

L2 The trust should assure itself that the current process for Care Programme Approach (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report its findings to the board.

L3 The trust should ensure that all staff adhere to the trust's policy and procedure for managing formal and informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments.

Communication between agencies involved with Mr P's care and treatment

6.15 Mr P was known to a number of services between November 1997 and June 2005:

- Abraham Cowley Unit (mental health service)
- mentally disordered offenders service (through psychology input)
- community mental health team (CMHT)
- crisis team
- drug and alcohol service
- primary care (through his GP)
- supported housing service
- probation service (through probation officer IP)
- police
- courts.

6.16 Mental health services understood Mr P's propensity towards violence and were aware that he had served custodial sentences for violent acts. Beyond gathering this information, there did not appear to be further communication with the police or the probation service in order to manage the risk that Mr P posed.

6.17 Mr P was not at any point during his contact with mental health services subject to Multi Agency Public Protection Arrangements (MAPPA)[1]. As Mr P had not committed a 'serious offence' since 1998 he was unlikely to have qualified for management under MAPPA.

6.18 Teams and agencies involved in Mr P's care shared information appropriately on a number of occasions. For example Mr P's probation officer alerted mental health services when she felt Mr P's mental health was deteriorating. However, despite the fact that Mr P was particularly difficult to engage with when in the community, there were occasions when services could have worked together better to provide a more holistic approach to his care and treatment. For example, consultant psychiatrist 1 did not appear to be aware of Mr P's presentation to A&E in December 2004 as in January 2005 he wrote to housing services stating that Mr P had been symptom-free for a while. If consultant psychiatrist 1 had been alerted to Mr P's A&E presentation less than a month earlier his views of Mr P's presentation and risk would probably have been different.

6.19 There were also occasions when Mr P presented at A&E departments and the assessing staff were not fully aware of the extent of his involvement with mental health services. This certainly seemed to be the case when Mr P attended the Royal Surrey County Hospital, Guildford, on 20 December 2004 and was assessed by a CMHT nurse. If the nurse had known the extent of Mr P's involvement with services, risk factors and diagnosis, then attempts may have been made to try to reengage Mr P with mental health services.

6.20 The lack of sharing of information in Mr P's case may have been, in part, due to different services operating different IT systems.

[1] MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and was strengthened under the Criminal Justice Act 2003. It tasks the 'responsible authorities' (including the local probation and mental health services) with the management of high-risk offenders in the community.

6.21 Irrespective of the different operating systems the agencies involved in Mr P's care and treatment could have worked together more closely to share information about the risk he posed and develop a robust plan to manage the risks.

6.22 There is little documented evidence to suggest that attempts were made to reengage Mr P when he failed to attend appointments. There was an occasion when consultant psychiatrist 1 wrote to Mr P's GP to inform him that Mr P had discharged himself and sought his help in persuading Mr P to reengage with trust services. However, there were a number of occasions where Mr P's failure to engage resulted in him being discharged from services. This was the case with the Windmill Drug and Alcohol Service. There is no information recorded to say what attempts were made to engage Mr P with its services.

6.23 The trust was unable to locate a copy of the policy in place to manage non-attendance (DNA) at the time Mr P was discharged from drug and alcohol services in October 2003. The trust did, however, provide a copy of the DNA policy introduced in February 2006. The policy says that if a service user fails to attend a follow-up appointment then the professional is to assess risk and liaise with the referrer and any appropriate others. In Mr P's case there is no evidence that his risk was assessed before being discharged from the drug and alcohol service.

Findings

There are some examples in Mr P's care and treatment of effective communication between trust services and external agencies. However, there were a number of instances when trust services did not share information which may of helped the assessing team to understand better the complexity of Mr P's needs.

When Mr P failed to attend appointments with trust services there is no evidence to suggest that his non-attendance was shared with the appropriate services to allow for follow-up action to be taken.

Learning point

L4 The trust should continue to develop relationships with partnership agencies. This should include, within the next three months, the trust reviewing the protocols with partnership agencies to ensure effective communication and information sharing for the safety of patients and the general public e.g. information to service providers such as housing associations and hostels.

Mr P's management under CPA

6.24 Mr P was first recorded as needing to be managed on enhanced CPA on 15 February 2003. By this point Mr P had been known to mental health services for over five years. He was diagnosed as having a 'serious mental illness' in December 2000 which should have triggered management under CPA.

6.25 Once Mr P was assessed as needing to be managed under enhanced CPA, further enhanced CPA meetings took place on:

- 10 July 2003
- 10 August 2003
- 11 September 2003
- 2 October 2003
- 10 May 2004.

6.26 Between 10 May 2004 and the offence in June 2005 no CPA meetings were held (or certainly no details of any such meetings were recorded). In line with Mr P's final CPA, he should have continued to be managed under enhanced CPA during this period. However, when he presented at the A&E department of the Royal Surrey County Hospital and was seen by a CMHT nurse on 20 December 2004 he was discharged and encouraged to register with a GP. There does not appear to have been any attempt to reengage Mr P with mental health services or manage his care in line with enhanced CPA requirements. It is quite possible that the CMHT nurse was unaware that Mr P was subject to enhanced CPA requirements.

