VERITA

IMPROVEMENT THROUGH INVESTIGATION

An independent investigation into the care and treatment of Mr G

Jointly commissioned by:
South West Strategic Health Authority and
East Midlands Strategic Health Authority

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Authors:
Brendan Ward
Chris Brougham

Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

Verita
53 Frith St
London W1D 4SN

Telephone **020 7494 5670**
Fax **020 7734 9325**

Email: enquiries@verita.net
Website: www.verita.net

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1. Introduction

1.1 This report provides an independent account of the care and treatment of Mr G who killed Mr V on 6 July 2006.

1.2 Mr V was a 43 year old man with a learning disability who was identified as vulnerable. The year before he died he moved into a one-bed flat in St Austell. After his death, Cornwall adult protection committee commissioned a serious case review to see if there were any lessons about how local professionals and agencies worked together to safeguard vulnerable adults.

1.3 NHS South West (the strategic health authority) commissioned this independent investigation into the care and treatment of Mr G with the full cooperation of Cornwall Partnership NHS Trust[1], Cornwall and Isles of Scilly Primary Care Trust, Cornwall County Council, Northamptonshire Healthcare NHS Trust[2], and South Western Ambulance Services NHS Trust. The investigation was commissioned in accordance with guidance published by the Department of Health in HSG 94(27), *Guidance on the discharge of mentally disordered people and their continuing care in the community,* and the updated paragraphs 33-6 issued in June 2005. It also takes into account the *Good practice guidance* issued by the National Patient Safety Agency in February 2008.

1.4 The amendment to the health service guidelines (HSG 94(27)) published in June 2005 proposed three purposes for an independent investigation:

- openness — the investigation should provide an open, transparent, factual and independent account of the incident and all associated matters
- learning lessons — finding out what has gone wrong and proposing how performance can be improved while balancing individual accountability with criticism of organisational systems and processes
- creating the circumstances for change and service improvement — making recommendations that help NHS organisations improve and develop and creating a climate in which organisations and individuals accept and act on what the report says.

[1] Cornwall Partnership NHS Trust became a foundation trust in March 2010 and is now known as Cornwall Partnership NHS Foundation Trust.
[2] Northamptonshire Partnership NHS Trust became a foundation trust in May 2009 and is now known as Northamptonshire Healthcare NHS Foundation Trust.

1.5 Verita, a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations, was commissioned to carry out this investigation. The investigators were Brendan Ward, a Verita associate, and Chris Brougham, one of Verita's senior investigators. Both have wide experience of managing health services and conducting reviews and investigations. The investigation team was supported by Dr Jayanth Srinivas, a consultant forensic psychiatrist from the Hatherton Centre in Stafford, who provided professional advice.

Acknowledgements

1.6 We would like to thank everyone who gave up time to give evidence to the investigation and who spoke so freely to us. Their contributions and reflections form the basis of any learning that can be usefully applied in the future provision of services.

2. Terms of reference

2.1 The terms of reference for this investigation were to:

- investigate the care and treatment of Mr G, including risk assessment and management
- produce a comprehensive chronology of the contacts between Mr G and the health and social care agencies and other appropriate agencies from the date of his first contact with the NHS in 1991
- identify gaps and omissions in the reviews carried out so far
- evaluate these gaps and omissions in order to make recommendations for the local health community.

This investigation was not a disciplinary process.

The investigation methodology

2.2 The investigation comprised three phases. The first phase resulted in the presentation of a tabular comprehensive chronology (with commentary) of the care and treatment of Mr G by health and social care services and his contact with other relevant agencies. The chronology starts in 1991 and includes his contacts with relevant agencies in Cornwall, Northamptonshire and London. The tabular chronology was discussed at a meeting with NHS South West in June 2009.

2.3 As a result of the complexity of involvement with various agencies, an additional narrative chronology of more than 100 pages was developed by us from the case notes. This afforded a valuable method of cross-checking information through the individual interviews.

2.4 The development of both chronologies formed the basis of the second phase of the investigation.

2.5 The second phase consisted of an evaluation of the various NHS and other investigations and reviews carried out to date with the purpose of identifying gaps and omissions. We reviewed the internal investigation by Cornwall Partnership NHS Trust, the independent quality assurance review commissioned by the trust and the serious case

review commissioned by Cornwall adult protection committee. We took into account the issues and recommendations identified by the chair of the Mr V serious case review dated December 2007. This was commissioned by the adult protection committee for Cornwall. We also took into account the chairs subsequent review and correspondence.

2.6 The third phase consisted of an evaluation of any relevant gaps and omissions, and included interviews with key NHS staff and those from relevant other agencies such as social services and the police. We looked primarily at organisational systems and processes, and in particular how different agencies worked together and at the governance arrangements supporting inter-agency working.

2.7 We conducted our work in private.

2.8 NHS South West obtained written consent from Mr G for access to any of his health or other records relevant to this investigation and to make the report public knowledge through publication of this report.

2.9 We met with Mr G to explain the terms of reference, to explain and discuss the process of the investigation and to hear his comments.

2.10 We wrote to the relatives of Mr V through a manager from the learning disability directorate of adult care and support at Cornwall County Council explaining the process of the independent investigation and enclosing a copy of the terms of reference. The manager told us that Mr V's nearest relative did not want to be involved in or contribute to this investigation. We wrote to the relatives again with an open invitation to see us at any point during the investigation but they did not take up this offer. We understand and respect their decision not to be involved.

2.11 The documentation we reviewed included Mr G's clinical notes from Cornwall Partnership NHS Trust, Cornwall children's and adult social services, South Western Ambulance Service NHS Trust, Northamptonshire mental health services, probation services and GP records. We gathered chronologies of events leading up to the murder which had previously been developed by the police and Cornwall social services. We also looked at incident reports, trust policies and procedures, board minutes and other relevant committee papers. In total we considered more than 6,000 pages of case files and operational policies. Some agencies submitted summaries of their involvement with Mr G

either because there was so much source material or references to Mr G were contained in case files for other clients. It was not possible to access historical case records from the specialist children's centre in Newton Aycliffe or the earlier notes from the probation service because services were unable to locate them.

2.12 We interviewed 44 people — see Appendix A for a list of interviewees.

2.13 We followed established good practice in the conduct of interviews. Interviewees were given the opportunity to be accompanied by an advocate or friend and to comment on the factual accuracy of the transcript of their evidence. Those criticised were shown extracts of the draft report so that they had the opportunity to comment before the report was finalised.

2.14 Part of the complexity of this case related to the number of agencies that had contact with Mr G at any one time, not always with the knowledge of others.

2.15 We set out a narrative of the main chronological events in the main body of the report so as to help the reader understand the key events and to provide an analysis of them. This provides the context of what was happening in Mr G's life at any time, alongside the analysis of the key processes applied by the organisations in engaging with him. It also presents the main evidence and details the investigators' findings and recommendations.

2.16 We examined how assessment (including the assessment of risk to self and others), care management and coordination and multi-agency working interacted in the care and treatment of Mr G. This narrative, rather than a simple analysis of the procedures alone, provides the reader with an understanding of the complexity the key professionals faced in providing care and treatment to Mr G.

2.17 Mr G's experience of the health, social care and criminal justice systems was influenced by the application of a number of procedures aimed at improving multi-agency assessments, risk formulations and treatment plans. These include:

- the care programme approach (CPA)
- Multi Agency Public Protection Arrangements (MAPPA)
- child protection procedures

- domestic abuse.

2.18 Each of these policies or procedures is explained in more detail in appendices at the end of the report. The investigation team examined the local policies and procedures that related to the above areas, allowing a view to be formed about how far they were applied.

2.19 We also comment in the report about the lack of specialist personality disorder services provided and whether Mr G should have been subject to safeguarding adult procedures.

2.20 The concept of 'risk' was synonymous with Mr G's presentations throughout his contact with health, social care and criminal justice agencies from his early teens onwards. Agencies made many assessments over the years of the risk he posed — to himself and/or to others. The fact that risks were identified is not in doubt. Many of these risks were common to a vast array of people these services see and treat every day.

2.21 The focus of this investigation has therefore been to explore how far these risk assessments informed the subsequent action of the professionals involved, were acted upon, shared with others (including the recipient of the assessment, Mr G), were proportionate, reviewed, and influenced the delivery of a clear and coherent plan to manage the presenting risks.

2.22 At the request of the commissioning body (NHS South West) individual names have been excluded from this report. The main subject of this report is referred to as Mr G, his partners and children as Partner A – D and Child 1 – 5. The professionals involved are referred to by their role e.g. consultant psychiatrist 1 – 6 or community psychiatric nurse 1 – 6.

2.23 Of necessity, this investigation report examines policies, procedures and practice in place at the time of the events that are reported. However, it is equally important to acknowledge the progress that has been made in the period since Mr V's untimely death. For example, a Serious Case Review (into Mr V's care and treatment) resulted in significant improvements in the Adult Safeguarding procedures in Cornwall. In turn, clinical and corporate governance factors have been subject to detailed scrutiny both prior to the acceptance of both Cornwall Partnership Trust and Northamptonshire Healthcare Trust

being approved as Foundation Trusts and via other external validation of their updated policies and procedures. Finally, central government guidance has assisted further development in areas such as the CPA, MARAC and Safeguarding procedures. It is clear that the two mental health trusts in Cornwall and Northamptonshire are different organisations today than they were in 1995 or 2005. However, we hope that the reflections and recommendations contained in this investigation report help them continue their overall improvements in the care and treatment they provide.

3. Executive summary and recommendations

Introduction

3.1 This report provides an independent account of the care and treatment of Mr G, who killed Mr V, a 43 year-old man, on 6 July 2006.

3.2 Mr V's body was found at the base of the St Austell railway viaduct.

3.3 Mr G was found guilty of the murder of Mr V and sentenced to 25 years' imprisonment in August 2007.

3.4 Mr V had learning disabilities and was identified as vulnerable. After his murder a separate serious case review of his care was carried out under safeguarding vulnerable adults' procedures.

3.5 NHS South West (the strategic health authority) commissioned this independent investigation into the care and treatment of Mr G with the full cooperation of Cornwall Partnership NHS Trust, Cornwall and Isles of Scilly Primary Care Trust, Cornwall County Council, Northamptonshire Healthcare NHS Trust, and South Western Ambulance Service NHS Trust.

3.6 The investigation is commissioned in accordance with guidance 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.

Overview of Mr G's treatment and care

3.7 Mr G was born in Northamptonshire on 26 February 1977. He spent his formative years living with his mother and her parents in Corby. His father left the area and joined the army before Mr G was born and had only intermittent contact with him nine or ten years later. Mr G's mother re-married when Mr G was aged three and a stepbrother was born in December 1980, followed by a stepsister in December 1982.

Concerns about "*behaviour difficulties*" at home began to emerge in 1989 when Mr G was 12, and he first saw an educational psychologist and later a child psychiatrist. Two years later Mr G was alleged to have had inappropriate contact with young girls. The following year similar allegations involving family members were made after Mr G ran away to London and had been sexually abused by a man in a homeless hostel. Both allegations of inappropriate sexual conduct with minors were investigated by police and social services but resulted in no further criminal proceedings because of insufficient evidence.

3.8 A period in residential care followed in 1992 (aged 15). Mr G's performance at school was poor and he was given a work experience placement in an older person's day centre. In January 1993 he was charged (and subsequently convicted) of sexually assaulting an elderly woman who attended the day centre.

3.9 A period of remand in care was followed by a period of assessment at a specialist adolescent psychiatric service in Manchester. The assessment team recommended a placement at a specialist residential treatment centre in County Durham. At his court appearance in July 1993 the court enacted this recommendation. Mr G remained at this residential centre until discharged in February 1995 around the time of his 18th birthday.

3.10 As Mr G was no longer subject to the care of the local authority and could not return home, he was placed in a flat in Kettering. His first experience of independent living did not appear to offer particular stability or security. He was arrested for offences of affray and arson early in 1996 and a period in HMP Glen Parva (Young Offenders' institution) preceded him being placed on a two-year probation order.

3.11 In September 1996 he decided to move to the Devon/Cornwall area. Within weeks of his arrival there, he was placed on remand at HMP Exeter, having been charged with robbery. A two-year probation order was imposed in March 1997, supported by a condition of residence at Meneghy bail hostel in Camborne.

3.12 Mr G's first contact with mental health services in Cornwall took place in 1997, with threats of self-harm preceding his admission to a psychiatric ward in November 1997. He was seen by a number of (mostly junior) doctors, but continually failed to keep follow-up appointments. No coordinated plan appeared to be in place to guide the proactive management of him when he did turn up.

3.13 Mr G met Partner A while he was a resident at the bail hostel. Their first child (Child 1) was born in December 1998 and Partner A was planning to return to live with her parents when Mr G set light to her jumper, causing £1,000 of damage to the flat. He was given a 30-month prison sentence in April 1999.

3.14 A Multi Agency Public Protection (MAPP) meeting was held before Mr G was discharged from prison in June 2000. Representatives from the police, probation and Cornwall Partnership NHS Trust attended the meeting. A multi-agency plan was put in place which resulted in Mr G residing at Meneghy bail hostel and receiving visits from a community psychiatric nurse (CPN). His earlier conviction for a sexual offence prompted child protection concerns in relation to his first child. His licence from prison made it possible to restrict his access arrangements to his child and to encourage his commitment to engage in a treatment programme run by the probation department. The forensic mental health team were also actively engaged in his care and treatment at this time.

3.15 When Mr G's prison licence expired in February 2001 his involvement with the probation service ceased. The forensic mental health team began to assume greater responsibility for Mr G, not only in respect of his mental health but also in supervising child access and offering specific sessions to explore his previous sexual offending behaviour. Mr G offered limited compliance and presented to mental health services mainly in crisis mode.

3.16 Child 2 was born in October 2001 and Child 3 was born in December 2002, both with Partner A. In May 2003, Child 3 was admitted to the high dependency unit at Treliske Hospital with injuries that were suspected to have been caused by shaking. Mr G's claims that he had accidentally dropped Child 3 were subject to further investigations. Mr G left Cornwall and returned to Northamptonshire. There was insufficient evidence to proceed with any criminal charges against Mr G.

3.17 Contact with mental health services in Northamptonshire was sporadic. Mr G continued a pattern of not engaging with the services by failing to turn up for appointments and discharging himself from hospital against medical advice. Between May 2003 and September 2004 Mr G moved frequently between Northamptonshire and Cornwall.

3.18 On one visit to St Austell, Cornwall, he met Partner B, a young woman who had been in the care of the local authority. Their relationship resulted in one miscarriage and the birth of Child 4 in August 2005. Concerns about domestic abuse (in relation to Partner B) and child protection (in relation to Child 4) resulted in a number of multi-agency meetings in 2005. Although the agencies involved were calling for greater input for Mr G from the mental health services, the predominant focus of their actions was in relation to Partner B and Child 4. These concerns reduced when Partner B chose to move from St Austell to Camborne shortly after the child's birth.

3.19 Mr G's frequent contact with the police, health and social care agencies continued on a mainly crisis basis during 2005. He unofficially moved into Mr V's flat at around September 2005. His frequent crisis contacts with the agencies continued over the ensuing months, the mental health and ambulance services adopting a policy of "*Do not visit alone*".

3.20 Mr G met Partner C and Partner D at Mr V's flat. Partner D reported a miscarriage in May 2006 and Partner C (who had previously been in the care of the local authority and had had a previous child with another partner) had Child 5 in October 2006. Concerns from neighbours about drug-related activity, alleged assaults, self-harm and domestic abuse emanated from Mr V's flat. Because the full picture was not known, either by one agency or through a collaborative mechanism for information sharing and risk assessment between those agencies involved, each incident was treated on face value rather than being interpreted as part of an escalating pattern.

Themes arising from independent investigation

3.21 As can be seen from the overview above Mr G received care and treatment from several agencies across counties for about 20 years. In that time the policies and practice of the agencies that engaged with Mr G have developed significantly. While we have commented on the quality and effectiveness of the services as they relate to the various periods covered in the chronology we provide a summary of the key themes that run throughout this period (see 3.24 below).

The assessments conducted during his childhood focused on:

- his presenting behaviour

- the need to address his vulnerability and risks
- the safety of others around him.

3.22 The focus on these three areas resulted in the requisite actions and management plans from the agencies involved. In his contact with adult services the attention given to each of these three factors was often less consistent or robust, often focussing predominantly on his presenting behaviour alone.

3.23 The themes we have identified are those that had a direct bearing on Mr G's risk profile. We identify several missed opportunities that would have provided a more systematic and organised approach to Mr G's care and treatment. Given the risks identified at regular intervals, it is conceivable that a continued targeting of those more vulnerable than himself might have been predicted. We have no evidence however to say that the homicide was preventable.

3.24 The key themes we identified from our investigations were:

- application of care programme approach (CPA)
- implementation of 'did not attend' protocols
- multi-agency working
- cross-county communication
- diagnosis of personality disorder and the provision of services to Mr G
- domestic abuse.

Care Programme Approach

3.25 The CPA was introduced in 1991 to provide systematic arrangements for the assessment and care planning of those people who are accepted by mental health services. It specified that for each patient a care coordinator should be appointed and a formal care plan drawn up that outlined any risks and included details of what should happen in an emergency or crisis.

3.26 There was an inconsistent approach in the application of CPA in relation to Mr G over the time he was in receipt of mental health services in both Northamptonshire and Cornwall. There were some periods (between 1998 and 1999 for example) where there was no documentary evidence that the CPA was applied at all. The first full CPA care plan in

the Cornwall Partnership NHS Trust notes was in February 2003 — five years after its initial contact with him.

3.27 Both before February 2003 and at stages thereafter, there was often a lack of clarity about who had been allocated as the care coordinator and what action was taken. In turn, throughout Mr G's care there was lack of evidence that care plans had been regularly reviewed.

3.28 A systematic approach to Mr G's health and social needs was important as, during his adult years, he was in touch with several different agencies and received care in two different counties. CPA, if used correctly, would have provided the approach needed.

'Did not attend' protocols

3.29 Mr G failed to attend outpatient appointments with both Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust on a regular basis.

3.30 Whilst there was evidence that, at times, concerted efforts were made by clinical staff to offer him further appointments and re-engage him with services, there was not a consistent approach. In particular, neither trust made sure that there was an assertive approach to missed appointments such as assessing the degree of clinical risk presented by Mr G based on the referral and past history.

Multi-agency working

3.31 Mr G presented to several agencies including the criminal justice system (the court, the prison, probation, both in Kettering and Cornwall), the primary care service (in Northamptonshire and Cornwall), secondary care services (in Corby and Cornwall), the emergency services (police and A&E in Kettering, Bedford, London, Plymouth and Cornwall) and inpatient psychiatric services (in Kettering and Cornwall). He also had a history of contact with child and adolescent psychiatric services in Prestwich and child and adolescent family service in Kettering. The local authorities (in Northamptonshire and Cornwall) were involved in his care and MAPPA systems (in Cornwall) were applied at various points in time.

3.32 Due to the above complexity, it would have been improbable if not impossible for a single care coordinator/team/agency to maintain oversight of Mr G's care and risks without robust communication and collaboration between services and agencies involved in his care.

3.33 There were examples during Mr G's care when agencies worked well together, for example when Mr G was subject to MAPPA (Multi Agency Public Protection Arrangements) and child protection procedures in 2000/01. Overall though, we found that information about Mr G was held separately by various services and not effectively shared. This led to clinicians and agencies working in isolation, dealing with the presenting crisis without necessarily exploring the historical or contextual factors influencing his presentation. Apart from the aforementioned period, no single agency had an up-to-date accurate, collateral history of the risks that Mr G posed.

3.34 On a number of occasions Mr G was discharged from mental health hospitals without multi-agency plans or risk management strategies having been put in place. On one of these occasions (March 2005), the local social services department challenged the mental health ward about why he had been discharged with no accommodation to go to. No further support was offered to the duty social worker and Mr G was simply presented with a travel warrant so he could return to Northamptonshire. This absence of effective discharge planning and multi-agency work was not registered formally with the mental health trust by the social services department.

Cross-county communication

3.35 Mr G moved between Northamptonshire and Cornwall on a frequent basis. He presented in crisis to criminal justice agencies, emergency services and to health services across both the counties. Effective liaison appeared to take place where a formal transfer of case responsibility was required, for example, the transfer of the probation order from Northamptonshire to Devon/Cornwall in 1998, the request (from Cornwall to Northamptonshire) for background information on child protection issues in 2000, and the formal transfer of the case between Cornwall and Northamptonshire mental health services. There were other times when requests for further information were not followed up, for example, the request from Northamptonshire mental health services for more detail from Cornwall forensic services (2003).

3.36 A joint risk management plan was not in place to manage his presentations when he arrived in one area or the other. It was often not obvious how he could re-engage with a service and the absence of such a plan led to the agencies having to deal with him on an emergency basis. Consistency and continuity of care was lost as a result.

Diagnosis of personality disorder and its effect on the services Mr G received

3.37 Mr G was diagnosed at different stages of his adult life with a personality disorder and we therefore examined whether he received effective services for people with this diagnosis. Before the publication of *Personality disorder: no longer a diagnosis of exclusion* by the National Institute for Mental Health in England in January 2003, in January 2003 acknowledged the inherited position whereby:

> "*Many clinicians and mental health practitioners are reluctant to work with people with personality disorder because they believe that they have neither the skills, training or resources to provide an adequate service, and because many believe there is nothing that mental health services can offer.*"

3.38 We accept that much of Mr G's treatment and care was provided before national guidance on the provision of specialist personality disorder services was in place. However it is our view that irrespective of the guidance on the treatment of personality disorders, the risks posed by Mr G were not effectively managed. Clinical teams and agencies involved in his care did not work together consistently over the years to share information and jointly manage his risks. This absence of coordination was influenced, in no small part, by the intermittent engagement with services on the part of Mr G. Although we found some good examples of how information was shared across agencies there were many times when a collaborative approach did not take place. See our comments on multi-agency working and the implementation of the care programme approach.

Should Mr G have been defined and managed by services as a vulnerable adult in terms of the relevant policy guidance at that time?

3.39 We gave careful consideration to whether Mr G should have been defined and managed by agencies as a vulnerable adult because we wanted to find out whether agencies had used all available mechanisms to assess, review and coordinate his care. We used the definition from the No Secrets guidance March 2000 and Cornwall County

Council's definition because this was the guidance in place at the time when Mr G received care. Both documents described a vulnerable adult as a person:

> *"…who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation."*

3.40 Although Mr G was in need of community care services by reason of mental illness, he did not have other disabilities. He did demonstrate that he could attend to his own care. He appropriately sought help from services and at certain times even engaged with them and at other times refused help. At all times he was able to understand, consent to and reject treatment.

3.41 In the light of the definition of a vulnerable adult in place at the time and Mr G's capacity to consent, we conclude that he was unlikely to meet these criteria.

3.42 Since the period covered by this investigation, the safeguarding definitions have changed and now the Safeguarding Vulnerable Groups Act (2006) recognises that *any adult* receiving any form of healthcare is vulnerable. This new definition would now lead to a more active consideration of Mr G under the revised safeguarding adults' procedures.

Domestic abuse

3.43 Allegations of domestic abuse were raised in relation to several of Mr G's partners. On a number of occasions reference was made in case notes to the police completing domestic violence forms. Although actions may well have been taken in relation to the alleged 'victim', i.e. the partner of Mr G, no evidence was presented to show how the future risks and vulnerabilities would be handled — either on an individual or joint agency basis. As a result, the actions all appeared to be 're-active' rather than 'pro-active'.

3.44 The national introduction of MARAC (Multi-Agency Risk Assessment Conference) procedures in 2006 is now accompanied by a stronger set of multi-agency protocols for responding to and mitigating future risks around domestic abuse.

Recommendations

3.45 We set out below our recommendations. Most (but not all) of our recommendations are focused on the themes identified above. Our recommendations relate to those matters that we believe are relevant to the way services are currently operating rather than to events that occurred a considerable time ago.

Care programme approach

R1 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust should, as part of their clinical governance and performance management mechanisms, audit cases presenting with complexity and risk in order assure themselves and their commissioners that their CPA and/or risk assessment procedures are robust and compliant with current guidance. Particular attention should be paid to whether:

- mechanisms for information sharing, care planning and review are subject to explicit protocols and agreements

- assessments of individuals by mental health teams take account of previous psychiatric history, risk assessments, issues of compliance with the treatment offered and review processes, and ensure that this information is incorporated in their resultant care plans

- validated risk assessment tools form part of each new mental health assessment process, with an agreed escalation process that would lead to a wider multi-professional and/or multi-agency consideration of a case where necessary

- care plans are explicit about the suggested handling of issues of non-compliance (with medication and/or appointments) and crises

- referrals between internal teams (e.g. community and forensic mental health teams) or external agencies are governed by protocols confirming the CPA status and risk assessment of the individual, together with written agreements on where the coordinating and case responsibility rests before, during and after the referral.

Did not attend

R2 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust should assure their commissioners that patients who do not attend outpatient appointments are risk assessed and plans to re-engage or discharge are based on the outcome of the risk assessment as outlined in their respective trust policies.

Handling referrals

R3 Cornwall Partnership NHS Trust should ensure that referrals to mental health services by external agencies, or internally within mental health services, are governed by clear protocols identifying the timescales to be applied, the next-stage actions and the communication of the outcome(s).

Record keeping

R4 Cornwall Partnership NHS Trust should assure its commissioners that the use of separate notes and recording systems in mental health services (e.g. general, forensic and psychological services) is subject to regular review and scrutiny and continued only where a clear evidence-base can be provided. (We note that the trust's revisions to their CPA policy (2010) indicate that all disciplines now use a single record for contacts, management and contingency plans).

R5 Cornwall Partnership NHS Trust should ensure that when sharing risk assessments with other agencies, e.g. the police or local authority, services should make explicit whether additional action is implied on behalf of the receiving agency e.g. the application of legal and/or criminal proceedings. Any agreements should then be recorded and documented.

R6 Health, social care, police and probation services in Cornwall and Northamptonshire should use local Multi-Agency Risk Assessment Conference (MARAC) procedures to communicate the investigation and outcome of incidents of reported domestic abuse to relevant agencies on a confidential basis as part of child protection, Safeguarding Adults, CPA and MAPPA reviews. (We are advised that Northamptonshire Healthcare now applies these arrangements in full.)

R7 Cornwall adult social care services should audit and review their recording systems governing the routing of referrals through to mental health services, ensuring that the outcomes of such referrals are documented and subject to review.

R8 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust should provide a report to their commissioners on how the management of risk and vulnerability for those involved in incidents of domestic abuse addressed on a multi-agency basis and how Multi-Agency Risk Assessment Conference (MARAC) procedures are being used. (We are assured that this data is now regularly received by Northamptonshire Healthcare's commissioners.)

R9 Cornwall Partnership NHS Trust should assure their commissioners that a clear protocol between the probation and mental health services is in place to ensure that all relevant information is included in pre-sentence reports for clients who are receiving both services.

Cross-county working

R10 NHS South West should discuss with the Department of Health the need to issue national guidance on producing protocols and agreements covering the assessment, re-allocation and treatment of individuals who are subject to CPA and who move between areas of the country. The purpose of such protocols would be to ensure that individuals receive a consistent approach to their treatment, risk assessments and plans.

Personality disorders

R11 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust should ensure that where an assessment of 'personality disorder' is made, it should not exclude the person from access to services. Local service need and provision should be reported to their boards, reflecting the DH guidance issued in 2003 and the subsequent guidance for the commissioning of services, published in 2009 (*Recognising complexity: commissioning guidance for personality disorder services*).

The management of serious untoward incidents (SUIs)

R12 A clear process should be put in place for allocating SUI investigating officers in Cornwall Partnership NHS Trust.

R13 Cornwall Partnership NHS Trust should hold a list of nominated senior managers and clinicians to act as investigating team members so that investigations into serious untoward incidents can be carried out in a timely way.

R14 Cornwall Partnership NHS Trust's SUI monitoring group should exercise its responsibility to provide advice, support and guidance for staff undertaking investigations into serious incidents so that all parties are clear about their role, particularly when investigating an incident that might give rise to serious criminal charges.

R15 Cornwall Partnership NHS Trust's SUI monitoring group should ensure that recommendations from trust internal investigations are put in place as outlined in trust policy.

4. Mr G: The early years (1977–1995)

This section of the report summarises the contact Mr G had with the statutory agencies during his childhood. Behavioural difficulties at home and school preceded the involvement of social services, children's mental health services, the police and courts. In this period he spent two years in a specialist residential unit. When he reached the age of 18, he was discharged to a flat in Kettering.

4.1 Mr G was born on 26 February 1977. For the first three years of his life he lived with his mother and maternal grandparents in Northamptonshire. His natural father joined the army before his birth, only resuming intermittent parental contact with him nine or ten years later. In 1980, his mother married and Mr G's half-brother and sister were born in 1980 and 1982 respectively.

4.2 At school, Mr G's educational attainment was not high, with him being described initially as "*borderline learning disability*" although subsequent assessments suggested that this initial view masked a higher level of ability.

4.3 The first documented referral of Mr G to health or social care services was in 1989 when reports of "*behavioural difficulties*" at home and at school led to meetings with a psychologist in the local child and family guidance team. Two sessions took place before the case was closed, with the offer of follow-up if requested by the family.

4.4 Two further statutory agencies, the police and social services departments' were involved in July 1991, following the school's receipt of allegations that Mr G had acted "*inappropriately*" with two young girls. Investigations failed to ascertain sufficient evidence to afford further action.

4.5 The police and social services were involved again in November 1991 when Mr G alleged that he had been physically abused by his stepfather. These allegations were unproven. Mr G ran away from home on 6 December 1991 and was admitted to Kettering General Hospital the following day after an attempted overdose — the first reported incident of this kind. The psychiatric registrar made a referral to the child psychiatrist who, upon seeing him on 10 December, concluded that "*…this was not a serious attempt at suicide, but rather a cry for help*". A follow-up appointment was made for 8 January.

Mr G did not attend this appointment and the psychiatrist subsequently closed the case, with an option to resume if Mr G requested it.

Comment

Mr G is now almost 15 years old and has already been involved with a number of agencies including the police and made his first suicide attempt.

4.6 In January 1992, Mr G ran away from home and was sexually assaulted by a man at a hostel in London. The man was subsequently convicted. In February 1992 allegations emerged about Mr G having inappropriate sexual conduct with family members. A non-accidental injury investigation was conducted by the police and social services department. Once again, the evidence proved inconclusive. Child protection at risk procedures were implemented at that stage. The social worker subsequently reported in a March 1992 court report that:

> *"Although no further action was taken following the alleged abuse of youngsters from within and outside his family, I have little doubt that it occurred. I would consider Mr G to be damaged, confused and, without ongoing treatment and education, potentially a threat to the vulnerable."*

4.7 A child psychiatrist saw Mr G's parents in April 1992 and Mr G himself attended an appointment accompanied by his natural father in May. However, in a letter written in October 1992, the psychiatrist stated:

> *"…Mr G has not approached me for [another] appointment…I am now closing our file…"*

4.8 From May until November 1992, Mr G was accommodated by the local authority in two children's homes. He also had short periods living with his maternal and paternal grandparents. Formal exclusion from school in October was followed by the commencement of a volunteer placement in an older person's day centre. His "*indecent assault*" of an elderly woman from the centre, in January 1993, led to him being remanded to St John's Tiffield, a residential unit for children in Northamptonshire.

4.9 In a report covering Mr G's time at St John's Tiffield (January–May 1993), his social worker described Mr G as:

> *"…an adept liar…he manipulates staff and peers and is skilled at turning one against another…he has a derisory attitude to victims, anyone with power over him or anyone who begins to uncover his image…I suspect he uses grooming techniques to put himself in a situation where he can abuse the vulnerable…"*

4.10 On 12 May 1993 Mr G was remanded to the Gardener Unit under section 35 of the 1983 Mental Health Act for a 28 day assessment. The Gardener Unit was a 12 (now 10) bedded adolescent inpatient psychiatric service in Manchester. At that time, the Gardener Unit was the only secure psychiatric unit in the United Kingdom specifically for adolescents. His remand was extended on 7 June and 5 July 1993.

4.11 In his pre-sentence report, the child and adolescent psychiatrist from the Gardener Unit described Mr G as:

> *"…grossly disordered in terms of functioning…"*

4.12 In June 1993, a registrar at the Gardener Unit wrote that:

> *"…Mr G is not suffering from a major mental illness, but rather a severe mixed disorder of conduct and emotion. He does appear to have mixed educational delays and to have mild learning difficulties. In addition, Mr G sometimes somatises[3] his distress. Because I do not know whether Mr G is being truthful I find it difficult to predict his dangerousness."*

4.13 On 2 August 1993, following his earlier conviction for indecent assault, Mr G was made the subject of a two-year supervision order. Residence at the Collingwood Unit, a specialist service for sexual offenders within the broader provision at Aycliffe Young People's Centre in County Durham, was a condition for the first 90 days. This centre had expertise in the assessment and treatment of young sexual abusers who may also have displayed a range of other anti-social behaviours.

[3] Turns his distress (consciously or unconsciously) into physical bodily symptoms.

Comment

Aycliffe became Mr G's seventh alternative to his parental home in 15 months.

4.14 After the second quarterly review of Mr G's care in February 1994, social worker 1 wrote:

> *"I hope that we are not enabling him to be a more confident offender."*

4.15 We asked social worker 1 to explain what was meant by the above comment when we interviewed her. She told us:

> *"What they (Aycliffe) did was teach the offenders about their offending so they knew exactly what they were doing, they knew about the targeting, they understood the techniques, and at that stage they're really dangerous. It was at that stage they wanted to withdraw funding…I said, 'We've got him to this stage and he's much better at it now, he understands it and he's a professional now.' But he needed the next bit so he needed to know how to stop himself doing it."*

4.16 The quarterly review from Aycliffe in April 1994 noted that:

> *"Mr G…described at some length how he plans revenge for perceived wrongs to himself…(he) explained that holding grudges gives him a sense of power over his intended victim and that he is aware that he would select smaller, weaker people as his targets. Mr G admitted that he would only stop his planned revenge, sexual or otherwise, if he was actively prevented by others…he regarded it as the staff's responsibility to do this. Thus he has actively avoided taking personal responsibility for his behaviour and admitted for the past eight months or so he has paid little more than lip service to the Collingwood programme."*

4.17 In August 1994, the quarterly review concluded:

> *"…Mr G continues to rely on intimidation of peers, but is becoming more clever and subtle in the methods he chooses…it was worrying to note the extent to which Mr G gloated over the way his behaviour has affected peers."*

"…it appears that his responses are those which he thinks staff want to hear, thus paying lip service to the expectation of the programme rather than honestly dealing with his behaviour."

"Recommendations: continue to participate in the offence specific group programme in Collingwood. Specific areas that require addressing are his difficulty in accepting any *responsibility or accountability for his deviant sexual interests."*

4.18 During his period at Aycliffe, Mr G retained contact with his family, both through their visits to him and on home leave. As Mr G approached the conclusion of his stay plans were made for him to return to the Northamptonshire area. Responsibility for these plans fell to the local authority social worker.

Comment

This transition from Aycliffe back to local area services was clearly an important step which needed handling with care. Unfortunately as the following paragraphs show this was not handled in a multi-agency way, acknowledging the importance of this transition, which minimised the risk Mr G posed.

4.19 Mr G was given tools to help him recognise his risky behaviour and manage it when he was discharged from Aycliffe. There was no evidence however that a comprehensive discharge care plan had been put in place. There was no evidence either of a risk management or formal support plan to help Mr G in his move from care to accommodation in the community.

4.20 The child psychiatrist advised the local authority:

"I recently received a message from…Mr G's personal tutor at Aycliffe, informing me of his discharge. As Mr G is now almost 18 and not in full time education, I am writing to let you know that our file is now closed."

4.21 Social worker 1 assisted Mr G with his placement in a flat in Kettering and, although she had no formal role once he had reached the age of 18, continued to offer to see him on an informal basis. On interview, she told us:

"There wasn't a care plan. It was the conclusion of the supervision order and we could just have closed it, end of story, but that didn't seem very responsible."

Comment

The social worker is to be commended for offering to continue to see Mr G.

4.22 Mr G's supervision order with the local authority concluded on his 18th birthday. No multi-agency risk assessment or management plan was enacted. Social worker 1 maintained informal contact with him. She told us that the lack of formal follow up would not pertain today:

"…Because it's all there. He'd be registered, he'd have a risk of serious harm assessment, he'd be MAPPA'd[4], all the agencies would know about him, and he wouldn't be able to move out of the area and start again. We're much safer. We'll never be safe, but we're safer and there would be more control over him now. Of course, if he'd not gone on to offend, none of that would have affected him."

Analysis

Assessment and eligibility for services

4.23 Throughout his teenage years Mr G presented as a troubled, and often troublesome, individual. The assessments conducted during his childhood focused on:

- his presenting behaviour
- the need to address his vulnerability and risks
- the safety of others around him.

4.24 In the period between 1991 and 1995 (between the ages of 14 and 18) the assessments conducted by the involved agencies appeared to be appropriate, applying the powers of intervention available to them.

4.25 Once Mr G turned 18 he became ineligible for child and youth services and encountered difficulties in accessing services from the agencies that had invested so much

[4] Subject to Multi Agency Public Protection Arrangements.

in his care and treatment in the preceding years. No clear process appeared to be in place to manage the transition, if required, between child and adult services.

Risk assessment and risk management

4.26 We have reviewed the records of risk assessments, management and treatment plans accompanying his time in care. The risks identified at that time were sufficient to instigate more thorough assessments and dedicated treatment programmes. The professionals involved reported having to argue strongly for continued financial support from the statutory agencies to allow for his treatment in both residential care and specialist placements. We believe this reflected their views as to his vulnerability and need for treatment or care at that time.

4.27 A consultant child and adolescent forensic psychiatrist at the Gardener Unit wrote a statement for us. Within it she explained that there have been changes to the system:

> *"From 1995 onwards risk assessments were introduced specifically for adolescents and young people…for young sexual abusers and young people displaying high risk behaviours."*

4.28 She explained that these risk assessments would not have altered the treatment plan recommended for Mr G at Aycliffe. However, it may be that their application would have assisted the multi-disciplinary team planning and the management and reintroduction of Mr G to his local community.

Care planning and the range of services made available

4.29 Between 1992 and 1995 multi-agency care plans and child protection procedures were put in place in relation to Mr G's siblings and for Mr G himself. This included an intensive treatment programme for Mr G.

4.30 It would appear that his time at St John's Tiffield, the Gardener Unit and Aycliffe provided the structure and containment that his presenting behaviour required at that point.

Risk assessment and multi-agency work

4.31 From the case notes and our interviews it appears that the previous concerns about Mr G had not dissipated at the point of his discharge from care. Despite this the formal remit of the involved agencies (local authority social services, education services and child and adolescent mental health service (CAMHS)) ceased at that point with no identified plan to manage any transition between children's and adult services.

Comment

***Many of the issues faced by Mr G in this period have been addressed by the* Children Leaving Care Act 2000*, in particular by the introduction of 'pathway plans' and continuing assistance for care leavers aged 18-21. In turn, the more recent introduction of Multi Agency Public Protection Arrangements (MAPPA) and/or Anti-Social Behaviour Orders (ASBO) may have assisted in his management following his return to Northamptonshire and, if applied, made it less likely that Mr G would have been without supervision and care. A summary of the scope of these new arrangements is included in appendices to this report. See appendix C for a fuller explanation of the* Children Leaving Care Act 2000.**

Conclusions from the early years (1997-1995)

C1 The care and treatment provided to Mr G during his childhood years was commensurate with his identified needs.

C2 A multi-agency risk assessment and risk management plan did not accompany the cessation of services once he reached the age of 18, with no identified plan to manage any potential transition between children's and adult services.

5. Adult years in Kettering (1995–1996)

This section examines the period from March 1995 to September 1996. Mr G made contact with adult mental health services in Northamptonshire; took an overdose; had six attendances at A&E; and was put on probation.

5.1 Within one month of his arrival back in Kettering, Mr G started a pattern of attending A&E, from where he was referred to community mental health services, and offending behaviour.

5.2 The mental health records indicate that he attended the A&E department in Kettering in March 1995 after taking an overdose of paracetamol. As part of Mr G's assessment, the psychiatric registrar spoke to the social worker 1 (who was still in contact with Mr G) and made a referral to the community mental health team (CMHT) reporting:

> "*…underlying personality difficulties and was at risk of self-harm.*"

5.3 An appointment for over two months later was offered. Mr G did not attend. After Mr G failed to attend a second appointment, the CMHT wrote to the GP, stating:

> *"…we felt it was unlikely that [Mr G] would turn up, as he had voiced his reluctance in the past, and I feel it is appropriate to refer him back to yourself…Please feel free to re-refer if you think [Mr G] requires further psychiatric assessment."*

Comment

Offering an appointment two months after an overdose appears to be far too long a gap. As this was in excess of 15 years ago we make no further comment.

5.4 Mr G was arrested for affray and arson in January and March (respectively) of 1996. The probation reports at the time indicated that Mr G claimed these two offences were related to him being intimidated by parties who were aware of the previous accusations against him of inappropriate sexual conduct towards minors. A period on remand in Glen Parva Young Offenders Institution, Leicester, was followed by Mr G being placed on a two-

year supervision order (April 1996), with a condition that he attend an alcohol awareness group.

Comment

In addition to health and social services, the prison and probation services were now involved in the assessment, care and treatment of Mr G.

5.5 Between June and August 1996, Mr G attended Kettering A&E department on four occasions — presenting firstly with abdominal pains, then vomiting of blood and finally with a fractured ankle. "*Schizophrenia*" was mentioned in the notes relating to his first attendance. It is unclear where this diagnosis originated from; what is clear is that no particular action appeared to result. These four attendances, either individually or cumulatively, appear not to have triggered particular concerns on the part of the A&E department, nor any referral to mental health services.

Analysis

Assessment and eligibility for services

5.6 Mr G was assessed by the police, prison, probation, A&E and psychiatric services during 1995 and 1996. Assessments undertaken by the police resulted in charges, a period on remand in prison and the introduction of a supervision order with the probation service.

5.7 The assessments conducted by the A&E department at Kettering General Hospital in 1995-96 were appropriate in relation to his presenting condition. The overdose in March 1995 triggered an additional psychiatric assessment, with the registrar making appropriate contact with the youth justice worker and referring Mr G to the local CMHT.

5.8 Mr G did not attend the appointments offered by the CMHT but this did not result in any assertive follow-up with the case simply referred back to the GP. We have seen no evidence that any attempts were made to gather any collateral evidence about his history, e.g. from the child and adolescent mental health team notes, to identify Mr G's current needs or to establish whether an outpatient appointment was likely to be taken up.

Comment

Although we did not receive a copy of the 'did not attend' (DNA) procedure from Northamptonshire Healthcare NHS Trust for this period, we have received a copy of the current procedure. This advises that when someone fails to attend, clinicians should take immediate steps to assess the degree of clinical risk presented by the client. The assessment should be based on the referral, past history and where necessary be undertaken in conjunction with the referrer.

Care planning, risk assessment and multi-agency work

5.9 The responsibility for coordinating the care and treatment of Mr G from March 1996 onwards rested with the Northamptonshire Probation Department. Their management of a two-year supervision order would appear to have been appropriate in the circumstances. In the absence of historical notes from the probation department it was not possible to ascertain whether a multi-agency case conference was held or whether a robust plan covering his future care and treatment was drawn up.

Conclusions from the adult years in Kettering (1995–1996)

C3 The Northamptonshire CMHT did not adopt an assertive approach to following up Mr G's referral in March 1995.

6. Initial years in Devon and Cornwall (1996–1997)

This section deals with Mr G's move to Plymouth, including his arrest and sentence for robbery and his moving to live with Partner A in December 1997. The assessments and care management arrangements that applied in respect of Mr G, during this period, are also examined.

6.1 Mr G claimed that his move from Northamptonshire to Cornwall was influenced by threats from local peers about his alleged previous "*indecent sexual practices*". He arrived in Plymouth in September 1996. Records from the probation service were not available for this period. As a result it was not possible to establish whether Mr G moved to Plymouth with the permission of his probation officer or when any transfer of case responsibilities took place. However, by the end of that month, he had been arrested and remanded into custody at HMP Exeter after committing offences of robbery and burglary. In court a probation officer assessed the risk of further offending as *"sadly, very high…"* A two-year probation order was imposed in March 1997, supported by a condition of residence at Meneghy bail hostel in Camborne.

6.2 In April 1997 Mr G was assessed by an approved social worker[5] after threatening to jump from a bridge over Camborne railway station. He was advised to continue receiving support from his probation officer and from Cornwall Alcohol and Drugs Agency. The conclusion at this time was that Mr G's behaviour was connected to his use of alcohol rather than a diagnosed mental health condition. Over the ensuing months, the notes refer to him being prescribed disulfiram (a medication that induces nausea if taken in conjunction with alcohol) amitriptyline (an anti-depressant), haloperidol (an anti-psychotic medication) and procyclidine (used to reduce the side effects of anti-psychotic medication). We interviewed GP1, Mr G's GP, who told us:

> *"I don't remember alcohol abuse being a big issue with him, but it's a very long time back. I think our chief concern was, in colloquial terms, how much was he naughty and how much was he mad. That was the judgment we were looking at, at that point."*

[5] An approved social worker is one who has been trained and registered with the local authority to undertake mental health act assessments with a view to possible detention under provisions of the mental health act.

6.3 GP1 referred Mr G to the Camborne CMHT in early November 1997 after he had cut his wrists on several occasions and threatened to jump off a bridge. The community psychiatric nurse (CPN) saw Mr G the following day and concluded:

> *"No problems reported which might be usefully addressed by Mental Health services."*

6.4 Within a week Mr G was back in the Camborne Custody Centre after threatening to jump under a train. The duty psychiatrist referred him to consultant psychiatrist 1 at the same time recording:

> *"…impression was that the psychopathy and the behavioural difficulties are more the product of a damaged personality rather than due to a primary treatable psychiatric illness."*

6.5 Between 1 November 1997 and 1 December 1997 Mr G was in receipt of four separate assessments by psychiatric services:

- via an inpatient admission to Trengweath Hospital, Redruth, on 1-2 November
- by a CPN on 6 November following a referral from his GP
- by a duty psychiatrist (an associate specialist registrar) at the Camborne Custody Centre on 13 November, and
- by a psychiatric senior house officer (SHO) on 1 December.

Comment

No consultant psychiatrist assessed Mr G in any of his four contacts with psychiatric services in 1997.

6.6 Consultant psychiatrist 1 told us he was supposed to have seen Mr G to assess him on 17 November but he did not attend. The next appointment on 1 December was offered as a 'follow-up', rather than a first assessment. A first appointment is usually conducted by the consultant rather than one of the junior staff. This explained in part why Mr G had not been assessed by a consultant psychiatrist (see comment above).

6.7 Mr G was first registered as an outpatient on the Cornwall Partnership NHS Trust's patient administration system (the recording system for appointments with psychiatrists) on 17 November 1997.

6.8 Mr G continued a pattern, previously established in Northamptonshire, of failing to attend appointments with psychiatrists and CPNs. However, on those occasions he was seen, the conclusions appeared to be fairly consistent:

> *"No role for the community treatment team"*
> (CPN: 21 November 1997)

> *"…not experiencing thoughts of self harm or suicidal intent…"*
> (Psychiatric SHO: 1 December 1997)

6.9 Consultant psychiatrist 1 acknowledged that the service did not appear to have researched Mr G's psychiatric history by asking for notes, either from the prison service or the mental health services in Northamptonshire. Consultant psychiatrist 1 assured us that such research is now mandatory; indeed it was noted to have taken place as a result of subsequent referrals.

Comment

Failing to seek relevant information from other agencies was not good practice even in 1997.

6.10 On 3 February 1998 the SHO recorded:

> "*Things not going very well for him…isolative behaviour…he stated that he could see himself harming someone else."*

6.11 The probation review of his supervision plan in December 1997 records:

> "*Major concern has been Mr G's mental health. GP and Trengweath*[6] *staff have been involved, but no radical action has been taken…"*

[6] Trengweath Hospital was an acute inpatient and outpatient mental health unit in Redruth.

6.12 The action listed in the probation service review notes included: "*Liaise with GP and mental health services as necessary*". The notes do not contain a plan to engage further with the mental health services in order to agree a joint plan of action.

Analysis

Assessment and eligibility for services

6.13 The probation and prison services in Devon and Cornwall made further assessments of Mr G when he arrived there in September 1996. They focused at first on the presenting issue of an offence and conviction. The probation service later produced a management and care plan, supported by his residence at Meneghy bail hostel.

6.14 Mr G's initial involvement with NHS services was predominantly with his GP, but a series of referrals and assessments of mental health services followed, beginning in November 1997. Mr G was under the care of consultant psychiatrist 1, but he was often seen by one of his junior doctors who tended to focus on the immediate presenting issue or crisis rather than on the development of a longer-term management strategy.

6.15 The multiple assessments mental health professionals carried out in late 1997/early 1998 took place in isolation, without the benefit of previous psychiatric history notes or a coordinated approach or care plan. The involvement of the probation service was clear (due to the fact of his residency at Meneghy bail hostel) but no actions were recorded by the respective agencies that sought to share the assessments or risk management plans between the probation and health services. We saw no evidence to confirm that the probation service had actively sought the input of the psychiatric services in the production of a court report or in the delivery of a joint action plan.

Comment

When Mr G was referred to consultant psychiatrist 1's team, it would have been appropriate for Mr G to have been seen by consultant psychiatrist 1 instead of his junior doctor due to the complex nature of the case, his previous involvement with mental health and criminal justice agencies and also considering that he was residing at Meneghy bail hostel. Furthermore, during this episode of contact, Mr G harmed

himself and attempted suicide. We saw nothing to suggest that consultant psychiatrist 1 knew this.

6.16 The assessments conducted by the mental health professionals explored Mr G's presenting condition and needs but not the wider collateral evidence. However, they also introduced an additional component, that of whether he was suffering from a diagnosed mental health condition or disorder. The case files began to refer to a potential diagnosis of "*borderline personality disorder*".

6.17 Sometimes the potential diagnosis of personality disorder leads to discussion described colloquially as 'mad or bad'. This was a consistent theme for many professionals who undertook assessments of Mr G over the subsequent years with the resulting dichotomy appearing to limit rather than enhance the assessments and care plans undertaken at the time.

Comment

In the late 1990s an assessment of 'personality disorder' was often accompanied by a conclusion that such a presentation was not amenable to active 'treatment' by mental health services. This challenge for mental health professionals was to feature in most mental health assessments of Mr G thereafter. There were no national guidelines at this time about services that should be offered by the NHS for personality disorder. Despite the lack of national guidelines some trusts provided dedicated services for this client group, but Cornwall Partnership NHS Trust did not. (See appendix D for further information about personality disorders and treatability).

Care planning

6.18 A care plan for Mr G was instituted by the probation service in 1998, resulting in his residing and being supervised at Meneghy bail hostel. The probation service was aware of his referrals to mental health services but no multi-agency review or care plan emerged between the two agencies at that time.

6.19 The initial contacts with mental health services resulted in a series of assessments, but no consolidated care plan. Consultant psychiatrist 1 believed that systems were in

place for his junior staff to consult him if they had concerns, but we found no evidence in the case files to indicate that they did so.

6.20 No evidence appears to exist of the application of CPA in any of the interventions in 1997/98. The main actions being recommended were for medication and further follow-up appointments — even though Mr G was known not to be particularly compliant with either of these interventions. (See appendix E for information on the policy and practice requirements for the CPA.)

6.21 Mr G continued a pattern of failing to attend mental health service appointments. Replacement appointments were offered but were not accompanied by plans to help engagement and attendance.

Risk assessment and risk management

6.22 Various services held separate information about Mr G but information was not shared effectively across the agencies. This led to clinicians and agencies working in isolation and maintaining a narrow view of his risks and possibly dealing solely with the crisis without exploring the underlying reasons for his presentation.

Conclusions from the initial years in Devon and Cornwall (1996–1997)

C4 Assessments undertaken by probation services in 1996/97 resulted in a care plan, but lacked the perspective or involvement of mental health services at that time.

C5 Assessments undertaken by mental health services in this period lacked the necessary collateral information, did not apply CPA, involve the consultant in reviewing Mr G's case or seek to build a multi-agency risk management or CPA.

7. Camborne, Cornwall 1997–1999

This section of the report examines the period from December 1997 to April 1999 when Mr G was under the supervision of the probation service and had sporadic contact with NHS mental health services in Cornwall. His first child, with Partner A, was born in December 1998. He also received a 30-month prison sentence in April 1999.

7.1 Mr G left Meneghy bail hostel in December 1997 to live with his partner (referred to hereafter as Partner A). She is reported to have had a miscarriage in early 1998.

7.2 Mr G was admitted to hospital in Kettering during a visit to his family in March 1998 after overdosing on procyclidine. A psychiatric bed was not immediately available and Mr G discharged himself against medical advice two days later (31 March). The discharge letter referred to a primary diagnosis of "*schizophrenia*" but did not confirm whether this was self-reported or the result of a formal psychiatric assessment.

7.3 Mr G was unemployed and seeking the enhanced social security payments as a consequence of being on Disability Living Allowance (DLA). A medical (perhaps including psychiatric) assessment would have been a prerequisite to awarding DLA. Whether this resulted in a perverse incentive, requiring him to have his status as *"mentally ill"* validated is open to conjecture at this stage, but the notes do not indicate whether this was factored in to any of Mr G's assessments at that time.

7.4 Mr G returned to Cornwall in April 1998 after discharging himself from Kettering General Hospital. Shortly after, Partner A reported Mr G to the police because he was "*causing problems*". Over the next two days, she made contact with a CPN and psychiatric SHO. Mr G was offered an admission to a mental health ward. He declined an inpatient admission but committed to attending his outpatient appointments. He subsequently missed appointments in April, June and July.

7.5 In the meantime, a further referral from the GP to the CMHT on 29 May included a suggestion that:

> *"…a little pastoral care may keep him out of more serious trouble…"*

7.6 The CPN assessment was conducted on 4 June and resulted in a letter to the GP, reporting:

> "*He did not have an idea as to how we may be able to help him and I am to a degree in agreement with that.*"

7.7 The CPN discussed the case with a junior doctor in the psychiatric team and agreed that the doctor should follow-up with Mr G, while the CPN would make a referral to the forensic team. The CPN told Mr G that:

> "*I do not think there is any need for you to see a community nurse at present.*"

7.8 We investigated how the management of cases in the Cornwall Partnership NHS Trust operated at that time. Consultant psychiatrist 1 said:

> *"…most of the patients carried by the community mental health team would be seeing the consultant as well, but the consultants and the medical team would carry a separate caseload…The community mental health teams operated a formal care plan…The care plan of those patients who were seeing the doctors was something more implied by the fact that they were seeing the doctors, and the letters constituted the care plan at that time."*

7.9 The CMHT referred Mr G to the forensic team at Cornwall Partnership NHS Trust in August 1998. The forensic team recommended further research into his case. The case notes do not make clear if other people in the mental health services took this 'research' to mean that the forensic team had formally taken on Mr G's case. However, the records do not indicate any further contact with mental health services between August 1998 and Mr G's subsequent imprisonment the following April.