6.27 When Mr P was seen by consultant psychiatrist 1 and social worker 1 on 13 January 2005 there was no recognition that he had presented at A&E three weeks earlier. Mr P was described as having been symptom free for several months. There is no documentation to suggest that during this review consultant psychiatrist 1 or social worker 1 reviewed Mr P's CPA level or amended his care plan. Therefore, by default, Mr P should have continued to be managed in line with the requirements of enhanced CPA.

6.28 On 6 May 2005 Mr P's GP referred Mr P to Guildford CMHT. The referral was marked as 'routine' (response required within 10 working days). Risks to others were felt to be "*low at present*". The reason for the referral was recorded as:

> *"History of schizophrenia, originally on Quetiapine. Seen by CHMT crisis team in December 2004 but then moved out of area. Is worried that people are controlling him."*

6.29 There is no indication that Mr P's GP was aware of the CPA level under which Mr P should have been managed at that time. He made no attempt to contact consultant psychiatrist 1 or the CPN as stated as the action to take in Mr P's crisis and contingency plan (attached to the CPA documentation) if there were concerns his mental health was deteriorating.

6.30 Mr P was discharged from the Abraham Cowley Unit on 11 September 2003 having gone on leave at the end of August and failed to return. As he had been under a Section 3 earlier in his inpatient stay, health and social services were obliged to provide aftercare services to Mr P through a Section 117.

6.31 Although a discharge plan was compiled for Mr P there is no evidence to suggest that appropriate attempts were made to reestablish contact with him once he failed to engage with trust services.

6.32 The trust's internal investigation report states that Mr P's treatment plan was effectively changed from enhanced CPA to standard CPA by virtue of him not turning up for appointments. This was despite being subject to Section 117 follow-up arrangements after he was discharged from Section 3. If staff involved in Mr P's care found that he was suitable to be managed under standard CPA this decision, and the justification for it,

should have been documented and the appropriate CPA and risk paperwork should have been completed.

6.33 Downgrading Mr P to standard CPA as a direct result of his poor engagement with trust services was not an adequate justification. Particularly given that Mr P should have been managed in line with Section 117 aftercare arrangements.

6.34 We acknowledge that Mr P was difficult to engage when in the community, primarily as a result of being homeless. However, when he did engage, more could have been done to encourage future engagement rather than reacting to each individual presentation as a one-off episode. Mr P often presented in crisis when he was homeless and using excessive amounts of cannabis. Given that his risk factors for deterioration were identified as homelessness and disengagement with mental health services (and sometimes recorded as cannabis use but not consistently) more could have been done to try to manage Mr P in a more long-term manner when he did engage with services.

6.35 CPA meetings were generally well attended by the services involved in Mr P's care and treatment. However once Mr P failed to engage there was little attempt to activate any risk management or contingency plan.

6.36 Drug use was a consistent feature in Mr P's deteriorating mental health since his first presentation in November 1997. Despite this, drug use did not feature as a sign of potential relapse in Mr P's care plans until an enhanced CPA meeting on 10 July 2003. Having identified this risk factor and despite it still remaining a feature of Mr P's deteriorating mental health it did not feature on his next CPA documentation, completed on 2 October 2003. It did, however, reappear in a clinical risk management form completed by CPN 1 on 17 October 2003. Drug misuse did not feature as a risk of relapse on the final CPA documentation that was completed on 10 May 2004. This was despite the fact that consultant psychiatrist 1 had assessed Mr P as having suffered from a brief psychotic reaction to drug misuse in February 2004. This clearly indicates a disconnection between addiction and mental health services.

6.37 Mr P had three inpatient episodes at the Abraham Cowley Unit. On the first occasion (2 September 1999 to 9 September 1999) he was discharged with no accommodation plans in place. It was agreed that psychiatric specialist 1, associate specialist in psychiatry, would review Mr P in his outpatient clinic. Despite drugs and

alcohol being a feature of Mr P's presentation on 2 September he was not referred to drug and alcohol services.

6.38 On the second occasion (13 January 2003 to 2 September 2003) Mr P went on leave at the end of August and did not return. He was discharged in his absence on 2 September 2003. During this inpatient episode Mr P was subject to a Section 3 and therefore Section 117 aftercare arrangements should have been instigated on discharge, but they were not. Mr P was not seen again by trust services until he re-presented on Blake Ward on 24 September 2003 seeking support with an accommodation application.

6.39 Mr P was discharged from his final inpatient episode (25 October 2003 to 16 December 2003) after allegations from other patients that he was bringing cannabis onto the ward. There is no documentary evidence to say that Mr P was considered 'ready' to be discharged, although his risk was recorded as low and he was deemed to be "*mentally stable at present*". Therefore, it can only be assumed that he was discharged as a direct result of these allegations. On discharge, the plan was for Mr P to be followed up by his CPN in two weeks and for CPN 1, his care coordinator, to liaise with Mr P regarding accommodation needs. Once again, Mr P was homeless as a result of being discharged.

6.40 Carers' assessments did not take place at any point during Mr P's involvement with trust services. There were attempts to engage Mr P's parents in his care and treatment, although it is recorded that Mr P was reluctant for them to be involved. This lack of carer support should have been recognised as a potential risk factor by staff working with Mr P.