7.10 In the absence of any further follow-up from the mental health services, the main contact Mr G had during the remainder of 1998 appeared to be via the police and probation services. Mr G was fined £150 on 3 September 1998 for making overt threats to a police officer a few days earlier. The court would probably have required a report from the probation officer (a copy was not available to us) but it does not appear that a report was requested from the mental health services. If any formal liaison about Mr G was taking

place between mental health services and the probation service at that time it was not recorded in the notes made available to us.

7.11 The quarterly probation review of Mr G in December 1998 noted that he was "*not taking script*[7] *any more*". A recommendation to "*…restart support group at Trengweath (mental health services) immediately…"* was included in the notes but no particular action was recorded about how to take this forward.

7.12 The first child of Mr G and Partner A was born in the winter of 1998/9. Shortly afterwards, she announced her plan to move back to live with her parents. Mr G set fire to a jumper that Partner A bought for him, resulting in a fire that caused £1,000 of damage to the flat they were living in. A series of court appearances followed, the outcome of which was that Mr G was sentenced to 30-months' imprisonment in April 1999.

7.13 The probation officer wrote in the pre-sentence report in March 1999:

> "*Other potentially useful sources of information which it was not possible to access included contact with the GP and the psychiatric service*."

7.14 The report gave no reasons for this absence. It goes on:

> "*He (Mr G) informed me that he takes prescribed medication for depression and schizophrenia, but is not in contact with the mental health services, having decided not to attend appointments some months ago*."

Analysis

Assessment and care planning

7.15 Given the complexity of Mr G's case, a referral by the Cornwall CMHT to the forensic team would appear to have been appropriate. It is unclear whether the offer of 'further research' constituted either the assumption of case responsibility by the forensic team or whether a new assessment process was to be initiated. In the event, contact with Mr G was lost in the months leading up to his imprisonment in April 1999. In other instances of non-attendance at appointments a letter would have been sent to the GP;

[7] Taking script is shorthand for taking his prescription medication.

however, no record of such a communication appears on the case files. The nominated CPN from the forensic team (no longer working for the trust) could not recall or explain why no further activity was recorded in the trust's notes. We asked consultant psychiatrist 1 why he thought Mr G's case was not followed up at the time. He explained:

> *"…once you had someone referred to mental health services including the medical team, there was a requirement to look after them almost indefinitely…there wasn't that sense of episodes and then discharging people absolutely."*

Comment

We accept the assurance of Cornwall Partnership NHS Trust that this system has been replaced by a more rigorous assessment and case management process.

7.16 It may be that assumptions were made that Mr G's case was open and subject to regular review. It appears that the promised action on behalf of the forensic team did not take place. Consultant psychiatrist 1 went on to explain that:

> *"We also had two systems of recording patient contacts…the integrated care system and that involved contacts with the community team, and …PAS [Patient Administration System]…that recorded consultant contacts….it was in 2000, that we then moved to that more formal care programming process."*

7.17 The operation of two systems for recording patient contacts within Cornwall Partnership NHS Trust cannot have made the coordination of Mr G's care easier for the professionals involved. Neither system appeared to record any documentary evidence that the CPA was applied in respect of Mr G, although the extent to which the national policy was fully implemented in Cornwall Partnership NHS Trust at this stage is unclear. Letters between doctors can help communication but they are unlikely to replace the requirement for a formal contribution to a care plan.

Comment

The trust told us that the introduction of a shared electronic health record (2000/01) had addressed many of the inherent difficulties highlighted above.

Risk assessment and risk management

7.18 As we say above, no reference to a clear risk assessment or risk management plan appears in Mr G's case files from this time. They mention incidents of domestic abuse (in relation to Partner A), but make no reference to any resultant assessment of risk or a forward management plan.

Multi-agency work

7.19 In the spring and early summer of 1998, Mr G's mental health case notes referred to issues of mental health, substance misuse, domestic abuse (in relation to Partner A) and to a possible referral to the forensic team. He was still on probation at the time but the notes make no reference to consulting the probation officer about his care and treatment. The probation report to court in March 1999 unaccountably lacks information from the mental health services or the GP.

7.20 With hindsight, it might have been beneficial for those involved (probation, police, GP, mental health services) to convene a case conference to agree joint handling strategies before the court appearances.

7.21 A pre-sentence report would have offered a further opportunity for the agencies involved to consider their roles and contributions to the assessment and care management plan for Mr G. This does not appear to have taken place. The reason for this not happening is not documented in the case files and therefore we have not been able to ascertain why.

Conclusions from the initial period in Camborne (1997-1999)

C6 The referral in 1998 to the Cornwall forensic mental health team was appropriate. Inadequate action resulted from the referral, with no system in place to register and respond to the absence of follow up. This resulted in Mr G losing contact with mental health services between August 1998 and his imprisonment in April 1999.

C7 Mr G's case file did not contain a risk assessment or risk management plan for the period 1998-1999, and we saw no documentary evidence that the CPA was applied at this stage.

C8 Mr G's court report in March 1999 was deficient because it did not contain information from the GP or mental health services.

C9 Incidents of domestic abuse were recorded in the case files, but not accompanied by a set of resultant actions (spring/early summer 1998).

8. Prison and the return to Camborne: April 1999–July 2001

This section of the report examines the period from Mr G's imprisonment in April 1999 to July 2001. He was released from prison in June 2000 and resettled in Camborne. A wide range of professionals, from the criminal justice and caring agencies, were involved at this stage with Mr G and his immediate family.

8.1 Mr G sought and received support from the prison medical services during his period in HMP Shepton Mallet (April 1999–June 2000). Cornwall Partnership NHS Trust sent medical records to the prison medical services. The discharge letter from the prison medical service to the local mental health services, when he was released in June 2000, referred to a number of salient points in relation to his period in prison, including:

- *"Very limited ability to cope with emotional stress"*
- *"Constantly been requesting to be transferred to either a prison hospital or even better a psychiatric hospital…& hoping that he could be admitted to a mental hospital straight from prison"*
- *"I feel he is not mentally ill but possibly suffering from borderline PD"*
- *"…likely that he will either self harm or re-offend in order to get himself back into a containing environment…and wish to refer him to you to ensure there is some kind of safety net for him"*
- *"Report* [from 12 sessions of psychotherapy in prison] *concluded that he continues to be a very dependent & vulnerable young man who will need continuing support with his coping skills."*

8.2 When he was discharged from prison, Mr G was referred to as a "*serious offender*" and was subject to the Multi Agency Public Protection (MAPP) procedures (refer to Appendix F for more detail about these procedures). He was required to reside at Meneghy bail hostel.

Comment

Multi Agency Public Protection Agency systems were not well developed throughout the country in 2000. It is to the credit of the Cornwall agencies concerned that they implemented the arrangements at this stage.

8.3 The local MAPP meeting considered Mr G's case in May, June, July and August. The first meeting decided to make a child protection referral to the social services department in respect of Child 1. The MAPP meeting in May was informed by the probation officer that:

> *"If Mr G drinks he can become aggressive & anyone who gets in his way could be a victim. Victims of self* [sic] *harm could be anyone living with him depending on his chosen method."*

The child protection meeting convened in August 2000 was advised:

> "*Mr G was considered to present a risk to Child 1 by virtue of his mental health problems and offending behaviour*."

8.4 The existence and application of the MAPPA and child protection procedures (accompanied by the court licence arrangements imposed on Mr G) succeeded in bringing together the key agencies in undertaking their separate and combined assessments of Mr G and his family situation. Clear management plans were agreed between the involved agencies: Child 1 was placed on the child protection register and the arrangements for Mr G's access to the child were restricted and controlled. A failure to adhere to the bail conditions (not residing at Meneghy bail hostel) resulted in Mr G being arrested and returned briefly to HMP Exeter. He broke his bail conditions again within a month of his release by not residing at Meneghy or the proposed placement being arranged by Stonham Housing. Within a week he was bailed to reside with Partner A's family in Camborne, but to have no contact with his son who was living elsewhere with Partner A.

8.5 Meneghy bail hostel expressed concern about taking Mr G following his release from prison in June 2000:

> *"He has a long history of involvement with GP and Trengweath. Abuses medication. Loves tablets…On reflection he achieved O (sic) here last time…We do not wish to stand alone without psychiatric support."*

8.6 CPN1 (CPN, court liaison specialist with Cornwall Partnership NHS Trust), attended the MAPP meetings and agreed that CPN2 would take responsibility for Mr G's care on behalf of Cornwall Partnership NHS Trust. The clinical notes do not indicate which

consultant psychiatrist would be responsible for his care – whether through the forensic team or the CMHT.) Cornwall Partnership NHS Trust told the child protection meeting that:

> *"…the most appropriate diagnosis…is borderline personality disorder…when* [Mr G] *loses control he can experience psychotic phenomenon. He can have paranoid thoughts & he can react dangerously…the condition responds badly to medication but anti-psychotic medication helps impulse control & helps transient phenomenon. There will be long-term psychiatric support."*

8.7 In progressing the child protection plans for Child 1, Cornwall social services department requested and received background case files on Mr G from Northamptonshire County Council. Cornwall Social Services had previously been apprised of Mr G's conviction for assault of an elderly lady but they had not been aware of the allegations of inappropriate sexual behaviour with family members and others. This added to their concerns about Child 1 and became a key reason for placing Child 1 on the child protection register until the spring of 2001.

8.8 The child protection management plan in relation to Child 1 contained clear parameters for Mr G e.g. access times, behaviour expected, consequences if arrangements not adhered to, etc (at this stage, Child 1 was living separately with Partner A while Mr G lived with Partner A's parents). At Mr G's quarterly probation review in October 2000 the risk of further serious offending was reported as:

> *"…reduced to 'very low' due to his not abusing drugs & his improved mental state."*

8.9 The mental health management plan for Mr G was neither detailed nor explicit in the health case notes. There was also very little information in Cornwall Partnership NHS Trust's files at this stage. In general, the focus of the mental health intervention appeared to be threefold:

- administration of medication
- assessment of Mr G's mental health state
- support to Mr G in achieving access to Child 1.

8.10 The involvement of the forensic team appeared to be more acceptable to Mr G and Partner A than the social services department. As CPN2 said:

> *"We were there doing stuff that was good for Partner A and Child 1, so they were fairly supportive of us, but generally didn't get on terribly well with authority figures."*

8.11 Cornwall social services undertook a risk assessment of Mr G that took account of the information from Northamptonshire. As a result of this risk and as a prerequisite to his continued access to Child 1, Mr G was referred for sessions with the probation department's sex offender unit.

8.12 Mr G attended seven sessions with a sex offender counsellor from the sex offender unit. She presented her report to the child protection conference in February 2001. It provided a summary of Mr G's history and the work undertaken with him to date. Recommendations were made by the sex offender counsellor for further sessions, to which Mr G initially consented. His prison licence expired in February 2001 but sessions continued to be offered, but declined, until April 2001.

8.13 The final supervision report from the probation service was produced on 8 February 2001. It referred to the good use Mr G had made of his licence period, the continuing support from the sex offenders unit and the mental health team. However, the report stated:

- *"Assessment of risk of re-offending at the end of Order/Licence: High*
- *Assessment of risk of harm at the end of Order/Licence: High…Any offence could be potentially harmful."*

8.14 The records show that 21 July 2000 was the last time a MAPP meeting considered Mr G. No reason is given why his case closed at that point.

8.15 The police were called to Mr G and Partner A twice at the end of February 2001. On the first occasion Mr G was accused of "*smashing up the place*" and on the second, of "*trying to strangle Partner A*". The police officers completed domestic violence forms but we were unable to find out what happened - for example, whether the police family

protection unit or other involved agencies were told about these incidents before the child protection case conference on 31 July 2001.

8.16 We interviewed inspector 1, the partnership inspector for Cornwall and Devon police in 2009. She told us:

> *"The focus is always on the victim rather than the offender. So it's offering support to the victim and doing a risk assessment, putting measures in place, whether it's securing the home, Home Office alarms, door chains or whatever, but it is very much on supporting the victim rather than focusing on the offender."*

She went on:

> *"There were several incidents of domestic violence between* [Mr G] *and young girls. A lot of it was no further action taken because it was one word against the other and it couldn't be proven."*

8.17 Appendix G provides further information about domestic abuse, including the role of the police in addressing such matters.

8.18 During this period CPN2 continued to support Mr G, taking on two additional roles:

- oversight of Mr G's access arrangements for Child 1 on behalf of the social worker - which provided an opportunity to monitor the child's welfare through his visits to the home
- sex offender counselling sessions once the probation service ceased its involvement.

8.19 According to CPN2, Mr G had told Partner A about his conviction for assault on the elderly woman in 1995, but not about the allegations in relation to family members and others. As this latter information had a bearing on the approach of the social services department in relation to Child 1, the decision was taken by CPN2 to support Mr G in presenting the information to Partner A and her family. CPN2 said:

> *"I suppose I was the man who got his foot through the door, so I was a useful person to act as an agent for lots of different people…I suppose I was a one-man assertive outreach team."*

8.20 Another CPN (CPN3) in the forensic team provided additional support. She worked predominantly with Partner A but took over from CPN 2 when he left the following year. Mr G's records do not indicate whether a focus of her work with Partner A related directly to the reports of domestic abuse.

8.21 CPN2 said he retained contact with colleagues in social services and probation throughout this period but what had been a multi-agency management plan began to be the responsibility of the forensic CPN team. We don't know whether the additional responsibilities the CPNs assumed were reviewed and considered appropriate by their managers.

8.22 At least three mental health professionals were now involved with Mr G (and Partner A). We were therefore keen to understand who was responsible for coordinating his care. We asked consultant psychiatrist 2. She replied:

> *"Definitely the CPN."*

8.23 The same CPN (CPN2) reported to us that:

> *"She* [consultant psychiatrist 2] *had responsibility for him for some time. I used to bring him to see her."*

Comment

These interviews suggest no one at the time was clear who Mr G's case coordinator was.

8.24 A child protection case conference was held in respect of Child 1 on 31 July 2001. The following factors were reported to the meeting:

- Mr G's mental health diagnosis was reported by representatives' of Cornwall Partnership NHS Trust to be "*Borderline personality disorder*"
- the police reported receiving three 999 calls about Mr G: two involving physical aggression by him and one reporting that he had taken an overdose
- Mr G was not living with Partner A and Child 1

- Partner A was pregnant with Child 2.

8.25 Child 1 was taken off the child protection register as a result of this case conference. The action plan said the social services department and mental health services should be told if Mr G returned to live with Partner A. Records we saw did not indicate how long Mr G and Partner A were living apart or whether the statutory agencies were told when they got back together.

8.26 In the same month, the adult social care records indicate that *"Primary worker for* [Mr G] *changed to CPN…"*. There is no record of why.

Comment

The case records provided by Cornwall County Council's adult social care services contained scant information during this period. Although their mental health social work team were seconded to Cornwall Partnership NHS Trust, the information in the local authority file was simply that of a transaction i.e.* "Case transferred to mental health"** ***or* "Case closed". It did not contain detail about any assessment of vulnerability, risk (to self or others) or subsequent management plan.***

Analysis

Assessment and care planning

8.27 The MAPP meetings and the child protection case conference (in respect of Mr G and Partner A's first child, then 18 months old) provided the opportunity for all agencies to undertake risk assessments, secure background information, establish risk management plans and agree the monitoring mechanisms.

8.28 The detailed assessments and care management plans that guided the year after Mr G's discharge from prison (2000) appeared to afford some stability. CPN contact was maintained through the forensic team, with medical support from the consultant psychiatrist. However, access to his medication was proving difficult because he was not visiting his GP regularly.

8.29 The potential sanctions for Mr G were explicit in relation to the child protection procedures and his potential recall to prison under licence, and these appear to have had positive effects on his compliance.

Comment

The assessments and interventions at this stage benefitted from not focusing on Mr G's mental health status alone, but on the wider issues of vulnerability and risk within the family.

We commend this broader focus on treating Mr G's mental health condition in the context of his wider family situation, rather than on his mental health status alone.

8.30 The support the forensic team provided appeared to be flexible and well received by Mr G and Partner A. In some ways CPN2 was a victim of his own success as he began to inherit tasks and responsibilities from partner agencies e.g. supervision of child access and the sex offender sessions. Additional CPN support was provided to Partner A, via the forensic team, resulting in a high level of resource from the mental health services dedicated to this family. These two CPNs had assumed a great deal of responsibility in respect of Mr G and Partner A. This clearly reflected the assessed level of risk this family presented.

Comment

We commend the engagement of the forensic team in providing practical support to Mr G and Partner A at this time. However, their work was not supported by the application of the CPA as outlined below.

8.31 However, despite a clear multi-agency approach to the family based on risk assessments, we found no evidence in the records of the Cornwall Partnership NHS Trust at the time of the application of the CPA, risk assessment or the recording of CPA reviews.

8.32 The lead psychiatrist and forensic CPN involved told us they were unclear who held case responsibility and who was supporting whom.

Comment

Both parties could be commended for their approach to operating as a team but the respective responsibilities of the general and forensic mental health services were not clear.

Risk assessment and risk management

8.33 The various risk assessments at this time resulted in a clear plan of engagement with Mr G: this applied to his offending, his mental health (albeit not applying the full elements of the CPA) and the related child-protection considerations.

8.34 Police records of their contacts with Mr G were increasingly noting "*domestic abuse*". Inspector 1 told us that a domestic violence form should have been completed and submitted to the lead officer in the police force. However, we could not find out if this happened or if it did, what action followed. The police or Crown Prosecution Service brought no direct charges but we don't know whether any of these incidents were reported to other involved agencies, apart from the July 2001 child protection case conference.

Multi-agency work

8.35 As stated above, the MAPPA[8], child protection, probation and forensic mental health systems worked well together immediately after Mr G's discharge from prison. The fact that he was referred to as a *"serious offender"* appeared to provide both cause and purpose to their multi-agency plans.

8.36 The probation team had provided a relatively high level of support to Mr G during the post-prison phase, with accommodation (Meneghy bail hostel), supervision (probation officer and Meneghy staff) and dedicated sex-offender sessions. The summary reports at the end of the licence period (February 2001) were detailed and comprehensive. However, Mr G's 'eligibility' was linked to his licence, the expiry of which resulted in the withdrawal of the probation services' involvement. This cessation in 2001 detracted from the overall supervision and accompanying stability of Mr G. An extension of 12 months to a previous probation order had been implemented in December 1998. This was not repeated. The

[8] Since 2006 MAPPA arrangements have been supplemented by Multi-Agency Risk Assessment Conferences (MARAC). See appendix G for further information.

"*risks*" (of "*harm*" and of "*re-offending*") identified in their closing probation report on Mr G, however, remained "*high*". The need for further intervention was identified and offered – in the form of continuing sex-offender sessions until April 2001 (see paragraph 8.12 above). The probation service could not maintain their involvement after that in the absence of Mr G's voluntary commitment to continue. A multi-agency action plan, including a range of mitigating actions, did not appear to result in the period immediately following the cessation of the Probation Service's involvement.

Conclusions from the return to Camborne from prison (2000-2001)

C10 The early implementation of MAPPA arrangements in Cornwall were successful in bringing the key agencies together and enabled them to assess risks and to construct a multi-agency management plan focusing on vulnerability and risk rather than on simple eligibility for a service.

C11 We commend the work of the probation sex offender unit and its report (February 2001).

C12 The cessation of MAPPA (July 2000) and probation service input (February 2001) led to a less coordinated approach and to the forensic CPN taking on additional responsibilities.

C13 We commend the work of the forensic mental health team in successfully engaging with Mr G during this phase, though we note deficiencies in record-keeping.

C14 The implementation and review of CPA was not recorded in the files and case responsibility between general and forensic mental health teams was not clear.

C15 No clear action plan was put in place after the involvement of the police in a number of allegations of domestic abuse to manage, mitigate or respond to future occurrences.

Devon and Cornwall Police have since told us of many improvements to their local systems including the implementation of DASH (Domestic Abuse, Stalking and Harassment.) This is a dynamic risk assessment process that seeks to improve the way the police investigate domestic violence. The public protection unit is also working to identify domestic abuse

serial perpetrators so that offenders are better managed through enhanced identification and management systems.

9. Camborne: 2001–May 2003

This section of the report examines the period after Child 1 was taken off the child protection register (July 2001), through to the births of Child 2 (October 2001) and Child 3 (November 2002) and the emergency admission to hospital of Child 3 (May 2003). Many of Mr G's recorded contacts with the statutory agencies (mainly mental health, social services and the police) during this period were in relation to crisis events.

9.1 In the latter part of 2001 many of the records relating to Mr G appeared to concentrate on the statutory agency responses to crises presented by him or Partner A. For example:

- police contact with Mr G in August (reported missing; rang later from Milton Keynes confirming that he was OK) and October (stop check by police in Camborne)

- the CPN reinstated the depot injection after Partner A reported that Mr G had been "*smashing pots and setting fire to her coat*" (8 January 2002)

- Mr G contacted the GP out-of-hours service claiming he was "*psychotic*" and threatening to jump off a bridge (11 January – the CPN visited the following day)

- Partner A called the GP out-of-hours service in January claiming that Mr G had hit her and was threatening further assault (the CPN visited the next day and Mr G claimed the call was made to get more medication for himself)

- "*special patient*" file notes were submitted to the GP out-of-hours service from the CPN in January advising to refer calls to the CPN unless obviously medical in nature (the police accompanied the out-of-hours GP to Mr G)

- a*mbulance transf*er to Treliske A&E after an overdose (24 January)

- Mr G was arrested after an alleged assault on Partner A (kept in police cell overnight, no charges brought, 27 January)

- non-attendance at outpatient appointments with the consultant psychiatrist (February and March 2002).

9.2 Cornwall County Council's Safeguarding Children report of 2007 recorded that the local authority's children's services received the following child protection referrals concerning Mr G's children (Child 2 was born in the autumn of 2001):

- November 2001 — a referral from community psychiatric nurse (CPN) expressing concerns about Child 1's rough handling of Child 2 (This is believed to have been CPN 2)

- January 2002 — a police child protection report about an incident at the family home where Mr G had made threats to slash his wrists in front of his children

- May 2002 — a police report about Partner A reporting an incident in which she said that Mr G had treated Child 1 roughly

- July 2002 — a referral from the CPN (CPN 2)expressing concerns about supervision of Child 2 in the family home

- January 2003 — a referral from police expressing concern about the poor state of the family home. The Safeguarding Children report of 2007, referenced above, recalled the local authority's conclusion at that time as being: "*Sure Start SPS, Health Visitor and Mental health Team were all having input and visiting and the concerns of the police were not substantiated.*"

9.3 The Safeguarding Children report of 2007 written by the local authority children's department, reported that all the above matters had been investigated at the time, but did not result in a multi-agency case conference or review.

9.4 The internal investigation into care and treatment of Mr G that Cornwall Partnership NHS Trust conducted in 2007 after the killing of Mr V reported that Mr G had contacted the out-of-hours service "*a number of times*" during January 2002. One incident involved claims that he had threatened Partner A with a knife. Mr G later claimed that this allegation was fabricated by him in order to secure additional medication for himself. The internal review went on to quote from the trust's records:

"…if either his girlfriend or children were threatened then the police would be informed & he would be charged."

9.5 Partner A reported incidents of domestic abuse to the police on 27 January and 12 April 2002. On the first occasion, Mr G was arrested, kept in a police cell overnight and released without charge in the morning. In April, a police unit attended the family home but no formal complaints had been made, so it only advised Mr G and Partner A. Domestic violence forms were completed by the police in January and April. The police had made assessments but the available records do not indicate what actions if any resulted in relation to the management of future incidents involving Mr G.

Comment

In cases of domestic abuse, it is acknowledged that police action has concentrated in the past on the reported victim, rather than on the alleged perpetrator. The introduction of the MARAC procedures in 2006 provides a more holistic approach to the investigation and management of allegations of domestic abuse. Devon and Cornwall Police have advised that the implementation of these new arrangements would now lead to a more robust assessment of risk, involvement of other relevant agencies and the development of an agreed action plan where required.

9.6 Mr G ceased both his depot medication and his contact with the forensic team in December 2001 because Mr G advised that he didn't need his medication as things were going well. His fortnightly depot injection was recommenced after the alleged assault on Partner A in January 2002. It is noted that CPN2, who had previously been most involved with Mr G, stopped working in the forensic team in early 2002. It is understood that his case responsibilities were assumed by CPN 3 who had also been working with Partner A.

9.7 Appointments with consultant psychiatrist 2 were offered by the trust in February and March 2002, but Mr G failed to attend. The consultant suggested that Mr G's previous notes be sought from Northamptonshire, the Gardner Unit and the prison service. The trust's files do not say whether this suggestion was followed up.

9.8 Mr G attended an outpatient appointment with consultant psychiatrist 2 at the end of May 2002. The notes of the appointment record that Mr G had re-established contact

with the forensic team. A follow-up appointment was offered for just over three months later. At this stage, Mr G and Partner A were reported to be expecting their third child.

9.9 CPN home visits continued during 2002, with reports that Mr G was not attending his GP and that access to medication was proving to be problematic.

9.10 The police were again involved in November 2002 as Mr G was arrested in relation to criminal damage to a phone box (The CPT clinical records state that charges were reported to have been dropped in early December 2002).

9.11 Child 3 was born to Mr G and Partner A in late 2002. The subsequent safeguarding children report (2007, following a review of the contemporaneous notes said Mr G was reported to be "*coping well*". In spite of previous child protection concerns, it did not appear that any apparent risk to the three children was considered to be present.

9.12 The police made a referral to the social services child protection team after visiting the family in January 2003, expressing concern about Child 1's behaviour towards Child 3.

9.13 Responding to a referral of Mr G to adult social care, the Cornwall adult social care records report only that on 23 January 2003:

"Referral taken for Mr G…Routed to Mental Health."

9.14 No detailed risk assessments or subsequent action plans were provided to us concerning these referrals. On 31 January the social services records note:

"CPN to deal with. NFA [No further action]."

The next entry in the adult social services notes was on 4 April:

"*Case closed.*"

Comment

The adult social care records made available to us provide little or no information about why Mr G presented to them or the outcome of any subsequent intervention.

9.15 Partner A requested help in her calls to the GP and Cornwall Partnership trust's out-of-hours service on 1 and 10 February 2003. These resulted in Mr G being seen by consultant psychiatrist 6 and another CPN from the forensic team on 5 February as the clinicians he normally saw (consultant psychiatrist 2 or CPN3) were unavailable. Consultant psychiatrist 2 was considering enrolling Mr G on a trial depot injection of risperidone. This trial was being recommended only for patients with a clear diagnosis or history of schizophrenia. The psychiatrist postponed a final decision because she was uncertain whether this applied to Mr G. Mr G told consultant psychiatrist 6 that a recent reduction in medication had made him more impulsive and less able to cope. Concern had been expressed in the medical notes that Mr G had developed a "*marked dystonia*" (a neurological movement disorder) as a result of his previous depot injection. On 19 February Mr G's depot medication was stopped and it was replaced with oral risperidone. Medical reviews were undertaken on a quarterly basis and the CPN visited monthly. These decisions were recorded by staff on a care plan, stating that Mr G was subject to "*Enhanced care*". However, the clinical files do not indicate whether a discussion about the proposed handling of Mr G's case by the mental health team was discussed with other involved agencies at that time. The CPN's notes after a home visit on 11 February record:

> "*No current concerns about mental state, I believe a clear division can be drawn between Mr G's current criminality and his mental state…*"

9.16 A care plan was completed on 21 February, followed up by CPN3's core assessment on 27 February. These formed the first full CPA care plan in the trust's notes and identified Mr G as subject to enhanced CPA. The presenting issues were recorded as "*suicidal ideation and housing problems*".

9.17 After the police and a health visitor expressed concern about the welfare of the children in early 2003, Cornwall County Council's children's services proposed a family support meeting in April 2003. According to the records provided, this was the first multi-agency conference since July 2001, when Child 1 was removed from the child protection register. This meeting was postponed and not reconvened before the events of 15 May (see

below). We were not able to ascertain whether the GP was invited to this meeting. He wrote to the mental health services on 23 April:

> "*Unfortunately, Mr G is not engaging with any service (including me as his GP), so it is potentially a very difficult situation. I wonder whether he would be a candidate for the Assertive Outreach Team*".

9.18 In her reply of 30 May, consultant psychiatrist 2 had not been aware of the intervening events (below) when she stated:

> *"I have met him on a few occasions myself & I am aware that he is a poor attender. I will make some inquiries about his current level of involvement with forensic services. Either way I would imagine that he will remain on my caseload."*

9.19 Child 3 was admitted to the high dependency unit at Treliske Hospital in May 2003. Mr G had been looking after all three children at home and claimed that he had accidentally dropped Child 3. Child 3 suffered a sub-dural haematoma and retinal haemorrhages suspected to have been caused by shaking. All three children were placed on the child protection register and at the end of the month were made the subject of emergency protection orders and placed with foster parents. Mr G moved to stay with his grandparents in Northamptonshire on 16 May claiming that Partner A's family was threatening him with violence.

9.20 The court proceedings that followed the investigation into the cause of Child 3's injuries were concluded in 2004. The 2007 safeguarding children review recorded that:

> *"…the Judge found himself unable to make a finding of fact in relation to who did cause the injuries to Child 3 although it was accepted that these injuries took place when in the care of [the child's] father and mother who were now separated."*

9.21 The Cornwall Area Child Protection Committee (ACPC) commissioned the first serious case review into the care of Children 1, 2 and 3 on 10 July 2003. The report recommended a number of actions to improve inter-agency working.

"The key messages from the report should be reported to the Cornwall Children and Young People's Strategic Partnership. In particular, the emphasis on the need for a more structured and co-ordinated multi-agency response to working with complex/hard to reach families where there are repeated referrals to one or more agency."

And:

"Although social services takes the lead role in the 'Framework for Assessment' all the key agencies involved with the child and family need to consider the impact of domestic violence on a child and the risks the violence poses even when it does initially not appear to be the main focus of the work."

Comment

ACPC serious case review once again raised references to domestic violence/abuse in relation to Mr G. However, apart from an inconclusive police investigation into the injuries sustained by Child 3, no specific action appears to have been taken in relation to Mr G as the suspected perpetrator of domestic abuse.

Analysis

Assessment and care planning

9.22 The period from the summer of 2001 to May 2003 brought major changes in the interventions and support provided to Mr G and his family. The professionals involved continued with a series of less coordinated individual assessments when the multi-agency review systems of MAPPA and child protection ceased. Limited opportunities were taken by them to share these assessments across agencies or to develop a coordinated action plan.

9.23 CPN2 left the team in early 2002 and another consultant psychiatrist took on Mr G's case (consultant psychiatrist 2). Three CPNs and two consultant psychiatrists saw Mr G over the next 15 months. Continuity of care was therefore interrupted and the intensity of contact from the trust (previously contact with the CPN two to three times a week) changed to monthly visits and quarterly medical reviews. The clinical decisions to amend Mr G's medication and to establish a different pattern of intervention and review may well

have been appropriate in the circumstances but our finding is that the overall management of his case became reactive, rather than proactive. We have been advised that one of the consultants in the team was on long-term sick leave and that a CPN had periods of sick leave.

Comment

We accept that it was preferable for another psychiatrist to have provided cover than for Mr G not to have been seen at all.

9.24 Record keeping of Cornwall Partnership NHS Trust in the period leading up to Mr G's appointment with consultant psychiatrist 2 in May 2002 was poor. His gradual loss of contact with mental health services did not trigger any review or assertive action.

9.25 The medical review of Mr G was hampered by his failure to attend appointments. The intensive involvement of the forensic CPN, mostly involving home visits, succeeded in engaging Mr G but he was less compliant when invited to medical appointments elsewhere. Given his record, after finally seeing consultant psychiatrist 2 on 28 May, a more assertive follow-up was required rather than the offer of a further appointment in three months.

9.26 We have seen no evidence that Mr G was referred to a psychologist for an assessment or treatment. We were told that one of the reasons he was not referred was because he did not engage with services.

Comment

We believe a referral would have been appropriate. Concluding that Mr G would not have engaged was premature and contradictory to his earlier engagement with the forensic team.

9.27 The linkage and formal responsibilities of the forensic and general psychiatric services were not clear at this time. Consultant psychiatrist 2 told us she worked closely with forensic CPNs in providing care to Mr G. Forensic CPNs provided care coordination while consultant psychiatrist 2 provided medical input into Mr G's care. Consultant psychiatrist 2 told us that this arrangement with the forensic service was akin to the new way of working which was now being advocated for complex cases. She also said she was

readily able to access information in the forensic file and that CPN2 accompanied Mr G in most of her reviews.

9.28 The evidence of staff in interviews suggested a lack of clarity between general and forensic services over case responsibility. CPN2 thought that the care was medically led. Consultant psychiatrist 2 felt that the forensic team was "*coming along for help, guidance, and assistance*" from her and that her role was to provide only medical input. CPN1 thought they were providing an integrated model of forensic care, indicating that the forensic CPNs were integrated with consultant psychiatrist 2's team and were able to add value by providing assertive follow-up and forensic expertise while the overall responsibility for service provision still rested with consultant psychiatrist 2's team. The consultant psychiatrist in the forensic team did not inherit case responsibility for Mr G.

Comment

Clarity of role, including the agreement of contingency plans, can be complex, but it is essential in cases such as Mr G's. Cornwall Partnership NHS Trust assure us that a more rigorous process is now in place, governing the roles and responsibilities of general and specialist mental health services.

Risk assessment and risk management

9.29 In January 2002 there were reports in the clinical notes of significant events in Mr G's life. These included reports of arson, threats of suicide, an overdose, arrests following suspected domestic abuse, advice to the GP out-of-hours service to avoid home visits and the restarting Mr G's depot injection (although it is not known when this had ceased). However, there is no record of a multi-agency review and risk assessment of the presenting circumstances. It would appear that each incident was treated in isolation, rather than any pattern of escalation being identified and acted upon.

9.30 Six entries were made on the trust's 'critical incident form' (for recording incidents of major risk) between 3 December 2002 and 17 February 2003. The mental health services were clearly undertaking assessments of Mr G at this stage. He was recorded as subject to enhanced CPA. However, the focus of the assessment and case management appeared to be primarily concerned with his mental health status rather than a broader assessment of vulnerability or risk (to himself or others) supported by a clear plan guiding future

interventions. We saw no evidence of any multi-agency review at this time under the auspices of the CPA.

9.31 The police registered several incidents of reported domestic abuse. The action that took place (within the police force) was unclear. These incidents did not, however, result in any multi-agency consideration of these issues or an action plan.

Multi-agency work

9.32 Mr G's home circumstances changed with the arrival of Child 2 in October 2001 and Child 3 in November 2002. Child protection concerns were registered on at least five occasions between November 2001 and January 2003.

9.33 The case files contain evidence of sporadic phone calls and individual discussions between professionals. However, in spite of the individual assessments being carried out and concerns voiced between partner agencies, no one instigated a multi-agency review between November 2001 and early 2003. The mechanisms to support such a review could have included the CPA, child protection and/or domestic abuse. The actions taken appeared to have been in response to the immediate presenting crisis alone.

9.34 The first serious case review, initiated by the Cornwall Area Child Protection Committee in July 2003 into the care of Mr G's children, produced recommendations for the future management of similar cases. It is understood that the second serious case review in 2007 considered the extent to which these actions were enacted.

Conclusions relating to Camborne: 2001–May 2003

C16 The overall management of Mr G became reactive rather than proactive between July 2001 and April 2003. The records (including the application and recording of the CPA) in the period leading up to Mr G's appointment with consultant psychiatrist 2 in May 2002 are inadequate.

C17 There was no clear indication whether case responsibility for Mr G rested with general or forensic mental health services.

C18 In response to the six "*critical incidents*" recorded in the trust's files between December 2002 and February 2003, the focus of the assessment and case management processes were primarily concerned with his mental health status rather than a broader assessment of vulnerability or risk (to himself or others) supported by a clear plan guiding future interventions.

C19 The adult social care records relating to Mr G provided scant information about his needs or the resultant care plans.

C20 Between July 2001 and April 2003 the CPA should have been used more effectively to bring the involved agencies together in order to share their assessments and to agree respective or multi-agency contingency plans.

C21 Several incidents of domestic abuse failed to trigger multi agency procedures which examined the extant risks and any future handling strategy.

10. Return to Northamptonshire in 2003

This section of the report examines events after Mr G's return to Northamptonshire from Cornwall after concerns were raised about his suspected responsibility for a non-accidental injury sustained by Child 3. Engagement with him was hampered by his visits to Cornwall. He attended various A&E departments and had inpatient stays in medical assessment or mental health wards.

10.1 Mr G was based in Northamptonshire between May and September 2003. The mental health trusts in Cornwall and Northamptonshire shared information about his psychiatric and forensic history. Cornwall Partnership NHS Trust (CPT) referred him to the Corby CMHT, which conducted a triage assessment on 2 June. A follow-up appointment was offered with the psychiatrist for 20 June and later changed to 22 July (which Mr G did not attend). In a letter to the Camborne GP, the Cornwall Partnership NHS Trust's forensic service said:

> *"If it is Mr G's intention to return to Cornwall then he will be automatically assigned to the forensic team."*

10.2 This position appeared to alter on 11 August when the CPT notes confirmed that Mr G had been discharged from the Cornwall forensic team's caseload, that his care was to be provided by Corby CMHT and that:

> *"If he returns to Cornwall then he would require reassessment."*

Comment

The above two statements from Cornwall Partnership Trust's forensic services gave slightly conflicting messages that may have influenced both the views of Mr G about any continuity of care that may be provided and those of CPT staff making contact with him after any return to Cornwall. A reassessment of current needs would be reasonable in these circumstances, but greater clarity about whether the assessment would also focus on Mr G's eligibility for a service might have been beneficial to him. A more formal contingency plan, jointly agreed between the services in Northamptonshire and Cornwall, could have made it clear how he could re-access services on a planned and/or emergency basis.

10.3 Mr G was being investigated by Devon and Cornwall Police in relation to the injury to Child 3, so we could not see records in order to determine whether information was made available from Cornwall agencies to partner organisations in Northamptonshire, for example: police, probation, MAPPA, local authority children's and adults' services.

Comment

Sharing information between professionals is acknowledged to be a complex area influenced by data protection and/or human rights concerns. We understand that protocols existed for sharing information between local agencies but these were not necessarily replicated across different parts of the country.

A number of investigations, including the Bichard report (2004) after the Soham murders in 2002, have highlighted the need for improved information sharing across organisational and geographic boundaries. Unlike the Soham case it is not suggested that any absence of information-sharing across organisations and/or geographical boundaries was followed by any specific crime by Mr G. In Mr G's case it would have helped the agencies to know about risks and risk-management strategies.

10.4 After his triage assessment on 2 June, Mr G's entry to mental health services in Northamptonshire was triggered by an overdose at a London railway station on 4 August. His mother collected him and took him to Kettering A&E. The psychiatric assessment referred to him as "*Actively suicidal (high risk)"* but recommended that he contact his GP or A&E if his situation deteriorated. He attended A&E again later that day and was admitted on a voluntary basis to a mental health ward (Addington). He discharged himself against medical advice on 8 August. The CPA discharge summary did not indicate any follow-up arrangements. His uncle telephoned the ward later that day, concerned about him and asking if he could be readmitted. He was told by ward staff:

> *"…that he would need to go through Keydoc [Kettering Emergency Doctors on Call] and A&E for him to be assessed as to whether he needed further in-patient treatment."*

10.5 The mental health trust did not initiate contact with Mr G after his discharge from hospital. The Corby CPN (CPN4) said:

"He phoned through and I suppose I was in the vicinity at that time and was asked to pick it up, and by virtue of that was identified as someone to be a point of contact until we had engaged and assessed him and got the appropriate support in place for him."

10.6 In the absence of a formal risk assessment and a CPA management plan after his discharge against medical advice, the contact between Northamptonshire Healthcare NHS Trust and Mr G became one of continual crisis management.

10.7 CPN4 rang the Cornwall forensic team on 8 August requesting information about Mr G, with the aim of securing input from the Northamptonshire forensic team. He said his:

"Local forensic team are unwilling to consider [Mr G] *as a transfer until medical referral and assessment undertaken."*

10.8 CPN4, who spoke to Mr G on the phone but never met him, explained that:

"I was asked if I would hold the case as a point of contact, because the plan, as I recall, was always – he had come from a forensic background – that forensic services would become involved…they would not accept referral from me as a nurse, it had to be medic-to-medic referral."

10.9 CPN4 told us he believed that Mr G's case would have been discussed in team meetings and that a formal referral to the forensic team would have resulted. Additional notes from the team meetings were not made available to us; however, the forensic team in Northampton did not pick up the case.

10.10 Consultant psychiatrist 3 confirmed to us that Mr G's referral to the forensic team was contingent upon his receipt of information requested from the Cornwall forensic team. He confirmed:

"*I cannot recall if I received the information I requested, hence I did not complete a referral to forensic services."*

10.11 CPN4 saw members of Mr G's family in August 2003. They were seeking help in accommodating Mr G – at one stage asking for a secure placement. CPN4 provided advice about potential housing options and offered further appointments to Mr G – all of which he failed to attend. We asked about the risk assessment of Mr G at that time. The CPN said he could not do it because Mr G failed to attend appointments.

10.12 We were keen to establish whether the CMHT had access to Mr G's background and his past history in order to inform its treatment plans. Northamptonshire Healthcare requested information from Cornwall Partnership NHS Trust. They confirmed that they had provided this information but Northamptonshire Healthcare could not confirm that they received it. We asked CPN4 whether he had access to the notes from the children's mental health services in Northamptonshire that contained details of Mr G's involvement with mental health services in his teenage years, he replied:

> "*Absolutely not…you didn't get access to the previous children's notes, absolutely not.*"

10.13 Northamptonshire Healthcare NHS Trust's medical director told us that he did not believe that such a restriction on access to previous notes applied.

10.14 The Corby CMHT discussed Mr G's case on 22 August 2003. It concluded that:

> *"In light of absence of formal restrictions on Mr G, will consider for discharge if he continues with non-engagement."*

10.15 Mr G made a further request for assistance (ostensibly for support with accommodation) on 1 September. Mr G was at Kettering A&E following an overdose so his grandparents attended the appointment the next day. The clinical notes recorded that he had been removed from the temporary GP list, that he had not completed the forms to gain access to another GP and that he had run out of medication. On discharging him from hospital, the psychiatrist who interviewed him in the A&E department recommended that he register with a GP and:

> *"If Mr G felt suicidal, he could present to A&E for psychiatric assessment."*

10.16 The CPN recorded in his case notes the next day:

"*Significant problems engaging Mr G with the service due to his failure to attend any appointments sent. Previously discussed with Assertive Outreach team who refused to accept Mr G as a referral due to diagnosis of personality disorder.*"

10.17 Mr G returned to Cornwall on 5 September 2003. We do not know if he phoned others about his plans, but he announced his imminent arrival to the out-of-hours team at Cornwall Partnership NHS Trust. He arrived at Treliske A&E, but left and was returned by police after threatening to jump off a bridge. He was assessed, agreed to stay overnight for further assessment by the psychiatric nurse liaison service the next morning when he agreed to informal admission to Bay Ward, Longreach House, Camborne Redruth Community Hospital. This admission preceded a temporary transfer to Bodmin Hospital where he was detained under section 5(2) of the 1983 Mental Health Act after stating a desire to leave and being considered a risk to himself or others.

10.18 On being discharged from the Bay Unit on 17 September, Mr G was given a travel warrant to allow him to return to Corby. A care plan was written, denoting Mr G as being subject to "*standard CPA*" (having been "*enhanced*" four days earlier). Consultant psychiatrist 2 recorded in the case notes:

"All imminent risks remain low. Not currently appearing to be psychotic…history of schizophrenia."

Comment

The reference to a* "history of schizophrenia" *is not consistent with the previous case notes because no clear diagnosis of schizophrenia had been recorded.

10.19 Cornwall Partnership NHS Trust responded to the "*crisis*" Mr G presented on 5 September by caring for him in hospital, reviewing his medication and making a clear care plan. The fact that he chose to leave the area, thereby forfeiting any continuing support that could be provided, remained a factor beyond its control. A discharge letter was sent to GP2 in Corby; this was the GP who had taken Mr G off his temporary list (presumably the trust was unaware of this). Consultant psychiatrist 3 (psychiatrist in Corby) spoke to consultant psychiatrist 2 (psychiatrist in Cornwall) who agreed that she would take responsibility for Mr G's case if he returned to Cornwall.

10.20 Consultant psychiatrist 3 saw Mr G with his grandfather on 19 September. In addition to advising on medication and offering to seek support from the forensic services, consultant psychiatrist 3 offered Mr G follow-up appointments. Once again, Mr G failed to keep his next appointment but rang consultant psychiatrist 3 enquiring about his continuing medication. Presumably in response to Mr G arriving at their surgeries, two GPs rang CPN4 on 23 October. The CPN advised that:

> *"Mr G had failed to attend any appointment with myself and would therefore be receiving support from the triage duty team and outpatients."*

10.21 CPN4 wrote to Mr G next day:

> *"As a consequence of your repeated non-attendance…and a change in my responsibilities…I am no longer able to offer you further appointments…You will continue to receive out-patient appointments with consultant psychiatrist 3. Should you require additional support please feel free to contact our team and ask to speak to the duty worker."*

10.22 Mr G rang the CMHT on 27 October for help with medication. He was offered an appointment with the locum psychiatrist on 30 October, when he was noted to be:

> *"…want[ing] to end his life…Still hearing voices…Also feels paranoid at times…It is my impression that he is clinically depressed & is suffering from acute dystonia.*[9]*"*

10.23 The locum psychiatrist offered to see Mr G four weeks later. Mr G did not attend the appointment and declined the offer of another (confirmed in consultant psychiatrist 3's letter to the GP of 3 December 2003). However, consultant psychiatrist 3 also wrote:

> *"I will keep an open outpatient appointment at his request or your request."*

10.24 Mr G saw the locum psychiatrist, a member of consultant psychiatrist 3's team, on 9 December. The psychiatrist noted that Mr G had stopped taking his medication and that he felt:

[9] Dystonia is a neurological movement disorder, in which sustained muscle contractions cause twisting and repetitive movements or abnormal postures.

"...more paranoid and suspicious about people…Also he says that he hears more voices and he was responding to the voices during the interview…his mental health has deteriorated in the last few weeks…"

10.25 The locum psychiatrist wrote to the GP on 29 December:

"…the plan is to continue current medication and review in three months time."

10.26 No reference is made to the involvement of the forensic service or to any additional CMHT supervision or support.

10.27 Mr G was transferred by emergency ambulance to Kettering A&E on 21 December 2003 and 19 January 2004. In spite of his attendance in December being the fourth since September and on this occasion, not waiting to be seen, there did not appear to be a mechanism for the A&E department to register this fact and develop an action plan to guide future attendances. However, when he attended again on 19 January they succeeded in securing a psychiatric assessment and made a further referral to the CMHT in Corby.

10.28 The psychiatric assessment in January recorded that:

"Mr G had been living in a caravan in Leicestershire…Corby CMHT have not, it appears, handed/passed his case on to the psychiatric services which cover the area in which the patient currently lives."

10.29 A CPN and social worker visited Mr G in his caravan. The CPN recorded in the clinical notes that a CPA risk assessment had been completed – although the notes did not contain a copy of the risk assessment nor evidence about whether a referral had been made to mental health services in Leicestershire.

10.30 Mr G returned to Corby on 2 February. He rang the local CMHT. An entry in the clinical record states *"…does not require any help from Mental Health services regarding this"*. The case notes go on to say:

"Knows he can contact duty person as necessary."

10.31 A passer-by found Mr G lying in the street on 7 February. He was taken by ambulance to Kettering A&E. He had a suicide note in his pocket but subsequently denied intent to commit suicide. He was admitted to Addington Ward at Kettering General Hospital. A psychiatric assessment concluded:

> *"No delusion no hallucination, no active suicidal ideas…To be discharged when medically fit; I will find out his key worker & ask for appointment."*

10.32 He was discharged from hospital and collected by his mother on 11 February. The CMHT notes do not include mention of this hospital admission or of any follow-up thereafter.

10.33 Mr G returned to Cornwall in late February 2004. He contacted the Cornwall Partnership NHS Trust's out-of-hours service *"in a tearful state"*. He telephoned consultant psychiatrist 2 asking about access to housing. She provided the requested information but the notes did not record an offer of re-engagement with mental health services locally.

10.34 Mr G was taken to Treliske A&E on 1 March 2004 with cuts to his arms. The psychiatric nurse liaison service (PNLS) recommended that he be discharged and that follow-up be provided by the GP and CPN in Northamptonshire. The clinical notes contain no evidence that the PNLS was aware of Mr G's contact with consultant psychiatrist 2 the previous week.

10.35 Later that same day, Mr G travelled to London and was seen and discharged from St Mary's Paddington (London) where he had presented with an ankle injury.

10.36 The forensic team in Cornwall contacted the Kerrier[10] CMHT offering to undertake a joint assessment of Mr G on 3 March. Once again, Mr G did not attend the appointment, having already returned to Northamptonshire, leaving the mental health services uncertain about how to proceed. The Cornwall Partnership NHS Trust's notes do not indicate whether contact was maintained with the Northamptonshire trust after this, but the next entry in the CMHT notes was not until 2 January 2005.

[10] Kerrier is a former local authority district in Cornwall.

10.37 Mr G was back in Northamptonshire between March and September 2004. The CMHT there continued to offer outpatient appointments and advise the GP about medication in the meantime.

10.38 In May 2004 Mr G visited Cornwall for a supervised access visit to his children. He attended Treliske A&E (Truro) after an overdose and was admitted to the medical assessment unit for three days. He declined a referral for a psychiatric bed in Northamptonshire and was discharged with a travel warrant to Corby. The Royal Cornwall Hospitals Trust records do not contain the following, but the psychiatric nurse liaison service, in its discharge letter to the GP, said:

> *"…that the Royal Cornwall Hospital will not fund his return home at any time in the future."*

10.39 Later that day Mr G arrived at Plymouth A&E having taken another overdose. A bed on Addington Ward (Kettering, Northamptonshire) was made available and he transferred there as an informal patient the next day (15 May).

10.40 Consultant psychiatrist 3 conducted an assessment on the ward. He concluded:

> *"…nil affective or psychotic symptoms…"*

10.41 The CPA hospital discharge summary confirmed his discharge on 17 May, with a follow-up appointment on 21 May. The CPA care coordinator was identified as a CPN with the CMHT, but no formal CPA care plan appears in the records. Mr G failed to attend his follow-up appointments in May or June, but finally saw a SHO in consultant psychiatrist 3's team on 15 July. A follow-up appointment three months later was offered, with no reference to any proposed contact with his care coordinator, CPN5, a CPN with Corby CMHT.

10.42 Mr G took an overdose on 17 July 2004 and was admitted to Bedford Hospital (via A&E) for two days. A psychiatric assessment was undertaken at the hospital, with a recommendation for psychiatric follow-up in Northamptonshire. Consultant psychiatrist 4 and the team leader of the CMHT in Northamptonshire undertook a joint review of Mr G on 22 July, resulting in a detailed assessment and treatment plan. This was the third assessment by mental health professionals in a week (15, 17 and 22 July).

10.43 The clinical records show that consultant psychiatrist 4 was now identified as the CPA care coordinator (although the absence of formal CPA documentation in the notes means that it was unclear whether Mr G was subject to standard or enhanced CPA). Recognising the difficulty of engaging Mr G in a chaotic living environment, the team recommended the exploration of a therapeutic environment (the Henderson Unit). Once again, Mr G failed to engage with the local services and spent the next four months variously in Northamptonshire or in Cornwall.

Analysis

Assessment and care management

10.44 During his time back in Northamptonshire Mr G did not comply with the processes for engagement demanded of him. For example, he consistently failed to attend appointments but frequently presented in 'crisis' mode. This made it difficult for the professionals to engage with him and led to their having to respond in isolation to each presentation rather than as part of a structured plan. The assessments appeared to be focused primarily on his mental health or physical status, rather than on his vulnerability or risk – either to himself or others.

10.45 Mr G had at least four CPA care coordinators in Corby during 2003-04. The CPA care coordinator is expected to maintain a good overview and to coordinate effective patient care. (The four CPA care coordinators included CPN4, consultant psychiatrist 3, CPN5 and consultant psychiatrist 4). Neither of the CPNs met Mr G. Risk assessments were conducted but not accompanied by the expected full CPA documentation.

10.46 Mr G's personality disorder and his risks were managed mainly through medication with some nursing input. Four doctors (including consultant psychiatrist 3) provided Mr G's medical input, causing a lack of continuity of care.

Comment

In complex cases like that of Mr G, consistency and continuity of care are imperative in developing a trusting relationship and improving engagement with the team. Continuity of care would also enable the clinician to retain oversight of the case and

to manage long-term risks effectively. These factors were lacking in the care and treatment available to Mr G at the time.

10.47 Nothing in the record indicates that the Northamptonshire Healthcare NHS Trust's full CPA process was followed consistently at this time. A CPA discharge plan accompanied his discharge from hospital in August 2003 but the case files generally lacked the expected CPA assessments, risk management and care plans.

Comment

We consider these absences a particular failure on the part of mental health services in Northamptonshire.

10.48 A referral to the Northamptonshire forensic mental health team was not completed because the requested information from Cornwall Partnership NHS Trust was reported not to have been received. The absence of an assertive follow-up of this information, together with the protocol that any referral should be made by a doctor, deprived Northamptonshire Healthcare Trust the opportunity of getting more help from their specialist forensic team.

10.49 A referral to the assertive outreach team was rejected on the basis of Mr G's diagnosis of personality disorder. Excluding people with personality disorders from the work of the assertive outreach team without proposing an alternative meant Northamptonshire Healthcare Trust could not involve specialist staff in engaging Mr G – when engagement with the CMHT was proving problematic.

10.50 The contact with Mr G's family in Northamptonshire appeared to centre on their concern for him to secure a place of safety – either in hospital or elsewhere. Discussion then focused on his eligibility for admission or re-admission to inpatient care. No discussion is recorded with his family about the range of mechanisms that would mitigate the risk of harm to himself and/or others e.g. accommodation, treatment, employment/training, avoiding offending, etc.

Comment

The more active engagement of Mr G's family members in the co-production of his care might have been beneficial at this point.

10.51 Mr G's action in not engaging with the CMHT in the manner required (attendance at follow-up appointments) led it to suggest that he should be discharged from its caseload. The team might have considered taking a more assertive approach to his non-attendance but did not.

10.52 It is good clinical practice to gather collateral information when risk assessing or planning care, which in this case would have meant obtaining information from Cornwall, children services in Corby and finally Mr G's family in Corby who were expressing serious concerns about his wellbeing. Evidence suggests that case file material from Cornwall was requested and that telephone discussions took place with the psychiatrist (consultant psychiatrist 2), the forensic CPN (CPN3) and the psychiatric nurse liaison service in the Royal Cornwall Hospital. However, there is no evidence that information was sought from the child and adolescent mental health services or the local authority children's services in Northamptonshire.

Comment

Northamptonshire Healthcare NHS Trust should have sought wider information from all the agencies involved when assessing Mr G and drawing up care management plans.

10.53 Many assessments of Mr G took place during this period but most resulted from his presenting 'in crisis'. In addition to assessing his immediate presenting physical and/or mental health condition, a secondary focus appeared to be his eligibility for inpatient or outpatient mental health services rather than a broader assessment of his vulnerability or risk.