Findings

Crisis and contingency planning in Mr P's case could and should have been more robust, consistent and focused. Once areas of potential relapse had been identified more could have been done by trust services to take action to reengage Mr P.

Mr P's CPA was not reviewed between 10 May 2004 and the offence in June 2005. In the absence of documentary evidence to suggest otherwise, Mr P should have continued to have been managed under enhanced CPA. We found no evidence to justify his lack of management after 10 May 2004.

New developments or improvements in services since Mr P's engagement with mental health services

6.41 Since Mr P was known to trust services there has been a considerable amount of change to service provision and service delivery.

Risk management arrangements

6.42 The trust is now using an electronic-based system called 'RiO'. RiO provides an electronic version of each patient's care record. This means that up-to-date client information is available to all trust staff. This enables healthcare professionals to take a holistic view of the patient and to provide a more joined-up approach to care and treatment. RiO has also helped practitioners to think about risk both in the short and long term and helps them to describe it more accurately. Trust managers described RiO as transformative in the way in which it enables staff to manage risk.

6.43 The trust's current policy entitled *Care planning and assessment procedure* (implemented September 2010) states that:

> *"Effective care planning requires good risk assessment and clear risk management planning."*

It goes on:

> *"A comprehensive multi-disciplinary assessment of the person's needs for health and social care and any risks they face or present and the subsequent agreement on the person's outcomes, managing risk and including crisis and contingency plans will take place. Assessment is an ongoing process which involves constant monitoring of any changes in needs. Assessments will be integrated where possible; in some circumstances assessments carried out separately by different agencies will be combined."*

6.44 The policy places emphasis on having a multidisciplinary approach to risk assessments. In Mr P's case, he would have benefitted from greater involvement from the community mental health team to ensure that his care continued in the community.

6.45 Mr P had a history of self-discharge and poor engagement once in the community. A multidisciplinary approach may have helped those responsible for his care and treatment to get a better understanding of his needs outside of hospital. It may have also given staff the opportunity to identify early warning signs of deterioration in his mental health rather than wait for him to present to acute services in crisis.

6.46 We also learnt that 96 per cent of staff have undertaken risk assessment training, which forms part of the trust's mandatory training programme.

Finding

The trust has taken significant steps to improve the way risk is assessed, managed and reviewed. This has included the introduction of a new electronic system for recording, reviewing and summarising risk. All trust staff have access to this system.

Risk assessment training will help to ensure that only suitably trained and competent staff undertake risk assessments.

Communication systems and processes

6.47 The trust has introduced a number of measures to improve communication between agencies.

6.48 The trust's relationship with Surrey Police has developed significantly over the past couple of years. The trust has setup a clinical referral unit at Surrey Police headquarters in Guildford. The unit is operated by two members of trust staff who have full access to RiO. This means that anyone who would have previously been automatically subject to a Section 136 can instead have his or her care plan accessed immediately by trust staff based at police headquarters. Trust staff can then inform police of the best course of action to take.

6.49 The trust has also introduced monthly multidisciplinary risk panels attended by expert clinicians in the area of risk. Clinical teams are encouraged to bring cases to the risk panel if they are struggling with the long-term management of a particular client. The

risk panel provides a comprehensive view on the case and recommendations for the way forward. Whilst these are only attended by trust staff, any member of the clinical team working with a patient can bring the case to a risk panel.

6.50 The trust introduced a CPA risk assessment and management procedure in December 2007. In relation to patients failing to attend follow-up appointments it says:

> *"Patients who presents risk to themselves or others and do not attend appointments (DNA) must be followed up. Any significant change of risk requires a review of the risk documentation. Care co-coordinators must make every attempt to contact service user (i.e. visit). Any significant change of risk to the service user or others must be discussed with the care team. The risk documentation and agreed care plan to address and minimize the identified risks must be shared with all members of the care team and others deemed necessary."*

6.51 We asked a senior trust manager how they work with service users who are homeless in a way which encourages ongoing engagement. He told us that all people who use trust services have an initial assessment of their health and social care needs. Regular reviews take place which take account of housing and homeless issues in line with CPA requirements. If housing or homeless issues are identified, staff provide information and support to liaise with the borough councils who are the responsible authority for assessing housing needs. The trust also works closely with the local borough councils, each council has a 'special needs housing panel' which community mental health response service (CMHRS) staff usually attend. CMHRS staff also work with other providers to find accommodation for homeless people such as night shelters and hostels.

Finding

The trust has taken significant steps to improve communication between teams and external agencies. One of the most notable changes has been the improved working relationship with Surrey Police. This relationship has had a significant impact on the care of patients in the community who come to the attention of the police. The introduction of RiO has also helped staff share patient information in a much more timely way.

The introduction of monthly multidisciplinary risk panels has given clinical staff the opportunity to gather the views of others clinicians in the management of difficult cases.

The trust has also taken steps to ensure that potential risk factors such as homelessness are regularly reviewed and discussed in conjunction with relevant partner organisations.

Learning point

L5 The trust should continue to encourage risk panel meetings. In circumstances where there is significant uncertainty about an individual patient's diagnosis and/or treatment plan, these cases should automatically be discussed in an appropriate forum, with other clinical colleagues, to assist in developing an appropriate care and risk management plan.

CPA arrangements

6.52 The trust now operates under the *Care planning and assessment procedure*, introduced in September 2010.

6.53 If Mr P was involved with trust services today, he would have been managed under CPA arrangements. Some of the qualifying factors outlined in the trust's policy include:

> *"• Severe mental health concern (including personality disorder) with a high degree of clinical complexity*
> *• Current or potential risk(s), including:*
> - *Suicide, self harm, harm to others (including history of offending)*
> - *Relapse history requiring urgent response*
> - *Presence of non-physical co-morbidity including substance/alcohol/prescription drugs misuse, learning disability*
> - *Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies*
> - *Currently/recently detained under Mental Health Act, on Supervised*

- *Community Treatment or Guardianship, and most people subject to S.117*
- *MHA or referred to crisis/home treatment teams*
- *Unsettled accommodation/housing issues*
- *Employment issues when experiencing a mental health problem"*

6.54 The trust's current policy states that CPA review meetings must be held:

"a) No later than 12 weeks after referral for all new people who use services
b) No later than one month after discharge from inpatient facilities
c) At least every 12 months
d) If there is a significant change in the person who uses services circumstances
e) Before discharge from CPA or secondary mental health services
f) Before transfer of care to another mental health service or team
h) If it is necessary to bring the care team together for any other reason"

Finding

The trust's policy for managing patients under CPA arrangements is clear and robust and is in line with guidance set out by the Department of Health.

6.55 On 16 December 2003 Mr P was discharged from Blake Ward after other patients alleged that he was bringing cannabis onto the ward. Mr P denied this but refused to give a urine sample. There is no documentary evidence to say that Mr P was considered 'ready' to be discharged. Therefore, it can only be assumed that he was discharged as a direct result of these allegations. We asked a senior manager at the trust what would happen today in such circumstances. He told us that if a patient was accused of bringing drugs onto a ward then a multidisciplinary team meeting and/or CPA meeting would be held to discuss potential discharge. In the event that discharge was deemed appropriate, the team would ensure that a risk assessment and management plan are completed and recorded on RiO before discharge. Following discharge from the inpatient setting they would be managed by the community mental health response service team in the community. Their care would continue to be supported in coordination with primary care services.

Personality disorder

6.56 The trust reports that at the time Mr P was known to their services the provision of services for people with personality disorder was patchy. It lacked a consistent approach to engagement, assessment and management and there was no clear pathway of care according to severity of need and complexity. There was inconsistent use of out of area placements and limited access to specific personality disorder focused interventions. There was no clear step down process to enable people to move into more mainstream services.

6.57 The trust has already taken a number of steps to improve the provision of personality disorder services.

- Over recent years trust staff have undertaken comprehensive training on treatment approaches to personality disorder to enable them to work more effectively with this client group.

- In April 2011 the community services were redesigned, the new system enables staff to more readily identify the needs of people presenting with complex conditions including personality disorder.

- People with personality disorder, who are engaged with working age adults services in the trust, are now able to access focused treatments including systems training for emotional predictability and problem solving (STEPPS) and dialectical behavior therapy (DBT).

- Ongoing use of the local risk panels has allowed clinicians to share assessments, risks and formulations with senior colleagues to help in the effective care and treatment of people with personality disorder.

6.58 The trust also has a number of ongoing plans to further develop the services for people with personality disorder[1].

- The 'improving services for people with personality disorder' strategy was passed at the trust's executive meeting in July 2012. The strategy aims to help all staff and service users to be clear about the pathway of care for people with personality disorder and to work from shared principles. There is a tiered approach across services to assist those with highest need to be robustly assessed, engaged and treated if appropriate. One initiative is a tiered model of care with a virtual team working across a number of teams in a specific locality. This model enables the referral process to be more streamlined, with a single point of access into the personality disorder services. The other initiative is the establishment of the Oasis Transition Service in North West Surrey which provides a step-up/step-down service within the trust's personality disorder service and offers therapeutic group work to clients.

- There is a bigger emphasis on consultation for staff in community mental health recovery teams and the acute care pathway to be able to access expert advice and support in a timely way to assist the care and management of people with personality disorder

- Specialist psychotherapy services are focusing on the needs of people with personality disorder

Comment

Trust managers told us that Mr P would have been eligible and referred to either of the trust's current personality disorder services if they had been in place at the time.

Given Mr P's poor compliance with appointments, it is unclear whether he would have engaged with such a service, but a referral to the service would have been a positive move in terms of long-term management of his care and treatment.

[1] A full copy of the trust's implementation plan can be found at appendix C

Finding

The introduction of two new personality disorder services has had a fundamental impact on the way in which personality disorder is managed within the trust.

Learning point

L6 The trust should monitor and review the newly-developed personality disorder initiatives to ensure that all staff, medical and otherwise, are aware of what personality disorder services are available, how to refer, and the waiting time for referral. This should include knowledge of the referral process and criteria for referring service users to the personality disorder service for assessment.

Other issues

6.59 We identified two areas that we considered would benefit from further exploration as part of our independent investigation. These were:

- Mr P's diagnosis
- the role of the drug and alcohol service.