Comment

As a result, the follow-up actions led to one service (e.g. A&E) being discontinued when a referral was made to another (e.g. mental health services). Little continuity of care was therefore evident.

10.54 Northamptonshire Healthcare NHS Trust had no dedicated pathways or services to support the treatment and care of people with a diagnosis of personality disorder at this time. This potentially increased the difficulty for the clinicians in deciding how best to treat and support Mr G.

Comment

The recommendation by consultant psychiatrist 4 to consider a* "therapeutic community" *environment for Mr G was an appropriate alternative method of securing care and treatment for him. Mr G chose not to engage in exploring this option.

Multi-agency work

10.55 Sporadic communication took place between the mental health services in Northamptonshire and Cornwall during 2003 and 2004.

10.56 There is no evidence to indicate that there was proactive liaison with other agencies via a multi-agency forum using the protocols available such as CPA or MAPPA, whilst Mr G was under the care of Northamptonshire Healthcare NHS Trust.

Risk assessment and risk management

10.57 Mr G's diagnosis of personality disorder, combined with his chaotic lifestyle and a reluctance to comply with follow-up arrangements, made it difficult for mainstream community mental health services to engage with him in the normal way. As a result, engagement was limited to providing medication and contact with members of the CMHT with no system for sharing risk assessment and management. This put the main focus on the immediate symptoms and not the underlying causes of his presentations.

10.58 Mr G's continued trips between Northamptonshire and Cornwall resulted in the mental health services being unclear about which of them was taking the lead in the coordination of his care and treatment. As a result, each of his presentations continued to be addressed as a 'crisis' rather than in the context of a continuing risk assessment and risk management plan. No agreed contingency plans were recorded as in place.

Comment

The lack of risk assessment , risk management and contingency planning were shortfalls in the care and treatment plans from both Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust.

Conclusions relating to the return to Northamptonshire in 2003

C22 Mr G made it difficult for the mental health services in Northamptonshire and Cornwall to engage with him because of his continued crisis presentations and failure to attend follow-up appointments.

C23 In respect of Northamptonshire Healthcare NHS Trust, we find the following:

- its case files were generally lacking the expected CPA assessments, risk management and care plans

- further collateral information, including further engagement with Mr G's family and background information from its Child and Adolescent Mental Health Service (CAMHS), should have been sought in relation to its assessment and care management plans for Mr G

- the identification of four CPA care coordinators (two of whom had never met Mr G) was poor practice and did not help provide consistent care for Mr G

- Mr G was excluded from the assertive outreach team as a result of his diagnosis of personality disorder

- it did not have dedicated pathways or services in place for people with a personality disorder.

C24 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust had no agreed contingency plans, apart from consenting to see Mr G if he arrived with them.

C25 Mr G is chiefly responsible for failing to engage fully with local services. However, between June 2003 and July 2004 he presented to health services in crisis on (at least) the following occasions:

- 12 attendances at A&E departments – with at least six involving transfers to hospital by ambulance (Treliske, Plymouth, Paddington, Bedford and Kettering)
- 5 hospital admissions (Treliske, Kettering, Plymouth and Bedford). On one occasion he was detained under section 5 (2)[11] of the 1983 mental health act (Cornwall)
- 14 self-initiated contacts with the Community mental health services in Northamptonshire
- 3 self-initiated contacts with mental health services in Cornwall.

In one week of July 2004, he was assessed or reviewed four times by psychiatrists and/or CPNs in both Northamptonshire and Bedford. The process and outcome of the assessments and reviews may have been detailed and robust; the follow-up arrangements were less so.

[11] Section 5(2) allows the compulsory detention of a patient already receiving inpatient treatment for a duration of up to 72-hours by the doctor in charge of the case.

11. Late 2004 until early January 2005

This section of the report examines the period between the summer of 2004 and early January 2005. Mr G began to visit Cornwall more frequently, although avoiding contact with Partner A and her family. On one of these visits he met Partner B and their relationship resulted in one miscarriage followed by the birth of Mr G's fourth child (Child 4) in August 2005. His contact with health services was sporadic and he continued to present in crisis mode.

11.1 During one of the visits to Cornwall during the summer of 2004, Mr G befriended a 16-year-old young woman who had been in the care of the local authority (Partner B). She visited him in Corby and he spent the ensuing months of 2004 between Cornwall and Northamptonshire. Towards the end of 2004, Partner B announced that she was expecting Mr G's child. She suffered a miscarriage in the late summer of 2004, becoming pregnant again by the end of the year.

11.2 We set out below Mr G's contacts with the emergency services in Cornwall during ten days in September 2004:

- 10 September — attended by emergency ambulance at Redruth railway station complaining of abdominal pain (no outcome recorded, nor any subsequent attendance at A&E)
- 13 September — attended by police and ambulance at Redruth railway station, after reports of his taking pills (he declined help or transfer to hospital)
- 13 September — later that day he phoned NHS Direct and then flagged down an ambulance, complaining of stomach cramps. Mr G was treated for a suspected overdose and a PNLS review was arranged. The PNLS at A&E said they knew Mr G well; He declined to be seen and he was discharged.
- 15 September — detained under section 136 of the Mental Health Act[12], after threatening to jump from a bridge. (Psychiatric assessment conducted by consultant psychiatrist 1 accompanied by a written care plan; consultant psychiatrist 1 made contact with Corby CMHT, provided Mr G with medication, and offered a follow-up appointment in two weeks.)

[12] Allows the police to remove a mentally ill person from a public place to a place of safety.

- 16 September — emergency ambulance transfer to Treliske A&E, reporting that he had been coughing up blood. Admitted overnight, accompanied by his girlfriend and following upper gastrointestinal tract investigations the next day was discharged with appropriate antibiotic therapy. No indication of any psychiatric symptoms or an assessment thereof.)
- 20 September — emergency ambulance attended Mr G in Camborne after a reported overdose (he declined treatment or transfer).

11.3 Mr G was transferred to Treliske A&E by emergency ambulance after a reported overdose (8 November). Again, the PNLS saw him on 9 and 10 November. Recommendations about discharge information being shared with Northamptonshire and Cornwall CMHTs were made on the first day. Next day, the PNLS reported:

> *"This patient has personality disorder and can behave in a very manipulative way. He also has a forensic history. I am concerned he is with a 17 year old female…with whom he is involved. I cannot do anything about this but will discuss with colleagues…"*
>
> *"(He) was somewhat uncooperative during the treatment process…(he) was seen by the forensic community psychiatric team in Cornwall but was discharged from them because he proved almost impossible to work with, unco-operative & difficult to engage. I understand also that Mr G was also under the care of Corby CMHT but was also discharged by them for similar reasons. I believe his diagnosis to be that of borderline personality disorder with depressive episodes a chaotic lifestyle and some significant self-injury episodes…Mr G claims that his girlfriend is pregnant."*

11.4 The letter was copied to the Corby CMHT, the Cornwall forensic team and the Cornwall local authority child and family department.

Comment

Sharing information with the various agencies involved with Mr G was good practice.

11.5 Mr G returned to Cornwall in December 2004 and came under the care of a new GP, received a further referral to the CMHT and failed to attend the appointment offered.

11.6 Cornwall police had contact with Mr G four times in December 2004: twice in relation to suspected domestic abuse involving Partner B. He was arrested and released without charge on both occasions.

11.7 On the 2 January 2005 Mr G presented at Treliske A&E after a reported overdose, the assessing psychiatric registrar noted:

> *"No evidence of psychosis…"*

11.8 The psychiatric registrar spoke to the Restormel CMHT, agreed a contact point there for Mr G (a CPN) and proposed that Mr G should be followed up the week after.

Analysis

Assessment and care management

11.9 Mr G moved frequently between Northamptonshire and Cornwall later in 2004, continuing to use services on a predominantly crisis basis.

11.10 Mental health services in Northamptonshire and Cornwall liaised when he arrived at one of their respective services but they did not draw up a joint risk management strategy. Each presentation was therefore dealt with in isolation and not as a part of an agreed management or contingency plan.

Risk assessment and risk management

11.11 Two of Mr G's four contacts with Cornwall Police in December 2004 related to alleged assaults on his girlfriend (Partner B). Insufficient evidence meant that no charges were brought. We found no evidence that domestic abuse procedures were initiated and/or any contact was made with Cornwall children's services. Again, each incident appeared to be treated in isolation, perhaps with a focus on whether an offence had been committed or a subsequent conviction might have resulted, rather than on an assessment of vulnerability and securing the necessary support for those involved.

Multi-agency coordination

11.12 The emergency procedures implemented by the agencies Mr G contacted in late 2004 were appropriate in response to his immediate presentation. Any shortfall was related not to the individual responses and taken together they did not trigger any mechanism or formal procedure (e.g. CPA, MAPPA, domestic abuse, child protection, etc) for the police, ambulance, psychiatric and A&E services to share their intelligence on Mr G or agree any necessary handling strategy.

Conclusions relating to late 2004 until early January 2005

C26 The absence of an agreed contingency plan denied the mental health services in Northamptonshire and Cornwall the opportunity of engaging with Mr G in a more structured and planned way. Such an arrangement is not a formal requirement, but it might have helped them handle his new presentations, rather than deal with them as unplanned emergencies.

C27 The further reports of domestic abuse failed to result in any follow-up action by the police or the convening of a multi-agency case conference.

Developments in handling domestic abuse and adult safeguarding issues in Cornwall since 2006, as outlined in the Mr V serious case review and the author's progress report 12 months later, have resulted in significant improvements to local systems. It is understood that similar presentations would now result in a more pro-active multi-agency response. These developments are welcome.

12. Arrival in St Austell

This section of the report examines the six months after Mr G's arrival in St Austell (January 2005). He continued a somewhat nomadic lifestyle. His contact with services was, again, predominantly on a crisis basis but the scale and number of these presentations increased considerably.

12.1 Mr G's girlfriend (Partner B) was living in St Austell in early January 2005, so he moved there. He registered with a local GP (GP3), who had a special interest in alcohol and drug problems. The GP referred Mr G to the CMHT (17 January). The GP rang the CMHT on 2 February because Mr G had taken two further overdoses and reported no contact with the CMHT. In fact, the team had offered two outpatient appointments to Mr G — neither of which he attended.

12.2 Between 3 and 19 February Mr G called on the emergency and mainstream services many times:

Name of service	Dates called on
Emergency ambulance	3, 7, 8, 9, 11, 15, 18 & 19 February
A&E	3, 7 & 19 February
Cornwall Partnership NHS Trust's out-of-hours service	8, 11 & 18 February
Cornwall Partnership NHS Trust's CMHT	10 February (an offer of an appointment at the GP surgery; Mr G did not attend),17 February (screening assessment) & 19 February (assessment at the police station)
GP out-of-hours service	13 February
GP	9 February (consultation with ambulance service) and 14 February
Police	8, 18 & 19 February

12.3 Recognising that his attendance at appointments was unreliable, the CMHT offered to see him at a venue he was known to attend, the GP surgery, but Mr G did not turn up for this appointment. A CPN from the CMHT finally succeeded in seeing him on 17 February 2005. The CPN concluded:

- *"No evidence of formal thought disorder*

- *Impression: diagnosis/problems unclear; actively seeking help and wanting to engage*
- *Consultant psychiatrist 5 to see for diagnosis and advice on plan*
- *Placed on CPN caseload (CPN6) for "ongoing assessment". Given appointment for 2 March".*

12.4 The CPN recorded in the formal 'risk identification':

- *"(Risk of) harm to others: from review of notes — significant risk of arson, sexual offences, threats of violence and of violence or neglect specifically of children in his care.*
- *(Risk of) Self harm: confirmed high.*
- *(Risk of) Relapse: confirmed high*
- *Hazards in the delivery of care: DO NOT VISIT ALONE. Ensure lone worker policy is followed.*

12.5 The CPN reported the above to the GP in a letter dated 18 February, saying Mr G was:

> *"...at moderate risk of suicide/self harm and harm to others."*

Comment

A moderate risk is not consistent with the record of the previous day's assessment.

12.6 CPN 6 saw Mr G, who had reportedly taken an overdose of aspirin, at the police station on 19 February. He called an ambulance to transfer Mr G to Treliske A&E and offered a follow-up appointment on 21 February. Mr G discharged himself from the A&E department against medical advice and did not attend the appointment with the CPN.

12.7 The GP wrote to the consultant psychiatrist 5 on 17 February (not being aware that the CPN assessment was taking place that same day) saying:

> *"…In view of this pattern of self harm, which is becoming rather hazardous, I would be grateful for your <u>urgent</u> attention."*

12.8 Consultant psychiatrist 5 offered Mr G an appointment on 23 February which he did not attend. He therefore reviewed the file and wrote to the GP (copied to the CPN team) advising:

> *"…the diagnosis since 1997 has been consistently one of personality disorder…he has a fairly extensive forensic history which would indicate a significant risk of arson, sexual assault, violence and neglect of children specifically in his care…I will discuss how we can arrange to see him again with CPN6."*

12.9 As part of his review of the case files in February, consultant psychiatrist 5 highlighted Mr G's diagnosis and significant risk factors. Consultant psychiatrist 5 told this investigation that when Mr G was referred to him in February 2005, he:

> *"…was not presenting with any immediate risk at that time – this is February – he was presenting with concerns. My view was this is a chap we need to be aware of and that was as far as I was going. Not forensic follow up because he had been there before it had not prevented risky behaviours and there was no new significant risk that needed further assessment of a forensic team."*

12.10 However, a number of incidents were recorded in the clinical notes which preceded Mr G's referral to consultant psychiatrist 5's clinic. These included allegations that Mr G had assaulted his pregnant girlfriend, locked her in his room and threatened her with a knife. Furthermore, since that alleged incident, Mr G had taken at least four overdoses and called the police once threatening suicide. He had presented to psychiatric services having taken an overdose. He failed to keep up appointments and was disengaging with services. These factors would indicate that:

- Mr G was presenting as a significant risk due to recurrent self-harm behaviour, alleged violence and disengagement
- the consideration of a further referral to the forensic services would have been warranted, given the previous relative success in engaging him and supporting a period of stability.

12.11 Mr G was arrested on 27 February after an assault on Partner B, who said she was around three months pregnant with his child. He was taken to Newquay custody centre,

detained under section 2 of the Mental Health Act and admitted to Fletcher Ward, Bodmin Hospital[13]. The clinical notes recorded:

> "*He said his girlfriend was winding him up and calling him a baby basher and a psycho…he said he had heard voices through microwave telling him he should kill Partner B."*

12.12 The letter to consultant psychiatrist 5 from the specialist registrar who interviewed Mr G in the custody centre included the following:

> *"He was not psychotic when interviewed but clearly was a risk to himself and others…I did not feel completely convinced that he was actually hearing an auditory hallucination…No evidence of psychosis or severe depression…To inform police if he leaves the ward."*

12.13 During his time in hospital, Partner B took out a non-molestation order on Mr G, saying their relationship was over.

12.14 Mr G was taken off section 2 of the Mental Health Act on 4 March and remained as an informal patient.

12.15 He was described in his second weekly care review on 6 March as subject to enhanced CPA. A referral to the Pentreath project for work experience was accompanied by a diagnosis of:

> *"?BPD; formerly "Paranoid Schizophrenia /?dual diagnosis."*

12.16 The ward notes refer to Mr G as "*…no longer part of the Forensic Community Team*" but offers no explanation. The clinical notes contain nothing to suggest the forensic team was consulted about this decision.

12.17 Mr G was moved to another mental health ward, took an overdose of aspirin and was transferred to Treliske A&E on 7 March. He returned to the mental health unit four hours later and was discharged next day.

[13] Fletcher ward, Bodmin Hospital is the acute psychiatric admission ward.

12.18 Mr G received a letter from Cornwall Partnership NHS Trust's mental health act advisor on 8 March, confirming his discharge from section. This stated:

> *"Should you wish to leave the hospital, you may do so. But it is recommended that you discuss this with medical or nursing staff…Prior to leaving hospital, you should be provided with a care plan. This will identify whom (sic) your community key worker is, what services have agreed to be provided, and when you are due to be visited. This care plan is provided for your benefit under the Care Programme Approach."*

12.19 He left the ward later that day. The notes do not say why he was discharged. No CPA discharge care plan appears in the notes and they do not say if he had accommodation available. He was reported two days later to be living in a tent in Liskeard.

12.20 The discharge letter to the GP (written on 14 March) says:

- *"No evidence of psychosis or severe depression at the time of admission*
- *Considered moderate risk with low probability*
- [Mr G] *clearly wanted some treatment to help with his aggression; we suggested risperidone injection which he was keen to start*
- *During his time on the ward it became clear that* [Mr G] *was not suffering from any mental illness. Staff made it clear to* [Mr G] *that he was responsible for all his actions.*

  Plan:

- *Tail off oral risperidone @ 1mg per week*
- *Temazepam prescribed for short term use only and we recommend that it is not continued*
- [Mr G] *will need short term CPN support for administration of his 2/52ly medication*
- *Review in a few months*
- *Psychiatric admission to be resisted unless there is objective evidence of imminent significant risk to himself or others or a substantial change in his mental state"*

12.21 Back in the community, Mr G phoned the police, threatening a further overdose and blaming them for his actions. The police and ambulance attended. He was stabilised but he refused further treatment. The next day on 9 March his mother phoned Cornwall police to tell them that he had taken another overdose. Police took him to Derriford A&E (Plymouth). A flurry of communications ensued over the next couple of days. The Cornwall Partnership NHS Trust's out-of-hours service asked its duty desk to ensure that the care plan and risk assessment were updated on the electronic health record; the Restormel CPN transferred his case responsibility to Liskeard CMHT. Consultant psychiatrist 5 recorded in the case notes:

> *"Three ODs in 3 days – should not be admitted on this basis…has clear diagnosis of Personality Disorder. Only admit if clear evidence of significant change in mental state including development of mental illness that of itself requires admission, or if objective evidence that he is imminently suicidal. He will say he is & subjective evidence is very suspect."*

12.22 An undated and unsigned referral/screening assessment form (presumably from Liskeard CMHT) referred to Mr G remaining under the care of consultant psychiatrist 5 and ended by stating:

> *"This man has a history of violence and must not be seen on his own. Danger to women."*

12.23 The form contained no plan of action to engage with Mr G or provide after care.

12.24 Avoidance of further unnecessary admissions was a clear objective from the above, but we found no evidence of any other strategies to engage Mr G. On 11 March the Cornwall Partnership NHS Trust's out-of-hours service sent a fax to the duty team:

> "*The initial plan was to transfer for assessment at Bodmin (psychiatric ward) but then found to need treatment therefore remains at Derriford (Plymouth) for treatment…I am uncertain which team are seeing Mr G. It is also unclear who is taking medical responsibility for this man…I have accessed Electronic Health record and note significant risk issues to others."*

12.25 Two further encounters with the police in Plymouth occurred on 17 & 18 March, the latter resulting in a charge of theft of alcohol for which Mr G was subsequently fined £50. Another psychiatric assessment was conducted at the police station on 18 March and Mr G was admitted to Fletcher Ward (Bodmin Hospital) under section 2 of the Mental Health Act.

12.26 Consultant psychiatrist 5 saw him three days later, discharging him from section and from the hospital. The papers recording Mr G's discharge from section were accompanied by a discharge assessment, which said:

> *"Support on discharge: CPN6*
> *Ability to self medicate: N/A; depot medication*
> *Will food be available at home? No. NFA [No fixed abode]*
> *Will heating be available? No. NFA*
> *Other information: Advised to contact homeless officer"*

12.27 The case notes did not say if Mr G had been assessed under the CPA and, if so, whether he was subject to standard or enhanced care. Follow-up arrangements were not outlined in the file.

12.28 Mr G attended the local social services department and threatened self-harm in their waiting room within hours of being discharged from hospital. Social services rang Fletcher Ward for advice:

> *"Mr G…very distressed…(I) phoned the ward to find out what his discharge plan was, as he had no idea…spoke to staff nurse…he did not have a mental illness…should never have been placed on the order (section 2) & that there was nothing wrong with him…when I expressed shock that he had been discharged from a closed ward to sleep rough…or even refer him to the mental health team early…she stated that was not their job…she suggested sending him to the housing department if I did not want to be bothered."*
>
> *A social worker had been trying to get* [Mr G] *an assessment by the CMHT.As he had come from St Austell (Restormel), the North Cornwall team would not pick him up. On contacting Restormel, the social worker was informed by a receptionist that* [Mr G's] *CPN was away until Tuesday…'if the ward believed he was fit for discharge he*

was fit'. Mr G requested a train ticket to Northampton. As there were no further options I took him to the train station…"

12.29 In the next 48 hours Mr G returned to Corby, was arrested under section 136 after telling a stranger he wanted to hang himself. Mr G underwent a psychiatric assessment in custody and was provided with a rail warrant to return to Cornwall. This information was shared with police and healthcare agencies in Cornwall. The agencies involved in Northamptonshire conducted assessments of the presenting circumstances, but they made no continuing risk assessment or risk management plan.

12.30 On 25 March 2005 he was taken to Derriford A&E by the police after threatening to jump under a train on the station. He informed the SHO that he:

"Does not like his CPN, consultants from Cornwall/Northamptonshire…"

12.31 He was provided with medication and discharged, with a follow-up letter to consultant psychiatrist 5.

12.32 We do not know when the CMHT in St Austell learned of Mr G's return there. However, the police took him to the CMHT offices on 19 April after he rang them threatening suicide. He was asked to wait while his notes were located but he left, promising to return within half an hour. He failed to do so. No follow-up action was recorded by the CMHT apart from detailing that telephone advice was being provided to the local housing office because Mr G had turned up there later that day. The discharge letter from Bodmin Hospital the previous month outlined that contact with his CPN would be fortnightly. Case responsibility had been transferred to Liskeard when Mr G was reported to have moved there. The records do not indicate that they acted to re-engage Mr G at this point.

12.33 Police interventions were required later that month, in relation to Mr G's contact with his girlfriend (Partner B) and her earlier injunction against him. He was arrested again under section 136 of the Mental Health Act on 23 April. He was assessed in custody and released – no notes of this event appear in the records Cornwall Partnership NHS Trust provided.

12.34 Section 136 was again used to detain Mr G on 9 May 2005 after he threatened suicide. He was assessed by a duty psychiatrist and an approved social worker (ASW). The psychiatrist reported that:

> *"Hospital admission not an appropriate solution…there was, of course, a risk of attempts at self harm & indeed a risk that he might assault members of the public, we felt that the most appropriate way forward was firstly to share the risk assessment with the Police, secondly to give the Crisis/OOH [out-of-hours] team telephone no. to the patient, thirdly to encourage him to make contact with the Restormel team after 9 a.m. and finally to recommend that further such manipulative behaviour or aggression should be handled through the Criminal Justice system."*

12.35 The ASW contacted the Restormel CMHT, whose duty CPN wrote in the notes:

> *"I suggested that he had consistently been found to be not mentally ill and I was unsure what benefit could be derived from sending him over to the CMHT. Mr G had apparently set fire to his tent and had nowhere to live."*

12.36 The above two statements indicate a level of (perhaps understandable) frustration felt by the mental health professionals about Mr G's current presentations. The paradigm *"mad or bad"* came to the fore once again. If his "*manipulative behaviour or aggression*" was to be handled via the criminal justice system, no evidence was provided about how this had been communicated either to the police or to Mr G. The approved social worker made further contact with the CMHT but the duty CPN questioned the value of seeing Mr G. He did not arrive there next morning and no attempt was made to follow up.

12.37 We asked the CPN what advice was given to the social worker. We were told:

> *"I was on the phone to her and I said, 'Why are you sending him up if he's already been assessed today?' I know it sounded not very nice, but we wouldn't normally see people twice in one day if they'd been assessed like that, that was all. I would have seen him if he'd come up but he didn't."*

12.38 GP3 referred Mr G to the CMHT again on 11 May 2005, followed up by another referral to the consultant psychiatrist (consultant psychiatrist 5) two days later. We found

no record of a direct response from the consultant psychiatrist but the CMHT wrote to Mr G on 31 May, offering an appointment for 13 June. The midwife for Child 4 also wrote to Restormel CMHT on 24 May, saying:

> *"…we would appreciate your involvement as soon as possible."*

12.39 Mr G failed to attend on 13 June or for the re-arranged appointment on 16 June. He had previously been reported to be homeless (paragraph 12.35), so we do not know where the appointment letter was sent or if he received this. We asked the duty CPN what the CMHT would have done about his failure to attend for appointments:

> *"I didn't do anything. It was just documented in the notes…I can't really think that there was a formal system in place for that type of thing (*follow up of missed appointments*) to happen. Quite a lot of people were told to come up to the mental health team and they didn't come. It didn't mean that we actively followed it up. The difference now is that our referral and assessment system is quite different, and it certainly would be followed up now."*

12.40 Mr G called the emergency ambulance four times between 3 and 4 July. He was not found on one occasion, refused transfer to hospital on two occasions and was reported to be uncooperative and refused treatment on the one time he was transferred to the A&E department. He rang the police later on 4 July, reporting that he was receiving threats from Partner B and others. The police records reported them becoming:

> *"….very concerned about his mental health at this time…"*

12.41 They made a referral to the CMHT on 5 July 2005. The duty CPN spoke with Mr G later that day, identifying his needs as:

- *"…low in mood and…not coping well…wants help re-establishing his medication…*
- *Also wants help with accommodation & other social needs. Feels isolated and doesn't know where to turn…I would ask for an assessment which would not be for a couple of weeks."*

12.42 The next entry in the CMHT notes is on 21 July 2005 when Mr G rang the team "*in tears*" and spoke to the duty CPN. It was recorded that the CMHT manager had recently

offered two screening assessments. Mr G had neither kept nor cancelled these appointments. The duty CPN noted that Mr G said:

> *"What do I have to do to get a CPN?"*

12.43 As Mr G had presented with a requirement to "*come off drugs*" he was advised to contact specialist drugs agencies. When we asked about her assessment of Mr G, the CPN replied that the CMHT was dealing with him as a closed case:

> *"If he was* [an] *open* [case] *he'd have a care coordinator and someone would be dealing with it; it wouldn't have come to duty…I don't think we had a team strategy about Mr G. There were long periods when we didn't hear about him…"*

12.44 The CPN confirmed that the CMHT discussed Mr G's case at meetings but records were not kept at that stage. (Cornwall Partnership NHS Trust has since rectified this. All case discussions at team meetings are recorded and emailed to each member.)

> *"I would say a huge proportion of the people we offer assessments to don't attend. It's not as if that was something unusual. It was just somebody else that didn't turn up who had a crisis and it blew over".*

12.45 The CMHT team manager wrote in a submission to a child protection case conference in August 2005,:

> *"Mr G has been known to Cornwall's mental health system for approximately four years although he is not currently on anybody's case load. His most likely diagnosis is that of Personality Disorder. Since April 2005 Mr G has failed to attend three assessment appointments…At present he refuses to see me. One of my staff is in the process of arranging an appointment: He has a fairly extensive forensic history which would indicate a significant risk of arson, sexual assault, violence and neglect of children specifically in his care".*

12.46 The CMHT wrote to the GP on 19 August to say that Mr G had not attended a screening assessment the previous day and advising:

> "*I will not offer a further appointment but will do so if you feel it is warranted.*"

Analysis

Assessment and care management

12.47 Mr G had many contacts with health agencies and the police in the weeks after arriving in St Austell. His contact with social services was indirect, through their continuing support and supervision of his girlfriend (Partner B).

Comment

The GP referrals to the CMHT and consultant psychiatrist were an appropriate means of seeking specialist assessments and a multi-agency approach.

12.48 Mr G's second discharge from hospital in March 2005 (after being subject to formal detention under the Mental Health Act) also lacked CPA documentation, discharge planning or follow-up arrangements. His discharge, together with the attempts by the local social services to secure adequate discharge planning, was dealt with in a somewhat peremptory manner. The statement from ward staff that he should not have been admitted to hospital focused on his eligibility for a service, rather than on a broader assessment of his needs, vulnerability and risks (to himself and/or others). Discharge with no formal CPA care plan or any idea of where he would be accommodated did little to decrease the risks faced by Mr G or others he came into contact with.

12.49 The further psychiatric assessment in May 2005, under section 136, offered another opportunity for the CMHT to re-engage with Mr G. The duty CPN's response to the referring social worker indicated a reluctance to offer this support. Mr G did not attend the CMHT, as recommended by the psychiatrist and social worker; the CMHT undertook no active follow-up of Mr G at this stage.

12.50 The CMHT received additional referrals in relation to Mr G in May and June 2005 – this time from professional colleagues involved in the child protection plans in relation to Child 4. Appointments were offered, but no follow up procedure was in place when he failed to attend. No process was invoked for a formal case discussion and a subsequent risk management plan with other involved professionals. Cornwall Partnership NHS Trust has identified this gap in procedures and we are assured that more robust follow-up

arrangements are in place. This assurance is based on a review of the trust's CPA policy (May 2010), the revised operational protocol for the forensic team (February 2010) and the trust's board report on the implementation of the Bradley report (April 2009)[14].

12.51 By July 2005 any formal care planning by the trust appeared to have lapsed. Mr G's medication was being overseen by the GP, who had requested advice and support. The fortnightly CPN contacts discussed when he was discharged from hospital in March had stopped, partly because of his nomadic lifestyle and his failure to turn up to appointments. The various assessments had identified clear risks. A clear management plan aimed at mitigating those risks — on an individual or multi-agency basis — was lacking.

12.52 No formal review of Mr G's enhanced CPA status nor any decision formally to close his case is recorded in the notes. Other agencies believed he was still receiving support from the CMHT – hence the requests from the GP, police and health visitor.

Risk assessment and risk management

12.53 The risks the CPN recorded in the case files on 17 February 2005 were uniformly "*high*", yet in the following day's letter to the GP they were recorded as "*moderate*". These statements were not consistent.

Comment

The consultant psychiatrist's review of the case files was appropriate and warranted in the circumstances. Historical risk factors were adequately noted in consultant psychiatrist 5's risk summary but recent risk factors (recurrent self-harming behaviour, alleged violence and disengagement) do not appear to have been adequately considered. Furthermore, consultant psychiatrist 5 (as stated during his interview) appeared to conclude that Mr G was not presenting as a significant risk at the time. However, these events appear to indicate that Mr G presented a significant risk. He would have warranted and conceivably benefited from forensic input/referral. An over-arching multi-agency approach to Mr G would have allowed all professionals to be kept up to date with all the information. No such approach was in place or enacted at this time.

[14] Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, 30 April 2009, Department of Health.

12.54 The criminal justice system did not pursue the alleged assault on Partner B on 27 February because Mr G was sent from custody to hospital. He continued to say while he was there that he had heard voices asking him to kill his girlfriend. However, no evidence in the files indicates sufficient enquiry about this incident or the attendant risks during his brief time in hospital. We found no evidence to indicate that any collateral information (from the girlfriend or the police) had been obtained.

12.55 Mr G's hospital admissions in early 2005 provided the mental health services with the opportunity to assess him to identify his needs, devise a multi-agency handling strategy and a detailed care plan. The ward staff had regular contact with Mr G's mother and other members of her family in Northamptonshire during this time. In particular, his mother expressed fears he would take another overdose if he were discharged in the near future.

12.56 The emphasis in early 2005 appears to have been on crisis risk management instead of on risk formulation. Medication appears to have been considered because Mr G was willing to take it. Nothing indicates that other avenues of intervention including psychological treatment were adequately considered.

12.57 The "*significant risks*" the CPN identified in the report to the August child protection conference were not accompanied by a risk management strategy.

12.58 The Cornwall Partnership NHS Trust's internal review (2007) identified the following:

> *"The benefit of hindsight demonstrates that the only prolonged community support received was embedded within the Forensic Mental Health Service, therefore there may have been a case at this juncture for a further referral to this team to undertake a joint assessment with the CMHT, although there is little evidence to suggest that he would attend an assessment interview."*

Multi-agency coordination

12.59 Mr G had many contacts with statutory services during early to mid 2005 but it appears that no mechanism existed for other parties (including the mental health trust) to be apprised of these or to incorporate them in their risk assessments.

12.60 After Mr G's second detention and psychiatric assessment under section 136 of the mental health act (1983) in May 2005, the consultant psychiatrist recommended that "*…further such manipulative behaviour or aggression should be handled through the Criminal Justice system*". Once again, the paradigm 'Is he mad or bad?' re-emerged. However, the psychiatrist's recommendation did not result in a management strategy agreed by the agencies involved (including the police).

12.61 Throughout this period, neither MARAC nor CPA procedures were instigated to consider the multi-agency care and treatment requirements for Mr G. The child protection reviews in respect of Child 4 identified the requirement for support to be provided to Mr G; referrals to the CMHT and adult social care were made as a result (addressed in the next section of this report).

12.62 Mr G's presentation to the CMHT in July 2005 was dealt with by the duty worker, who confirmed that he did not have a care coordinator in the team and was seen as a "*closed case*". These features are not documented in the notes and run counter to the assertion in March that year that Mr G had a nominated care coordinator in the CMHT.

Conclusions relating to the arrival in St Austell

C28 The interventions of Cornwall Partnership NHS Trust in early–mid 2005 concentrated on alleviating the immediate crisis and on the diagnosis of his mental health status.

C29 Mr G's refusal to see the nominated CPN three times in early-mid 2005 did not result in an assertive follow-up by the CMHT. The wider collateral information was not considered sufficiently in the subsequent screening assessments, which focused on his stated needs for housing support and help with drug misuse.

C30 The "*significant risks*" the CPN identified in the report to the August child protection conference were not accompanied by a risk management strategy, either on behalf of the CMHT or designed in conjunction with others.

C31 In March 2005 Cornwall Partnership NHS Trust's electronic case records identified Mr G as being *"...a significant risk to others..."* but this assessment was not accompanied by

a clear risk management strategy or a mechanism to secure the input and support of other partner agencies in mitigating those risks.

C32 We agree with Cornwall Partnership NHS Trust's internal review 2007 that the forensic service provided the only sustained community support.

C33 Hospital discharge plans and the community follow-up arrangements (in early to mid 2005) were not backed up by the application of the trust's CPA policy.

C34 Each of the agencies involved was only partly aware of the demands that Mr G was making on local statutory services, so no multi-agency review or planning mechanism was instituted.

C35 The risks associated with Mr G's alleged assault on his partner were not adequately researched and acted upon during his hospital admission in March 2005.

C36 Inspector 1 told us that arrangements at that time excluded under 18s from domestic abuse reports so the police could not pursue Partner B's allegations of domestic abuse because she was under 18. We understand revised processes now include all over 16s. We could not find out if the police made an alternative referral to the local authority's children's department.

13. Partner B and Child 4: St Austell, 2005

This section of the report examines a number of issues in relation to Partner B and Child 4. As we say above, the issues relating to Mr G's children have been subject to a separate serious case review by Cornwall Area Child Protection Committee (ACPC). We concentrate therefore on how child protection arrangements interacted with the care and treatment plans for Mr G.

13.1 Throughout 2005, Mr G came to the attention of Cornwall local authority's children and family service as a result of his relationship with Partner B. The 2003 child protection considerations in relation to his first three children raised anxieties for the statutory agencies, as did his stormy relationship with Partner B. In August 2005, it was agreed by a multi agency child protection case conference that the Child 4 be placed on the child protection register at birth. The police and the court system were aware of suggestions of violence towards Partner B and an injunction against Mr G was served in March 2005.

13.2 The records show that there were reports of arguments and threats by Mr G towards Partner B which were often accompanied by his threats of self-harm. The police responded but made no charges, in spite of an injunction banning Mr G from contact with her (March 2005). This may have been because the police had received conflicting messages from Partner B saying she intended to overturn the injunction and re-establish a relationship with him. Further allegations of domestic abuse were reported to the child protection case conferences in May and August 2005.

Comment

We acknowledge the difficulty involved in handling cases like this, especially when both sides make conflicting claims. However, Mr G continued to breach the injunction but the police failed to bring charges against him.

13.3 Partner B received support and guidance from her 'leaving care' worker, encouraging her to distance herself from Mr G during the latter stages of her second pregnancy in 2005.

13.4 A child protection case conference in May 2005 agreed that Mr G would be referred to the social services department (adult services) so that a social worker could be

allocated to him. The case files provide no details on how this request was processed, but in any event a social worker was not allocated to Mr G. The midwife for Partner B also requested CMHT support for Mr G.

13.5 The child protection case conferences appeared to be aware of the continuing risks Mr G posed to Partner B and Child 4. His hospital admissions in March had been followed by a period of homelessness (he was reported to have set fire to the tent he was temporarily living in). They sought the input of the mental health services and adult social care, with limited success. They were so concerned that they discussed extra security at the local maternity unit if Mr G arrived there when Child 4 was born.

13.6 With the knowledge of the statutory services, Partner B was allowed to move into bed and breakfast accommodation with Mr G in June 2005 after saying she wanted to move from her placement with Stonham Housing. She later moved to alternative accommodation.

13.7 The child protection case conference on 10 August 2005 (in respect of Child 4) concluded that both mother and baby were at risk if contact was maintained with Mr G. The conference decided to put Child 4 on the child protection register and to apply for an interim care order at birth. However, neither of these proposals was enacted because Partner B moved towns shortly after Child 4's birth and had intermittent contact with Mr G thereafter. The conference also agreed that input would be sought for Partner B from the police domestic violence officer. The case notes available do not say if this was followed up.

Analysis

Assessment and care management

13.8 Records from child protection case conferences show that referrals were made to the CMHT and adult social care for additional support for Mr G. No documentation was provided to us to confirm the response of the adult social care team. The responses from the CMHT, as detailed in the previous section, focused more on his mental health status and less on his overall vulnerability or the risks he posed to himself or others. No proactive plan was in place to guide his care and treatment at this time.

Risk assessment, risk management and multi-agency coordination

13.9 The police, the court system, child protection and mental health services were all aware of the reported risks Mr G posed to Partner B. An injunction was served in March 2005, preventing him from having contact with Partner B. She subsequently undermined them by re-establishing the relationship. This lack of consistency made it difficult for the statutory agencies to respond. No multi-agency action plan was put in place to mitigate the risks.

Conclusions

C37 As a direct result of the perceived risk Mr G posed, concerns about Partner B and the unborn Child 4 were shared and documented at child protection case conferences during the spring and summer of 2005.

C38 The involvement of the CMHT in child protection case conferences in 2005 did not result in a CMHT care management plan for Mr G.

C39 The actions of the mental health services at that time focused more on Mr G's mental health status, rather than on his broader vulnerabilities or the risks he posed to himself or others.

C40 Incidents of alleged domestic abuse were not subject to rigorous follow-up.

14. Period spent at Mr V's flat

This section of the report examines the period between Mr G's moving into Mr V's flat on an unofficial basis (September/October 2005) and Mr V's death in July 2006. Many of the events of this period have been detailed in the Mr V serious case review; the content of this section of the report therefore places emphasis on the key events that directly involved Mr G.

14.1 Mr G regularly visited Mr V in his flat in St Austell in the summer of 2005. Around September/October 2005 Mr G unofficially moved in without the knowledge of the housing provider, Ocean Housing. They confirmed that they visited the flat in response to a claim that Mr G had taken up residence. They advised Mr V that his tenancy agreement did not allow others to move into the flat without their consent. However, Mr G said he spent only an occasional night there, so Ocean Housing appear not to have been able to take further action.

14.2 After the birth of Child 4 (summer 2005) care workers discouraged contact between Partner B and Mr G. Partner B left St Austell, returning to stay briefly with Mr G at Mr V's flat around Christmas 2005.

14.3 During the summer of 2005 Mr G established relationships with two other young women, Partner C and Partner D. Partner C had been through the care system, had mild learning difficulties and had previously had a child who had been taken into care and subsequently adopted. Partner D, aged 16, had no previous involvement with the social services department. Over the next eight months, both reported pregnancies as a result of their relationships with Mr G. Partner D reported that she had miscarried in May 2005. Child 5 was born to Partner C in summer 2006.

14.4 As outlined in the chronology of this report and in the Mr V serious case review, Mr G was often involved with the emergency services in the later part of 2005. He appeared to have both influence and control over residents and visitors alike as he acted in a *"cuckoo-like"* fashion at the flat, ejecting previous temporary residents.

Mr G's contact with statutory services: August 2005–July 2006

14.5 Mr G had direct contact or was in communication with various agencies and services 138 times in the 11 months leading up to Mr V's death (1 August 2005 and 14 July 2006). We provide here a summary of these contacts. Appendix B provides more detailed information.

Agency	No of contacts
Police	42
GP	23
Ambulance	16
A & E	10
Cornwall Partnership NHS Trust's out-of-hours service	15
NHS mental health services	16
Child protection CC & local authority	6
Housing	8
Member of Parliament	1
Mental health inpatient unit	1

14.6 Mr G presented as an emergency in most of these contacts. In the absence of any over-arching assessment procedure, e.g. CPA, MAPPA or child protection, each presentation appears to have been assessed in isolation.

14.7 The following incidents/contacts between August and December 2005 are of particular significance:

- 10/11 August — Mr G taken by ambulance to Treliske A&E with reported chest and abdominal pain; he was kept in overnight (the A&E notes refer to "*previous bi-polar disorder*" but are not accompanied by any psychiatric assessment or referral).

- 18 August — Restormel CMHT wrote to Mr G's GP saying it would not offer him any more appointments unless the GP requested them.

- 3 September — emergency ambulance transfer to A&E. Self-discharged against medical advice.

- 30 September — emergency ambulance called for Mr G at St Austell police station.

- 12 October — Mr G's partner (no name given) contacted Cornwall Partnership NHS Trust's crisis resolution team claiming that Mr G's mental health was deteriorating and he was engaging in bouts of self-harm. Phone advice was given and a report was faxed to the CMHT. No subsequent assessment or intervention is recorded in the CMHT records.

- 21 October — Mr G contacted the emergency ambulance service on three occasions. He was transferred to Treliske A&E on the second occasion (02.17 hours). The single assessment process and a self-discharge form were partly completed before he complied with assessment and treatment and was discharged home. The ambulance service attended him again later that day (14.00 hours). The A&E department wanted to see him but he declined treatment or transfer on the third occasion.

- The serious case review into Mr V which took place in August 2007 identified that Partner B and Partner C had spoken with their respective leaving care workers and expressed concerns about events at Mr V's flat. Partner C informed her leaving care worker that she had been "*…involved with beating up an innocent man by hitting him on the head and in the eye with a plank of wood…she may be pregnant by Mr G…*" It is not known if these claims led to either a sharing of information with other involved parties or the convening of a multi-agency case conference.

- Late October and November — concerns were raised with Ocean Housing about the number of people living at Mr V's flat and the suspicion that people there were taking drugs. This was also reported to the police, whose records state: "*Information was placed on file*". An Ocean Housing representative visited the flat with a police escort on 24 November. Mr G denied living there.

- 11 November — Mr G went missing and left a suicide note. The police reported their concerns about him to the duty CPN at Bodmin Hospital. Cornwall Partnership NHS Trust's case files do not record any further investigation or action as a result of this information.

14.8 Apart from occasional medication for headaches and somatic problems, the primary medication received from the GP comprised citalopram (an anti-depressant) and temazepam (a sedative, often used to treat insomnia). Mr G was noted to be using amphetamines and was referred to CADA (drug and alcohol service) in 2006.

14.9 We asked Mr G's GP about the existence of a clear psychiatric diagnosis (during 2005/06):

> *"I never saw him at any time where he was frankly psychotic; no hallucinations, so my impression was he was just one of these people who falls between these actual diagnoses and gets labelled as 'personality disorder'. He just came across to me as somebody who was very damaged, really."*

Comment

In the first bullet point in paragraph 14.6 above, the hospital records referred to "…previous bi-polar disorder". This incorrect diagnosis was also included in the communication from the health visitor to the August 2005 child protection case conference. As mentioned later in this section (paragraph 14.21), we question whether "BPD" – referring to borderline personality disorder - was mistaken for bi-polar disorder. We do not consider that this possible mis-recording adversely affected Mr G's subsequent treatment in either case. However, it is important that services recognise such potential anomalies.

14.10 Throughout the latter stages of 2005, Mr G disengaged from mental health services and was discharged. He had been reported as difficult to engage, but Mr G succeeded in securing contact or support from primary care, emergency ambulance services, GP out-of-hours services and the police. However, in spite of the concerns these agencies registered no system appears to have been implemented by which they could share their risk assessments and share the management of these risks.

14.11 Partner B left Camborne shortly after the birth of her child (Child 4) in August 2005 and re-established contact with Mr G later that year. She came to stay with him at Mr V's flat in late December 2005/early January 2006. Mr G asked Partner C to leave the flat while Partner B came to visit. At this same time, Partner B's child (Child 4) was admitted to hospital with a suspected fractured rib that turned out to be a congenital defect rather than the result of an injury.

14.12 In early January, Partner C went to the police station and said she was "*…in growing fear from her boyfriend, Mr G… She reported increasing intimidation that was*

escalating into physical attacks". Partner C was referred to the police domestic violence officer, provided with support to secure her belongings from Mr V's flat and social services found her alternative accommodation. The following week (9 January 2006) Mr G phoned the police claiming to have raped Partner B. The police attended, but Partner B claimed that nothing had happened so they took no further action.

14.13 Between 1 January and 6 July 2006, Mr G had at least 60 direct contacts with the statutory services and these were mainly 'crisis' presentations with no multi-agency action plan to manage or mitigate the risks.

Comment

We think it highly likely that the professionals involved with Mr G experienced considerable frustrations during this time. Apart from referral to another agency, they lacked a system for sharing their concerns and planning a joint management or handling strategy. Each was left to cope with crises as they happened.

The involvement of MAPPA or the probation service appears to have been excluded because Mr G had not been recently charged or convicted of any serious offence. The child protection arrangements for Child 4 did not have a direct focus on Mr G when Partner 4 and the child moved away from St Austell. Any potential MARAC/domestic abuse procedures in respect of Partner C ceased to apply when she moved from Mr V's flat. It appears that any domestic abuse procedures for Partner D did not apply because she was under 18.

The Mr V serious case review identified the above shortfalls. Agencies in Cornwall are to be commended for implementing changes to address these shortfalls (see section 15).

Events in 2006

14.14 The GP made a further urgent referral to the CMHT in early January 2006. The CMHT wrote to Mr G on 10 January inviting him to get in contact "*…when you wish to see someone*". A CPN conducted a screening assessment on 21 January and Mr G was advised to contact drug treatment services and the Citizens Advice Bureau. The CPN could not recall

advising the GP of the outcome of this assessment but told us she had told the CMHT about it: *"I just said I'd screened him out, as we say"*.

14.15 As a result, no risk assessment, risk formulation or CPA process accompanied this contact with the CMHT. Equally, no measures were sought at this stage to establish any collateral information about Mr G's presentations to other agencies or to institute any multi-professional or multi-agency review of his care and treatment. Again, Mr G's presentation to the mental health service was seen in isolation of his contact with other agencies.

14.16 We asked the CPN if she was aware of the numerous other contacts Mr G had with other agencies at this time:

> *"No. I've seen all that subsequently, and I'm amazed at how many other things were running concurrently that we knew nothing about."*

14.17 From February 2006, the ambulance service requested police back-up when they responded to an emergency call to Mr V's flat. The ambulance service were involved with Mr G, or called to attend others at the flat, on five occasions during February 2006.

14.18 In March 2006, Child 4 was placed in foster care and Partner B informed her leaving care worker that she had stayed with Mr G for a few days, when he had "*head butted and tried to strangle her"*. The case notes do not confirm whether this allegation was taken forward. However, no charges of assault were made. On 4 April, Mr G made a counter accusation against Partner B. The police interviewed her and offered support from their domestic violence support officer.

14.19 At the end of March 2006, Mr G wrote to his MP, complaining that he could not access support from the CMHT. Cornwall Partnership NHS Trust investigated this complaint and offered a screening assessment for 25 June. (The handling of this complaint is set out in section 15.)

14.20 Mr G phoned the police on 2 May 2006 to tell them he felt suicidal. The police later arrested him at St Austell railway station for "*…behaving erratically*". He was detained under section 136 of the Mental Health Act and assessed by a psychiatrist and an approved

social worker. He was not deemed to be mentally ill or to require hospital admission, so he was discharged and sent home.

Comment

Given the previous difficulty in securing his engagement with mental health services and his recent complaint to his MP about not being able to get support from the CMHT, this situation provided an opportunity to formulate a risk management plan and agree any future involvement of Cornwall Partnership NHS Trust's services. However, once again, a broader assessment or future plan did not form part of the crisis intervention.

14.21 The police recorded five further contacts with Mr G in May 2006:

- in response to a member of the public reporting a fight between two men (the police later concluded that they were Mr G and Mr V) in St Austell
- a report of two men assaulting Mr G and Mr V – the police assessment was that this was a "*domestic dispute*" and no further action was taken
- a complaint from Mr G that a man was on his doorstep demanding money — the police attended and concluded that this was a civil dispute, not requiring further police involvement
- a request from Mr G to resolve a dispute about the ownership of some property (addressed and resolved by the police)
- Partner C went to Truro police station, saying she was 27 weeks pregnant, had left Mr G and was frightened that he would try to find her — Partner C was referred to the police domestic violence officer for support.

14.22 The opportunity of a further screening assessment from Restormel CMHT was offered to Mr G for 26 May. He did not attend and was subsequently seen on 8 June by locum social worker 2, recently arrived with the CMHT and occupying his first post in mental health services. A misreading of the diagnosis in the case file (interpreting *"BPD"* as bi-polar disorder, rather than as borderline personality disorder) did not directly influence the subsequent care plan which highlighted accommodation together with relationship and parenting problems as the focus for future intervention. The social worker told us the CMHT had not told him of its prior involvement with Mr G, nor had he read the case files before seeing Mr G.

Comment

These were serious omissions which we comment on in our analysis below.

14.23 Like the previous CPN (above) the locum social worker (locum social worker 2) reported that he had taken a *"task-oriented approach"* to his assessment of Mr G. The aim here was to identify and address the areas of pressing concern. He therefore concentrated on the presenting issue of housing and succeeded in securing temporary bed and breakfast for Mr G. Wider collateral evidence was not sought from other involved agencies.

14.24 Locum social worker 2 completed another risk assessment on 19 June. He said Mr G *"…was having a relapse…"* Locum social worker 2 told us he had not had access to Mr G's full psychiatric records and had not known about the forensic team's previous involvement. He advised that he had requested a medical or CPN review of Mr G's medication, but the case notes do not record that this took place. Locum social worker 2 told us that his assessment of Mr G was discussed in the CMHT but we found no record of this. In a subsequent updating of the electronic health record (completed by another member of the team because the locum social worker did not have access to the system), Mr G was identified as subject to standard CPA, with locum social worker 2 identified as the care coordinator.

14.25 Cornwall County Council's children's services called a care strategy meeting on 26 June 2006, because of concerns about Partner D and her recent miscarriage. Her parents said she had begun drinking alcohol heavily and taking drugs since starting a relationship with Mr G. They also reported trying to separate Partner D from Mr G, to no avail. The police agreed to undertake an "*intelligence report*" on Mr V's flat but we were not able to establish whether this was enacted before the death of Mr V on 6 July 2006. The police said in a subsequent report that Mr G had been living at the flat with Partner D and that both were now being investigated in relation to the murder of Mr V.

Comment

We understand that the mother and stepfather of Partner D tried several times to get help from the statutory agencies on their daughter's behalf. They had expressed serious concerns about their daughter's relationship with Mr G. These factors fall outside the scope of this investigation. We understand that Cornwall police and

representatives from the Cornwall and Isles of Scilly Children's and Adult Safeguarding Board have since reviewed these matters. We believe this is the correct approach. Any further comment or reflection should come from bodies involved at the time.

14.26 The case files show that Mr G's last contact with the statutory services before Mr V's death was on 3 July 2006. The police were called to his flat after receiving a call from an unidentified man who reported that Mr G was "*kicking off*". The police records report that:

> *"A unit attended and all was in order."*

14.27 Mr V was intimidated and tortured at his flat and killed by Mr G and others at a viaduct on the outskirts of St Austell on 6 July 2006.

14.28 Mr G returned to Mr V's flat shortly after Mr V died and at 2am called an ambulance for himself. He claimed he had returned there, found blood and vomit and had been sick himself. The ambulance attended and recorded that they left Mr G in the care of the police. Mr V's flat was now being investigated as a crime scene.

14.29 Two days later, Mr G arrived at Derriford Hospital (Plymouth) saying he had taken an overdose of aspirin. A duty psychiatrist saw him and deemed that he was not mentally ill but referred him to his care coordinator at the CMHT.

14.30 The locum social worker saw Mr G on 10 and 11 July. His immediate presentation was in relation to getting his clothes and belongings from Mr V's flat, but he then told the social worker about being present when Mr V died. Mr G was encouraged to tell the police. In turn, the locum social worker sought guidance from Cornwall Partnership NHS Trust on how to handle this information. We consider this matter elsewhere in this report when we examine the trust's serious untoward incident procedures.

14.31 The police arrested Mr G in July 2006. He was later charged, with two others, with the murder of Mr V.

14.32 Cornwall Partnership NHS Trust closed Mr G's case on 21 July 2006.

14.33 Mr G was convicted of the murder of Mr V on 31 July 2007. He was sentenced to 25 years in prison. Partner D was convicted and jailed for ten years. A third accomplice was convicted of manslaughter and jailed for eight years.

14.34 Cornwall Partnership NHS Trust completed a serious untoward incident investigation in relation to Mr G on 21 October 2006. Its internal report, in April 2007, concluded:

> *"There was nothing in his* [Mr G's] *presentation suggestive of mental illness nor were there concerns regarding clinical risk indicators."*

Analysis

Assessment & care planning

14.35 Between August 2005 and July 2006 Mr G had contact with the statutory agencies (directly or indirectly) on at least 138 occasions. Most of these were as a result of 'crisis' presentations and invoked the emergency assessment and handling procedures of the respective agencies.

14.36 The CMHT tried to engage Mr G with the offer of a further outpatient assessment in August 2005. After he failed to attend, the CMHT wrote to Mr G's GP confirming that it would not offer a further appointment unless the GP requested one. No information was provided to confirm whether a case review or discussion had taken place (within the CMHT or with partner agencies) before this conclusion was reached.

Comment

Given the history and the risks, a more assertive follow-up and/or a multi-agency risk management strategy meeting (involving the GP) would have been warranted.

14.37 Mr G's partner contacted Cornwall Partnership NHS Trust's crisis resolution service on 12 October and the police contacted the trust's out-of-hours service on 11 November. The respective parties shared information but the trust's files do not record whether any action resulted.

14.38 The assessment or screening processes the CMHT adopted concluded that Mr G was not mentally ill. When he was seen in January 2006 he was encouraged to identify specific needs (housing and drug misuse services) and was advised to contact alternative services. No risk assessment, risk formulation, CPA process or broader assessment of vulnerability or risk was undertaken at this point, nor was the case recorded as having been discussed in the CMHT.

14.39 The screening assessments (in January, May and June 2006) did not consider the potential involvement of the forensic mental health team (which had been successful in engaging with Mr G between 2000 and 2002).

14.40 The detention of Mr G under section 136 of the Mental Health Act (2 May 2006) provided an additional opportunity for the mental health services to engage with him. However, he was not considered to be in need of hospital admission or detention under the Mental Health Act, so he was sent home with no follow-up arrangements. A broader assessment of needs or vulnerability did not form part of the intervention at that stage.

14.41 A further screening assessment was arranged for Mr G in early June, however the CMHT fell short in the following respects:

- it allocated the case to the least experienced member of the team — a locum social worker with no experience of mental health services
- the locum social worker interpreted *"BPD"* as bi-polar disease rather than borderline personality disorder and no checks were in place to correct this misunderstanding
- it did not insist that the local social worker read the background files/information before interviewing Mr G
- a subsequent multi-professional review of the assessment did not take place
- the additional psychiatric assessments, reportedly requested by the locum social worker, did not take place.

Comment

With hindsight, the good intentions of the locum social worker are to be applauded, but he should have been supported by a formal review of Mr G's case with other

members of the CMHT. It is possible that such a review might have succeeded in identifying a broader mental health risk assessment and risk management plan.

14.42 The police were made aware of at least two claims against Mr G of domestic abuse in January 2006. They referred Partner C to the domestic violence officer and accepted Partner B's assurance that Mr G's claims that he had raped her were untrue. The police did not report having taken any additional action or inquiry in respect of these events.

14.43 Throughout its numerous call-outs to Mr V's flat in 2005/06, the ambulance service implemented its emergency handling procedures. It liaised with the GP and out-of-hours services where necessary, eventually seeking a police escort when responding to emergency call-outs. However, its concerns did not result in any wider risk formulation in conjunction with partner agencies.

14.44 Bi-lateral liaison took place between a number of the agencies involved but no over-arching assessment or care management process took place.

Risk assessment and risk management

14.45 The information in the serious case reviews, internal investigations, the subsequent court case and this independent review, makes clear that five of the former residents at Mr V's flat (Mr V, Partners B, C & D, and Mr G) were subject to significant vulnerabilities and risks. Partners B and C managed to leave with the support of the police and their leaving care workers. In spite of the efforts of her mother and stepfather, Partner D was unable (or unwilling) to extricate herself.

Comment

The absence of a multi-agency risk formulation and management plan in relation to Mr V, partners B and D was a serious omission because the cumulative risks were not brought together and acted upon.

Three of the five contacts Mr G had with the police in May 2006 related directly to reports of violence. Given the earlier claims of domestic violence (in relation to Partners B and C), the concerns expressed by the stepfather of Partner D and the various reports of drug-related activity, the police should have followed up more assertively. The records do not

indicate whether the *"intelligence report"* on Mr V's flat, promised at the care strategy meeting on 26 June (13.23 above), was undertaken, reported back to other agencies, and/or influenced the subsequent risk management plan.

Comment

The absence of a multi-agency risk formulation and management plan in relation to Mr V, partners B and D was a serious omission because the cumulative risks were not brought together and acted upon.

Multi-agency work

14.46 Most of Mr G's presentations during late 2005 and into 2006 were in 'crisis' mode. No single agency appeared to be aware of the overall extent of his demands on statutory services. The involved agencies did not seek or implement a multi-agency process (e.g. CPA, child protection, MAPPA, MARAC). As a result, the information that each party had to hand was incomplete, lacking the broader collateral information, and failed to trigger a multi-agency risk management strategy.

Comment

The agencies in Cornwall have acknowledged the shortfalls in their inherited systems and have succeeded in implementing more robust safeguarding adults procedures. They are to be commended for these improvements and encouraged to keep these processes under regular review.

Conclusions relating to the period where Mr G lived at Mr V'S FLAT

C41 The CMHT, having failed to secure Mr G's engagement in mid 2005, proceeded to exclude him from its service or "*screen him out*" between August 2005 and May 2006. Given Mr G's presenting circumstances, we find that the CMHT should have discussed its proposed approach with others involved in the case, and considered a referral to the specialist forensic team and the development of a joint risk management strategy. The CMHT should have been more assertive in its follow-up of Mr G rather than simply referring his case back to the GP.

C42 Cornwall Partnership NHS Trust told the strategic health authority (SHA) on 31 August 2007 that:

> *"Mr G (was) discharged from the CPN's caseload in May 2005 and was not subject to the CPA from that date on. He did have some contact with mental health services following May 2005, but was not allocated to the community services."*

The evidence presented in the sections above suggests this is not entirely accurate and Mr G's case was only formally closed after he was charged with the murder of Mr V. We were advised that trust did not check with the electronic CPA system before reporting the above information to the SHA.

Comment

We accept that the trust provided the information to the SHA in good faith but it would have been prudent for someone from the trust to check the electronic CPA system beforehand.

C43 The psychiatric assessment (under section 136 of the Mental Health Act) in May 2006 offered a further opportunity of engaging with Mr G. Referral to the CMHT resulted once again on the focus on his mental health status rather than a broader assessment of vulnerability and risks.

15. Identifying gaps or omissions in previous reviews

15.1 The terms of reference for this investigation include identifying and evaluating any gaps or omissions in previous reviews carried out and to make recommendations for the local heath community.

15.2 Cornwall Partnership NHS Trust undertook three separate reviews and an investigation into a complaint made by Mr G:

- The trust internal investigation into the care and treatment of Mr G carried out by NC, consultant nurse, and LN, lead locality nurse
- an assurance checking exercise on Cornwall Partnership NHS Trust's involvement with Mr G carried out by Dr CS from an independent consultancy company
- a serious case review into the murder of Mr V carried out by an independent consultant
- an investigation by the Trust into a complaint Mr G made to his MP.

15.3 Cornwall Local Authority's Children's department undertook a second serious case review. This examined the measures carried out in relation to Mr G's children. We have not scrutinised the report because it did not relate directly to Mr G.

The Cornwall Partnership NHS Trust's internal investigation

15.4 We examined the following evidence to find out if the serious untoward incident (SUI) policy was adhered to and to look for any gaps or omissions in the internal investigation process and the investigation report:

- the trust's serious untoward incident policy
- the immediate notification form (of a serious incident)
- the trust's internal investigation report
- minutes of the trust serious untoward incident meetings.

SUI policy and procedure

15.5 The Cornwall Partnership NHS Trust's SUI policy was developed by the SUI policy working group and ratified by the trust's director of nursing in January 2006. The policy states that a SUI may involve a single factor or several factors. They include:

- a number of unexpected/explained deaths
- incidents that might give rise to serious criminal charges
- incidents of such seriousness that media attention may be attracted
- death resulting from violent or unusual circumstances including suicide.

15.6 The SUI policy states that staff involved in an SUI must immediately tell their line manager what has happened, and as soon as practically possible complete an 'immediate notification of a serious untoward incident form'. At the latest, the form should be completed before the end of the shift during which the incident occurred.

15.7 Locum social worker 2 told us he saw Mr G at the CMHT base on 11 July 2006. Mr G told him he had chased Mr V up to the viaduct and that he was there at the time of Mr V's death. Mr G told locum social worker 2 he had seen him fall. Mr G did not provide further details about his involvement in the killing. Locum social worker 2 told us he wrote all the information in the clinical notes and on the electronic notes and shared it with members of the community mental health team and TM, the team manager.

15.8 TM told us in her interview that locum social worker 2 had told her about the incident but she could not recall the extent of Mr G involvement or the exact date on which she had been told. She said:

> *"At that point I immediately told my line manager and I was advised to contact the clinical governance team and let them know."*

15.9 TM went on to say that she asked a member of the clinical governance team whether the police should be informed but she was advised "*not at the moment"* because it was Mr G's version of events and no other facts were available.

15.10 Mr G was arrested on 29 July 2006 for the murder of Mr V but it was not until 23 October 2006, four months after the incident, that the team manager for North Restormel

CMHT completed an 'immediate notification of a serious untoward incident form' which stated that a murder investigation was being carried out into the death of Mr V. The record on the form said "*it is not still clear at this stage whether Mr G had been charged with his murder*".

Comment

TM could have contacted the police to find out if the information Mr G was presenting was reliable and if so she could have found out more about any legal proceedings.

Completing the form and making sure it was in the system in a timely manner would have been important so that the trust could gather more information, monitor and respond to events in a timely manner.

Conclusions

C44 Locum social worker 2 complied with trust policy in part by informing his line manager and making a record of what Mr G told him.

C45 Mr G reported the incident himself and the details of his involvement in the incident were not known but locum social worker 2 had enough information to confirm that this incident met the criteria as an SUI because it might give rise to serious criminal charges. Our view corresponds with that of the internal investigation team on this matter.

C46 Neither TM nor locum social worker 2 completed an immediate notification of a serious untoward incident form as outlined in trust policy.

C47 The advice from the clinical governance team was wrong and Mr G's information should have been reported to the police immediately. The incident was not reported until three months later and even then the full facts had not been obtained.

Setting up the internal investigation team

15.11 The trust held a weekly SUI executive group meeting attended by key senior managers. Its terms of reference included the following:

- to monitor and oversee all issues relating to SUIs within the trust
- to consider individual incidents reported as an SUI and comply with NHS guidelines
- to allocate investigating officers and ensure that there are processes in place for training and support.

15.12 We received and reviewed copies of the minutes of the meetings for 17 November, 24 November, 1 December and 8 December for 2006.

15.13 The minutes of 17 November record that FA had previously been allocated as the investigating officer for the internal investigation into the care and treatment of Mr G. They note that "*it would be inappropriate to allocate FA"* and that *"JT was identified as a possible investigating officer with support from GS"*.

15.14 The minutes of the SUI meeting on 24 November 2006 record:

> *"The group was informed that both nominated officers are unable to carry out the investigation. The group then identified the following as investigating officers: TM and NC."*

15.15 NC told us she had been asked to carry out the internal investigation into Mr G and that she had been given the name of one of the team managers (TM) to undertake the investigation with her. The minutes of the SUI meeting held on 1 December 2006 record that TM was unable to carry out the role of investigating officer but that NC agreed to support the SUI panel's chairperson as the investigating officer.

15.16 Minutes of the trust SUI meeting on 8 December 2006 show that the chief executive requested that a non-executive director should be involved with the investigation into the care and treatment of Mr G instead of the SUI panel's chairperson.

15.17 NC told us she was pleased that a non-executive had been allocated to the internal investigation team:

"I was then informed that one of the non-exec directors was going to lead the investigation, which I have to say, I was really pleased to hear. Unfortunately, when I contacted her, she was going to be off work for ill health, and I was on my own."

15.18 NC told us that she contacted LN, a senior nurse, because:

"I was scrabbling around, really, trying to find someone to help me, and at that point, I think I asked LN, because I didn't know what else to do."

15.19 LN confirmed to us that he had joined the internal investigation team because NC was on her own and he had an interest in carrying out the investigation.

Conclusions

C48 The trust's SUI meeting allocated seven managers as investigating officer for the internal investigation but none was able to carry out the internal investigation.

C49 The trust took five months to set up the internal investigation team.

C50 LN was not formally allocated to the investigation team through the trust's SUI meeting.

C51 Both NC and LN had a background in nursing. It would have been useful to have someone on the team from a different discipline to bring a fuller approach to the investigation.

15.20 We interviewed the chief executive who told us that her first day in post was 5 July 2006 and she was not aware of difficulties in setting up the investigation team and the time lapse between the index offence and the reporting of the incident in the trust. She explained that there "*were problems in the trust at the time because they were in special measures because the governance processes weren't working properly*".

15.21 The chief executive explained to us that governance was an issue in learning disability services but she took the opportunity to carry out a governance stock-take across

the whole trust. She said new SUI governance procedures and subcommittee structures had been put in place.

Comment

The context within which the trust operated at this time was difficult and challenging. The trust have pointed out that the Healthcare Commission had recently placed them under "special measures" (in respect of their learning disability services), the new chief executive had an incomplete management team and the overall level of external scrutiny experienced by the trust was high. Together, these factors may explain why some of the governance systems were sub-optimal at that time.

The internal investigation process

15.22 NC and LN expressed reservations to us about undertaking the internal investigation because the case had not yet been to court. LN said:

> *"…it was like looking straight in a big light that said, this person hasn't been to court yet."*

NC told us:

> *"I think it was more about the sub judice of the case that we had grave concerns; we were really worried about it."*

15.23 The Department of Health guidance (94) 27, as amended in June 2005, concerns the conduct of independent inquiries into mental health services. This makes it clear that local investigation processes should start as soon as possible. The guidance advises that the police should be contacted if there are continuing legal proceedings so that the timing can be agreed with them or with the Crown Prosecution to ensure that the proceedings are not undermined.

Comment

The confusion of NC and LN about whether they could start the internal investigation because the case had not been heard in court reinforces our earlier comment about the need to contact the police at an early stage so that the timing of the trust's internal investigation could be agreed.

The terms of reference of the SUI executive group indicate that support is provided to investigating officers. However, NC and LN said they had not received training or support from the trust in relation to how to carry out an investigation.

Conclusion

C52 Cornwall Partnership NHS Trust did not adhere to the terms of reference outlined in the serious untoward incident executive group

The internal investigation report

15.24 The department of health guidance HSG 94(27) as amended says that in the event of a homicide, an internal trust-led investigation should take place using a systematic approach such as root cause analysis (RCA). It also says that the investigation should establish a clear chronology of events leading up to the incident; determine any underlying causes and whether action needs to be taken with respect to policies, procedures, environment or staff.

15.25 Cornwall Partnership NHS Trust set these terms of reference for the internal investigation report:

1. *"To investigate the events leading up to the alleged incident*
2. *Identify and examine clinical management decision making processes used to determine interventions with Mr G*
3. *Examine record keeping around this paying particular attention to risk management planning*
4. *Could what have happened been predicted /prevented*
5. *Consider if it should have been reported as an SUI*

6. *Identify for the locality manager who should attend the learning from experience meeting"*

15.26 The terms of reference are narrowly focused and do not provide a clear scope for the investigation team (i.e. how far back the investigation should go and whether information from any other agencies should be sought). No mention is made of the need to examine issues of MAPPA or child protection, neither do the terms offer guidance on whether the investigation team should involve and provide support for the family or carers of Mr G and the victim.

15.27 The trust investigation took evidence from Mr G's clinical notes and interviewed two members of staff, locum social worker 2 and Ms LH.

15.28 The investigation report provides details of the following aspects:

- personal history
- relevant psychiatric history
- history of contact with Cornwall Partnership NHS Trust
- chronology of events leading up to the incident
- clinical management decision making processes
- record keeping and risk management.

Conclusions

C53 The terms of reference did not provide the scope and clarity needed to carry out an effective internal investigation.

C54 The trust's internal investigation report met the Department of Health guidance in part as it included a clear chronology of events leading up to the incident.

C55 The report did not demonstrate that a systematic approach such as RCA had been used in the investigation.

C56 There was no evidence that issues had been scrutinised for any underlying systemic issues.

15.29 We focus our criticism on the trust for not having robust clinical governance systems for carrying out internal investigations rather than criticise NC and LN, who were left to carry out the investigation without guidance, training or support. We accept as indicated above that the trust was working under considerable pressure at the time and that the trust has provided training for managers carrying out internal investigations since this incident took place.

Action plan from internal investigation

15.30 The trust's SUI policy at the time states that an action plan should be developed identifying implementation responsibilities after the investigation. The chief executive told us that there was no action plan from the investigation because the trust board focused on the serious case review into Mr V rather than doing anything further on the Mr G investigation. She recognised that the serious case review was heavily focused on the victim. She said it took precedence over everything: *"That's what was reported to the board and that gained its own life…"*

Conclusion

C57 The trust's SUI policy outlining the need for an action plan was not followed. This resulted in the recommendations from the internal investigation report not being put in place.

The length of time of the internal investigation

15.31 The trust's SUI policy indicates that the investigation should be completed within 50 days. As we discuss earlier, problems in setting up the internal investigation team caused a considerable delay. NC said she was told on 6 December that she would be carrying out the investigation but she did not receive the health records until the first week of January 2007 and no-one was allocated as a second investigating officer until 31 January. NC and LN carried out the investigation and the report was completed on 12 April 2007.

Conclusion

C58 There were considerable delays in reporting the incident and setting up the investigation team, but once these had been put in place, the investigation team carried out the investigation within the 50-day target trust policy required.

Review of the serious case review into the murder of Mr V

15.32 Mr V was identified as a vulnerable adult as defined in the Department of Health's guidance, *No secrets: guidance on developing multi-agency policies and procedures to protect vulnerable adults from abuse* published in March 2000. The definition says a vulnerable adult is a person who:

> "*is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.*"

15.33 Mr V met the criteria because he had been diagnosed with a learning disability and was unable to protect himself against significant harm or exploitation.

15.34 On 31 August 2007 Cornwall adult protection committee commissioned an independent consultant to carry out a serious case review into the murder of Mr V. It followed the Department of Health's *No secrets* guidance. Its purpose was to:

- establish whether there were any lessons to be learned from the circumstances of the case about the way in which local professionals and agencies worked together to safeguard vulnerable adults
- review the effectiveness of procedures, both multi-agency and those of individual organisations
- inform and improve multiagency practice
- improve practice by acting on learning
- commission an overview report that brings together and analyses the findings of various reports from agencies in order to make recommendations for further action.

15.35 The following agencies carried out individual management reviews:

- Children's social care, children, young people and families, Cornwall County Council
- Cornwall and Isle of Scilly Primary Care Trust
- Cornwall Partnership NHS Trust
- Department of Adult Social Care, Cornwall County Council
- Devon and Cornwall Police
- Multi-Agency Adult Protection Unit
- Ocean Housing Ltd
- Children, young people and families services, Cornwall County Council
- Youth offending team, Cornwall County Council.

15.36 The independent consultant also received written information from:

- relatives of Partner D
- Restormel Borough Council
- South Western Ambulance Service NHS Trust.

The executive summary from the serious case review was made public on Cornwall County Council's website on 5 December 2007.

Conclusion

C59 Cornwall and Isles of Scilly Safeguarding Adults Board commissioned the serious case review in line with the Department of Health's guidance *No secrets*.

Overview of the findings from the serious case review

15.37 The serious case review found that agencies had "*no lack of information*" about Mr V. Many warnings signals should have invoked the adult protection procedure. The serious case review revealed weaknesses in all the agencies in contact with Mr V. The review concluded that with better inter-agency working Mr V would have been spared the physical, financial, and emotional abuse that he suffered. The serious case review made recommendations for improvement at three levels:

- system-wide adult protection
- agency
- individual.

Serious case review recommendations

15.38 The review made recommendations for the Department of Health, central government and individual agencies as well as recommendations for involving and supporting the parents of Partner D. We focus our attention on the recommendations to individual agencies to find out whether there are plans in place to address them.

Agency recommendations

15.39 The recommendations from the SCR for individual agencies were:

- intelligence regarding 'warning markers' against individuals should be shared within the NHS and externally with services in direct contact with vulnerable adults
- all agencies associated with a case review should invest in processes which systematically investigate the event leading to the review
- in parallel with the work of the national confidential inquiry team, the strategic health authority should commission a homicide enquiry and seek to determine why MAPPAs were not employed and the reasons for the failure to engage with the fact of domestic violence as experienced by Mr G's girlfriend and children
- the director of adult social care and chief executive of the primary care trust should develop a joint understanding of the expenditure necessary to support vulnerable adults in the community
- Devon and Cornwall Constabulary and the primary care trust should adopt the Department of Health's term 'learning disability' to limit the scope for any potential ambiguity about a person's long-term support needs and status as a vulnerable adult
- Children, young people and families services and the Devon and Cornwall Police should collaborate in determining a shared approach to concerns regarding young people who associate with dangerous men and engage in under-age sex
- the local medical committee should become party to Cornwall's adult protection committee.

The successes achieved and barriers encountered in delivering the action plans from the serious case review into Mr V

15.40 In December 2007 the director of adult social care invited the author of the serious case review to return in 2008 to undertake a review of progress in delivering the serious case review action plans.

15.41 Meetings took place with board members, middle managers and front-line staff from all the agencies involved. The independent consultant also met with Mr V's relatives and the relatives of one of Mr G's co-accused.

15.42 The independent consultant wrote a paper outlining the successes achieved and the barriers encountered in delivering the actions plans from the serious case review. She found setbacks and disappointments but considerable progress in delivering the action plans.

Comment

It was good practice for the Cornwall and Isles of Scilly Safeguarding Adults Board to invite the independent consultant to return to see whether the recommendations from the serious case review had been taken forward. We understand that local parties have welcomed her findings and recommendations.

Review of the assurance checking exercise on Cornwall Partnership NHS Trust's involvement with Mr G

15.43 The chief executive of Cornwall Partnership NHS Trust commissioned Dr CS, who runs a mental health consultancy company, to undertake an assurance checking exercise on the trust's involvement with Mr G. The chief executive told us that the purpose of the exercise was twofold: an external review of the serious untoward incident report, and to determine whether the case met the Department of Health's guidance requirements (HSG (94)27) for an independent homicide inquiry investigation.

15.44 Dr CS's report also covered Mr G's diagnosis and the accompanying inter-agency working but we focus on his analysis of the serious untoward incident report, and also whether the case met the Department of Health guidance.

15.45 Dr CS received a copy of the trust's internal investigation report and Mr G's clinical records from Cornwall Partnership NHS Trust. He did not have the opportunity to interview staff or see any clinical records from other agencies, so his considerations were limited to documents the trust provided.

Cornwall Partnership NHS Trust's internal investigation report

15.46 Dr CS said in his report that the trust's internal investigation was insufficient and that it did not go into enough depth or apply enough rigour to extract the key learning points. He also noted that there was no action plan.

Comment

We concur with Dr CS's comments about the lack of depth and rigour of the internal investigation.

Whether the incident met criteria for an independent investigation under Health Service Guidance HSG (94)27 (amended in June 2005)

15.47 The above guidance provides criteria for when an independent investigation should take place. The criteria are:

- When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.
- When it is necessary to comply with the state's obligations under article 2 of the European Convention on Human Rights. Whenever a state agent is, or may be, responsible for a death, there is an obligation on the state to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.
- Where the Strategic Health Authority determines that an adverse event warrants independent investigation, for example if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides.

15.48 Dr CS concluded that Mr G was not assigned to a team and was not under the regular care of a psychiatrist in the six months leading up Mr V's death.

15.49 Dr CS told us:

> *"The view I arrived at was that I didn't feel he* [Mr G] *met the criteria* [for an independent review] *under the two areas, which was about the six-months prior to the event and whether he was subject to a regular enhanced care programme approach, and secondly whether or not it was a systemic failure on behalf of the trust."*

Dr CS added:

> *"Whilst, I do not believe that the criteria for a formal independent investigation are met much may be gained by the SHA and the Trust working together in addressing issues raised by the Trusts own review and supplementing this with some further investigation. I believe this may be best achieved by engaging clinicians external to the Trust with extensive knowledge and expertise in service review who could bring fresh insights and benchmark best contemporary practice."*

15.50 Our review of the case files demonstrated that Mr G had considerable contact with Cornwall Partnership NHS Trust in the six months before the death of Mr V:

- 3 January — urgent referral to CMHT by GP
- 10 January — CMHT wrote to Mr G inviting him to get in contact
- 21 January — Mr G seen by CMHT and advised to contact specialist drugs services and Citizens Advice Bureau
- 23 March — Mr G wrote to his MP complaining about lack of access to CMHT support; Cornwall Partnership NHS Trust wrote a letter to Mr G on 11 May, offering Mr G an appointment with a social worker from the CMHT on 21 June
- 2 May — Mr G was arrested under section 136 and assessed in Camborne custody centre by a psychiatrist and an approved social worker. Mr G was not considered detainable under the Mental Health Act and discharged home. A discharge summary letter was sent to the GP and copied to Cornwall Partnership NHS Trust's out-of-hours team at Bodmin. The social worker faxed a copy of her screening assessment to the St Austell CMHT stating that: "*I had to open a new episode on EHR*

(electronic health record) and have not closed it, in case you wish to follow this up"

- 25 May — Cornwall Partnership NHS Trust's internal review recorded that Mr G did not attend his planned appointment with locum social worker 2 at the CMHT
- 8 June — seen by locum social worker 2 who secured temporary bed and breakfast accommodation for Mr G
- 19 June — a further risk assessment was carried out. This identified that Mr G was having a relapse. Under the section entitled *Action to be taken*, the following was included: "*To look into possible hospitalisation, or a high level of support wherever he is placed in the community.*" A medical or CPN review of Mr G's medication was requested by locum social worker 2 although there is no record whether this request was followed up.

15.51 The six-page risk assessment form identifies locum social worker 2 as the "*care coordinator*" but contains no information about Mr G's CPA status. Locum social worker 2 told us his assessment of Mr G was discussed in the CMHT but there is no record of this.

15.52 Poor record-keeping means that we cannot form a clear picture of the care and treatment provided to Mr G at this point. There is evidence that the trust's electronic health record was updated to reflect that Mr G was subject to standard CPA, with locum social worker 2 identified as the care coordinator. This demonstrates that Cornwall Partnership NHS Trust had accepted Mr G for treatment and care.

15.53 The trust's internal review summary said:

> "*…a referral to the Consultant Psychiatrist was requested, though this did not occur as locum social worker 2 (Locum SW) had moved areas, he therefore was not in a position to follow this up.*"

We also note that the team manager from North Restormel CMHT recorded that Mr G was on standard CPA on the 'immediate notification of serious untoward incident form' that she completed on 23 October 2006. LN also told us that Mr G was on standard CPA when locum social worker 2 was seeing him. We therefore do not concur with Dr CS's view about the case not meeting (HSG (94)27).

Comment

We can understand how Dr CS may have arrived at the view that the case did not meet (HSG (94)27) criteria, given the limitations of his review.

Conclusions

C60 Mr G was placed on standard CPA and allocated to a care coordinator less than three weeks before Mr V died.

C61 The case met the first criteria set out in the Health Service Guidance HSG 94(27): when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months before the event.

Cornwall Partnership NHS Trust's handling of the complaint made by Mr G

15.54 , Mr G wrote to his MP at the end of March 2006 complaining that he could not access support from the CMHT. This complaint was sent to social services at Cornwall County Council before being redirected to Cornwall Partnership NHS Trust. The trust's complaint procedure at the time highlights its commitment to continuous improvement and the need to view complaints as a valuable way of bringing positive changes to the trust.

15.55 The complaint was investigated by TM, at the time the trust's manager for Restormel CMHT. She told us that she tried to contact Mr G several times by phone to discuss his complaint. We were told by TM that the standard for investigating complaints was 20 days but the delay in the letter reaching the trust meant it was not possible to investigate it within that time.

15.56 The chief executive signed a letter to Mr G on 11 May 2006 offering him a screening assessment for 25 May. Mr G did not attend this appointment so another appointment was made for 6 June.

15.57 As a result of the complaint, TM also decided to review the procedure for clients who do not fully engage with services and who frequently fail to attend appointments.

Conclusions

C62 The trust took seriously Mr G's complaint to his MP and managed it in the spirit of its complaints procedure.

C63 Mr G was given the opportunity to access support from the CMHT as a result of his complaint

C64 TM took the opportunity to improve services in addition to taking Mr G's complaint at face value.

16. Recommendations

Care programme approach

R1 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust should, as part of their clinical governance and performance management mechanisms, audit cases presenting with complexity and risk in order assure themselves and their commissioners that their CPA and/or risk assessment procedures are robust and compliant with current guidance. Particular attention should be paid to whether:

- mechanisms for information sharing, care planning and review are subject to explicit protocols and agreements

- assessments of individuals by mental health teams take account of previous psychiatric history, risk assessments, issues of compliance with the treatment offered and review processes, and ensure that this information is incorporated in their resultant care plans

- validated risk assessment tools form part of each new mental health assessment process, with an agreed escalation process that would lead to a wider multi-professional and/or multi-agency consideration of a case where necessary

- care plans are explicit about the suggested handling of issues of non-compliance (with medication and/or appointments) and crises

- referrals between internal teams (e.g. community and forensic mental health teams) or external agencies are governed by protocols confirming the CPA status and risk assessment of the individual, together with written agreements on where the coordinating and case responsibility rests before, during and after the referral.

Did not attend

R2 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust should assure their commissioners that patients who do not attend outpatient appointments are risk assessed and plans to re-engage or discharge are based on the outcome of the risk assessment as outlined in their respective trust policies.

Handling referrals

R3 Cornwall Partnership NHS Trust should ensure that referrals to mental health services by external agencies, or internally within mental health services, are governed by clear protocols identifying the timescales to be applied, the next-stage actions and the communication of the outcome(s).

Record keeping

R4 Cornwall Partnership NHS Trust should assure its commissioners that the use of separate notes and recording systems in mental health services (e.g. general, forensic and psychological services) is subject to regular review and scrutiny and continued only where a clear evidence-base can be provided. (We note that the trust's revisions to their CPA policy (2010) indicate that all disciplines now use a single record for contacts, management and contingency plans).

R5 Cornwall Partnership NHS Trust should ensure that when sharing risk assessments with other agencies, e.g. the police or local authority, services should make explicit whether additional action is implied on behalf of the receiving agency e.g. the application of legal and/or criminal proceedings. Any agreements should then be recorded and documented.

R6 Health, social care, police and probation services in Cornwall and Northamptonshire should use local Multi-Agency Risk Assessment Conference (MARAC) procedures to communicate the investigation and outcome of incidents of reported domestic abuse to relevant agencies on a confidential basis as part of child protection, Safeguarding Adults, CPA and MAPPA reviews. (We are advised that Northamptonshire Healthcare now applies these arrangements in full.)

R7 Cornwall adult social care services should audit and review their recording systems governing the routing of referrals through to mental health services, ensuring that the outcomes of such referrals are documented and subject to review.

R8 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust should provide a report to their commissioners on how the management of risk and vulnerability for those involved in incidents of domestic abuse addressed on a multi-agency basis and how Multi-Agency Risk Assessment Conference (MARAC) procedures are being used. (We are assured that this data is now regularly received by Northamptonshire Healthcare's commissioners.)

R9 Cornwall Partnership NHS Trust should assure their commissioners that a clear protocol between the probation and mental health services is in place to ensure that all relevant information is included in pre-sentence reports for clients who are receiving both services.

Cross-county working

R10 NHS South West should discuss with the Department of Health the need to issue national guidance on producing protocols and agreements covering the assessment, re-allocation and treatment of individuals who are subject to CPA and who move between areas of the country. The purpose of such protocols would be to ensure that individuals receive a consistent approach to their treatment, risk assessments and plans.

Personality disorders

R11 Northamptonshire Healthcare NHS Trust and Cornwall Partnership NHS Trust should ensure that where an assessment of 'personality disorder' is made, it should not exclude the person from access to services. Local service need and provision should be reported to their boards, reflecting the DH guidance issued in 2003 and the subsequent guidance for the commissioning of services, published in 2009 (*Recognising complexity: commissioning guidance for personality disorder services*).

The management of serious untoward incidents (SUIs)

R12 A clear process should be put in place for allocating SUI investigating officers in Cornwall Partnership NHS Trust.

R13 Cornwall Partnership NHS Trust should hold a list of nominated senior managers and clinicians to act as investigating team members so that investigations into serious untoward incidents can be carried out in a timely way.

R14 Cornwall Partnership NHS Trust's SUI monitoring group should exercise its responsibility to provide advice, support and guidance for staff undertaking investigations into serious incidents so that all parties are clear about their role, particularly when investigating an incident that might give rise to serious criminal charges.

R15 Cornwall Partnership NHS Trust's SUI monitoring group should ensure that recommendations from trust internal investigations are put in place as outlined in trust policy.

Appendix A

List of interviewees

Cornwall Partnership NHS Trust

[name deleted]	Chief executive
[name deleted]	CPN
[name deleted]	Network associate director
[name deleted]	CPN
[name deleted]	Social Worker
Consultant psychiatrist 1	Consultant psychiatrist
Consultant psychiatrist 2	Consultant psychiatrist
Consultant psychiatrist 5	Consultant psychiatrist
Consultant psychiatrist 6	Consultant psychiatrist
CPN1	CPN
CPN2	CPN
CPN6	Former CPN
LN	Lead nurse
NC	Nurse consultant
TM	Children's service manager

Devon and Cornwall Probation Area

[name deleted]	Probation officer
[name deleted]	Senior Probation officer

Cornwall County Council

[name deleted]	Assistant director
[name deleted]	Social worker
[name deleted]	Manager
[name deleted]	Safeguarding manager
[name deleted]	General manager, East Cornwall
[name deleted]	Social worker
[name deleted]	Social worker

[name deleted]	Head of improvement and social care
Locum social worker 2	Locum social worker

Northamptonshire Healthcare NHS Foundation Trust

[name deleted]	Associate medical director
[name deleted]	Medical director
Consultant Psychiatrist 3	Consultant psychiatrist

Cornwall and Isles of Scilly Primary Care Trust

[name deleted]	Health visitor
[name deleted]	Deputy director
[name deleted]	Former mental health commissioner
[name deleted]	Director of service improvement

Devon and Cornwall Police

Inspector 1	Partnership Inspector
[name deleted]	Detective sergeant

GPs

GP	Lakeside Surgery
GP1	Trevithick Surgery
GP3	The Park Medical Centre

Others

[name deleted]	Paramedic supervisor, South Western Ambulance Service NHS Trust
[name deleted]	Managing director, Ocean Housing
CPN4	Community psychiatric nurse, Corby Mental Health Team
Dr CS	Independent consultant
Social worker 1	Social worker, Corby Youth Justice Team

Appendix B

Mr G contacts with statutory services August 2005 to July 2006

August 2005	
1 August	• GP
2 August	• Police • Ambulance (twice) • A&E
3 August	• Cornwall Partnership NHS Trust crisis resolution team
5 August	• GP attendance • Minor injuries unit attendance
6 August	• Ambulance • Police
7 August	• Ambulance • GP out-of-hours service
8 August	• CMHT (DNA)
10 August	• A&E • Child protection case conference (Child 4)
11 August	• Ambulance • A&E
16 August	• Police: Partners C and D reported to be staying at Mr V's flat
18 August	• DNA CPN assessment
19 August	• CPN letter to GP
23 August	• Ambulance attendance
28 August	• Child 4 born
September 2005	
3 September	• Ambulance • A&E
30 September	• Police • Ambulance
October 2005	
4 October	• CP case conference (Child 4)
8 October	• GP out-of-hours service
9 October	• GP (seeking appointment)
11 October	• GP out-of-hours service
12 October	• GP (DNA) • Cornwall Partnership NHS Trust out-of-hours service
16 October	• Ambulance • Police
17 October	• Police

21 October	• Ambulance (three times) • A&E
22 October	• Job Centre • GP
30 October	• GP out-of-hours service
31 October	• Ocean Housing
November 2005	
1 November	• GP out-of-hours service
11 November	• Police • Duty CPN
16 November	• CP conference (Child 4) • Police • GP
17 November	• Police • Ocean Housing
18 November	• GP • Police
22 November	• Police
24 November	• Police • Ocean Housing
December 2005	
17 December	• Police
20 December	• GP out-of-hours service
25 December	• Ambulance • GP out-of-hours service
27 December	• Police
28 December	• GP out-of-hours service
29 December	• Mr G wrote to GP
January 2006	
3 January	• GP (urgent referral to CMHT) • Police
5 January	• Police
9 January	• Police
10 January	• CMHT wrote offering appointment
15 January	• Police • Ambulance
19 January	• GP (DNA) • Police
21/24 January	• CMHT
27 January	• Police
31 January	• Police
February 2006	

6 February	• GP (DNA)
8 February	• GP • GP out-of-hours service
9 February	• GP • Police • Ambulance
10/11 February	• Police • Ambulance • A&E (incl. psychiatric nurse liaison service)
13 February	• Ambulance • Police
15 February	• Ambulance • Police
18 February	• Ambulance • Police
March 2006	
12 March	• GP out-of-hours service
13 March	• Ambulance • Police • A&E(re Mr V)
20 March	• GP
23 March	• Letter to MP
31 March	• GP (DNA)
4 April	• Police
12 April	• Police
18 April	• GP out-of-hours service
20 April	• GP
24 April	• GP out-of-hours service (twice) • Ocean Housing
25 April	• GP
May 2006	
1/2 May	• Police • Psychiatrist • Approved social worker
3/4 May	• GP • Police • Minor injuries unit
8 May	• Police
16 May	• Police
17 May	• Police
18 May	• Police • A&E (follow-up – DNA)
20 May	• Police
21 May	• GP out-of-hours service (three times) • Ambulance • Police

22 May	• GP
25/26 May	• CMHT (DNA)
June 2006	
6 June	• CMHT • Housing
9 June	• CMHT (DNA)
14 June	• Police (14 Jun)
16 June	• GP out-of-hours service
19 June	• CMHT
21 June	• Local authority children & families • GP
26 June	• Local authority children & families • Police
July 2006	
3 July	• Ocean Housing (three times) • Police
6 July	• Death of Mr V – Police • Police • Ambulance
9 July	• A&E • Cornwall Partnership NHS Trust out-of-hours service
10 July	• CMHT
11 July	• CMHT
12 July	• CMHT
14 July	• Local authority children & families • Police

Appendix C

Children (Leaving Care) Act 2000

The act has two main aims:

- to ensure that young people do not leave care until they are ready
- to ensure that they receive effective support once they have left.

Definitions

The local authority has a duty towards eligible and relevant and former relevant children:

Eligible - are those young people still in care aged 16 and 17 who have been looked after for (a total of) at least 13 weeks from the age of 14.

Relevant - are young people aged 16 or 17 who have already left care, and who were looked after for (a total of) at least 13 weeks from the age of 14, and have been looked after at some time while 16 or 17.

Former relevant - are young people aged 18-21 who have been eligible and/or relevant.

Children in care - young people who are looked after by a local authority either through a compulsory care order or remanded or accommodated by voluntary agreement including accommodation under section 20 of the Children Act.

Local authorities' new duties under the Leaving Care Act

Aged 16-18

- duty to ensure pathway plan is in place by 16th birthday
- duty to make assessment and meet needs
- duty to provide financial support
- duty to provide personal adviser
- duty to ensure accommodation.

Aged 18-21

- duty to maintain contact and to provide support through personal adviser
- duty to assist with costs of education, employment and training.

Aged 21 and over

- duty to 18-21 year olds continues if still in education or training
- duty to ensure vacation accommodation for higher education.

Responsibility

The last local authority to look after the young person is the local authority responsible for meeting duties under the Leaving Care Act wherever the young person may be living in England or Wales.

Assessment

Social services must carry out an assessment of each eligible and relevant child. The young person must be involved in the preparation and review of this assessment.

Pathway plan

Social services must prepare a pathway plan. This plan should look at the young person's need for support and assistance as identified in the assessment and how these needs will be met until the age of 21 (or longer when the young person is in education or training). Areas covered will include:

- accommodation
- practical life skills
- education and training
- employment
- financial support
- specific support needs
- contingency plans for support if independent living breaks down.

Both the assessment and pathway plan must be recorded in writing. Social services must review the pathway plan:

- if the young person requests it or
- a personal adviser considers it necessary or
- at intervals of not more than 6 months.

Personal adviser

Each young person covered by the act will have a personal adviser. The personal adviser:

- does not have to be a social worker
- will not be a budget holder
- will have close links with Connexions.

The personal adviser will be involved in:

- providing advice and support
- drawing up the pathway plan and ensuring it addresses any changing needs
- keeping in touch with the young person
- co-ordinating services, linking in with other agencies.

Appendix D

Responding to a diagnosis of personality disorder

In the late 1990s an assessment of 'personality disorder' was often accompanied by a conclusion that such a presentation was not amenable to active 'treatment' from mental health services. This challenge for mental health professionals was to feature in the majority of mental health assessments of Mr G thereafter.

The document, *Personality disorder: no longer a diagnosis of exclusion*, produced by the National Institute for Mental Health in England in January 2003 highlighted certain themes as being common in cases of personality disorder that are pertinent to this case. The document states that *"in many services people with personality disorder are treated at the margins - through A & E, through inappropriate admissions to inpatient psychiatric wards, on the case loads of community teams staff who are likely to prioritise the needs of other clients and may lack the skills to work with them"*. It further states that *"many clinicians and mental health practitioners are reluctant to work with people with personality disorders because they believe that they have neither the skills, training or resources to provide an adequate service, and because many believe that there is nothing that mental health services can offer."*

A number of validated assessment tools in relation to personality disorder are now available to all services. Two particular approaches are referenced below:

1. Alwin, N, 2006. The British Psychological Society. *Understanding personality disorder*.
2. Department of Health, 2003. National Institute for Mental Health in England. *Personality disorder: no longer a diagnosis of exclusion: policy implementation guidance for the development of services for people with personality disorder*.

Another useful source of information about personality disorders is www.personalitydisorder.org.uk

Appendix E

Care Programme Approach

The Care Programme Approach (CPA) was introduced in 1991 [*HC(90)23/LASSL(90)11*] to provide a framework for effective mental health care. In a Department of Health review paper published in 1999, *Effective care co-ordination in mental health services*, its four main elements were described as:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services
- the formation of a care plan which identifies the health and social care required from a variety of providers
- the appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care
- regular review and, where necessary, agreed changes to the care plan.

Before October 2008, two levels of support and coordination via CPA were in place:

- standard support for individuals receiving care from one agency, who are able to self-manage their mental health problems and maintain contact with services
- enhanced support for individuals with multiple care needs from a range of agencies, likely to be at higher risk and to disengage from services.

The current position is summarised on the NHS Choices website as follows:

> **"What CPA should provide:**
>
> *The CPA ensures that there is communication between everyone involved in the assessment of the patient's care needs. Social care needs will be assessed as part of this process.*
>
> *There will be a formal written care plan, which outlines any risks and includes details of what should happen in an emergency or crisis.*

A CPA care coordinator should be appointed to coordinate the assessment and planning process. The coordinator is usually a nurse, social worker or occupational therapist. You and the person you're looking after will be given their name and contact details.

A formal review is made at least once a year. This may include consideration as to whether CPA support is still needed.

It's recommended that the person who needs CPA support is involved in the assessment of their own needs and in the development of the plan to meet those needs. The person should be informed about the different choices for care and support available to them, and they should be treated with dignity and respect."

The Department of Health reviewed CPA in 2006/07. In the forward, Dr Appleby, national director for mental health, pointed out that:

"*I am aware that services are not always organised to identify and meet the needs of some vulnerable and high risk groups. This applies particularly where an individual's personal and family needs go beyond those usually described as mental health services – for example those of housing, support for drug and alcohol misuse, and child support services.*"

Dr Appleby went on to say:

"*The CPA does not replace the need for good clinical expertise and judgement but should act as a support and guiding framework which can help achieve these positive outcomes for service users by enabling effective co-ordination between services and joint identification of risk and safety issues and a vehicle for positive involvement of service users in the planning and progress of their care.*"

The review undertaken in 2006/07 resulted in new guidance, *Refocusing the Care Programme Approach: policy and positive practice guidance*, produced in March 2008. The introduction to this document was very clear in explaining that:

"*In particular, people with a personality disorder should be able to benefit from treatment and support, and this guidance applies to them just like anyone else.*"

The Department of Health guidance went on to say:

> *"Individuals with a wide range of needs from a number of services, or who are at most risk, should receive a higher level of care coordination support. From October 2008 the system of co-ordination and support for this group only will be called the Care Programme Approach (CPA). The revised characteristics of this group is set out (below) and trusts should review policies against this."*

Characteristics to consider when deciding if support of (new) CPA needed (2008)

- Severe mental disorder (including personality disorder) with 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
  - self neglect/non concordance with treatment plan
  - vulnerable adult; adult/child protection e.g.
    - exploitation e.g. financial/sexual
    - financial difficulties related to mental illness
    - disinhibition
    - physical/emotional abuse
    - cognitive impairment
    - child protection issues

- Current or significant history of severe distress/instability or disengagement.

- Presence of non-physical co-morbidity e.g. 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 or referred to crisis/home treatment team.

- Significant reliance on carer(s) or has own significant caring responsibilities.

- Experiencing disadvantage or difficulty as a result of:
  - parenting responsibilities
  - physical health problems/disability
  - unsettled accommodation/housing issues
  - employment issues when mentally ill
  - significant impairment of function due to mental illness
  - ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices; sexuality or gender issues)

The key groups are service users defined as those:

- who have parenting responsibilities
- who have significant caring responsibilities
- with a dual diagnosis (substance misuse)
- with a history of violence or self harm
- who are in unsettled accommodation.

Appendix F

Multi Agency Public Protection Arrangements (MAPPA)

The Criminal Justice and Court Services Act 2000 introduced a requirement for the police and National Probation Service to work together to make arrangements for assessing and managing risks posed by sexual or violent offenders and other persons who may cause serious harm to the public. These arrangements are known as Multi Agency Public Protection Arrangements (MAPPAs).

MAPPA is a system by which police, probation, prison and other partner services work together to manage the risks posed by specified sexual and violent offenders in the community. Local authorities and NHS bodies are under a statutory duty to cooperate with MAPPA arrangements. Where there is risk to children, such as with child sex offenders, safeguarding children teams are included in the discussions. Some areas have begun to take specific account of adult safeguarding within MAPPA where adults identified as 'vulnerable' are thought to be at risk.

The initial MAPPA guidance associated with this legislation (Home Office, 2001) set out the minimum requirements for the first year of implementation. This included setting up Multi-Agency Public Protection Panels (MAPPPs), to deal with those offenders in the community who pose a high-level risk, comprising of the police and probation – as the responsible authorities – with other statutory and voluntary agencies as appropriate. The 2001 guidance outlined the role of the MAPPPs as being to:

- share relevant information about targeted offenders
- assess the level of risk and recommend action to manage this risk and
- monitor and review this action plan periodically.

A Home Office report, *Strengthening Multi Agency Public Protection Arrangements* (2005), provided the following background material:

> "*More detailed national guidance was issued in March 2003 (National Probation Service, 2003) setting out the principles of public protection and the basic structure of MAPPA. It also developed the key elements of oversight required of the Responsible Authority in each area, and discharged through Strategic Management Boards (SMBs). Revised guidance was then issued by the Home Office*

and National Probation Service (National Probation Service, 2004a) relating to sections 325-327 of the Criminal Justice Act 2003, which set out to strengthen and extend MAPPAs by:

- *including HM Prison Service in the Responsible Authority;*
- *introducing a 'duty to cooperate' with the MAPPA, requiring a range of statutory and other social care agencies to cooperate with the Responsible Authority; and*
- *including two lay advisers to assist the Responsible Authority in the MAPPA review function in each area.*

MAPPAs have additionally a key role in the protection of children. The inter-agency inspection, 'Safeguarding Children' (DoH, 2002) made important recommendations to strengthen and formalise links between MAPPAs and Area Child Protection Committees (ACPC) to improve intra-agency and multi-agency responses specific to child protection."

Appendix G

Domestic abuse

Domestic abuse is defined by the British Crime Survey as non-sexual emotional or financial abuse, threats, physical force, sexual assault or stalking carried out by a current or former partner or other family member to a victim between the ages of 16 and 59 years old.

A Department of Health report, *Women's mental health: into the mainstream* (2002), acknowledged that:

> "*…around 50% of women service users have been sexually victimised as children, notwithstanding further abuse in adulthood and the significant number of men service users who have also experienced abuse.*"

Following further work in this area, Department of Health policy from October 2008 states that, following appropriate training for staff, all mental health assessments should explore presence of violence or abuse.

The Domestic Violence Crime and Victims Act 2004 (DVCVA 2004) was the first dedicated piece of domestic violence legislation for 30 years. Key provisions included:

- making the breach of a non-molestation order a criminal offence
- granting courts the power to impose restraining orders for any offence, on conviction or acquittal and
- introducing a new offence of "*familial homicide*".

Royal assent for the act coincided with the publication of a joint report by the Crown Prosecution Service and HM Inspectorate of Constabulary, *Violence at home* (2004). The report found that only five per cent of domestic violence cases result in a conviction and victims are often denied access to civil remedies because of limited access to legal aid. The act amended the provision of the Family Law Act 1996 (part 4). The stated aim was to strengthen the rights of victims and witnesses, introduce new offences and include tougher sanctions for perpetrators.

Breach of a non-molestation order was made a criminal offence punishable by five years' imprisonment on indictment (section 1) and common assault became an arrestable offence

(section 10). The courts were given a power to impose a restraining order for the protection of a victim, even where a defendant has been acquitted of an offence relating to them, but the court believes an order is necessary to protect the victim (section 12).
The main provisions of the DVCVA were enacted over the following year, with the remainder implemented in 2007.

Within Cornwall, it is understood that the approach to domestic abuse in the early 2000s was patchy. A domestic violence form (form 61) would be completed by attending officers in certain circumstances, but the follow-up procedures enacted by a designated domestic violence officer were less clear.

In turn, the above procedures only applied to over 18s and if the victim was under 18 we were advised that such events would not be recorded as domestic violence incidents and therefore did not go through the same procedure.

This investigation was advised that the above situation did not pertain today as procedures have changed to include people under 18.

We also researched the more recent approach to domestic abuse adopted by Devon and Cornwall Police. In a 2009 report, *Domestic abuse*, Devon and Cornwall Police outlined their priorities in respect of domestic abuse as follows:

> *"a) To protect the lives of both adults and children who are at risk as a result of domestic abuse.*
> *b) To adopt a professional and proactive approach in preventing and reducing domestic abuse.*
> *c) To effectively investigate all reports of domestic abuse and ensure positive action is taken.*
> *d) To facilitate effective action against offenders in order that they can be held accountable through the Criminal Justice System."*

They defined domestic abuse as:

> *"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between partners (16 years and over) who are or*

have been in an intimate relationship or between family members (18 years and over), regardless of gender and sexuality."

The significance of repeat victimisation is acknowledged and the commitment is to:

"…identify repeat victimisation as more than one reported incident by the same victim of domestic abuse in a rolling twelve month period following the date when the incident was first reported to the police."

MARAC

Multi Agency Risk Assessment Conferences (MARAC), now present throughout the country, began as a pilot in Wales in 2003. MARACs formed a central element of the Home Office's *National domestic violence delivery plan* in 2006. This document acknowledged the fact that there is often a wealth of information known by various professionals about the victims and/or perpetrators of domestic abuse, but that it takes a multi-agency approach such as a MARAC to bring this together in a meaningful way. Such arrangements were not in place in Cornwall at that time, but now form part of the approach to managing domestic abuse as detailed elsewhere in this report.

Appendix H

Safeguarding adults

The Department of Health and the Home Office issued joint guidance in 2000 on keeping adults safe called *No secrets: guidance on developing multi-agency policies and procedures to protect vulnerable adults from abuse* published in March 2000. This set out an expectation of formal adult protection procedures encompassing a single process of alerts, referrals, strategy meetings, investigations and case conferences, that would be largely the same for all types of incidents and all types of harm.

No secrets was issued as guidance under section 7 of the Local Authority Social Services Act 1970. This meant that it was statutory guidance, and local authorities were required to follow it unless they could demonstrate a clear reason why they should not. It created, for the first time, a framework for multi-agency action in response to the risk of abuse or harm. Local authority social services departments were tasked with playing a lead role in developing local policies and procedures for the protection of vulnerable adults from abuse.

The *No secrets* guidance created a lead agency for safeguarding and encouraged the collaboration of other agencies. The lead agency with responsibility for coordination became the local social services authority. Fifteen other agencies — such as providers of health services and of supported housing, the police, the Crown Prosecution Service, voluntary organisations and many more — were invited (but not required) to work in partnership.

Since *No secrets* was published in 2000, many police forces have concentrated all safeguarding issues – whether they involve children, adults, management of dangerous offenders, missing persons or domestic abuse – into single teams generally referred to as public protection units (PPUs). In many police forces the PPU works together with other key agencies under local Multi Agency Public Protection Arrangements (MAPPA) to manage specified sexual and violent offenders, and under the Multi-Agency Risk Assessment Conferences (MARAC) arrangements, in relation to high risk victims of domestic abuse.

In 2009 the Department of Health reported the outcome of the consultation into the *No secrets* guidance — the adult safeguarding measures introduced in 2001.A core finding was that adult safeguarding was under-developed in the NHS and clearer procedures were

required to clarify the relationship between adult safeguarding, adverse incident reporting, serious untoward incidents (SUIs) and complaints.

The Department of Health subsequently published additional guidance, *Clinical governance and adult safeguarding: an integrated process* (February 2010), "*to encourage organisations to establish local robust arrangements to ensure that adult safeguarding becomes fully integrated into NHS systems*."

The Department of Health's 2009 review of *No secrets* acknowledged an inherited focus on reacting to events after harm had taken place. The prevention of harm was less explicit in the previous documentation. The ministerial response to the 2008/09 consultation included the following actions:

- the establishment of an Inter-Departmental Ministerial Group, coordinating government policy and setting the framework for effective local arrangements
- a commitment to introduce legislation to establish safeguarding adults boards on a statutory footing and
- a programme of work with representative agencies and stakeholders to support effective policy and practice in safeguarding vulnerable adults.

In recent years government policy has encouraged progress in the identification of high risk victims of domestic violence through MARAC arrangements, and of convicted sex and dangerous offenders of serious crime through MAPPA arrangements.

Following the serious case review into the care of Mr V, agencies in Cornwall have made significant strides forward in implementing new safeguarding adults arrangements.

Appendix I

Description of services

Cornwall Partnership NHS Foundation Trust

Cornwall Partnership NHS Trust provides mental health and learning disability services to the population living in Cornwall and the Isles of Scilly estimated at 501,000. It was approved as a foundation trust on 1 March 2010.

Cornwall Social Services

Social services are provided by Cornwall County Council. It includes adult care and support and children's social care. Adult social care and support provides help for adults with physical disabilities, drug or alcohol problems, hearing or sight loss, HIV and AIDS, learning disabilities, or mental health problems; older people; and carers. A safeguarding adults team deals with protection of vulnerable adults in the community. Children's social care includes foster care, residential services and a children in care development team.

Devon and Cornwall Police

Devon and Cornwall Constabulary employs 3,500 police officers and covers the largest geographical police are in England, serving a population of 1.5 million.

National Probation Service

The National Probation Service is a law enforcement agency that works to rehabilitate offenders given community sentences and those released from prison. It also enforces the conditions of court orders and release licences. The Devon and Cornwall Probation Trust manages about 3,000 offenders on community sentences and 1,000 in prison each year.

NHS Cornwall and Isles of Scilly

NHS Cornwall and Isles of Scilly is primary care trust which manages the community hospitals and health centres in the region and works with GPs, dentists, and pharmacies to ensure that patients receive appropriate services as close to their home as possible

NHS Northamptonshire

NHS Northamptonshire is the primary care trust for Northamptonshire and is responsible for commissioning of services including GP surgeries, dental practices and ophthalmic practices. It controls a budget of almost 1 billion pounds.

Northamptonshire Healthcare NHS Trust

Northamptonshire Healthcare NHS Trust provides mental health, learning disability, sexual health and drug and alcohol services for the county's population, estimated at 630,000. It operates from three main centres: Princess Marina Hospital and Berrywood Hospital in Northampton and St Mary's Hospital in Kettering. It also works from 12 community bases across the county, 40 smaller buildings, through GP practices and the county's two main general hospitals. It became a foundation trust in May 2009 and is now known as Northamptonshire Healthcare NHS Foundation Trust.

Northamptonshire Social Services

Social services in Northamptonshire are provided by Northamptonshire County Council.

Ocean Housing Ltd

Ocean Housing Ltd is a registered social landlord with a stock of approximately 2,700 general needs homes and 725 sheltered properties throughout Cornwall.