Mr P's diagnosis

6.60 During his engagement with trust services, Mr P did suffer from psychotic symptoms but there are two alternative explanations other than primary mental illness that could have accounted for these symptoms:

- result of street drug misuse
- result of psychopathology consequent to disturbed personality. For example the externalisation of internal psychological self-states.

6.61 The scope of our independent investigation and also the likely limitations of what evidence can be acquired means that we are not able to definitively say what Mr P's

diagnosis was in terms of mental illness versus personality disorder. Arguably this may not even be an appropriate question.

6.62 A more pertinent question is: "*Was there a personality disorder/dysfunctional aspects to his personality and if so what was done about it?*"

6.63 Another factor to consider is whether or not Mr P had a 'dual diagnosis' of various permutations of schizophrenia, brief psychotic episode, drug induced psychosis, direct effects of street drugs, and malingering.

6.64 In relation to personality disorder/dysfunctional aspects to personality there was:

- under recognition – the focus seemed to be more on Mr P's presenting symptoms of psychosis and response to incidents and events
- under emphasis – there did not appear to be any focus on the underlying issues of personality per se
- under engagement – unless you understand someone you cannot fully engage with them
- under treatment – there appeared to be little attempt to engage in psychological treatment of underlying personality dysfunction or proactive interventions on the social aspects of Mr P.

Finding

Having a better understanding of Mr P's diagnosis may have helped trust staff to engage him better and provide a more holistic approach to his care. In the absence of a firm diagnosis, Mr P's risk should have been assessed on his presenting behaviour.

The role of the drug and alcohol services

6.65 Mr P was first referred to drug and alcohol services on 24 February 2003 despite drug use being a feature of his presentation since his first contact with mental health services in November 1997. The first time drugs featured as part of his risk management plan was on 10 July 2003. Less than two months later it was documented that Mr P had

not engaged in any treatment offered by the Windmill Drug and Alcohol Team. Having had no further contact, he was discharged from its services on 27 October 2003.

Finding

Despite Mr P's mental health deteriorating following the use of heavy cannabis use (a feature in all his A&E presentations) there was little consideration of this being a factor in Mr P's deteriorating behaviour. His offending behaviour also escalated at times when his cannabis use had increased and mental health had deteriorated. There was clearly a disjunction between addiction and mental health services throughout Mr P's engagement with trust services.

6.66 A senior trust manager told us that drug and alcohol services are commissioned by Surrey Drug and Alcohol Action Team who manage the collective budget. The funding is received from NHS Surrey, the Home Office and the Department of Health.

6.67 Locally, the teams ensure that they work in conjunction with mental health services through nominated link workers. The link workers in the Drug and Alcohol Services are registered mental health trained workers. They attend meetings with mental health services to ensure that joint working is standard practice for dual diagnosed clients. They work to one CPA document with clearly defined roles for workers from each service. CPA's are reviewed jointly. A dual diagnosis list is reviewed regularly at local drug/alcohol services meetings and clients are only discharged with the agreement of both services.

Finding

The trust has taken steps to ensure that patients with a dual diagnosis are managed in a more holistic way with regular multi agency meetings and one jointly reviewed care plan.

7. The internal review

7.1 In this section we examine the trust's incident policy and whether the investigation into the care and treatment of Mr P met the requirements set out in the policy. We have not had sight of the incident management policy that was in place at the time of the incident, although we have been assured that there was one. We have, however, reviewed the trust's current policy.

Reporting of serious incidents

7.2 The trust's incident management policy (August 2011) states:

> "*The Trust recognises that it has legal, contractual and specific duties to report certain incidents to the various statutory and other bodies. It also has a duty to ensure that incidents are not only identified and reported, but that appropriate investigations are carried out to ensure that any actions arising or lessons to be learnt are transposed into the organisational culture to improve practice.*"

7.3 On 2 July 2005, social worker 1 saw on BBC Ceefax that Mr P was one of the men charged with the murder of Mr Q in Surrey on 26 June 2005. Social worker 1 informed his team manager. The team manager instigated the trust's serious untoward incident nvestigation process by informing all relevant managers and securing Mr P's clinical notes. The trust's chief executive was also informed that day.

7.4 On 4 July 2005 the trusts director of operations adult mental health completed an 'initial written report of a serious untoward incident' form. On 7 July 2005 the team manager completed an interim management report.

Trust's internal review

Finding

The trust commissioned an internal review into the care and treatment of Mr P. There were clear terms of reference and a non-executive lead was appointed.

The report documented the relevant aspects of Mr P's care and appropriately identified the learning points for the trust. The investigation team reviewed Mr P's records and interviewed the relevant staff involved in Mr P's care and summaries of the meetings were recorded.

Recommendations from the trust's review

7.5 The trust's report identified that improvement was needed in a number of areas and made seven recommendations (see table below).

Trust's progress against the recommendations made in the internal investigation report

Recommendation	Progress made
1. The teams and services need to examine and change their CPA and MHA practices to ensure full compliance with policy and procedure, with particular reference to the use and implications of Section 117 policies, transfer from enhanced to standard CPA and the need for a formal recording of decisions.	Completion of action signed off by scrutiny panel on 4 July 2007. Action taken included: • new CPA policy developed and implemented • CPA included in clinical audit and effectiveness plan • development of register of service users subject to Section 117.

2. The teams and services need to ensure that clients who display similar characteristics of an itinerant lifestyle, illicit drug use and a risk of aggressive acts are followed up proactively, to minimise the risk of losing contact and also to attempt to change and moderate behaviour through risk managements rather than crisis management.	Completion of action signed off by scrutiny panel on 7 November 2007. Action taken included: • review way in which services are provided to young adults across the three founder trust areas • benchmark practice against national standards to inform future delivery • develop trustwide DNA policy
3. There is a requirement for a protocol on actions to be taken when clients avoid contact with services, covering actions, timing and a decision-making mechanism for closing cases due to non-contact.	Completion of action signed off by scrutiny panel on 7 November 2007. Action taken included: • development of DNA policy which encompasses guidelines for clients who avoid contact • audit of discharge CPAs
4. The teams and services need to ensure that formalised risk assessment and management processes, including assessment of longitudinal risk over longer time periods, are in place and effectively used.	Completion of action signed off by scrutiny panel on 3 September 2008. Action taken included: • implementation of new CPA risk management protocol • HCR-20 training has taken place
5. The teams and services need to ensure that there is a pool of staff sufficiently trained and experienced in risk management to provide support to less experienced staff.	Action does not feature separately in the trust's action plan – but action completed through the training of staff in HCR-20.
6. All services need to ensure that there is a mechanism to enable communication of care details for itinerant clients with complex mental health needs to all local services and agencies, if there is a possibility of them moving area.	Completion of action signed off by scrutiny panel on 7 November 2007. Action taken included: • teams now have access to electronic CPA (as of 31 March 2006) • CPA policy includes system for both interim and final handover for clients who move areas.

7.	Systems and protocols to enable access to details of client care for all services need to be implemented, with particular need for access to information out of hours. Where these systems are in place there is a need to audit to identify shortfalls and problem areas, and to inform ongoing development of this facility.	Completion of action signed off by scrutiny panel on 20 May 2009. Action taken included: • electronic access to CPA • development of information recording and sharing policy • Development and implementation of TRACE (IT system).

Finding

Many of the recommendations are not result focused and do not identify how such proposed changes will be achieved. They do, however relate to the main issues in Mr P's care and treatment identified in the trust's internal investigation.

Learning point

L7 Point 4 of the trust's action plan states that the trust has delivered Historical, Clinical, Risk Management – 20 (HCR-20)training in response to the need to ensure that formalised risk assessment and management processes, including assessment of longitudinal risk over longer time periods, are in place and effectively used. However, HCR-20 is one tool for assessing risk and the trust needs to ensure that robust mechanisms are in place to support the actual management of risk.

Action plan

7.6 The trust developed an action plan to take forward the recommendations. In addition to examining the action, we interviewed the current medical director, the director of quality and performance and the deputy medical director. They were able to talk us through the action plan and demonstrate what improvements have been made.

Finding

The trust has provided significant evidence to demonstrate that the recommendations set by the trust's internal review team have been actioned and considerable improvement has been made in all the areas identified.

Timescale

7.7 The investigation began in September 2005 and was completed in January 2006. It was considered at the trust board the same month.

7.8 In relation to timescales for completing internal investigations into grade two incidents (which Mr P's case would have been classed), the trust's incident management policy (August 2011) states:

> "*The Operations Directorate Associate Director or nominated deputy along with the Investigator presents the serious incident investigation report and action plan to the Trust Scrutiny Panel within the following timescales:*
>
> - *Grade 2 incidents: within 55 working days (11 weeks) of the notification of the incident. For Grade 2 incidents the Trust Scrutiny Panel is required to formally approve the investigation report and action plan.*
> - *Grade 2 incidents will be shared with the Quality Committee, Executive Board and Trust Board following approval."*

Finding

The review team took 16 weeks from first convening to presenting the investigation report to the trust scrutiny panel. We have not had sight of the incident management policy that was in place at the time of the internal review. However, the trust's current policy stipulates that investigations should be completed within 11 weeks.

8. Overall analysis

8.1 There were several important aspects that could have changed the way in which trust services understood and engaged with Mr P. Greater attempts to engage Mr P and provide appropriate treatment options, such as in the management of personality disorder, could have provided Mr P with a better understanding of his mental health and equipped him to manage it.

8.2 First, there was a lack of recognition in the role drug use played in Mr P's deterioration in his mental health. This resulted in a disconnection between addiction and mental health services.

8.3 Mr P first came into contact with mental health services in London in November 1997. He was not deemed to have a serious mental illness at this time, but drugs and alcohol were recorded as an aspect of his presentation. From then on, throughout all Mr P's contact with mental health services both in the community and as an outpatient, excessive drug use continued to be a consistent feature of his presentation following deterioration in his mental health.

8.4 Despite this consistent feature, Mr P was not referred to the drug and alcohol service until 24 February 2003, over a month into his third inpatient episode. And drug use did not feature in his risk management plan until 10 July 2003. Thereafter, it was inconsistently referred to and no action was taken when it became clear that Mr P had returned to drug use.

8.5 Mr P was discharged from the drug and alcohol service on 27 October 2003 as he had failed to engage with the service. By March 2004 consultant psychiatrist 1 had assessed Mr P's deterioration in mental health to be the result of a brief transient psychotic reaction to drug misuse. Despite this, no attempts were made to reengage Mr P with drug services or amend his CPA documentation or risk management/contingency plan to reflect this change in diagnosis.

8.6 Mr P had committed numerous offences of a violent nature and had disclosed extremely violent thoughts. Despite this, there is no evidence in Mr P's clinical documentation to suggest that the extent of his dangerousness was ever fully explored. He was assessed as 'high risk' on numerous occasions. However, when he displayed behaviour of a potentially dangerous nature little was done to understand his behaviour fully or reassess the risk of harm he posed. For instance, after he absconded from the Abraham Cowley Unit and travelled to his father's address in Essex to carry out his "*mission*" (murder his parents), there is no evidence to suggest that when he returned to the ward, consideration was given to what might have occurred if his parents had been at home, or whether Mr P was capable of such acts of violence.

8.7 Mr P's risk was regularly reviewed whilst he was an inpatient between January 2003 and August 2003. However, documentation was often only partially completed and clinical risk management forms were frequently not filled in. For example, the level of CPA under which Mr P should be managed was not identified until 15 March 2003, when he had already been an inpatient for two months.

8.8 There is no evidence to suggest that in view of Mr P being discharged into the community that his risk management plan was reviewed or amended. Irrespective of whether a firm diagnosis had been reached, Mr P's risk should have been assessed based on his presenting behaviour.

8.9 When Mr P was discharged following an eight month inpatient stay he should have been subject to Section 117 aftercare arrangements as he had been on a Section 3 earlier in his admission. There is no evidence to suggest that the appropriate level of aftercare was provided to Mr P. He was readmitted to the Abraham Cowley Unit six weeks after being discharged following an eight month inpatient stay. This would suggest that his discharge in September 2003 was unsuccessful.

8.10 Trust services responded to Mr P's presentations, generally through the A&E department when he was in crisis. There were some attempts to engage Mr P following discharge. For example, on one occasion consultant psychiatrist 1 contacted Mr P's GP asking him to request that Mr P re-engages if he sees him. However, overall, there was a lack of long-term planning and recognition of Mr P's needs in order to reduce his risk of harm and of deteriorating mental health while in the community. Mr P could have

benefitted from a more long-term view on his care and treatment needs rather than reacting to his presentations when in crisis.

8.11 Throughout Mr P's CPA documentation there is reference to various triggers to his deteriorating mental health. They frequently included:

- homelessness
- disengagement with services
- non-compliance with medication
- cannabis use (although not consistently recorded in his CPA documentation).

8.12 Mr P was known to have a history of poor compliance with his medication in the community. He was frequently homeless and regularly disengaged with trust services. There was, therefore, a high likelihood that his mental health would deteriorate and he would subsequently require input from mental health services. Had these triggers been acted upon sooner, it may have been possible to manage Mr P in the community rather than him deteriorating to the point where he required an inpatient admission.

8.13 Mr P clearly did not cope well in the community and there was little support in place once he left the Abraham Cowley Unit. This resulted in him continually going in and out of inpatient services. A more long-term view of Mr P's treatment needs may have helped staff to understand and manage him in a better way. There should also have been recognition that lack of carer involvement and support in the community may have been a risk factor in Mr P's case.

8.14 On a number of occasions, information was appropriately shared between agencies. For example Mr P's probation officer alerted mental health services when she considered Mr P's mental health to be deteriorating. However, there were occasions when services could have worked together better to provide a more holistic approach to Mr P's care and treatment, particularly when he was discharged into the community. Nonetheless, we do recognise that Mr P was particularly difficult to engage with once in the community.

Lessons

8.15 Given the incident took place in 2005, the comprehensiveness of the trust's internal action plans and the evidence provided to demonstrate changes in practice, we have chosen not to make any recommendations. Instead we have identified seven areas in which the trust should continue to focus its efforts on improving and evaluating practice.

Risk assessment and management

L1 The trust should continue to ensure, through personal development plans and supervision, that all staff in direct contact with patients receive training in the assessment, planning and management of risk. The trust should ensure that staff receive risk assessment training and are declared competent before conducting any risk assessments. Compliance should be audited no less than every three months by the clinical governance team. Findings should then be reported to the trust board at appropriate times, as defined by the trust's governance processes.

L2 The trust should assure itself that the current process for Care Programme Approach (including care planning, risk assessment, risk management planning) is robust. The clinical governance team should audit compliance at least every six months and report its findings to the board.

L3 The trust should ensure that all staff adhere to the trust's policy and procedure for managing formal and informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments.

Partnership working

L4 The trust should continue to develop relationships with partnership agencies. This should include reviewing the protocols with partnership agencies to ensure effective communication and information sharing for the safety of patients and the general public e.g. information to service providers such as housing associations and hostels. This should take place within the next three months.

L5 The trust should continue to encourage risk panel meetings. In circumstances where there is significant uncertainty about an individual patient's diagnosis and/or treatment plan, these cases should automatically be discussed in an appropriate forum, with other clinical colleagues, to assist in developing an appropriate care and risk management plan.

Personality disorder service

L6 The trust should monitor and review the newly-developed personality disorder initiatives to ensure that all staff, medical and otherwise, are aware of what personality disorder services are available, how to refer, and the waiting time for referral. This should include knowledge of the referral process and criteria for referring service users to the personality disorder service for assessment.

Internal investigation finding

L7 Point 4 of the trust's action plan states that the trust has delivered Historical, Clinical, Risk Management – 20 (HCR-20)training in response to the need to ensure that formalised risk assessment and management processes, including assessment of longitudinal risk over longer time periods, are in place and effectively used. However, HCR-20 is one tool for assessing risk and the trust needs to ensure that robust mechanisms are in place to support the actual management of risk.

Appendix A

Mr P's history of violent behaviour

Date of incident	Nature of incident
1993	Abusive behaviour at school/assaulting a teacher
1995	Threw father down the stairs and hit mother over the head (she required 18 stitches)
1997	Mr P involved in two separate violent altercations –Mr P stabbed a young man in the leg on both occasions
1997	Mr P arrested for possession of a knife
1998	Mr P violent towards his foster father
1998	Mr P became involved in physical alterations with other residents at a bed and breakfast where he was living
1998	Mr P hit his mother's boyfriend in the face with a cricket bat resulting in a fractured jaw, cheekbone & broken nose
1998	Mr P given a caution for possession of a knife
1999	Mr P forced entry into a psychiatric unit in a violent manner
January 2000	Mr P appeared in Kingston Crown Court for an affray
January 2004	Mr P was in custody and charged with possession of a weapon
March 2004	Mr P was verbally abusive and threatening towards staff at Vaughan House
September 2004	Mr P had threatened to kill partner and unborn baby if she left him
December 2004	Mr P assaulted a stranger at a train station
March 2005	Two physical assaults on another resident at Vaughan House

Appendix B

Documents reviewed

- Absent without leave/missing person policy, September 2011
- Care planning and assessment procedure, September 2010
- Care programme approach policy, January 2007
- Care programme approach policy, October 2008
- Discharge from in-patient services, October 2007
- Dual diagnosis policy and procedure, October 2009
- Incident management policy, August 2011
- Integrated paper/electronic health records, September 2011
- Management of alcohol and drug use by service users/visitors on trust premises, March 2006
- Management of people with a dual diagnosis of mental health and learning disability, February 2007
- Medicines procedure: discharge notification and prescription sheet, November 2009
- Partnership policy on confidentiality and information recording & sharing, September 2007
- Policy and procedure for nonattendance of patients at appointments (DNA), February 2006
- Record management policy, October 2011
- Records management, November 2007
- Retention of records policy, March 2006
- Risk management strategy, October 2011
- The records management: NHS code of practice, April 2007

Appendix C

Surrey and Borders NHS Foundation Trust personality disorder implementation plan

Action	Date	Lead
Period of consultation on the proposal	August – October 2012	AL, HW and VB
Workshops to establish the Tier 3 teams – staffing and pathways	August – October 2012	Ads, psychology leads, medical consultant in psychotherapy, representatives from CMRS
Professional groups to audit their specific training needs and prioritise this training in collaboration with learning and development	August – September 2012	Professional leads for each of the professional groups
CMHRS review engagement, assessment and review process to ensure local alignment with strategy	August 2012	Operational Ads. CMHRS managers, CMHRS psychiatrists, multidisciplinary staff and QAG chairs
New pathways set up specifying the approaches and interventions provided by Tiers 2 and 3	September – October 2012	Ads, psychology leads, medical consultant in psychotherapy, representatives from CMHRS
Training programme developed and cascaded for CMHRs and 24/7 services	August – November 2012	Operational Ads, learning and development, psychology and psychotherapy clinicians
Communication plans	In progress	SC, AL, operational and professional Ads
Workshop to include practitioners from all SABP care groups to promote best practice across services	November 2013	Tier 3 leads, Ads older adults, CYPS and learning disability
Local audits of pathways and access to interventions	March 2013	Lead psychologist supported by an assistant-reports to QAGs
SABP workshop to celebrate progress on improving services for people with personality disorder	September 2013	Tier 3 leads in collaboration with Tier 2 and people who use services and carers
Review the strategy and update with improvements in access for all care groups	October 2013	Tier 3 in collaboration with Tier 2 and people who use services and carers

Appendix D

Team biographies

Amber Sargent

Amber joined Verita as a senior investigator in 2009. Previously she worked at the Care Quality Commission (CQC) where she led on several major investigations into patient safety, governance and concerns around performance.

In addition to carrying out reviews and investigations Amber leads Verita's work on reducing sickness absence within NHS trusts and improving medical devices safety. Amber is also involved with helping a foundation trust develop its care pathway for cardiology services and benchmarking the service both nationally and internationally.

Ed Marsden

Ed has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management before founding Verita in 2002. He combines his responsibilities as Verita's managing partner with an active role in leading complex investigations and advising clients on the political repercussions of high-profile investigations. He is an expert in investigative techniques and procedures. Ed is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration.