

**Report of the
Independent Investigation
Into the care and treatment of Mr MH**

**A report commissioned by
South West Strategic Health Authority**

We were commissioned in February 2009 by the South West Strategic Health Authority to undertake this Independent Investigation into the circumstances surrounding the treatment and care of Mr MH.

Despite the co-operation of the Trust, the process of completing the Investigation has been significantly hampered by the late discovery of key records and some difficulty in contacting significant witnesses, some of whom we were unable to see despite our view that they had material evidence to inform the Investigation.

At the request of the Authority, the names of all those involved including the victim, the patient, their families and those of staff or others involved in MH's treatment and care have been anonymised.

We now present our Report.

CHRISTOPHER MALE
Former Tribunal Judge
Chairman

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EXECUTIVE SUMMARY

This Independent Investigation was commissioned by the South West Strategic Health Authority under the provisions of national guidance issued by the NHS National Patient Safety Agency *'Independent investigation of serious patient safety incidents in mental health services - Good practice guidance'*. In the introduction to the guidance, it is stated to be the responsibility of the strategic health authorities (SHAs) to commission an independent investigation, and there are clear criteria that determine the need for one. Included in the criteria is *'When a homicide has been committed by a person who is, or has been, under the care, that is subject to regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event'*.

Our remit was to review the care and treatment afforded to MH during the period of his contact with NHS services provided by Avon and Wiltshire Mental Health Partnership NHS Trust from September 2004 until March 2007 when the homicide occurred; and to make appropriate recommendations which would lead to improvements in mental health services and minimise the risk of future deaths. It was also our task to consider any issues in the interests of the public in general.

MH killed CJ on 4 March 2007. At Bristol Crown Court on 27 July 2007, he was convicted of manslaughter by reason of diminished responsibility and was made the subject of a Hospital Order indefinitely, it appearing to the Court that to protect the public from serious harm a restriction order should be made.

We were appointed in February 2009 and in the course of the Investigation we examined all the available records and operational policies and received written and oral evidence from a wide range of professional witnesses, and from the families of both MH and CJ. We identified a number of other witnesses we would have wished to interview but discovered they were unavailable for a variety of reasons, including retirement, suspension from duty, no longer in the country or otherwise untraceable. We sought advice from an expert witness; and were supported by an Investigation manager who was also a panel member.

Our Independent Investigation followed an initial service management review by the Trust and a later internal NHS mental health trust investigation using the root cause analysis (RCA) process which was undertaken by senior members of the Trust's staff who had not been directly involved in MH's care and treatment.

We acknowledge that, on taking up post in 2006, the Chief Executive, LMCM, was faced with an organisation, which was failing to meet a number of required standards. She faced a difficult and challenging change agenda in order to address these issues as a matter of priority.

MH's entry to mental health services followed a referral by his GP and he remained continuously under their care and treatment. The first Trust team to undertake MH's care was the Crisis Team (Crisis and Home Treatment Team) which had been formed during 2003, was in its early stages of operation and was then without an

aligned Consultant Psychiatrist. In December 2004, his care and treatment were handed over to the Community Mental Health Team, which was depleted of staff and members of which were carrying caseloads substantially in excess of standards prescribed by the Nursing and Midwifery Council. Staff in both teams were reported to be working long and anti-social hours. In addition, MH was provided with psychological support throughout by a Psychologist from the separate Early Intervention Team, which was also in embryonic stage of development. On 25 October 2006, a referral was made to the Assertive Outreach and Recovery Team but this was not progressed because that team was not taking new cases onto their caseload and was without an aligned consultant psychiatrist.

Following a marked deterioration in his mental health, in July 2006 MH was compulsorily admitted under an assessment order (Section 2 of the Mental Health Act 1983) to the Trust's in-patient unit at Sandalwood Court, Swindon. Whilst an in-patient, MH was reviewed by the hospital consultant psychiatrist and an Approved Social Worker, who considered that his condition did not warrant detention under a treatment order (Section 3 of the Mental Health Act 1983) and he was subsequently discharged from section. However, MH agreed to continue to remain in hospital as an informal patient. In November 2006, he was again assessed under the Mental Health Act on two occasions with eventual informal admission to the Trust's Green Lane Hospital in Devizes. After a week as an in-patient he was discharged back to the care of the Swindon Crisis Team.

From December 2004, the Trust was without a substantive Chief Executive and, following her formal appointment with effect from April 2006, the current Chief Executive embarked upon a major change process, which inter alia, included structural change to the organisation. From the evidence we have received, this was the subject of adverse reaction from within and outside the Trust although this was not universal. It became evident from what we heard from a range of witnesses that, at that time of intensive, yet protracted, change, the Trust's senior management had not exercised appropriate control, which might have ensured greater continuity of care for MH by the teams involved.

Both from the evidence of witnesses and our examination of MH's care and treatment records, a picture emerged of fragmented working at material times both within and between the Community Mental Health Team, the Crisis Team and the Early Intervention Service; and between them and the in-patient services.

We heard from the Chief Executive that, at the time of her appointment, a number of clinicians, including very senior clinicians, thought that the Integrated Care Plan Approach (ICPA) process was really cumbersome and did not add a great deal to the sum of clinical management and that it was not terribly important complying to it. However, the severity of MH's mental disorder from the outset of his care and treatment led to his being appropriately placed on an enhanced care plan under the Trust's ICPA.

From the early stages of his treatment onwards, MH made repeated threats to kill or harm other people, notably CJ and a fantasised person, who was a character from a television series (*Referred to hereafter in this report as (TV).*) These threats appear to have been based on MH's beliefs about incidents of sexual abuse by CJ and (TV),

albeit that there was no substantiated evidence to support those beliefs. Those serious threats were variously recorded by the Early Intervention Team psychologist, by MH's assigned Community Psychiatric Nurse and by members of the Crisis Team, but were not fully evaluated by them, their team colleagues or the consultant psychiatrists by thorough risk assessments. The fact that CJ was a real person under threat was never explored or established.

MH's behaviour became increasingly disturbed throughout 2006, as evidenced by his hospital admissions, the need for Mental Health Act assessments, and reported concerns, particularly by his mother and his Care Co-ordinator. However, his diagnosis and the treatment plan were not systematically reviewed. He was subject to several changes of accommodation at various times and his family, on whom he fell back for support, found difficulty in gaining recognition from some staff of the Trust as to the reality of their concerns for MH, his disordered thinking, his threatening behaviour and his non compliance with medication.

Later in 2006, the response of the Crisis Team became less focused, in that MH was often not seen on visits and medication was left for him to self administer, despite it being known that he hoarded prescribed medication which had allowed him to take a serious overdose in February 2006. MH was discharged from the Crisis Team's care back to the Community Mental Health Team without thorough review or transitional arrangements in January 2007. At that time, his Community Psychiatric Nurse had to take planned absence and her temporary replacement made only minimal contact with MH between then and the homicide, creating a situation where prescribed medication was not given for almost three weeks.

At this crucial time, the roles of the psychologist and the consultant psychiatrists remained largely separate from the rest of the community staff, so that their potentially vital role in examining the true nature of MH's threats and agreeing a clear diagnosis and treatment plan played no active part in his ongoing care from the Trust.

The course of our Investigation and completion of our report were protracted. We encountered difficulties surrounding record keeping, missing records, and discovery of the names of staff (both those who had been in direct contact with MH and the identities of their managers or supervisors). Important documentation was not available at the outset, particularly minutes of meetings with staff, including individual interviews of a number of staff with the RCA panel, and records and statements held by the police. Indeed some of the minutes of the RCA panel, which contained important information, did not come into our possession until March 2011, despite requests for that information having been made earlier in the course of our Investigation. We were also unable to access some of the Trust's operational policy documents extant at the time that MH was under the care of local services.

We found that there had been a number of serious failings in the care and treatment of MH in relation to the practices of individual staff employed by Avon and Wiltshire Partnership Trust. There were many serious gaps in recording important information and sharing it between professions and teams. There were notable failures to consider the views of MH's mother and to record her firsthand accounts of MH's disturbed thinking and behaviour. We also found that there had been organisational

failings in relation to systems, the supervision, support and development of staff, and managerial approaches to the delivery of services, including the quality of the initial service management review undertaken by the Trust immediately following the homicide.

We found significant deficits in organisational, management and clinical practices and we have developed recommendations, in respect of these service issues, for improvements in the provision and management of services. These 71 recommendations, arising from our conclusions drawn from the verbal and written evidence available to us are set out in Chapter 12 of our report and relate, inter alia, to clinical processes, record keeping, and Trust policies. Given the length of time since the homicide, we gave the Trust the opportunity to comment on the 69 recommendations specific to that organisation and were pleased to learn that action had been taken in respect of all of these. The majority of those recommendations are reported as having been fully implemented and action is reported to be in progress in respect of others. Final and ongoing implementation of all the recommendations is supported by a system of monitoring and review.

We have identified a number of missed opportunities which, if the facts had been recognised through the sharing of, and acting upon, readily available information, would have provided sufficient evidence to indicate that MH's mental health was deteriorating to such an extent that it would probably have led to his admission to hospital and, on that basis, that CJ's death could have been avoided.

Key amongst these missed opportunities was the collective failure to respond appropriately to the unexpected decision to hand over MH's care and treatment from the Crisis Team to the CMHT in January 2007. This handover was made in circumstances where it was known that the capacity to manage MH was not available in any of the four teams involved, a situation which had not been addressed or escalated by senior managers within the Trust. This situation warranted a multi-team case conference, involving senior managers and consultant psychiatrists, to resolve this dilemma. We conclude that this omission had a direct causal bearing on the failure to manage MH effectively thereafter and this impacted directly on the death of CJ.

We conclude that, on the balance of probabilities, CJ's death was avoidable, at least at the time and in the circumstances in which it occurred, as we believe that proper adherence to Trust policies and procedures, combined with effective multi-team working, would have resulted in a focused and coordinated approach to the care and treatment afforded to MH, including admission to hospital in early 2007 for a full assessment, risk assessment, formulation of an appropriate management plan and a formal diagnosis, followed by appropriate care and treatment. Whilst we have necessarily been critical of the acts and omissions of individual AWPT staff at clinical operational level, we have also been cognisant of the wider organisational culture and environment in which they operated and conclude that, overall, some staff felt disempowered from, and fearful of, delivering their responsibilities and obligations. Whilst staff registered with professional bodies cannot abrogate those responsibilities and obligations, we are of the view that the Trust itself failed to engender an environment where all clinical staff felt able to exercise appropriate judgment, based on their skills, training and experience. We heard from staff in the

Swindon area that they felt that, at Executive level, there was a lack of appreciation of the reality of the pressures caused by organisational change, demonstrating a disjunction between Board level priorities and the provision of effective services to patients, which latter must be the *raison d'être* and driving force of any NHS provider organisation. The situation prevailing at the time is illustrated in a view expressed to the Root Cause Analysis investigation to the effect that the general idea at operational level was 'getting on with it'. We heard from LMCM that it was decided to introduce organisational restructuring, which replaced 'Locality' (geographically) based management with Strategic Business Units (SBUs), which operated Trust wide. That the SBUs 'went live' in November 2006 and that this change process was complete by April 2007. And that there were no changes in the Executive management team from the time that LMCM took up post until February 2008.

We noted that the consultant forensic psychiatrist who examined MH immediately following the homicide found him to be profoundly psychotic by virtue of paranoid schizophrenia and that he was very badly damaged by his disorder. We noted also his view that MH was suffering from this illness at the time of the offence and that his abnormality of mind (his illness) directly influenced his actions at the time of the offence. No such clear diagnosis and assessment of its damaging consequences appear in the records of the teams responsible for his care and treatment in the two and half years up to the homicide.

Our recommendations address the failings, influencing factors and service issues identified in our report.

Those statements were patently obvious in evidence to our independent Investigation.

In our report we extend our sympathies to the families of CJ and MH. We recognise that every Investigation of this nature impacts on the professionals involved but that for the family and friends of the deceased; for the perpetrator and his family and friends, it is a terrible personal tragedy.

Our findings and recommendations are not dissimilar to the findings and recommendations of other homicide Investigations in England and Wales, where common themes have emerged.

The statistical improbability of such events does nothing to assuage the concerns of the public or provide any comfort to the families involved.

Chapter 1

Introduction

Independent Investigation

This report sets out the findings and recommendations of an Independent Investigation into the care and treatment of MH. The Investigation was commissioned in February 2009 by the South West Strategic Health Authority and established under NHS Executive Guidance (HSG (94) 27) following the homicide of CJ by MH on 4 March 2007. The terms of reference for the Investigation are set out in Appendix 1 to the report.

At the time of the homicide, MH was subject to monitoring (under the Care Programme Approach) in the community by a Community Psychiatric Nurse (CPN) employed in the Swindon East Community Mental Health Team (CMHT), which is part of the Avon and Wiltshire Mental Health Partnership NHS Trust (AWPT).

Membership of the Investigation panel comprised Mr Christopher Male, former Tribunal Judge; Dr Claire Royston, Consultant Psychiatrist; and Mrs Rae Wallin, former NHS Director and Manager; and manager of this Investigation. We sought and received expert evidence from Mr JM, Independent Social Worker.

At the request of the South West Strategic Health Authority, all names in the report have been anonymised (with the exception of the names of a television character and of real and famous people incorporated into MH's delusional ideas)

In February 2008, the National Patient Safety Agency issued Good Practice Guidance in the Independent Investigation of Serious Patient Safety Incidents in Mental Health Services and we complied with this guidance in the conduct of our Investigation. It should be noted that the Guidance contains reference to the Human Rights Act and noted that this may impact on the conduct of an Investigation. The Investigation has no statutory powers or status, does not receive sworn evidence and has to rely on the willingness of witnesses to support the Investigation process in giving a truthful account of matters within their knowledge.

This chapter deals with the procedures followed and explains the aims of the Investigation and the way in which the Investigation discharged its obligations in relation to the care and treatment received by MH from the mental health services.

The agreed Procedure for the Investigation is set out in Appendix 2 to the report.

Despite our desire to progress and complete the Investigation without undue delay, we encountered situations where delay was unavoidable. These included, for the Trust, difficulties in the discovery of documentation; incomplete records; and non availability of witnesses. And, as a consequence for us, the identification and non availability of witnesses.

Evidence

We had written and oral evidence from many witnesses, including both families, and from MH himself, whom we interviewed in the Medium Secure Unit where he is currently detained and treated, and were able to discuss with him his experience of the services offered to him.

As is expected of independent Investigations, the oral evidence was heard in private. The procedures were designed to mitigate any potential unfairness. Witnesses could not hear the evidence of others, which may have been relevant to them, but all witnesses had the opportunity to be accompanied by either a legal representative or other person and to comment on conflicts in the evidence which emerged during the course of the hearings and which were relevant to any findings of fact and to the recommendations and comments set out in our final report.

We sought to ensure that our agreed procedures allowed for openness and honesty and the treatment of witnesses in an atmosphere of fairness.

The selection of the panel guaranteed the independence of the process.

Approach of the Investigation

Guided by HSG (94)27, we conducted a thorough examination of events leading up to and surrounding a serious and untoward incident (homicide) which is considered to be in the public interest and which involves the accountability of public services and professionals to those in their care and to the public at large.

The purpose of such an Investigation is to minimise risk to the public or patients themselves in the future through recommendations, following investigation of the care received by the patient, his assessed social care needs and the exercise of professional judgement. Matters to be addressed include amelioration of public anxieties; and systemic failures.

We were acutely aware of the lapse of time between the homicide, the receipt of initial evidence and the commencement of formal interviews with witnesses. Given a lapse of over two and half years, we could have anticipated some difficulty in accurate recollection of the events particularly as some records were found to be missing for a crucial period of MH's care and treatment. Notwithstanding these circumstances, many witnesses had very good recall of events, whereas others said that they had little, if any, recollection. We identified significant issues in respect of record keeping (which are dealt with in Chapter 9). We were able to cross reference, and have corroboration of, some events from witness statements given to the police, effectively under oath, within days of the homicide.

During the course of our Investigation, we came to concur with a statement made in a meeting of the Clinical Risk and Incident Review Group of AWPT on 16 March 2007, that the Investigation following the homicide would be '*....a very protracted one*'.

We did not approach the Investigation in terms of seeking to attach blame or to find scapegoats. Indeed, we sought to make all witnesses comfortable with the procedure in the expectation that witnesses might find the event in itself somewhat stressful. In the initial process of asking potential witnesses to assist the Investigation, the Investigation manager provided every witness with a copy of the written procedures and terms of reference. She was also present to greet witnesses as they arrived and to provide reassurance where needed. It was made clear that we needed the help of witnesses and that we looked for areas of good practice as well as seeking out matters upon which we might wish to make recommendations. It was a matter of some concern to us that one of our professional witnesses in particular had been 'warned' by a senior colleague in AWPT of the conduct of the Investigation, which necessitated our manager and our Chairman both having to spend considerable time in reassuring the witness he/she would be treated with the courtesy and consideration, which had been, and would continue to be, extended to all witnesses appearing to give evidence. Indeed at the conclusion of that witness giving evidence, in answer to the Chairman that he hoped that (the experience) had not been too arduous the witness replied '*No, I think it was done very professionally. Thank you all very much*'.

We have endeavoured to be constructive in our criticisms and to give praise as appropriate. However, whilst we were pleased to hear of progress and positive developments in service provision since the homicide occurred in 2007, we were clear that our primary focus was in respect of the situation pertaining from the time MH first engaged with the service in 2004 until the homicide in 2007. We have not sought to find individuals to blame. We focused on those managerial and practice issues, which we considered to be relevant to the systemic framework within which individual roles were performed.

We recognise that different accountabilities apply in respect of Executive functions and actions; and those of senior managers. Senior managers are defined, and referred to, in the context of this report, as those managers between the Executive level and the direct clinical team management level in the organisation. Wherever possible and appropriate, we have distinguished between these two levels, but this was not always possible given, firstly, that Executive Directors carry responsibilities over and above those of their corporate responsibilities as Executive members of the Trust Board and, secondly, that there was shared responsibility in some matters. The term 'senior management' is used where we knew that both levels of management as defined were involved, albeit that not every member of the Executive Team was involved.

We were aware that serious untoward incidents sometimes occur and some may be unavoidable and it may not be productive to apportion individual blame. It is important to learn from the experience, but mental health professionals cannot be expected to control and influence the actions of patients or, indeed, the legal right of patients to refuse interventions by the services.

We investigated the care and treatment received by MH from the time when he came to the attention of mental health services in September 2004 until March 2007. The Chronology, which forms Chapter 3 of this report, is formulated from MH's clinical records as presented to us. Although we have had the benefit of hindsight, we have approached the Investigation on the basis of the current practice at the time insofar as information was available to us and we have, where appropriate, acknowledged changes in practice brought about following this tragic incident. We cannot be confident that we have had access to all of the operational policies extant at the time of the homicide.

We have throughout our Investigation and Report applied the standard of proof used in civil law, namely the 'balance of probabilities', judgement being based by reference to the practice of a reasonable and responsible body of practitioners in the relevant field. We considered it appropriate to seek expert advice from an Independent Social Worker, who considered documentation surrounding Mental Health Act assessments and formal care plans and advised us accordingly.

Investigations of this kind do not operate as a court of law. In adhering to the terms of reference, we consider that we have fulfilled our obligations and acted fairly and as expeditiously as possible. We have treated all the evidence, oral and written, including all records, as being received in confidence. Any disclosure of evidence in this report is in the public interest and is proportionate to our legitimate aims.

This report sets out our unanimous findings, comments and recommendations.

Documentation

MH gave written consent to the disclosure of medical and other records relevant to the Investigation, which included his past history relating to his mental illness, conduct and behaviour. The Chronology in Chapter 3 indicates the agencies with whom MH had contact and which held relevant records.

We also had access (with MH's consent) to statements and material in the possession of the police, which allowed us to find some corroboration of the clinical records. Some records were not available, specifically the non-clinical records of the Swindon Forensic Service which, we were told, had been destroyed. The contemporaneous notes of one of the assessing social workers had also been destroyed and other clinical records were found to be incomplete or missing. Our findings with regard to record keeping are set out in fuller detail in Chapter 9.

Commentary: We noted that the Crisis Team members were not interviewed by the Police although they had continuous contact with MH from July 2006 until eight weeks prior to the homicide.

The records maintained by the Crisis Team often fell far short of required standards. Of particular concern in the context of the Investigation process, is that many entries were not attributable to specific individuals because names or signatures were not legible. We sought the assistance of the manager of the Crisis Team but to no avail.

Had we been able to attribute entries in all cases, then we would have been highly critical of the record keeping of some individuals. Our criticisms would have been significantly more stringent than those made of other clinicians. In the circumstances, we can only record this fact and draw attention to our recommendation (*number 11*) in Chapter 4. We noted, however, the assiduous approach to record keeping (with very minor exceptions) by SG, Care Co-ordinator.

Hearings

With the exception of receiving evidence from MH and his then Consultant, Dr PC, both of whom we saw at a Medium Secure Hospital, and EP (CJ's then partner who was seen at Swindon) all meetings with witnesses were held at the Holiday Inn, Filton, Bristol, between October 2009 and June 2010. The evidence was recorded and transcripts were provided to panel members, and to witnesses, who were asked to verify the content, make amendments as they felt appropriate and confirm their accuracy. A list of all witnesses is set out at Appendix 3 to this report.

Acknowledgements

We extend our deepest sympathies to the family and friends of CJ. We recognise the terrible impact and consequences of the homicide for them; and also for MH and his family.

We are grateful to all witnesses for their co-operation with the Investigation; the family of CJ; and MH and his family. The statutory and voluntary agencies from whom we received evidence were Avon and Wiltshire Partnership NHS Trust, the Primary Care Trust, Wiltshire Constabulary, Swindon MIND, and Jephson Housing Association.

Our grateful thanks are extended also to the staff of Ubiquis for their services and patience in their assistance with the process and for the prompt delivery of transcripts of evidence.

Good Practice Guidance (Issued by the National Patient Safety Agency (NPSA) in February 2008)

The introduction to this guidance on good practice describes the three stages of the independent investigation process:

1. Initial service management review: an internal Trust review within 72 hours of the incident being known about in order to identify any necessary urgent action.
2. Internal NHS mental health trust investigation: using root cause analysis (RCA) or similar process to establish a chronology and identifying underlying causes and any further action that needs to be taken. This would usually be completed within 90 days.
3. Strategic Health Authority (SHA) Independent Investigation: commissioned and conducted independently of the providers of care.

It is clear from the guidance that the criteria for commissioning this Investigation are satisfied in that:-

1. MH, who committed this homicide, is a person who was under the care of specialist mental health services in the 6 months prior to the event and was subject to the enhanced care programme approach. (He had in fact been continuously under the care of mental health services from September 2004)
2. Article 2 of the European Convention on Human Rights applied
3. A serious patient safety incident warranted an investigation (e.g. the event may represent significant systemic service failure)

In Appendix 1 of the NPSA Good Practice Guidance, under the heading, 'Human Rights Act', the scope and format of Investigations are set out as follows:- *'Article 2 imposed on States a procedural obligation to initiate an effective public investigation by an independent official body into any death.....occurring in circumstances in which it appears that Article 2 has been or may have been violated and it appears that agents of the State are or may be in some way implicated.'*

Where an individual's Article 2 rights may well have been breached, then the State must conduct an effective investigation into that death or incident. The minimum requirements of such an investigation are:

- *the authorities must act of their own motion*
- *the investigation must be independent*
- *the investigation must be effective in the sense that it must be conducted in a manner that does not undermine its ability to establish the relevant facts*
- *the investigation must be reasonably prompt*
- *there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory*
- *the degree of public scrutiny required may well vary from case to case*
- *there must be involvement of the next of kin to the extent necessary to safeguard his or her legitimate interests'.*

The guidance also states:- *'It is also important to note that any duty to carry out an Article 2 compliant investigation covers the whole span of investigations following death or incident, and not simply an investigation under this guidance in isolation.....The SHA (Strategic Health Authority) mental health independent investigation described in this document will probably not of itself have to be fully Article 2 compliant.'*

The Initial Service Management Review

The Initial service management review was carried out by AWPT immediately following the homicide and is of particular relevance to the main body of our report. This review is entitled 'Initial Management Investigation following homicide of CJ on 4 March 2007'. The report comprises some 14 pages and stresses that *'This is a preliminary investigation, undertaken in the immediate days and weeks following the homicide. It will form the basis of further investigation, but should not be construed as definitive'*.

It also states *'This report sets out information about MH's contact with mental health services from 2004 until the time of the incident. It draws on information provided by key staff, and through the health records'*.

The report is neither dated nor signed.

At the end of the report under the heading 'Potential Risks and Concerns Arising from this Case', it is stated, *'The following is an early indication of potential risks for service delivery or for the Trust as an organisation'*.

'The potential risks and concerns' are then detailed under the headings:-

- *Care co-ordinator arrangements*
- *Joint working between CMHT, Crisis Team and Early Intervention Service.*
- *Risk Assessment*
- *MAPPA and Vulnerable Adults Referrals*
- *Concerns expressed by MH's mother (JM hereafter)*
- *Previous Lessons from Homicide Enquiries*, under which heading is stated, *'It is important to cross reference the early findings of this investigation with previous homicide enquiries within AWP. Anecdotally, there are some common themes emerging'*.

Commentary: The author did not sign or date this report. Furthermore, the key staff who contributed to the review are not identified therein, although this information was provided to us subsequently by the Trust.

The Good Practice Guide by NPSA is dated 2008. However, we had access to AWPT's Serious Adverse Incident Policy and Procedure dated 24 February 2006, in which is stated:- *'The management investigation should be completed within 72 hours'* We also noted that there is no reference to missing records, a fact which we discovered on our examination of the Crisis Team clinical records. There was reliance by the review team on records relating to another patient which we discovered had been misfiled in MH's records. We were aware that there were formal meetings of certain staff with Trust Solicitors on 8, 12 and 13 March 2007 the purpose of which was stated to *'assist in the preliminary investigation around the death of CJ and the involvement of MH.'*

We observed from notes from the Interagency Meeting Regarding The Murder of CJ and dated 7 March 2007, that under 'next steps' is stated that *'Solicitors will commence AWP fact finding, within strict parameters, taking care not to contaminate any police investigation.'*

Recommendation 1: The person completing the initial service management review must sign and date the report and set out his/her full job title. (S)he must also list the names and job titles of those contributing to the review and of those interviewed.

The Internal NHS Mental Health Trust Investigation (RCA)

Stage two of the Good Practice Guidance Procedure (Root Cause Analysis) Report is dated 31 August 2007 and comprises 50 pages with appendices of 234 pages in

addition. Included was AWPT's Risk Management Strategy dated 3 March 2007, marked 'Draft for approval'. Other policy documentation attached was all dated March 2007.

The RCA team members were Dr SO'C, Medical Director, JMcD, Area Manager, Bath and North East Somerset, and MR, Consultant Nurse/Senior Lecturer Acute Adult Care, Bath and NE Somerset and of the University of the West of England. The independent Investigation received evidence from the RCA Team in the same manner as for all other witnesses.

The list of staff shown in the RCA Report to have been interviewed on 9 July 2007 were SG (Community Psychiatric Nurse (CPN) and MH's Care Co-ordinator in the CMHT); AG (Consultant Psychologist, Early Intervention Service); (XX) (CPN in the CMHT); and Dr PS (Consultant Psychiatrist attached to the CMHT). In fact, it was established in March 2011 that SG was interviewed on 2 July 2007 and PC was interviewed on 9 July 2007 but was not shown in the notes of the meeting as being present.

On 17 July 2007, 12 members of the CMHT were seen by the RCA team including Dr PS, SG, (XX), DQ (Community Support Worker in the CMHT) and RG (then Manager of the CMHT)

On 25 July 2007, 9 members of the Crisis Team (later re-named the Crisis and Home Treatment Team but referred to throughout our report as the Crisis Team) were seen by the RCA team. Not all Crisis Team members were present at this meeting.

Commentary: Records of these four meetings were provided to us only towards the end of the Investigation process (early 2011) although the information contained therein was of material significance to our task.

PC, Manager of the Crisis Team, was recorded as being present at the meeting on 25 July 2007 and there are notes of an individual meeting with him on 9 July 2007. In his verbal evidence to the panel, he asserted twice to the effect that he was not interviewed or involved in the Root Cause Analysis. This could not be tested because individual comments recorded in the RCA report were not attributed.

At the conclusion of the RCA report, there are provisional recommendations relating to:-

- Clinical care
- Communication
- Formulation/Mental State/Treatment
- Risk assessment
- Dual Disorder Strategy and Training, it being stated:- *'The Trust needs to ensure staff are able to detect, assess, risk manage and treat those individuals with alcohol and drug difficulties in an integrated treatment approach'*
- Managing Service Capacity
- Early Intervention services
- Managing Staff Absence

- Managing Conflict between Teams
- Relationships between Members of Staff.

The RCA team under the heading, '*Psychiatric History*', identified 22 January 2004 as the date of first contact with mental health services by MH. This is incorrect and no doubt occurred due to the indistinct nature of the date recorded on the Crisis Team contact sheet. There was information in the body of the record as to MH's residence which alerted us to the apparent discrepancy and it was established through MH's mother, JM, that in all probability the record was made in 2006. This is important because the Crisis Team contact sheet recorded that JM reported at the time of this contact, now established to be 22 January 2006, that MH was '*saying nasty things re his brother and threatening to kill people.....*'

Whilst the RCA team had noted the presence of some of another patient's clinical notes in MH's records, it was not recorded by them that this was misfiling and a breach of patient confidentiality. The file for MH had a clear warning note for staff to the effect that there was another user of AWPT mental health services with the same name.

The RCA team also overlooked the absence of Crisis Team records for the crucial period between November 2006 and 11 January 2007 for the time leading up to and immediately preceding the hand back of MH's care to the CMHT.

We noted that the RCA team had not discovered that, due to the family relationship between RG as Manager of the CMHT and SG, CPN and Care co-ordinator for MH, (XX) was SG's supervisor and therefore should have been well aware of MH, not just as supervisor but also through weekly team meetings when patients were discussed. We also noted that SG's notes on one occasion referred to (XX) as having gone out to see MH. There was no record of this by (XX) in the clinical notes. This had not been picked up by the RCA team.

Given that the RCA report refers to information gleaned from the meetings held with CMHT and Crisis Team members, we enquired as to whether minutes of those meetings and the formal interviews with the 4 members of staff were taken and we were advised that notes were taken by the Personal Assistant of the then Medical Director. The then Medical Director advised us that she could not access the notes, having left the Trust, but that they could and should be made available to us. Towards the end of this Investigation, we acquired notes of RCA meetings with the CMHT and Crisis Team members. One set of notes was not provided until March 2011, and this necessitated a significant review of and considerable changes to the draft report.

We reviewed the notes of the RCA meeting with the Crisis Team on 25 July 2007 and noted the following themes and concerns from comments made (which had, with one exception, not been attributed and which were not verbatim but a short version of what was said):-

- That in December 2006 it was identified at a meeting that MH had '*lots of problems with non compliance and accommodation*' and that in January 2007,

over 28 envelopes of untaken medication for MH were found in the flat, where he was living with his girlfriend (referred to as (G/F) hereafter).

- That this contrasted with other evidence from staff in the meeting that they *'Would be watching him take medication – he took his meds twice a day – see him take medication in the morning and leave his evening medication with him'*, and that it had been policy for at least two to three years that no medication would be left with a patient, if they were being seen twice a day.
- That, in January 2007, the Crisis Team believed MH's care should be transferred back to the CMHT but his Care Co-ordinator did not want this to happen and that there was no meeting to discuss this although usual protocol was reported in the RCA meeting as *'Always ask the care co-ordinator, do a joint assessment and then hand him back'*
- That MH's care was, in fact, handed back to the CMHT that month, despite the reservations of his Care Co-ordinator, but that *'Crisis team felt he was well enough to go back to the cmht, assertive outreach could not help and we could not pick up this work. He would have gone to assertive outreach and he fell between two camps. The cmht did not want him back and the crisis team did not feel they could cope with him.....He remained with the cmht'*.
- That there was reported (in the RCA report) to be no process to obtain a third party agreement when there was a different opinion between teams but that PC had raised this with his manager, who advised that MH should be handed back to the CMHT. That PC had spoken with RG of the CMHT about this several times and that both (teams) had not wanted to continue to work with MH. That MH's care should have been managed by the Assertive Outreach Team, which, unlike the Crisis Team, had the function of long term engagement with service users, except that they were not taking any new cases. (This important issue is dealt with in Chapter 7 of our report)

Commentary: We noted that the information relating to the 28 envelopes containing medication was not disputed by Crisis Team members present at the meeting. This included AB, Senior Nurse Practitioner, who had been identified by SG as having been given the envelopes by her and a colleague on their retrieval. However, at a hearing with us in January 2010, AB said that she did not remember this event, although, on receipt of the notes of the RCA meeting, we became aware that she had not challenged it at the time of the RCA meeting.

Recommendation 2: The Trust should ensure that its Medicines Management Policy is understood by all staff involved in its application and strictly adhered to, with particular reference to the administration and delivery of medication to a patient in his/her own home or other place of residence. (See section, *Medication Record Keeping, in Chapter 4 for further commentary on this issue*)

Commentary: The notes made by the RCA team that PC had raised with his manager the issue of MH's discharge from the Crisis Team in 2007 contrasted with what PC stated in his verbal evidence to us in a hearing. He did not mention the reported conversation with his line manager, but stated:- *'The decision (to hand back) is made as a team, so all decisions to hand back and discharge are made in the handover meetings'*. He also advised us in respect of the fact that there were no Crisis Team records of the decision to hand MH

back to the CMHT *'Right, well that's remiss. That should be there. That was one of the functions of the handover team, to consider each person and to discuss, 'Is this person ready for discharge?' and to look at a discharge, and for those reasons to be documented.'*

Recommendation 3: All discussions and decisions concerning a patient, and other information of relevance to his/her care, must be recorded in accordance with Trust procedure and national guidance.

- That MH's hand back to the CMHT coincided with a period of absence (for planned surgery) by SG; and MH's missing appointments with AG of the Early Intervention Team. That MH was not getting the right support at the time.
- That, at the time of the hand back, there was no formal meeting between the two teams and no formal care plan was created in respect of the hand back.
- That there were strong feelings by some Crisis Team members about how they felt treated by the CMHT in terms of intensive criticism and lack of engagement with them and recognition of their role. .

Commentary: We enquired of the previous Medical Director as to the reason why the two teams were seen separately by the RCA team on different days and were advised that this was due to the significant tension between the two teams. It is fair to say that this view was not universally held by the people we interviewed but at the RCA meeting, one member of the Crisis Team is reported to have stated *'This is going to happen again and again unless the cmht and the crisis team get on with each other ...'*

The issues of tensions between the teams and the impact thereof are dealt with more fully in Chapter 9 of this report.

Commentary: Except in respect of comments and recommendations made above and the fact that the notes taken at the time of the RCA meeting were, on occasions, reduced to the point where it was not possible to make full sense of what had been said, our view was that the RCA process and report were comprehensive and professional.

Recommendation 4: An RCA panel investigating an incident of this gravity should be supported by a person, who understands the issues and is able to take comprehensive and attributed verbatim notes for greater understanding when referred to much later in the overall Investigation process.

Commentary: In conclusion, we would say that our Investigation agrees with most of the conclusions of the RCA Team, but has seen other evidence to inform our findings and recommendations.

Chapter 2

Factual summary and overview

Introduction

MH killed CJ on 4 March 2007. At Bristol Crown Court on 27 July 2007, he was convicted of manslaughter (by reason of diminished responsibility). The record states that *'The Court was satisfied that the defendant was suffering from the following forms of mental disorder within the meaning of the Mental Health Act 1983: (schizophrenia) (mental illness)'* and made a Hospital Order pursuant to Section 37 of the Mental Health Act 1983 and being subject to restrictions under Section 41 of the Mental Health Act 1983 indefinitely it appearing to the Court that to protect the public from serious harm a restriction order should be made.

Thereafter MH was, and has been, detained in a Medium Secure Unit where he continues to receive treatment for his illness. Decisions on discharge from hospital fall to the Home Secretary or the appropriate Tribunal.

MH and CJ had known each other since childhood but due to MH moving to various other areas had lost touch and became re-acquainted when MH returned to live in Swindon. They lived in the same area of Swindon, their respective homes being approximately 1 mile apart.

We provide some biographical detail of both CJ and MH in this chapter so as to present a broad impression of what they were like as people and provide some basis of understanding of the events requiring investigation. Events leading to the homicide and issues arising are summarised. Our chronology of his care and treatment is set out in Chapter 3.

We are grateful for the assistance of both families for their straightforwardness and patience in their cooperation with the Investigation process.

On the evening of 4 March 2007 CJ was with his fiancée in her flat together with a friend of hers. CJ was engaged on the computer and was listening to music when the intercom buzzer sounded. CJ answered the intercom and established the caller to be MH who was a long standing acquaintance of CJ and who was a regular caller at the address. CJ went down to the communal hallway of the block of flats to speak with MH and was stabbed 6 times by MH. CJ was taken to hospital by ambulance and was pronounced dead at 20.50 hours. Following the stabbing MH threw the knife he had used into bushes and this was later retrieved by police. After leaving the scene MH went to his mother's home and told her that he had stabbed CJ. She informed the police and MH was later arrested on suspicion of murder.

CJ: A Brief Biography

CJ was born on 7 March 1985 and was 21 years of age when he was killed by MH on 4 March 2007.

Up to the time that he was killed, CJ spent a great deal of time with his girlfriend and their young daughter at an address close to the address occupied by his parents. CJ and his girlfriend were planning to marry. Since leaving school, CJ had some periods of short term employment but had been unemployed for some 9 months prior to March 2007 and had spent time pursuing his interest in fixing electrical and computer items.

From information provided by CJ's mother, we were informed that CJ had been referred to the Department of Clinical Psychology in Swindon, and that he had enrolled on a Stress Management Course with ongoing appointments in 2006 and 2007.

CJ was variously described as being '*Happy go lucky*', '*Jack the Lad*', '*loving*' and having '*loads of mates*'. CJ and MH were part of a group both jointly and individually and it appears that they met regularly, particularly at CJ's parents' house or at his girlfriend's. CJ was also described by his older brother as being secretive, especially regarding MH. Although CJ was not informed of MH's intentions towards him through official channels, it appears from evidence we heard that he was probably aware of threats via a mutual friend of CJ's girlfriend and MH's sister.

MH: A Brief Biography

MH was born on 13 December 1986 and was 20 years old at the time of the homicide. He was generally recognised as being a pleasant boy, who was courteous, quiet and respectful although latterly he presented as being preoccupied and withdrawn at times, due to deterioration in his mental health, his behaviour then being described as anti-social and worrying.

Due to difficult family circumstances, MH lived at various addresses in Swindon, Yeovil and Cardiff, eventually returning to live with his father in Swindon. MH's smoking of cannabis prompted his father to require him to move out and he moved to live with his mother, who had returned to Swindon from Cardiff. MH has an older sister and a younger half-brother. It was due his behaviour towards his half-brother and his mother's concerns with regard to that behaviour that she required MH to leave her home and he moved into a hostel called Culvery Court on or about 1st September 2004. His sister SH also moved out of the family home at some time because of MH's behaviour towards her.

He was unemployed at the time of the homicide and reportedly had only one short period of employment in a factory.

Initial Referral

On 1 September 2004 his mother, having been concerned by his behavioural changes, which had been apparent to her for some 8 months, persuaded MH to

accompany her to their GP. This initiated MH's first coming to the attention of psychiatric services. On 1 September the GP referred MH to the GP Practice Psychologist by letter under a Problem Title '*Depressive episode unspecified.*'

Included in the history was reference to heavy use of cannabis for 12 months, allegations as to sexual assault(s) and feeling paranoid. This was followed up by a letter to the CMHT dated 10 September 2004. The Practice Psychologist made a referral to the Crisis Team asking for an assessment of MH's mental state due to '*Psychotic symptoms linked to abuse? Bizarre symptoms. Preoccupations. Paranoid*'..

In the Crisis Team record of a telephone referral from the GP Practice to the Crisis Team on 17 September 2004, reference was made to MH '*.....having thoughts of suicide and murdering person he believes abused him....TV speaking to him.*' And that MH '*... was showing psychotic symptoms, but MH does not believe he is ill.*'
(The comprehensive chronology attached at Chapter 3 sets out fully the history and commentary thereon)

Following the referral by the GP Practice, he was seen by the Crisis Team on 17 September 2004. The Crisis Team noted the reasons for referral as '*Bizarre behaviour - ? Early onset of psychosis. Expressing suicidal and homicidal ideas*'.

The Crisis Team referred MH to the Early Intervention Service (Psychology) and he was later referred to the Vulnerable Adult Unit (Child Protection).

A Care Co-ordinator from the CMHT (SG) was appointed and she became involved with MH in December 2004. In 2006 MH was also referred to, but not assessed or accepted by, the Assertive Outreach Team.

Residence

During the period under investigation, MH lived in several places sequentially. After leaving Culvery Court, he moved to Hazelmead (supported accommodation for people with mental health problems) from where he was eventually evicted; then moved to (*name*) Guest House (Bed and breakfast accommodation); and finally to M. Avenue where he lived with (G/F) who was herself a service user. In addition he had single periods of in-patient treatment in each of Great Western General Hospital, Swindon following an overdose of prescribed medication; in Applewood Ward at Sandalwood Court (Psychiatric Unit) in Swindon; Windswept Rehabilitation Unit, Swindon; and Green Lane Hospital, Devizes (Psychiatric Unit).

There were occasions throughout the period 2004 to 2007 when MH spent time and slept overnight at his mother's home.

Other Services Involved

As part of his package of care, MH had dealings with SUNS (Swindon Users Network Service); TWIGS (Providing opportunities for gardening, arts and crafts), CONNEXIONS (an organisation supporting young people seeking employment),

Swindon MIND (a charity, which provided in addition to other services, a drop-in facility in Swindon for people with mental health problems) and FLEX (for mentoring and boosting self confidence).

For there to be an understanding of how the various teams and agencies worked, particularly with MH, we consider it appropriate to formulate an analysis of the involvement of each of the teams/agencies with MH as described in Chapters 5, 7, and 8.

Treatment Episodes

There were effectively 4 periods, which we deal with in succeeding chapters:-

1. **September 2004 to December 2004** when he was under the care of the Crisis Team and the Early Intervention Service and when he was living at Culvery Court (hostel) and Hazelmead (supported accommodation)
2. **December 2004 until July 2006** when he was under the care of the Swindon East Community Mental Health Team and the Early Intervention Service, with the Crisis Team becoming re-involved on 15 April 2006. During this period, he was admitted to Great Western General Hospital, following an overdose of prescribed medication (February 2006) and was an in-patient under Section 2 of the Mental Health Act 1983 at Sandalwood Court, Swindon (psychiatric unit) (July 2006), subsequently becoming an informal patient there, and at Windswept Rehabilitation Unit. At one stage, he was living at (*name*) Guest House (Bed and breakfast) having been evicted from Hazelmead, and latterly at (*address*) with (GF).
3. **July 2006 to January 2007** when he was under the care of the Crisis Team and Early Intervention Service. His Care Co-ordinator, SG, (with effect from December 2004) also remained involved. During this time he was admitted as an informal patient to Green Lane Hospital, Devizes (November 2006) when he was living at M Avenue
4. **January 2007 to March 2007** when he was under the care of the Community Mental Health Team and the Early Intervention Service, at which time he lived at (*address*). During this period his care was handed back from the Crisis Team to the Community Mental Health Team and responsibility for his care was allocated to another Community Psychiatric Nurse (XX) as his nominated Care Co-ordinator (SG) was on leave for planned surgery.

Note: During all but the first of these four key periods, SG remained throughout the Care Co-ordinator for MH but the Responsible Medical Officer (RMO) role moved to a Consultant in the relevant service. This is usual practice.

MH's Recollections

Before dealing with each of the 4 periods referred to above it is appropriate here to report on our interview with MH, whom we visited in the Medium Secure Unit in which he is currently detained.

We saw him on 7 October 2009, some two and a half years after he killed CJ. Whilst we had evidence from his doctors of an improvement in his mental state, it was clear

to us that MH remained unwell from a psychiatric perspective. Despite this, he was quite forthcoming but he was uncomfortable and reluctant to talk about his beliefs, although he referred to them as '*peculiar ideas*'.

He talked to us about his early childhood and the various places where he had lived. He told us that the only job he had had was a Christmas job in a warehouse, which he gave up because he found it too hard (manual work), that, at the age of 15 he was '*doing*' cannabis every day and later he began drinking alcohol. He described something of his delusional beliefs and that he now recognised one of the symptoms as seeing things in his head and thinking that the person with him could hear it. He said also that he now recognised that he was very unwell whilst in (*name*) Guest House

MH had a very poor opinion of the Crisis Team in that they were not spending time with him and that they did not see what was going on in his head. He had a high opinion of both AG (Psychologist) and SG (Care Co-ordinator) but not of Dr PS (RMO), of whom he said '*Because they don't know what's going on in your head unless you talk about what's in your head, but if you can't talk about it they're not going to know, are they*'.

He also spoke of his relationship with (G/F) and reported that they were drinking every day and smoked cannabis every few weeks.

As to his killing of CJ, MH told us that he did it because he believed he had to do it - believed his beliefs and that was it. That it was not malicious. He was clearly remorseful, expressing his regret, feeling very sad for CJ, and saying that he felt '*gutted*', that it was a waste of life and that he had not wanted to hurt him (CJ).

MH also spoke to us about his overdose in 2006. At that time he had been prescribed Olanzapine and had been getting his own prescription. He had been taking only half of the medication and had hoarded 80 - 90 pills, which he took (the overdose) He told us '*.....I just thought that I'd have to like do it. That's what everybody wanted me to do for a while.... I didn't take it because I wanted to harm myself or hurt myself, I was supposed to do it*'.

As part of his psychosis, MH referred to 'RIA' (*Real I Ain't*) which he described as feeling really horrible and really awkward and annoying. SH, MH's sister, had told us in her evidence of MH referring to 'MIA' (later discovered to be RIA), some time before he committed the offence. However, MH told us that he had only had it (RIA) just before he committed the offence but that it was not the reason for the offence.

We were advised by Drs PC and SB, Consultant Forensic Psychiatrist and Staff Grade Psychiatrist respectively at the Medium Secure Unit, that such improvement as had been noted in MH's presentation had been brought about by a change of medication in the form of Clozapine, introduced some 12 months before we saw MH.

Potential Victims

We noted that, early in his involvement with psychiatric services, MH referred to an individual named (TV) on at least 3 occasions as someone against whom he was motivated to exact harm. He also referred to CJ as someone on whom he wished to exact revenge for alleged sexual abuse. From the evidence we heard, it had not been considered appropriate by AWPT to investigate the existence of these two individuals so that they could be identified and, if appropriate, warned of MH's intentions towards them.

We were able to elicit from family of MH that (TV) was probably a character from the television serial Eastenders and that there was no person of that name in MH's circle of friends and, therefore, that the existence of (TV) was part of his delusional system. With regard to CJ, despite the allegations of threats to kill, we had no evidence that it was considered prudent to establish his identity thereby missing the opportunity to locate him. It had not been ascertained by the staff of the Trust that CJ actually lived within a mile of MH in the same district in Swindon and such was the lack of enquiry that, after the homicide, it appeared to come as a complete shock to some of the professionals charged with MH's care that CJ existed and lived in such proximity.

Initially on contact with AWPT services, MH was focused on issues of sexual abuse and the desire to exact retribution on CJ, the person, whom he believed to be responsible. Although these thoughts appeared to have ameliorated during 2005, in 2006 he expressed and demonstrated a desire to harm his family, his girlfriend, an acquaintance of his girlfriend, a friend, CJ and members of the Crisis Team.

Compliance with Treatment

MH's compliance with medication prior to the homicide was at best patchy and he missed many appointments with psychiatric services. The purpose of these appointments was to monitor his compliance with medication and to assess his mental state. Although MH had received a depot injection shortly before the homicide, it was known to clinical staff that he was, and had been, non-compliant with oral medication (including a mood stabiliser) for some time before the killing. MH did not have an adequate (if any) understanding of his illness. At the time of the homicide, the diagnosis for MH was confirmed by Dr PC as paranoid schizophrenia.

When assessed by Dr PC, Consultant Forensic Psychiatrist, shortly after the offence, he was described as being *'floridly psychotic.... one of the most profoundly psychotic men I've treated Very badly damaged by his disorder'*.

In his psychiatric report of 31 May 2007 for the court, Dr PC stated of MH's treatment resistant schizophrenia *'In my view, MH was suffering from this illness at the time of the alleged offence (homicide) and I am further of the view that it directly influenced his actions at the time of the offence'*.

Some time after admission, the formulation of the clinical team at the Medium Secure Unit was that MH was a young man with a treatment-resistant schizophrenia and the medication, Clozapine, the treatment of choice for MH's condition, was then prescribed, leading to notable improvement in his health.

Issues for Investigation

In conducting our Investigation, we adhered to the Terms of Reference agreed with the South West Strategic Health Authority, commissioner of the Investigation. (These are attached as Appendix 1) The process followed involved the development of a chronology, which set out key aspects of MH's care and treatment and engagement with AWPT. This chronology, which forms Chapter 3, informed our assessments of staff and organisational practice against national guidance, best practice, national and local policies, analysis of the evidence we heard and, thereby, the development of conclusions and recommendations.

Longstanding Concerns

During the course of the Investigation, we were provided with a copy of a letter, dated 6 August 2008, 17 months after the homicide, and written by the then Medical Director, who has since left employment with the Trust. The letter is addressed to the Chief Executive of AWPT and other senior staff of the organisation, and sets out a range of concerns about mental health services in the Swindon area. The letter indicates that two homicides and a near homicide all involved to a greater or lesser degree the Swindon Crisis Team and that there were several common themes, of particular importance in Swindon:-

- Lack of good communication between the teams, '*indeed the presence of conflict and disagreement*'.
- Lack of sufficient senior continuous medical input into the Teams. There clearly are very good medical staff in Swindon but the staff particularly in the Crisis Team appear overstretched. In the ... MH case there were insufficient frequent reviews by the same senior clinical practitioners of (a) very difficult to engage, very unwell individual.
- Mental State Examinations of individuals by members of Crisis Teams are often rather perfunctory and are not well informed by a good psychological understanding of the individual. Mental State Examinations by medical staff tend to be more comprehensive but even this is not always the case. The Mental State Examinations are ... often not probing and negative symptoms and paranoid delusional systems not explored. This was a very critical issue ... (in the MH case)
- ... the lack of good engagement with families was identified as a root cause of serious problems (in all of the investigations). Critically in the absence of good Mental State Examinations, vital information held by families was not known to the teams.

The Acting Medical Director responded to this letter on 19 August 2008.

Commentary: We received this letter late in the Investigation process and it did not, therefore, inform our questioning of other witnesses. Notwithstanding, the above themes emerged as consistent issues in evidence given to us, with one exception. Our view is that vital information held by MH's mother was regularly shared by her with members of the three teams caring for MH (Crisis Team, CMHT, Early Intervention Service) but that this was not effectively communicated between teams or, where key information was communicated,

it was not given due credence by many members of staff and appropriate and necessary action was not taken. A consistent theme of our own findings indicated as late as 2010 that many of the factors pertaining at the time of MH's engagement with the service as well as those set out in the letter of 6 August 2008 were still evident. That is, up to 3 years after the death of CJ. (The Trust's response to ongoing issues in Swindon is dealt with in Chapter 10)

Chapter 3

Chronology

Introduction

The following chronology is drawn from Trust records and highlights what we consider to be key entries in those records. We examined the records presented to us relating to the Swindon East Community Mental Health Team (CMHT hereafter), the Swindon Crisis Team (Crisis Team hereafter in this report although AWPT notes also use abbreviation 'CT'), the Early Intervention Service, and hospital and ancillary documentation for the whole of the period of MH's contact with Mental Health Services in Swindon commencing in September 2004 and ending on the date of the homicide on 4 March 2007. Initially the continuous records of the Crisis Team from 22 November 2006 onwards were missing although some records for this period came into our possession later in the Investigation process (as explained later in this Report). The gaps in the record up to the time of the homicide presented problems for the Investigation. It has been possible to fill some of the remaining gaps in the chronology from the staff witness statements to the Police immediately following the homicide and to the RCA shortly afterwards. Crisis Team members were not interviewed by the Police although they had had continuous contact with MH until eight weeks before the homicide. We have sought to reproduce faithfully extracts from clinical notes but were on occasions hampered by the poor quality and/or legibility of some entries. We excluded (or paraphrased) parts of some records on the grounds of sensitivity and where doing so made no material difference. We have not amended spelling or grammatical errors in the original notes.

The records for MH are extensive and we have endeavoured to include in this chronology only matters of relevance to highlight key aspects of MH's presentation, deterioration and apparently conflicting mental state (at times from day to day).

We highlight the following consistent themes throughout MH's engagement with the service:-

1. Records indicate that MH believed that he had witnessed an incident of abuse against another child, when he himself was 9, and that he believed that he had himself been the victim of sexual abuse when he was 16. These and other references to beliefs about abuse persisted intermittently and it is recorded that MH believed at times that CJ was the perpetrator of the alleged abuse. The alleged incident against the younger child was formally investigated and found to be unsubstantiated. The other allegations were not pursued through the appropriate agencies.
2. There were regular 'markers' to indicate concerns and to trigger actions but whilst these were mostly picked up and recorded, they were not addressed in many cases.
3. Communication between the individual services caring for MH was generally inadequate, resulting in individual teams not having a full picture and failure to call a Multi Disciplinary Team meeting at critical points.

September 2004 - Initial Referral

Due to her concerns for MH's mental state, his mother (JM) persuaded MH to attend his GP practice with her where they saw Dr S (GP) on 1 September 2004. Dr S referred MH to the Practice Psychologist that day by letter under a Problem Title of *'Depressive episode, unspecified'* and included in the history reference to heavy use of cannabis for 12 months, allegations as to having been sexually assaulted and feeling paranoid. This was followed up by a letter of referral to the CMHT (Dr PS) by Dr JB (GP) dated 10 September 2004. That same day, the Practice Psychologist made a referral to the Crisis Team asking for an assessment of MH's mental state due to *'psychotic symptoms linked to abuse?, bizarre symptoms, preoccupations paranoid'*.

There was a telephone referral by the GP Practice dated 17 September 2004 to the Crisis Team where the Reason for Referral is shown as *'thoughts of suicide and murdering person he believes abused him...TV. speaking to himself and others'*, that MH was showing psychotic symptoms but MH did not believe he was ill. This referral was timed at 11.12. A copy of the psychologist referral was faxed to the Early Intervention Team (AG) on 20 September 2004.

Continued Involvement with Mental Health Services

On 17 September 2004 at 1800 hours DB (then Crisis Team Manager) carried out a core assessment which shows the reason for referral to the Crisis Team to be *'Bizarre behaviour - ? early onset of psychosis. Expressing suicidal and homicidal ideas'*. At that time MH was living in a hostel (Culvery Court). The core assessment records that *'MH appears to be very troubled about some abuse that he is unable to verbalise well. His thinking appears very disordered, and he is unable to be coherent at times. MH is obsessed by these abuse allegations but is vague and disjointed in his explanations. He made poor eye contact, was quite guarded, nervous and suspicious in presentation. He states that his sleep is "OK" he also says his appetite is fine although staff at the hostel report MH to be 'very scared and will not eat meals or socialise with other residents'. MH is desperate to confront the abuser that he talks about, he says he also 'wants to gouge his eyes out'. He also expresses a low mood and at times says that if he is unable to confront his abuser then he will jump in front of a train to end his life. MH has ensured his safety at this time.*

MH has been thrown out of his mother's house for social reasons and also due to a risk to his 6 year old brother highlighted by Social Services. He also says he smashed up a stereo + cups at his step-fathers house in Cardiff. MH believes that a DJ on the TV is pointing at him, he also has some strange and unexplainable delusions relating to "Rusk". MH also believes taking medication will show the "scar on his face" (No visible scar) and is therefore very suspicious of taking medication. (Brief reference to family history of mental illness here)appears to have used cannabis to cope with feelings.....MH has used Cannabis moderately for the past year though says he has not smoked for the past 1/12..... Mother (JM) very concerned by MH's odd behaviour'.

Under the Mental State Examination heading were recorded the following:- *'Casually dressed. Guarded and suspicious. Poor eye contact.....Spontaneous and cautious (in speech).... quite low, very frightened and confused obsessed about abuse at 9 years + 16 years "Rusk" unclear at presentPossible delusions re abuse...*

paranoid about people on the street plus in the hostel orientated to place and person able to be attentive to conversation though thoughts jump around quite a bit' The core assessment form is not signed or dated by the assessor but refers to Next Steps/Management Plan – *'ISSUES – Thought disorder. ACTION Commence home treatment – Daily visits – 10mg Olanzapine Velotabs – Administered by Crisis Team'*.

Commentary: This core assessment by DB was thorough and should have been adopted as the standard by other staff assessing MH.

The records show that the Crisis Team commenced visits on 18 September 2004, *'MH visited at Culvery Court, took meds still apparently isolating himself in his room. Slept well & appears to be eating more. MH made poor eye contact during conversation & his body language was closed and defensive. MH stated he spent time with his mum today as he does every day, he mentioned Abuse & wanting to go to the police but agreed to wait for a week to give meds a chance before making a Decision. He agreed to be seen between 6 – 8 tom'*.

On 21 September 2004, Crisis Team records stated:- *'..... MH asked us if we knew who the person is, who deals with sexual abuse, we told MH that we did not know but we would find out. He also asked to see a psychiatrist, informed that we would speak to Dr Ra'*.

On 22 September 2004, Crisis Team records noted *'T/C from (name) (friend of the family) reporting that MH had been verbally aggressive and was throwing lumps of concrete at his mother's house yesterday and this morning. (Name) had removed MH from the property several times. The police were called but MH had left and had not caused any damage. Advised we would discuss these issues with MH this evening'*.

On 23 September 2004 he was arrested and cautioned by the police for swearing at a police officer.

On 24 September 2004, Crisis Team records noted *'Joint visit to MH at his mothers house. MH calm in presentation though still very concerned about abuse. Assured he would be able to discuss abuse and police with AG, Consultant Psychologist in the Early Intervention Team, on Weds 13th 10:30. Advised to write things down as they cleared in his mind. Vulnerable adults meeting TBA on EIT return'*.

On the same date, AG noted in her records *'Went to Culvery Court with (Name) (Crisis Team) – MH had left there, but (Name) managed to locate him at his mum's house. Went there and briefly introduced myself. Explained I was about to go on leave, but arranged meeting for when I returned for 13.10 04 (sic). Agreed that we would be able to arrange for him to meet with someone from the police (via the Vulnerable Adult Team) and that we would discuss this more on my return.'*

On 25 September 2004 Crisis Team records stated *'Home visit with DQ. MH was observed taking his medication. MH still troubled by thoughts of abuse and feels that he needs to make a film (documentary) of the events to be screened on national TV & asked guidance on how to go about this. Although initially guarded, he went on to*

talk about the abuse & appeared to be preoccupied at times. MH reported that he'd spent time with his mum today, but other than that does not leave hostel. However, when we left & were sat in car – saw MH hurrying down street in direction of train station. Plan – visit tomorrow to medicate & continue assessment & continue monitoring'.

On 26 September 2004 MH was not present at Culvery Court and the Crisis Team left medication with staff and did so again on 28 September 2004.

On 29 September 2004 Crisis Team records stated *'T/C MH was confused about seeing Dr Ra. Confirmed we would visit tonight between 6 – 9 pm with medication. MH was still saying he had had thoughts of killing himself but ensured his safety and said he would be at Culvery Ct at 6 pm tonight. Advised to call us if in crisis'.*

A later entry on the same day stated:- *'21.00. Visited MH at Culvery Court MH was still very pre-occupied with thoughts of abuse etc. He also said that he knew where (name of someone confirmed by MH's family to be a fictional TV character (referred to as (TV) hereafter)) worked & had been to the garage that he works at – he didn't do anything but his time will come soon. Also – talking about suicide & not being here. The medication does not appear to be reducing any of his thoughts. Does the Olanzapine need to be increased? Need team discussion as to how to manage MH + consider full risk assessment.....'*

Commentary: records for this month establish patterns and concerns which continue intermittently thereafter, including beliefs and concerns about abuse and fragility of mental state.

October 2004

On 1, 7 and 10 October, Crisis Team left medication for MH with staff at Culvery Court; and records show that MH accepted from the Crisis Team on 2, 3 and 5 October and was reminded by them on 16 October to take his medication.

On 4 October 2004, Dr Ra (Consultant Psychiatrist) recorded in the Crisis team notes *'3 PM. I saw MH (Jr) along with his mother. Both were interviewed separately. His mother described that since childhood he has been lonely, withdrawn and introvert. His present problem started about 2 years back when he started smoking cannabis. Slowly his talk became irrelevant and his behaviour very erratic. He started saying that there is a news (sic) about him on the television and people look at him in a special way that only he can understand. He stopped seeing his old friends and has been not much bothered about his personal appearance. At times he continuously looks in the mirror and says there is a scar on his face which is not visible to anybody else. He tried 2 – 3 jobs but did not last for more than 0 weeks. The reasons are unknown of late he has been talking about his sexual abuse last year and for this he even contacted the police. . She reports some improvement in his behaviour. MH talks most of the time about his sexual molestation and wants something should be done (sic) to the person who (indecipherable word) done it. He did not express any suicidal ideas.*

On MSE MH was casually dressed. Eye to eye contact was poor. He gave very brief answers and muttered to himself at times. Mood is a little angry. His thoughts were preoccupied by his sexual abuse ideas (delusional ideas). His orientation, memory and concentration were normal. He lacked insight. Treatment Plan – to continue Tab olanzapine (20mg) daily for 2 weeks – Crisis team to visit daily to administer medicine. To contact CMHT as he is going to be under treatment for a longtime (sic). Social Services involvement’.

Commentary: This is the first examination of MH by a psychiatrist. Just over one month since first referral, the service had the following information: thoughts of murdering and or harming his alleged abuser, thoughts of suicide, concern about food contamination, fears of taking medication, pre-occupation/obsession with sexual abuse, lack of insight, delusional ideas, speaking to himself when engaged with others, family history of psychiatric problems, unhappy childhood, use of illicit drugs, Television speaking to him (thought broadcasting), scar on face invisible to others, people ‘looking at him’, social isolation and introvert, delusional ideas about sister and girlfriend, frightened and confused, thought disorder, psychotic symptoms, paranoid, and bizarre symptoms.

These are recurring themes throughout MH’s engagement with the service, albeit not all of them were constant. Our view is that an immediate full Risk Assessment should have been completed. MH was subject to the Enhanced level of the Integrated Care Programme Approach from the start of his contact with the service. However, no Enhanced Level Care Plan was formulated at this point, so that all Care Plans thereafter could have been informed by the initial Care Plan and the above information, outstanding amongst which were indications of non compliance with medication and an intent to kill, both of which transpired. Had they been completed, then the initial Risk Assessment and Care Plan should have been filed and retained in a prominent position in MH’s notes.

Commentary: Given the presentation noted by Dr Ra the previous afternoon, the Crisis Team should have explored further the details of his mental state. This is the first of many occasions when MH was apparently able to conceal issues and when his assurances were accepted on face value.

On 5 October 2004, Crisis Team records stated ‘MH warm and appropriate in affect. Said the tablets were making his thoughts easier. Took medication. Borrowed £2 for a drink. Asked about living at Hazelmead.

On 6 October 2004, Crisis Team records stated ‘Visited MH, Meds Given, he was quite (sic) & withdrawn still preoccupied with Sexual Abuse & reporting it to the police and speaking to those concerned MH admitted he had been thinking of killing himself “TO MAKE A POINT”. As he is feeling frustrated at not getting help to Report Abuse. AG to wait for this meeting before approaching family & police. MH completed Hazelmead paperwork’.

On 8 October 2004, Crisis Team records stated '*Seen at Culvery Crt, he appeared to be a bit subdued. He accepted 10mgs of olanzapine and tried to hide the other, 10mgs. When challenged he stated that he wanted it for his friend. We advised him to take it but he refused; it was taken off him*'.

Commentary: This should have triggered a new Risk Assessment. His later overdose was of prescribed Olanzapine, which he had hoarded.

On 9 October 2004, Crisis Team records stated '*T/C From Culvery Court – not been back since yesterday evening. T/C. Mother – MH has been there all night. MH returns to Culvery Court*'. A further entry on the same date stated '*Visited MH this evening with his medication, the team leader of Culvery Court (Name) said "Why do we keep going to MH every night when we can supervise his medication, she said "it made better sence (sic). I told name that I would talk to the team about it. MH took his medication and I checked his mouth afterwards*'.

Commentary: There is no record of any discussion at team level or of a formal decision to countermand the medication plan prescribed 6 days previously by a Consultant Psychiatrist or to leave batches of medication for administration by Culvery Court staff. This does not accord with the requirements of the Trust's Medicines Management Policy.

Hereafter some notes are erroneously shown as being November rather than October but are clearly in chronological sequence.

On 11 October (Shown as 11/11/04) 2004, Crisis Team records stated '*MH had not returned to culvery court yesterday so had missed medication. Supervised MH taking 20mg px Olanzapine. MH talking about taking cannabis and about seeking revenge on boy from childhood. When questioned about this became vague and giggled. Then said he wouldn't really do it. Appeared quite preoccupied, poor eye contact. Given £1 for a drink. To visit tomorrow*'.

On 13 October (Shown as 13/11/04) 2004, Crisis Team records stated '*HV. Seen MH at home. Doesn't want to talk to the police anymore. Wants to shoot (TV). When questioned further said he wouldn't kill him that he was "just joking". Given £1 for a drink. MH agreed to take his meds either before going out or to be back in time for staff to administer before bedtime. Plan: To call AG + to visit tomorrow*'.

On 13 October 2004, AG noted in her records '*Session One – at Culvery Court, with (Name, staff member) sitting in with MH's permission. MH told me that he had spent a lot of the last fortnight thinking about the things that have happened in the past. He said that he was able to distract himself from these thoughts if he was round his mums or with mates. But when he was by himself, they tended to be there. The thoughts tend to leave him confused, and a bit angry and that he felt he wanted to kill the chap (only he wasn't sure how long he would get) or maybe himself. I suggested that there may be other ways of dealing with the situation, and reminded him that we*

might be able to arrange for him to meet with someone from the police. I asked MH if he'd mind telling me a little bit about the two incidents, which he was happy to do.

MH then gave AG a description of his beliefs of abuse by CJ towards a young boy aged 6, which MH said he witnessed when he was 9 years old, and abuse against himself when he was 16 years old.

Commentary: the first instance was referred to the VAU and found to have no substance. There is nothing in the clinical notes to verify MH's belief of abuse towards himself but the notes indicate that these beliefs remained unchanged throughout his engagement with the service, albeit assuming greater prominence at different times.

Discussion then continued around domestic matters and it was agreed that, '1. I would try and arrange for him to meet someone from the police to find out what, if anything, they were able to do about the incident when he was 6 yrs old, and also to check on things like how the law would stand on sexual abuse carried out by a child, sentencing if he were to kill someone etc. 2. We would meet again to try and unravel a little about what has been going on with these more recent incidents which are more confusing. We fixed to meet at 11 am Wednesday 20th October....'

Commentary: There was limited recognition of the relationship between the content of the psychological formulation developed by AG, MH's psychotic illness and the resultant risk he presented to others, in particular to individuals, who formed part of his thinking, including CJ eventual victim of the homicide. Although AG told us that the relevant information was in her notes, was discussed in telephone conversations and in informal discussions and at meetings, the communication of this information and formulation by AG to other clinicians was critically limited.

On 14 October 2004, Crisis Team records stated '10.05. Late entry from yesterday. (Name) from Culverly Court contacted the crisis team on the 13/10/04 – concerned that Hazelmead hadn't received MH's referral as yet. MH's contract with Culverly Court expired today, but they will keep him on currently. Advised will find out re: situation and recontact (sic) them'.

A further entry on the same date stated '12.30. Visited Culverly Court gave staff 4 days olanzapine. MH was out so not seen. Contacted AG from Early Intervention Team, she will try to see MH once a week & set up a meeting with Vulnerable Adult team to resolve past issues she is next seeing Wednesday. T/C to Haselmead (sic) S/W (Name) needs Application form & core Assessment before he can interview MH'.

Commentary: Our view is that the function of the Crisis Team was not only to administer medication but also to monitor MH's mental state, which would have been very important at this early stage of treatment provision. The two draft operational policies for the service in use at the time state that the Crisis Team also provides 'intensive intervention in the community' which must necessarily be informed by regular assessment of mental state. We consider that mental state examinations in MH's case were intermittent and, at times, inadequate.

On 15 October 2004, Crisis Team records stated *'Visited MH at culvery court, MH spent all day with mother yesterday & didn't take his meds, denies current use of cannabis – MH is still withdrawn & insular, he wants to find closure on past Sexual Abuse Issues by his Birthday ie speak to other participants – agreed to see Vulnerable Adult's (sic) team & wants to move into Hazelmead. Agreed we will pursue Hazelmead vacancy and then look to hand over to CMHT. MH is due to get £1,000 from father in next few days, lent £1 & stressed the need to take meds regularly..... Application & CORE Assessment Given to Hazelmead'*.

On 17 October 2004, Crisis Team records stated *'Attempted to visit MH at 10:45, not in. No answer on Mother's phone'*.

A further entry on the same date stated *'Seen at his mothers (sic) house. His mother stated that MH is getting messages from the Television. MH spoke about killing the person that abused him, we advised MH that he couldn't take the law into his own hands, MH didn't appear to see the seriousness of this and stated that the only reason he wouldn't want to go to prison was because he would be harassed. His mother said that his father was (sic) given MH £1,000. We have advised that this is not a good idea while MH is unwell, but may be to just take £100 to buy some clothes..... we were not sure if MH should be there when (Name - half brother) was there but will check that out to be seen at Culvery Crt in the morning about 11am'*.

On 18 October 2004, Crisis Team records stated *'Visited at culvery court. MH remains delusional re. beliefs about people from the television talking to him and telling him what to do. Advised not to contact the people in connection with abuse until having spent time talking things through with Police + E.I.T. Plan: To visit tomorrow. Medication left with Culvery Court.'*

Commentary: There is no evidence that the information about people on TV telling him what to do was relayed back to the full team or to Dr Ra.

On 19 October 2004, Crisis Team records stated *'Attended to culvery court to see MH but he was reported to be out. Staff stated they "weren't sure how he was due to him not communicating with them much". A further entry on the same date stated '11.00. Arranged interview with (Name) at Haselmead (sic) 12.45 tom 20/10/04. S/W Culvery Court. agreed 1 week extension on MH's license (sic) on condition that his final extension'*.

A later entry on the same date stated *'Seen at culvery court arranged to pick up at 12.30, MH is due to see AG tomorrow but doesn't know what time. MH was preoccupied with previous events & clearly delusional talking about killing others involved by his 18th Birthday & asking if he had sex would the "mark" on his face go away. When questioned he appeared to mean the shape of his mouth when he smiles'*

On 20 October 2004, Crisis Team records stated *'Visited MH and taken to Haselmead (sic) for Interview. Haselmead want an integrated visit approach arranging visits for 19.30 this Friday & following..... to visit during day as spending time with mother. MH had a meeting with AG & spoke about past abuse issues.'*

Strategy Meeting with Vulnerable Adults arranged for Weds 27/10 13.45 at The Mall. MH spoke continuously about his Abuse Issues after the meeting up to the interview & then did not mention it during the interview. He spent time at Haselmead & spoke to a member of Haselmead staff about Abuse Issues, agreed plan with Haselmead that MH needs to be encouraged to only speak about these Issues with EIT or Crisis Team. Negotiated with culvery court extension to licence they are reluctant without a firm date but will consider if we keep in information loop'.

On 20 October 2004, AG recorded in her notes 'Session 2 – at Culvery Court MH said that he had told JE (Crisis Team) about something yesterday, and JE had suggested he check it out with me. MH went on to discuss his ongoing concerns in detail and AG agreed to carry out some appropriate research. MH said of the incident that 'he had had a bong, felt sick and dizzy, went out into the passageway and passed out. His evidence that something had happened was.....he had sharp pains in his stomach and couldn't walk; his friend looked at him and said "Are you alright?"

MH agreed that these incidents were less clear – I suggested that although he had given it much thought and drawn the conclusions he had, other people may draw different conclusions. MH was asked about talking to the police – he was not so sure now that this would be a good thing – he was worried that they wouldn't believe him or that they would think it was his fault. He felt that he needed to do something about it, as it would put Swindon on the map/on the streets – which would be a good thing. He asked again about how long he'd get for killing someone, and about extenuating circumstances. I said I didn't know, but it would be a long time. I also flagged up that if people thought he had not been well at the time he killed someone, he could end up in a special hospital for a long time. MH clarified that this wasn't a prison, which I confirmed, but said that there were locked doors and he wouldn't have much freedom – he looked quite pleased by this prospect and agreed that it would be nice to be safe. I stressed that I knew it was difficult having to be patient, but it would be better for him to go down the route of talking to police.

He later went on to talk about his friend who he now believes has taken the blame for him all these years, evidenced by the fact that he is repeatedly beaten up. Previously MH thought this was because he was a tramp. Now he feels angry that the friend must have known, but didn't tell him – he said he wanted to stab him in the face. I tried to float the idea that we draw different conclusions when we are stressed, and that he might think differently about this at a different time. I asked if we could spend some of the session filling me in on his life more generally. Family background: (MH told SG that his mother was very nice and that 'he feels closer to her than to his dad. AG recorded that 'He couldn't remember when she had split with his dad. MH said that after his parents split, he lived with his mum. Then he was in foster care twice. Then went to live with dad. In year 7 he moved back to mum down in Yeovil – it was hard starting a new school. After 10 months he moved back to dad's, where he stayed until last year. He said that all the changes did bother him at the time, but not now. MH said when he was 9 years he saw death and hated it. (couldn't get a clear explanation). At some point (Name of allegedly abused 6 year old) said to him "I know it wasn't you" which reassured him a bit. But he still felt bad as he let it happen and didn't do anything about it. I asked what he wanted to do once he was back on his feet – he said "smoke cannabis, drink, spend time with mates". I asked if he got bored, and he said he did. He did say he used to hope he could MC/DJ – interested in rap, and drum and base. Asked him if he wanted to go

ice skating with the activity group on Friday – he said he didn't feel well enough. Suggested he might like to join them another time – he said he doubted it, he was alright with his mates. Agreed to meet next Thursday 10 am'.

Commentary: This was key information obtained early in MH's involvement with the service and should have been shared with the Crisis Team. There is no recorded evidence that AG did so although this is contrary to the Trust's guidance on Risk Management.

On 20 October 2004 AG completed a form to make a referral to the Vulnerable Adult Unit. The form recorded inter alia MH's description of his beliefs of abuse by CJ against a 6 year old boy, that MH was frightened that they blamed him; and that there were no witnesses'.

On 22 October 2004, Crisis Team records stated '*Took MH's medication to Culvery court. They informed me that MH has an appointment to visit hazelmead today. I asked JE (Crisis Team) about it and he told me that is was at 7.30 this evening and he is making his own way there. MH was at his mother's this morning'.*

On 23 October 2004, Crisis Team records stated '*Visit to Culvery Crt but MH not there. Hazelmead contacted to find out if MH visited them last night, but he hadn't. To be followed up on Monday'.*

On 26 October 2004, Crisis Team records stated '*T/C. Attempted to visit MH at his mother's as planned. MH contacted at Culvery Ct, impressed upon him the importance of staying in until he is collected for his visit to Hazelmead this evening'.* A later entry on the same date stated '*Visited MH at home. MH continues to express thoughts re: past sexual abuse and rape experienced. He discussed he is responsible for putting Swindon on the map and talked about wanting to go to Wales and be part of the (unreadable word) who control (name of major city . MH is concerned people won't believe him re: the abuse/rape and doesn't wish to talk to the police. Advised that it would be best to talk about this once his thoughts were more settled. He agreed to do this. MH's parents expressed concerns re: him becoming aggressive and spending all his time at mother's home. Arranged to visit this afternoon for education.....'*

There is no record of this planned afternoon visit but a further entry on the same date stated '*Picked MH up this evening and took him to Hazelmead for the evening, he was to find his own way back'.*

On 27 October 2004, Crisis Team records noted '*Attended Early strategy meeting with AG and Child Protection officers. In view of MH's repeated distress re. abuse issues at a younger age it was felt that an interview should take place to ascertain the facts. Child Protection Officer will phone tomorrow afternoon to arrange visit to interview. Interview will be videoed'.*

Commentary: There is no corresponding record in AG's notes, or note of the extent to which the meeting familiarised Crisis Team members with the content of MH's thinking as previously recorded by AG.

On 28 October 2004, AG recorded new information in her records 'Session 3. Told MH about the meeting with the Child Protection officer yesterday, and outlined that he would like to meet with MH and, if MH agrees, to do a video interview. MH said he was pleased this was going to happen. He would like (name of alleged abused child) to get some money. I said I wasn't sure whether that would happen or not. MH said he often feels weird/different/batty..... I asked if I could ask him some more about the assault when he was 15 or 16.

AG then recorded MH's description of the assault, which he believed had been made on him at a time when he had been smoking cannabis with a group of friends. This included MH's belief that CJ had been the perpetrator of the assault. There is no record in the notes to indicate that this was referred to the appropriate authorities. AG's record continued:- *MH has smoked a lot of cannabis and bongs since thenOn a later occasion, his friends said "It occasionally shows when you are angry or frightened" He assumed they were talking about his friend (Name of girl in (name of city)) who had been raped but now realised they were talking about him and the scar. He met up with CJ again when he was 14 years old – CJ was intimidating him I also showed MH some information I had printed off the internet I said I would type up a summary for him. We agreed to meet next Thursday'.*

On 29 October 2004, Crisis Team records stated 'Collected from Culverly Court and taken to Hazelmead House.....'

On 30 October 2004, Crisis Team records stated 'Made T/C to Hazelmead and spoke to (Name) –she gave feedback on MH's stay there yesterday. She reported that MH integrated well with the staff and patients. He asked appropriate questions and spent some time in the lounge watching TV. Overall positive feedback'

On 31 October 2004, Crisis Team records stated 'Called to Culverly crt to take MH to Hazel Mead (sic), MH was out – staff said he was at his mothers, tried to contact mother by phone, but unable to. Message left for her. Hazel Mead informed to be followed up tomorrow'.

Commentary: This month saw lack of monitoring of medication compliance and mental state. There were references to killing and harming his alleged abuser. We were concerned that there is no record by AG that she made any attempt to identify CJ and his proximity; or to establish whether TV was a real person or the extent of contact between MH and these individuals.

November 2004

On 2 November 2004, Crisis Team records stated '14.00. Visited MH at Parents S/W Mother agreed plan as follows: (1) Allow MH to visit AM ONLY. (2) Take MH to Hazelmead DAILY. (3) IF UNABLE TO TAKE MH contact C/Team. She will visit with Hazelmead tom to see place. INFormed (sic) MH of Pending Police Interview, MH agreed with plan. S/W (Name of staff member) happy to take MH on permanent basis 8/11 if sticks with plan. S/W culverly court to ask for time extension until morning of 8/11 they unable to give answer as yet'.

On 3 November 2004, Crisis Team records stated '13.00. Visited haselmead (sic) with mum & stayed on after, culvery court have agreed small extension until 8/11, 20.00. medication dropped at culvery 3 days'.

On 4 November 2004, Crisis Team records stated '13.30. Taken to Haselmead (sic), informed of visit by AG at 3 pm. Settled in presentation£2000 from his dad & was talking about going to the bank & drawing £1k in cash, talked into not doing this & using his Debit Card. Informed AG of above. Haselmead happy with progress so far appropriate when visiting. MH will visit first thing tomorrow morning.'

On 4 November 2004 (clearly wrongly dated in records as 4.5.04), AG recorded a lengthy session with MH in her notes. This included 'Session 4 We acknowledged that it was hard for him growing up - MH found it "definitely tough" when he was 11-13 years old. He only spoke to her (His mother, JM) on the phone and missed her a lot. He had two spells in foster care but otherwise was with his dad..... MH says he is really close to his mum – he is very pleased that she has said if he gets really well again, maybe in a year or two, he could live with her again. We talked a little about mental health and recovery..... MH said he is starting to feel more relaxed with things though he still gets freaked out by seeing "Russ" or "Rusk" as it means he has to do something. I tried to introduce the idea that sometimes the brain is misleading when its (sic) been stressed in the way his has – MH said that he knew this and his mother told him clearly that things weren't true, only in this case they were.....'

On 7 November 2004, Crisis Team records stated 'Visit at culvery court. Brighter in mood states his thoughts are less distressing. Advised of interview with police re abuse issues. Interview on Wed 10th Nov at 10.30 am at Central Police station. AS to attend with MH'.

On 8 November 2004, Crisis Team records noted 'Visited @ Culvery court. Assisted to remove his remaining belongings to Haselmead (sic), taken to princess Hse to complete p/w (paper work) MH was settled in presentation & slightly more relaxed than of late. Pleased to be moving into Haselmead spent c £800 at W/E buying (indecipherable) TV/stereo/video & clothes – MH spoke about Abuse Issues in vague terms pleased about appointment with police on Wednesday @ 10.15. Has meds until Thursday @ Haselmead'.

On 10 November 2004, Crisis Team records stated 'Attended Police Station to give interview re. abuse issue between two acquaintances in childhood. MH was video interviewed by (Name), police officer with Child Protection and Vulnerable Adult unit. MH was able to give a clear & concise account of events. Was happy and relieved to be able to give his account of what happened. In view of what was disclosed (Name – police officer) will have to discuss with his managers & team to ascertain what to do next. (Name – police officer) will inform the team of the outcome'.

Commentary: records show that these allegations were never substantiated.

On 11 November 2004, AG saw MH and recorded inter alia 'MH had done the video interview – said it had been alright and he was glad he'd done it. Some of the questions had been difficult but he'd said what he could remember. He had been

wondering about something (Name of police officer) said – he'd asked how MH would feel about going round to (Name of mother of 6 year old allegedly abused) now – he hadn't answered at the time. He wasn't sure that he meant. However, he'd like to see him again soon and would be prepared to go with (Name – police officer) to visit (name of mother) if that is what he meant. I said I'd try to get hold of (Name – police officer) In general he said he felt easier now that the interview was out of the way.

It makes him sick to think that CJ might get away with it..... (name of DJ (DJ hereafter)) – a DJ on the drum and base scene with a name of (DJ). He witnessed abuse and years down the line went to court and both he and the victim were awarded money and the right to do anything. He knew about this because (name) had told him. Also he'd seen it on a rave video where (DJ) told how he'd got to be a DJ. MH hopes that he will get money and the right to be a DJ through taking things forward about (Name of 6 year old allegedly abused)' During this session MH made reference to other suggestions of past events of a sexual and aggressive nature.

On 15 November 2004, Crisis Team records stated 'Visited at Culvery Court. MH pleased to be at Culvery Court. He feels his thoughts are clearer and now he has told the police about the abuse is not thinking about it as much. MH admitted to buying and smoking 1/16 of cannabis resin – advised about the dangers of this – MH admitted to feeling paranoid after so says he won't use anymore. Culvery Court staff will support MH to change GP (so his medication can be organised through them) MH needs a "sick note" so he can get his income support. Plan To visit between 3 – 5 pm Wednesday.'

On 18 November 2004, AG, recorded inter alia in her notes 'MH was concerned about whether the police should talk to CJ and whether he should have raised it at all. He seemed very agitated and said that he had felt anxious and panicky since last night. MH said he wanted to get a street name – a tag – and that he wouldn't get it if the police talked to CJ, and he wouldn't be crowned. I asked about this and he said you could put a crown on your tag if you had killed someone and got away for (sic) it, or if you had been let down. He would also have "elib" on his tag. I asked how you got a tag, and said I thought it was something that people chose themselves and made up their own design for. MH said most people got given them to show for something they had done. If he was choosing (sic) his own tag, he would go for (Name) or (Name). I asked MH if he had seen CJ – he said he had seen him for five minutes, although he hadn't talked to him. He was worried that he would be beaten up – if he were blamed for what had happened. He wanted to speak to (Name of police officer) to find out what he was going to do. I said I'd try to speak to him but reassured MH that they were unlikely to barge in with hobnailed boots. He had been thinking again about going round to (Name of mother of allegedly abused 6 year old) – he thought this would make it safer. I advised against this and said that it might corrupt the evidence when the police got to speak with her. Fed back about my research into DJs and gave info to MH. MH went on to talk about a party he had been to when he was 14 years of age – the DJ (DJ) had come at the last minute..... he had had some cannabis. He said this often left him feeling bad the next day, and did perhaps explain why he was extra tense today.'

On 19 November 2004, Crisis Team records stated *'T/C. MH at his mother's today feeling good and not wanting a visit. Will call us over the weekend if needed. Plan to visit Monday.'*

On 22 November 2004, it was confirmed by the CMHT that SG would be Care Co-ordinator. Later that day SG contacted the Crisis Team, informing them that she was currently off sick but would speak with Early Intervention Team, read Crisis Team notes and arrange handover.

On 23 November 2004, Crisis Team records stated *'Home visit at Hazelmead. MH's presentation doesn't appear to have changed much – still talking about abuse as a child and DJing/being a professional footballer if awarded compensation through courts for above as he'll deserve it? Couldn't when I questioned him explain what he meant by this. Currently spends most of his time going to his mum's. Eating microwave meals currently, but agreed to engage with Hazelmead staff to do his shopping when he gets his money + to do some cooking with him on another day. T/C – message left for AG to ring us with an update. Appointment made for MH to see Dr Ra on Friday 25/11/04 at 1pm – message to this effect left on answerphone at Hazelmead advising of appointment & asking if they can bring him here'.*

On 25 November 2004, Crisis Team records stated *'MH was seen at Hazelmead noted to have made some improvement, however he admitted to smoking cannabis a few days ago. He stated he wanted to withdraw his statement he had made to the police. We discussed the pros & cons and advised (sic) to discuss with AG tomorrow. AG made contact she suggested that his medication be reviewed tomorrow because he still has the delusions'.*

On 26 November 2004, Dr Ra recorded in the Crisis Team notes *'MH came with an attendant from Hazlemead (sic). He had no particular complaints. He looked calm and co-operative and sat comfortably throughout the interview. He told me that he sits in the lounge and cooks sometimes and visits his mother every other day. He was satisfied that police was looking after his child abuse complaints; he told me that he plans to work with "Twigs" and live with his mum in future. On MSE he did not show any hallucinations or delusions. His mood was normal. Plan:- To continue Olanzapine 20 mg daily. He already has an appointment with CMHT so Crisis Team can hand over him to CMHT'.*

Commentary: AG made no corresponding record of her contact to the Crisis Team and Dr Ra appears not to have had reference to the relevant Crisis Team entry and would therefore have been unaware of AG's concerns about MH's continuing delusions and the need to review MH's prescription. It was not clear to us whether MH had adjusted his presentation to AG and Dr Ra respectively, but the verbal evidence of his mother and later recorded engagement with the Crisis Team indicated that he was able to control his presentation of psychiatric symptoms in certain circumstances, particularly if only superficial enquiries regarding his mental state were made.

On 26 November 2004, AG recorded inter alia in her notes *'.....we talked a little about the mark on MH's face – MH felt that when others saw it they would think he (was an abuser)He remembers (name of young boy whom he believed to have*

been abused)) saying "I know it wasn't you" He says his mum says she cant (sic) see anything – he thinks perhaps some people can and some people cant (sic). He thinks that (mother of the subject of alleged abuse) might be able to see it and might think that something bad has happened to him, but not know what...’.

December 2004

On 8 December 2004, SG, CPN in the CMHT, took over as Care Co-ordinator for MH and met with him, KO (a member of the Crisis Team), and two members of staff from Hazelmead House (supported accommodation where MH was now living). SG recorded in her notes *‘Due to not having yet received any information re MH the Current plan will be:-*

CPN to visit 1/7(i.e. weekly) Continue with Olanzapine 20 mg nocte. For myself to supply scrips and assist MH to fill dossette box. To continue work with Early Interventions Team (AG) Book review with Dr PS (CMHT Consultant) Book planning meeting with Hazelmead staff CT to discharge MH from their team. However they will supply his prescription for another 2/52 (2 weeks) in order for me to organise it’.

Commentary: There is no corresponding record of the handover in the Crisis Team notes for that date. Whilst the Trust’s current Records Management Policy did not provide detailed and practical guidance to staff, the national policy ‘Records Management: NHS code of practice’ makes absolutely clear the importance of completeness of recording. The failure by the Crisis Team to make a record was a significant failing and contrary to the Code of practice.

After the handover from the Crisis Team, SG saw MH on four occasions in December 2004. On 15 December 2004 he reported to her the two incidents of alleged sexual assault. In referring again on 30 December 2004 to the two incidents, MH told SG that his friends had told him that he should kill the man he accused and that this would allow him to be crowned (but that he would not do so as he did not want to go to prison) There were reports by him to SG of allegations of sexual abuse, aggression, killing and delusional beliefs on some 12 occasions. Whilst he appeared to be compliant with medication there were issues of compliance with his treatment plan in that he did not attend Keywork Sessions on 8 occasions.

In a session with AG on 10 December 2004, MH asked AG if she knew about schizophrenia. She recorded *‘He had been worried that he had given some boys schizophrenia when he was 9 years old through the way he had looked at them. I outlined key symptoms of psychosis to him, a stress vulnerability model, and something about recovery. We drew some of the stresses he had experienced to illustrate this, and discussed stress and cannabis as key triggers’.*

On 22 December 2004 AG recorded in her notes *‘MH seemed to have a higher level of unusual beliefs today - Said that they have painted the benches on the new platform at Swindon station blue – thinks they have done it for him – he likes trains and blue.’*

January 2005

MH was subsequently seen by SG and AG for what were described as Family, Keywork and psychology sessions, as well as other appointments. In January 2005 AG had six meetings with MH although one other intended session did not take place due to an administrative error. On 4 January 2005, AG's record includes in respect of MH's concerns about rape, that he said '*CJ made me do that so he could look at me, which helped him and made the thing go on his face – made him like he is now I imagine his eyes must be different it had a positive effect for him, but a reverse effect on me*'. She recorded also '*MH says he has changed a lot – he no longer worries about how he looks. He used to be concerned that he had a long face which was different to other peoples. (DJ) has a similar face, but it is less now that he has been raped/grown up. MH would still like to kill CJ for taking away what he should have had (DJ/MC) and for touching him. He thinks about it every morning – the mess that it has created – only for a few minutes, then he gradually gains control of it.*'

On 13 January 2005, SG saw MH and discussed a possible DJ-ing course, which MH declined, SG recorded '*MH went on to talking about (DJ) who's a DJ, he believes that he has also witnessed and a victim of a sexual abuse. MH believes on a video of (DJ) he points at MH and this means that it has happened. Attempted to explore the possibility of this however MH is fixed on those beliefs. MH also believes he caused one of his friends to be schizophrenic as he stared at him*'.

On 19 January 2005, AG recorded MH as saying '*Thinks about the rape in the morning – thinks of what he could be doing when he puts his music on*'.

On 27 January 2005, SG saw MH and she recorded inter alia '*MH's belief pattern is still disturbing, he was talking about "killing" CJ and that all his friends were telling him to, continues to believe that if he was to carry this out he would be "crowned". At present he doesn't feel he would act on these thoughts due to the risk of imprisonment. Spoke about the risks and dangers of these beliefs, unsure as to whether he accepted these.*'

Commentary: Throughout this four month period, MH was continuing to express fantasies of killing CJ and others; exhibiting delusional homicidal and sexual ideas; and repeating his belief that he had the ability to give people schizophrenia. This continuing pattern was known to both SG and AG.

February 2005

On 1 February 2005 SG saw MH at Hazelmead for a planning meeting. She notes:- '*APPEARANCE – Well groomed, appropriately dressed. BEHAVIOUR - Poor eye contact at times. SPEECH – Limited conversation, answers questions unable to elaborate on conversation. MOOD – 'Feels fine'. No obvious signs of depression although is quite (sic) and appears withdrawn at times however reports from his mother state he's always been like this. HALLUCINATIONS – Denies. DELUSIONS Some bizarre thought patterns present. Alleged abuse? MH believes if he was to kill CJ (alleged abuse against) then he would be "crowned". Also believes (DJ) points at him on a video – this is because he has also witnessed abuse (ideas of*

reference). He also has very strong feelings that he caused a friend of his to develop schizophrenia, despite information discussed MH continues to believe this. Delusional beliefs set around alleged abuse. Friends telling him to kill CJ. THOUGHTS -Denies thoughts of self harm, however when talking with his mother she said that MH has spoke (sic) about killing himself by throwing himself in front of a train, he has been to the train station and sat watching the train. When questioned he denied having these thoughts any more stating he was messing around. SLEEP – No problems, settled finds Olanzapine helps. APPETITE – Eats 2 – 3 meals a day, microwave meals, however work with staff to prepare alternative meals INSIGHT – Poor. MEDICATION – Olanzapine 20mg nocte. No side - effects reported’.

On 8 February 2005, SG completed a referral form to the VAU.

In February 2005, 5 entries are recorded by AG in notes, one of which shows the date only. On 11 February 2005, MH is reported by AG as observing rules set in the previous session and she also recorded ‘He wants to show me a photo of himself in year 7 as he thinks that the abuse shows on this went to the “Coping with Psychosis” workshop - it was interesting - sometimes seems like people can hear his thoughts – for example in the car he thinks to himself, “You can hear that”’.

Following a Family Session on 17 February 2005, AG recorded in her summary of the meeting ‘He had mentioned CJ on 3 occasions. On one, he had simply said that he would not mention it. On another, he said, “I don’t hate CJ but I’m going to kill him”. On the third, he was demonstrating to his mother and sister with a kitchen knife how he would cut CJ. – he said this was a joke’. She recorded also that JM said that, ‘MH teases the cats’.

On 18 February 2005, AG recorded JM as reporting in a telephone conversation ‘She is not sure how much more she can take..... MH had offered his (brother) his Olanzapine’.

On 21 February 2005, AG recorded ‘Talking about CJ, MH doesn’t think he will kill him – wishes he’d die. Talking about it makes him feel stronger’.

Commentary: We had no written or verbalevidence to indicate that AG took any steps to establish the identity and location of CJ in the context of these threats. We were concerned that AG did not explore the exact nature and impact of these comments made by MH, in particular the need to differentiate the risk MH posed to others if he was articulating threats towards a known individual with whom he had contact, as opposed to a fictional character, who formed part of his delusional thinking.

March 2005

On 1 March 2005 SG carried out an ICPA (Care Planning Approach) Review with Dr PS. A full Core Assessment was to be completed. This was the first occasion that MH was seen by Dr PS although Dr PS would have been aware of MH through discussion with SG and at regular team meetings. The clinical notes contain a Core Assessment completed by SG. It is undated and does not contain any new

information of note, any medical note, mental state examination or diagnosis by Dr PS.

Commentary: If Dr PS had had access to any existing clinical information, in particular the information documented by AG, then in our view he would have had sufficient clinical information to formulate a formal diagnosis of schizophrenia.

On 3 March 2005, SG saw MH and recorded '*Thoughts of killing CJ still occupy his time however he stated he will not act upon this*'.

On 17 March 2005, there was a Family Work session organised by AG, with a view to developing a relapse prevention plan. The records show that this was not completed but deferred to a future meeting. A further meeting on 31 March was cancelled. The plan was finally completed on 13 May 2005.

On 24 March 2005 SG recorded that '*MH appeared slightly elated, laughing inappropriately. Delusional belief pattern remains unchanged, he no longer fears going to prison as he believes that he would be fine, he would "beat" someone up and be "crowned" in prison and become the "leader" and the hardest person in Swindon. When questioned about these thoughts, they were fixed and I was unable to allow him to see from another perspective*'.

On 31 March 2005, SG recorded that MH reported to her that '*when in crowded places he becomes paranoid, he couldn't identify exactly how he felt only that he was uncomfortable*'.

April 2005

In April, MH attended a Family Session with AG and SG (recorded respectively by them as occurring on 16 and 15 April). On that day, SG provided MH and JM each with a copy of the ICPA Care Plan completed after the meeting between Dr PS and SG on 1 March 2005. The Plan highlighted the following risks: psychotic symptoms and delusions; use of illicit substances; disengagement from CMHT and Care Plan; non compliance with medication; and abuse allegations.

May 2005

On 6 May 2005, AG saw MH and recorded '*MH was talking about his anxiety going into town in the main part of town he feels that people are looking at him and talking about him. He thinks that they all know about CJ and (name of alleged subject of abuse) and that they all want him to do CJ in. This applies to people in Swindon and (another city) – he thinks they have heard through rumours – not everyone will know his name, but they will all know about him..... he said that he just knows*'.

On 13 May 2005, AG recorded that they had finished off the Relapse Prevention Plan by agreeing actions to take, should there be problems. Also, on 13 May 2005, SG recorded having received a telephone call from Hazelmead staff informing her of an incident between MH and another resident '*Have been behaving "childish", play fighting. This led to MH biting RW badly on the arm*'.

On 24 May 2005, AG recorded the identified progress by MH, which included *'Stopped cannabis'*.

During May 2005, MH failed to attend 2 Keywork sessions with SG.

June 2005

On 9 June 2005, AG recorded *'rehearsed the reasons for not killing CJ (as part of the Relapse Prevention Plan)*. Also, *'MH reported his anxiety about going into town and when passing a group of kids/young adults "they're probably thinking we're going to break your legs because of the CJ/(name) stuff."*

MH had not attended Keywork sessions on 2 and 6 June but at a Keywork session on 14 June 2005, SG recorded that MH reported *'Things are going well although he still feels paranoid at times also when he listens to music he starts to think about killing CJ. He states that he will not act out on these thoughts'*. She also recorded a plan, indicating continuation of current treatment approach.

On 17th June 2005 AG recorded that *'Drinking - this seems to be creeping up'* On the same date, both AG and SG recorded, albeit with minor variations, that MH's mother's relationship had broken up.

On 22 June 2005, AG recorded *'MH had a warning at Hazelmead following his behaviour after he had been drinking.'* On that date, the Relapse Prevention Plan was rehearsed with MH.

On 30 June 2005, SG recorded that *'I have received a letter from MIND stating MH has been band (sic) for x 2 wks for unsocial behaviour.'*

July 2005

On 6 July 2005, MH met with AG, who recorded *'Rehearsed relapse prevention plan. Gave copy to staff'*. AG also records *'MH hasn't seen any groups of youngsters; he thinks that they may be avoiding him, or that they quite admire him at the moment and are keen for him to get the crown, which will mean all the problems in Swindon can be sorted'*.

On 7 July 2005, SG saw MH at Hazelmead and recorded that *'MH appeared stable in mood however laughed at times inappropriately'*.

On 18 July 2005, SG received a telephone call from Hazelmead and she recorded *'They have had to give MH a 28 day eviction notice due to his behaviour over the weekend. He returned to Hazelmead "drunk" and became threatening to others, he was throwing bottles and assaulted (sic) other residents'*.

On 22 July 2005, AG had a Family Session with MH and JM and recorded *'Drinking – MH had a warning at Hazelmead following his behaviour after he had been drinking'*. On the same date SG saw MH at Hazelmead and discussed the incident with him and that his behaviour was unacceptable. She recorded that *'MH showed*

little remorse' She also discussed MH's alcohol intake with him and *'On this particular day he had drank (sic) x9 cans of lager'*.

Commentary: This period shows a marked deterioration in MH's behaviour, including increased drinking, in the context of increasing fragility in his family circumstances. There is no evidence of consideration of a referral to the Drug and Alcohol service, or referral for psychiatric assessment by Dr PS.

August 2005

On 2 August 2005, SG recorded having received a telephone call from JM *'She informs me that MH had exchanged his TV for a knife, which he is keeping in his room at Hazelmead. She didn't know what to do and she didn't want him thrown out of Hazelmead. She became tearful. Reassurance given. D/W RG (CMHT Team Leader), advised to contact the Vulnerable Adults Team.'* SG did so on that day and recorded *'T/C to VAT spoke with (Name 1 VAU). Informed him of the situation, he has advised that I d/w Dr PS and see MH and find out if there is any intent to use the knife and for what purpose he has it. Informed him of MH's thoughts about killing CJ by "slitting his throat". I will contact when further info obtained. T/C to CM (Hazelmead Manager) Informed him of current situation, I will see MH at 2 pm with CM. D/W Dr PS, advised that I go and see MH and discuss the situation in order to obtain all the details. Went to see at Hazelmead. CM believed MH was in his room however he had gone out. CM stated he would talk to MH on his return and inform me of the outcome'*. She attempted to follow up this matter with the Vulnerable Adult Unit on a number of occasions but without success.

On 3 August 2005, SG recorded *'T/C received from CM, he had spoken with MH yesterday PM. MH stated he had not exchanged his TV for the knife, he had sold his TV to get money. A friend of his then giving him the knife. He stated he had the knife to peel potatoes with and denied any intent of any other uses. Questioned RE killing CJ denied there to be any link between the two. The knife itself was a small oriental knife, MH agreed for CM to keep it in the office safe. Plan: 1. D/W (Name 1 VAU)R 2. See MH on 4/8/05 3. Contact JM'* (Contact with JM was duly made) *'T/C to (Name 1 VAU) no answer, no answering machine to leave message'*.

On 4 August 2005, MH did not attend the planned meeting with SG. A new appointment was made for 8 August 2005 when SG saw MH at Hazelmead as planned and recorded *'Spoke about the incident with the knife. He assured me it has nothing to do with CJ and that it was for peeling potatoes. Denied thoughts/plan for causing any harm to CJ. Continues to abstain from alcohol.'*

On 9 August 2005, SG discussed with Dr PS the current situation and the resolved problems with the knife and she recorded:- *'T/C to (Name 1 VAU) no answer'*.

On 31 August 2005 SG recorded *'T/C received from SC, they have discussed the subject of MH taking responsibility for his medication. I felt this was a positive step forward so was in agreement with this. Discussed with AG'*. There is no corresponding record by AG. On the same day, AG recorded that MH *'had not been to TWIGS, has been to MIND and to mums. Also went to Weston with MIND. Alcohol – Monday – 2 stellars'*. She also recorded *'Talked more about the paranoia – a*

feeling in his body – body shaky/shivery, tummy a little bit churning. Hasn't had it for a while. Paranoid re self – self aware. Sometimes worried that people are watching him'.

September 2005

On 7 September 2005, SG took MH to Connexions and she reported that it was agreed *'That he would try the first option, which is to meet weekly for one to one sessions with an adviser to discuss in depth hobbies, interests, possible work'*. SG completed a Common Referral Form to Swindon Occupational Partnership.

Commentary: This Form was not dated but was annotated 'new form from 7 September 2005'.

In that form she disclosed under the heading *'What do we need to know about your client's physical and mental health?'*

Physical... N/A Mental (e.g. nature of illness) Psychotic episode. Drug or alcohol dependency – History of Cannabis misuse + alcohol, using small amounts at present'.

Under the heading *'Please indicate below anything in your client's history or current mental state which may give rise to potential risks or dangers either to themselves or to others'* SG noted *'When MH's health deteriorates his behaviour becomes very erratic and at times aggressive, no incidents of violence with the in (sic) general public, however has 'hit' family members which he has tried to rationalise. At the end of this form the following appears 'Please attach a copy of your client's Care Plan and Risk Assessment (where applicable).'* There is no indication as to whether a copy of any Risk Assessment was attached to this form.

Commentary: There is no evidence that a either a Risk Assessment or appropriate risk management plans had been completed, either routinely or in response to the persistence of delusions and threats at a time when MH was known to have been drinking, at times excessively.

October 2005

There were arrangements for Family Work and Keywork Sessions with AG and SG and SG maintained contact with MH..

On 31 October 2005, SG recorded that she had been informed by staff at Hazelmead that *'MH had returned to Hazelmead one night "drunk" he was verbally abusive to another resident there and refused to go to his bedroom. They are unsure as to what will now happen but they will keep me informed'.*

November 2005

On 7 November 2005, SG recorded that discussions took place between her and AG *'We both felt that if MH were to be evicted (from Hazelmead) that Queen Victoria House would be a good place for him. AG has already discussed this with MH'.*

There is no corresponding record by AG but on 8 November 2005, SG recorded *'Referral completed and faxed for Queen Victoria Hs'*.

On 10 November 2005, SG recorded *'Message received on answering machine from overnight. I rang the number back and it was MH's mother, JM. On the message it was JM screaming at MH to get out'*.

On 11 November 2005, there was a Family Work session from which SG recorded *'Problems 1. MH's attitude to his Mum sometimes is very negative 2. Getting bored when at Mum's 3. (Symbol denoting increased) drinking leading to negative behaviours.'*

An appropriate plan was developed by SG. AG's record of the meeting was significantly less detailed than that prepared by SG.

December 2005

On 7 December 2005, AG recorded having received a telephone call from JM *'things not going very well – MH has been behaving badly when visiting – calling her names all the time, never saying "thank you". She gave him his Christmas presents and he said that they were rubbish. Has his meals, goes through her cupboards and takes what he fancies. She gives him money and it is never enough. He gets stropky. She feels that he hates her and is making sure she knows it. "I've lost the son I had"'*.

January 2006

On 27 January 2006, AG met with MH and recorded *'Alcohol – on Wednesday. Drank 6 pints. This was the first time he had drunk in 3 weeks – he noted it affected him more quickly.....On a last warning from Hazelmead'*.

Commentary: There is no record of discussion of renewed alcohol use with SG or of consideration of a referral to the Drug and Alcohol team or of the need for a thorough review of the risks MH presented in terms of a Risk Assessment. There is no record of a Multi Disciplinary Team meeting. These constitute serious policy failings.

SG saw MH on a total of three occasions in January 2006. On 31 January 2006, she saw MH for a Keywork Session and CPA Review. In her contemporaneous notes SG recorded *'MH's mental health appears stable at present, no psychotic phenomena present.'* PLAN- CPN to visit 2/52 Continue current medication Olanzapine 20 mg nocte MH to continue visiting family weekly Socialising with others Attending MIND/Fishing Engagement with FLEX's (Name) Work on budgeting skills with (Name) Monitor mental state Benefits to remain at £120 Incapacity 1/12 DLA £32.20 per week Support/advice/encouragement'.

The Care Plan Review dated 31 January 2006 and signed by MH and SG sets out MH's views as *'MH feels settled at Hazelmead, despite a few problems good relationship with staff. Happy to continue on current medication'*. Staff and others' views are recorded as *'Feel his mental state has settled however his alcohol intake*

has caused several problems. They would also like him to participate in more activities’.

February 2006

A record made by AG on Friday 10 February 2006 records ‘MH *not there*’.

On Saturday 11 February 2006, MH was admitted to Great Western (General) Hospital, Swindon, at 23.30 hours having taken an overdose of Olanzapine. It was reported by the ambulance crew that 48 x 10mg tablets were unaccounted for. MH remained in hospital until discharged at 17.20 on Tuesday 14 February 2006.

The hospital record of admission recorded ‘...*apparently distressed and agitated and hitting nursing staff ... no bloods obtained due to patient (sic)*’.

A Contact Sheet completed by the Crisis Team on 12 February 2006 at 02.50 records under Nature of call ‘*T/C from AAU – wanting details of NOK (next of kin) for MH. Found at Hazelmead early evening, ?fitting. 2 x empty boxes of Olanzapine found next to him, so ?O/D. I contacted Hazelmead for info: NOK Mother – JM*’. In the section of the Contact Sheet headed Advice given is recorded ‘*I called at 0.600 – more stable now but showing signs of Neuroleptic Malignant Syndrome*’.

Further records relate to a discussion with MH’s parents on 12 February 2006 and stated ‘*MH’s parents (separated) they report MH was diagnosed as schizophrenic 18/12 ago at which point he had florid symptoms, paranoia and also suicidal ideation (wanting to throw himself under a train). Psychosis was cannabis induced*’.

Commentary: The information given by MH’s parents is not reflected in AWPT clinical records and, at this stage, no formal diagnosis of MH had been made by medical staff in AWPT. This did not occur until 6 months later and was a differential diagnosis by a junior doctor (SHO). This differential diagnosis was not followed up and the opportunity to confirm the diagnosis and to consider more appropriate treatment and medication at this stage was missed.

The record of discussion with MH’s parents stated ‘*They understand that he will need an assessment in due course, prior to discharge.*’

On 13 February 2006, SG recorded in CMHT notes ‘*Informed by colleague that MH has been admitted to GWH at the w/e following an overdose. T/C to Hazelmead informed that MH was found on 11/2/06 in his bedroom on the floor ?fitting. Empty boxes of Olanzapine on the floor. They report MH was seen on the Friday night approx 11.30 pm drinking cans of lager. He was then found Saturday PM. They are unsure of what’s going on*’..

On 13 February 2006, AG recorded ‘*Phone call from JM. MH has told her that he remembers taking the tablets – says he took about 100. Has been only taking one of his tablets instead of two, and been saving them up. JM said that he was very matter of fact about the overdose – “We’ve all got to die sometime”. He said he didn’t know why he had done it..... Hazelmead didn’t contact JM when it happened. The hospital rang her yesterday lunchtime – JM was concerned to know why no one had*

contacted her'. On the same day, SG met with CM, Mental Health Liaison Nurse, then visited MH in hospital and made a comprehensive record.

Commentary: There was already evidence of a known attempt by MH to conceal medication. MH had been given responsibility for his medication some 6 months previously, on the suggestion of Hazelmead and with the agreement of SG and AG. MH's main carer, his mother, JM, was not informed of the overdose by either Hazelmead or the Crisis Team. However, Hazelmead records indicate that they did advise Great Western Hospital of JM's details as MH's next of kin. On 13 February 2006, two days after the overdose and MH's admission to hospital, SG herself recorded that she had been informed of the situation by a colleague and that she then rang Hazelmead to establish the facts.

The medical plan recorded on 14 February 2006 contains two further references to the need for a psychiatric review. However, the record made in the hospital notes on 14 February 2006 by CM states *'I have liaised with SG – MH's Community Psychiatric Nurse, she has arranged that MH be collected from hospital today by his mother with whom he will stay the night & SG will see and review him again tomorrow thus he may be discharged to his mother's care when medically fit'.*

Commentary: No psychiatric assessment was undertaken at the hospital prior to MH's discharge, contrary to national guidance and local policy, and none immediately after discharge. This was a failing to adhere to local policy and national guidance requirements.

The AWPT Mental Health Liaison service at the general hospital is available only from Monday to Friday and, as MH was admitted during the weekend, there appeared to be no process for mental state assessment/examination.(The hospital had alerted the Crisis Team of MH's admission to hospital on 12 February 2006 requesting details of next of kin.)

On 15 February 2006, in the absence of Dr PS, SG spoke with Dr Rm (Who was covering for Dr PS) for advice and recorded *'D/W Dr Rm RE: medication. Dr Rm has advised that to (sic) leave off the medication at present, monitor his mental state and D/W Dr PS next week as to whether we re-commence the Olanzapine or look at an alternative.'*

On the same day SG saw MH at Hazelmead and recorded, inter alia *'MH appeared bright in mood, spontaneous in conversation. We discussed at length what had happened'. She elicited that the overdose had been planned and this was because he sought attention from others at Hazelmead. She recorded that 'No evidence of any psychotic symptomatology'.*

On 21 February 2006, SG spoke with Dr PS and recorded *'Informed of the situation. Dr PS has advised to be medication free at present and to monitor his mental state at each visit and if there is any deterioration in his mental state then look at recommencing Olanzapine 5mg nocte and to closely monitor this'.*

Commentary: There is no evidence that there was any serious intention or attempt to review the overdose in the context of the unexpectedness of the event and MH's behaviour and presentation during his contact with the service. Of note, is that Dr PS did not undertake a full psychiatric review at this point, even though he should have been aware that none was taken prior or post MH's discharge from GWH.

On 17 February 2006, AG recorded the date in MH's notes but no further information, but on 22 February 2006, AG met with MH and recorded inter alia *'Overdose – MH said he had felt depressed for about a month. He had been saving his tablets. He liked the thought of going into hospital and getting some attention. He had thought 56 wouldn't be enough and he wouldn't have passed out. Took about 80. Wasn't wanting to kill himself..... MH thinks that the O/D has changed him – feels weaker physically and emotionally. Notices it in his voice and body.'*

On the same date and apparently coincidentally, SG went to see MH at Hazelmead and AG was already there. SG recorded *'MH seemed slightly subdued and hasn't been eating very well he denied any delusions or hallucinations. Spoke with staff who have reported a slight change in his presentation believing others think he is a paedophile. Discussed the possibility of re-starting the Olanzapine'. She then telephoned MH's mother and recorded her report that 'MH has been more subdued and withdrawn reporting negative thoughts'.*

SG then formulated a plan

'1 To commence Olanzapine 5mg nocte FP10 x 28 days given RISK Deterioration in mental health ? compliance with medication Unemployed Delusional beliefs/paranoia 19 yr old male Past history of overdose (serious) however denied any further intent Withdrawing Disengagement from care plan.'

Commentary: There is no evidence that AG or SG raised the need for a psychiatric assessment of MH following his discharge or of a Risk Assessment as part of his ongoing Care Planning. However, SG documented risks in her notes of 22 February 2006.

March 2006

On 1 March 2006, SG saw MH at Hazelmead and recorded *'I was informed by staff that MH wanted to cancel our appt he wanted to see his mum. He appeared preoccupied and slightly guarded, he asked if there were any paedophiles in Hazelmead but won't disclose why he thought or asked this. Both sleep and diet appear to be reduced he appears to of (sic) lost weight but he couldn't confirm this. He has been spending a lot of time at his mums drinking attempted to discuss this with him however he declined to do so. He was subdued and the staff also report this. Also he has not been attending MIND which is unusual for him. I will D/W Dr PS'.*

On 6 March 2006, SG recorded *'T/C received from JM, she's really concerned, she has noticed a marked deterioration in MH's behaviour she reports he is back to how he used to be before under the MH (mental health) services. He is very withdrawn,*

subdued and doesn't want to talk about his thoughts and feelings. Reassurance and support given'.

On 8 March 2006, AG recorded the date in MH's notes but no further information.

On the same date, SG recorded '*D/W (discussed with) Dr Rm, informed of history and current presentation. PLAN Increase Olanzapine 10 MG NOCTE If no improvement, increase to 15 MG NOCTE in x5 days Seen at Hazelmead, MH's presentation remains unchanged. He was suspicious of the questions I was asking wanting to know why I needed to know etc. Agreed with the (symbol representing increase) of Olanzapine. Informed staff of changes'.* The change in medication was notified to Hazelmead in writing the following day, but on 21 March 2006, SG recorded '*T/C from Hazelmead staffthey report that he isn't complying with his medication'.*

On 23 March 2006, AG recorded '*phone call from JM to say that they were going through a bad time at the moment. MH comes round and refuses to leave, and whilst there gives her constant verbal abuse.....up until today JM had felt she was doing really well. But now has had enough..... the other day he kicked the outside door in – "I'm coming in". When there, he chases the cats and attempts to strangle them he is always swearing. Two days before he took the overdose he had brought round his bank statements – overdrawn – (Family member) bailed him out, but this is happening regularly'.*

On 29 March 2006 SG recorded '*Seen at Hazelmead, MH appeared preoccupied and guarded. Suspicious of me asking any questions. He did report to be thinking about the alleged rape again, which he hasn't mentioned for some time. Spending a lot of time with his mum, which she reports to be difficult. He's also drinking a lot more. Spoke about his medication, he reports he doesn't like taking it because it makes him tired and he likes staying up til 4AM talking with another resident. Encouraged MH to re-commence to which he agreed, however I will D/W Dr PS'.*

On 31 March 2006, SG recorded '*Returned T/C to JM, she reports MH had been drinking last night and he has just woken up and is going back to Hazelmead so to cancel The Family Work. JM reports that MH appears to have taken a step back and his behaviour is similar to when he first came into the services. I will D/W AG to re-book'.* On the same day, AG recorded that the Family Work session had been called off.

April 2006

On 3 April 2006, SG recorded that '*T/C recieved (sic) from Hazelmead, to inform me that MH had 1) thrown his stereo out of the window 2) been brought back by the police as he had been sat outside his mums refusing to leave'.*

On 4 April 2006, SG recorded '*D/W with Dr PS, informed of current presentation PLAN: 1) Discontinue Olanzapine 10MG nocte 2) Commence Risperidone 2MG for one wk (? Once per day – shorthand here unreadable) if he can tolerate (symbol denoting increase) to 4MG (as previous unreadable) 3) D/W MH discuss Risperdal Consta'.*

Commentary: The dose of Olanzapine which was to be discontinued is less than that proposed on 8 March 2006. We found no record by Dr PS to support SG's records of this discussion.

On 4 April 2006, SG completed a record (in respect of MH) following a community patient review meeting, stating *'The above patient was discussed today with Dr PS. ACTION PLAN: MH has become non compliant with his Olanzapine, which has resulted in a relapse in his mental state. He is very guarded and his delusional beliefs appear to have returned. MH reports that he doesn't want the Olanzapine as it makes him sedated. He has agreed to take an alternative so he has now been commenced on RESPIRIDONE 2mg OD (1 wk) RESPIRIDONE 2MG BD. We will continue to prescribe his medication at present. Many thanks'*.

On 7 April 2006, SG recorded *'Seen at Hazelmead, MH appeared withdrawn and preoccupied, it seemed he didn't really want to talk. (Name) was also present. Discussed the new medication to which he accepted, unsure about the depot. PLAN 1) Monitor medication 2) Visit 1/7 3) Monitor and assess mental state 4) MH to contact Voluntary services 5) Engage with FLEX worker (name) 6) Attend MIND 7) Family work on 20/5/06'*.

On 12 April 2006, Hazelmead made a telephone referral to the Crisis Team for assessment of MH's mental state. Within the record of the referral completed by the Crisis Team, the reason for referral recorded as *'Deterioration in mental state. No boundaries'*. Under the section headed *'Degree of Risk'*, negative responses were given in respect of questions about Expressing self harm/suicide ideas; and Forensic History.

Positive responses were given in respect of questions about History of self harm/suicide ideas; Threatening/Aggressive; History of violence/aggression; dependents at risk; history of Drug/Alcohol; with two qualifying comments as follows *'History of self harm/suicide ideas overdose (sic) month to 6 week hospital 2x3 days Threatening/Aggressive Can be very hostile (sic) at times (sic) and is be'* (End of entry).

Under the heading Details of Current Problems/Crisis is recorded *(1)refusing medication. (2) Through (sic) stereo system out the window and becoming (3) sexual to member of staff, very inappropriate. Not adhering (sic) to the boundaries that have been set'*. Under the heading, Degree of Urgency is ticked as:- *'Today'*.

The referral to the Crisis Team was timed at 15.00 and at 17.00 an initial assessment was made at Hazelmead House by AS and GE (members of the Crisis Team). That assessment recorded the referrer as being SG. The section headed Presenting Problem/Crisis Assessment records the following *'Referred by Hazelmead House + Care Co-ordinator SG, due to non compliance with medication and erratic (sic) behaviour i.e. throwing his stereo out of the window; making inappropriate (sic) remarks to Hazelmead House staff. Hazelmead staff reported that he has changed in presentation i.e. not going to MIND as he normally does, not catering for himself. Drinking alcohol (symbol for with) mother. Isolating himself at Hazelmead and refusing to go out. MH himself presented, low in mood, offering little eye contact and lacking any spontaneity. He said he's not well and when asked to*

explain he said he's too hot. He was observed to be wearing a quilted over coat (sic) (symbol for with) several other layers underneath in an already heated room. He responded to all questions asked. When asked why he threw his stereo out of the window he replied, "For a bit of fun". He also said the stereo wasn't working. When asked why he took an O/D of olanzepine (sic) recently; he replied "To get some attention from his (sic) family" When asked if he wanted to die. He replied "He didn't". When asked about wether (sic) he found support from his Care Co-ordinator and Keyworker, he replied, yes, but we did not illicit (sic) any inapropiateness (sic) regarding female staff. He said he got on well (symbol for with) other residents and said inparticular (sic), (Name). He said he stopped going to MIND because it "Was boring". He said he prefered (sic) it at Culvery Court due to "stricter" routine, i.e. had to be up in the morning and in before a certain time at night; and they cooked his meals. He admitted his mood was low but said to overcome this he "Needs to get off his arse". With regards to any psychotic symptoms none could be illicited (sic) at this time. He denies, hearing voices, seeing things, delusions and thought. He said he isn't sleeping at the moment because he likes to stay awake at night. Reports he's not motivated to cook at the moment but snacks'.

Under the heading Mental State Examination, where answers were given to specific sections, they are recorded as follows:- 'Appearance and behaviour Dressed in several layers of clothing and c/o (complained of) being hot. Behaviour appeared low in mood; little eye contact Speech Normal rate, low in tone. Mood Appeared low (mildly low) Delusions Denies Hallucinations and illusions Denies Orientation Aware of time and place and who we were. Attention and concentration Able to concentrate fully on assessment says he can watch films on T.V. without problems Memory Recalled short and long term memories Insight Some as he indicated the need to "Get off his arse" to lift his mood. Appetite Reports OK in that he snacks but lacks motivation to prepare food. Sleep Reports he doesn't want to sleep and purposely stay (sic) awake.'

Under the section headed Crisis Risk Assessment specific aspects are scored as follows:- 'Risk of violence/harm to others 0 (No apparent Risk) Risk of suicide 0 Risk of deliberate self harm 1 (Some, but not significant risk) Risk of severe self neglect/accidental self harm 1"

Under the section headed Next Steps is recorded:- 'Issues Non compliance with medication Arrange therapeutic activity Action and who is responsible Recommenced (sic) risperidone 2mg nocte Crisis Team Monitor M/S (mental state) Crisis Team Daily visits for next 1/52 Hazelmead currently exploring activities Hazelmead/SG'

Commentary: This was a joint assessment but AS, the more senior and more experienced of the two members of the Crisis Team staff, did not sign the record. By her failure to do so, she did not accord with good practice guidance and policy.

On 20 April 2006, SG recorded 'Family Work Session, however JM did not attend. Myself and AG present. MH was withdrawn and preoccupied, no eye contact. At times, inappropriately laughing. Difficult to obtain information from him. Discussed medication compliance, as staff report he's refusing to take any. Discussed

Risperdal Consta, at first MH declined however he then agreed to it. Explained the benefits of having the injection etc, and then possible side-effects. Support given throughout'.

AG's record of that meeting was only to the effect that she met with MH.

On 25 April 2006, SG recorded 'D/W Dr PS. PLAN 1) STAT dose of Risperdal Consta 25MG IM written up 2) Continue with oral dose for 2 wks 3) D/W Crisis Team the problems with MH's compliance. JE stated that if they have any problems at Hazelmead to contact CT and they will attend. T/C to Hazelmead to inform them of this'.

On 26 April 2006, AG merely recorded 'MH met briefly with me for about 10 minutes before asking to go'.

On 28 April 2006 at 18.30, a Crisis Team contact sheet recorded a contact from Hazelmead staff. It states 'Nature of call – Not taken meds – refused them this pm. – Plan that CT will attend Hazelmead if this happens. Advice given – Crisis Team will attend around or before 8 pm this evening'.

Crisis Team records noted at 20.00 on that evening 'Visited Hazelmead as MH refusing meds. MH reported that since (symbol for increase) to two tablets of Risperidone (sic) – making him feel sick + dizzy. Had first depot on Weds (symbol for with) agreeing to continue with depot, but refusing oral meds. Negotiated (symbol for with) MH – that he take one tablet each night over W/E + Monday with SG will contact on Tuesday. Contact sheet faxed to SG re this.' Those attending were DB, Manager of the Crisis Service, and KO, trainee Social Worker attached to the Crisis Team.

Commentary: On 12 April it had been agreed by the two members of the Crisis Team who carried out the assessment that the Crisis Team would visit daily for one week to monitor MH's mental state. Records are clear that there were two visits, almost two weeks apart, which was a serious breach of the decision taken. We were concerned that:-

- 1. The manager of the Crisis Team initiated a negotiation on 28 April whereby the amount of prescribed medication, approved by the Consultant on 4 April 2006, was halved.**
- 2. Whilst we agree that the negotiation of medicine is within the remit of a registered psychiatric nurse but were concerned that no medical advice was recorded as being sought about either the medication or the appropriateness of a Mental Health Act assessment given the clear record of deterioration in MH's presentation.**
- 3. There was no record of this decision in the medical notes.**

May 2006

On 2 May 2006 AG saw MH and recorded 'MH seemed brighter – some eye contact. He told me that he is spending most of his time sitting in the upstairs lounge with (name) or going to the shops. He would like to be able to sleep all the time – for something to do – he is bored. He gets paid tomorrow – will go shopping and then sit

outside with a can or a little bottle of vodka. Food – said he is eating – yesterday had crackers and some noodles. Has been teasing another resident about the strange times he goes to bed. I asked MH if he ever had thoughts about CJ or abuse any more – he said he didn't. Dad brought him loads of shopping and tobacco about a week ago. He has had his first injection – has been told he has to continue with the pills for a few days. (Name) (Flex) – in their meetings he has played pool, been to the shop – (name) wanted him to do Millennium Volunteers, but he doesn't feel up to this. He would like to go fishing or camping'.

On 4 May 2006, SG attended a Keywork session with MH and recorded 'MH has had his first dose of Risperdal Consta and is happy to continue it. Appeared less preoccupied with better eye contact. More spontaneous in conversation. Informed MH that he needs to start engaging in activities etc. i/c staff as that is the purpose of living there, if he does not he may have to move on. He agreed to engage. Due to financial problems I will book app with the bank'.

On 5 May 2006, AG entered the date in her records but without any information.

On 16 May 2006 SG recorded in the notes 'On my return from leave informed that MH had refused his injection of Risperdal Consta 25MG IM, (XX) had gone out to see him. D/W Dr PS, informed of situation, advised to try again, discussed referral to Crisis team if unsuccessful. T/C to Hazelmead, informed them I will see MH tomorrow at 9.30 AM.'

On 17 May 2006, SG recorded 'Seen at Hazelmead, initially MH declined to see me. However, he then agreed. APPEARANCE BEHAVIOUR – Dressed causally (sic) dirty on clothes poor eye contact, hung head, looking at floor. SPEECH – rate slowed volume – Reduced Tone – mono – no emotion MOOD – SLB – "feel OK" rated mood at 7/10. CBJ – Appeared flat in affect, withdrawn, unmotivated, no interests, reduced dietary intake, no activities DELUSIONS – Some thoughts around pedophiles (sic), however wouldn't go into this. HALLUCINATIONS – Denied, although appears (sic) preoccupied & guarded. THOUGHT – Denied any thoughts of self harm, no evidence of plan or intent SLEEP – reports to be good 7 -9 hrs, goes to bed late. DIET – Marked reduction, some days not eating at all, others only x 1meal/snack. Evident weight loss ?how much. CONCENTRATION – Reports to be OK, although didn't follow conversation at times. MEMORY – No problems reported. INSIGHT – poor – feels things are OK. MEDICATION – Risperda (sic) Consta 25MG IM 2/52. However refused last wk, after discussion agreed (name) could administer on 18/5/06. RISK – young 19 yr old male. – Relapse of mental illness (psychotic episode) – Past suicide attempt – Non-compliance with medication – Disengagement from Care Plan/CMHT – Bizarre/erratic behaviours – Alcohol use. Due to financial problems, arranged to take MH to the bank on 23/5/06 at 10.30 AM. D/W Hazelmead staff, informed that (name) would visit on 18/5 to administer depot, if MH refuses or his presentation deteriorates further I will refer to the Crisis Team'.

At 7.45 Hazelmead staff completed a Supported Housing Incident Reporting Form as follows. (Named staff) 'Found MH drinking lager in the upstairs lounge. He was overheard describing to another resident how quickly he had drunk 2 cans. (Staff name) brought the 5 cans in his possession to the office. (Staff names) checked

MH's room with him present for any other cans of lager. 56 empty cans were collected from MH's wardrobe. MH's comment was he "likes lager".

A further Incident Reporting Form was completed at 8.05 pm on the same day, as follows 'MH seen returning to project after previous incident with 2 carrier bags with another resident. (Staff names) checked other residents room, MH & other resident had 8 further cans of lager. Staff took cans to office. Both MH & other resident asked for cans to take off the project to drink'.

On 18 May 2006, Crisis Team notes recorded 'Refused Depot from (name). hid in closset (sic) covered in duvet, discovered by staff, refusing oral Meds. Delusions about FOOD contamination, so not eating – appears to have lost weight. Not engaging in Activities, drinking in his bedroom. Staff unhappy with this. Having meeting today ?eviction. Talking Abused as a child – NON specific – Haselmead (sic) aware we have referral. Medication – 25mg Risperdal Consta fortnightly – Orals stopped last two weeks. No Drugs known'.

On 18 May 2006, SG recorded 'T/C received from (name) at Hazelmead. MH had refused his depot. Staff had informed him (Name) was going when he arrived they couldn't find him, they discovered him hiding in his wardrobe under his duvet. T/C to Crisis Team, referral made to JE, informed of current situation they will make contact'. A second entry in the Crisis team notes on the same date records 'Visited MH at his mums. MH accepted his 10mg olanzapine – states Reported that he has been given 28 days notice from Hazelmead. Mum was worried and stated that she can't have MH staying with her because the house is small and has two children staying with her. MH has agreed to start on 10mg olanzapine. Plan is to visit tomorrow at 8 p.m. with meds'.

On 19 May 2006 Crisis Team reported at 9.45 p.m. that 'Visit to MH at Hazelmead with PC. He was up and talking to other residents, little conversation with us but was polite. Took meds with no problems'. This entry is followed in records by a blank sheet which has not been crossed through.

On 20 May 2006 (noted as afternoon) the Crisis Team record states 'Attended H/V (home visit), not at Hazelmead had just missed him, project worker (name) took meds and said he would give them on return. Call from (name) at 7.23 pm to let us know that MH had returned shortly after we had left on giving meds and checking to see if he had taken them found on the floor, MH then refused and throw (sic) them in the bin. Will see MH tomorrow to try getting him to take 'meds.'

On 21 May 2006, (timed at 20.00) the Crisis Team record states 'Visited @ Hazelmead, MH was a little distant at first, he refused to take olanzapine explaining it was causing some (sic) unwanted side effects as Risperdal but unwilling to be specific as to it's (sic) nature..... MH agreed he would take Abilify so need to liaise with Dr PS SG or get Dr MS to review'.

On 22 May 2006, Dr MS, Consultant Psychiatrist, attached to the Crisis Team, saw MH and recorded 'c/o. Spinning feeling few week (sic). I feel dizzy – stopped taking Risperidone a week ago as had similar feelings – Also had Risp – Consta last inj 2/52 ago. Said – "I want to stop all the medication" – Drinking on and off – has been

asked to leave the (sic) Hazelmead – had – 4 cans of lager yesterday – due to see SG this week. – F History Visits Parents regularly....one younger brother & sister live at home – last employment – 3 yrs ago. 1st seen – 1 yr ago – Presented with – People were talking about me, looking at me, saying nasty things about – began to isolate him self lost motivation denied - aud. Hallu. Denied thought insertion and withdrawal. M state Took an O.D – around X Mar 05.....Plan. Agreed to go back on (1) Risp consta (2) Refuses to take oral Risp – for 2/52, then Continue with olanzapine for 1 week after receiving Consta. (3) Daily visit by CT (4) Reft (sic) back to CMHT’.

On 22 May 2006, SG recorded ‘Message received from (Hazelmead member of staff), MH has been given x28 days notice of eviction due to taking alcohol onto the premises x2. T/C to Dr MS, she has seen MH, initially he agreed to recommence Olanzapine 10MG NOCTE however his compliance is an issue so he has agreed to having Risperdal Consta 25MG IM 2/52. She is also concerned RE: eviction as the deterioration in his mental state may of (sic) contributed to his behaviour and a move may have a detrimental affect (sic) on his mental health. I am also of this opinion. I will D/W Hazelmead staff’.

On 23 May 2006, SG recorded ‘Went to see at Hazelmead, MH DNA’d his app. Spoke with staff who feel the eviction will be up holded (sic), due to previous problems, also due to MHs disengagement from the support plan. Discussed at length and felt Windswept maybe a suitable placement.’ A further entry by SG on the same day records ‘Common referral form completed + sent to Windswept. D/W AG, she also feels Windswept would be suitable. Informed of current situation. D/W Dr PS to inform of current situation’. There is no corresponding note in AG’s or Dr PS’s records.’

On 23 May 2006, AG recorded ‘MH not there’, but on 24 May 2006 AG reported that she attended a meeting with two members of Hazelmead staff and recorded inter alia ‘Recurring Themes that (name) has picked up on – family and his relationship with mother – I assured (name) that we would try to work on this one – he felt we needed to continue to do so, both on an individual basis and as a family.’ A second theme was ‘Lack of excitement/interest in life’. Included as Next Steps was ‘Flex and Connexions will terminate their involvements’

A Crisis Team record dated 25 May 2006, but with a continuation record dated 24 which indicates that the latter was the correct date, stated ‘Seen at Hazelmead House. Took meds but did querie (sic) why he needed to as he was having had his depot yesterday. He said he was fine apart from being arrested at 14.00 hours having caused a problem at his mothers i.e. mother called police, when they arrived MH moved on. But when the police left MH returned and started kicking the front door where he was arrested and released (symbol for with) out charge at approx 20.00 hours. Spoke (symbol for with) staff who confirmed above’.

On 25 May 2006, Crisis Team records (not made by the author of the previous day’s record) stated ‘Visited MH at Hazelmead accepted his meds. Staff informed that MH will be evicted from Hazelmead & had an opportunity to appeal but he refused. Staff reported that MH had a row with his mother yesterday & police was called, though he

was not arrested. MH reported that he has made up with mum was warm and appropriate.'

Records completed by the Crisis Team on 26, 27, 29 and 30 May indicate use of alcohol by MH.

On 28 May 2006, Crisis Team records noted *'Visited at Hazelmead settled in presentation better eye contact and body language – MH stated he had had a good day and accepted medication without any issues'*.

On 31 May 2006, SG recorded *'Seen at Hazelmead, he was not there initially however turned up just as I was leaving. Staff report no further incidents of concern at present however feel he's still unwell, not socialising with staff spending time out drinking alcohol. Spoke with MH he has been out drinking, x4 cans of fosters. Requested not to speak to me until he was "sober". He reports to be feeling "OK" spending his time drinking alcohol with friends. His presentation remains unchanged, poor eye contact, withdrawn, unmotivated, he didn't appear to show any emotion surrounding his eviction or where he would go after. Informed the prospect of Windswept which he agreed to. Discussed the incident where he was arrested for breach of the peace from his mothers. He showed no remorse, laughed. I asked what he think (sic) he should of (sic) done instead of remaining at the house causing a disturbance he stated "I should of left". He reports the Crisis Team are visiting daily to monitor him taking his medication however he has declined on several occassions (sic). Depot due next week. Denies any suicidal ideation no plan or intent present. Support given.'*

Commentary: Although daily visits by the Crisis Team had been agreed in April and May 2006, visits did not take place every day and MH was not available on some visits that were made. This is of significance because one reason for the intended daily visit was to monitor MH's mental state. The comprehensive records compiled by SG demonstrated her concerns, which she was sharing with others engaged in his care, but also record his variable presentation and increased use of alcohol. The Crisis Team also recorded significant use of alcohol but there is no record that they reported this back to Dr MS or considered seeking advice from the Drug and Alcohol service. The Crisis Team records at this stage were not fully sequential.

June 2006

On 1 June 2006 SG recorded having discussed placement at Windswept *'Referral faxed to Windswept. I have discussed this placement with all those involved in MH's care (Crisis Team, (PC), AG, Dr PS, Hazelmead) T/C to JM returning phone call. She is worried where MH will live after his x28 days notice. Reassurance and support given'*. There is no corresponding record by PC of this telephone call in the Crisis team records.

On the same day, Crisis Team records stated *'Visited MH at Hazelmead. MH did not want to talk to us, explained we planned to hand back his care to SG. Discussed with staff that we are no longer going to be visiting. They are under the impression MH is*

going to Windswept on the 19th June – Crisis team (sic) to discuss with SG tomorrow’

On 2 June 2006 SG recorded:- *‘T/C to Windswept returning and requesting a joint assessment. This has been arranged for 6/6/06 at 10AM. T/C received from SC Crisis Team they wish to hand MH’s care back to CMHT as they feel they are not achieving anything with him. He has accepted his depot however when they visit he doesn’t accept his oral meds (Olanzapine 10MG NOCTE) and that he doesn’t talk to them. Requested they do his depot on 6/06/06 and that at our joint meeting hand him back if felt appropriate by both parties’.*

On the same date, the Crisis Team record stated *‘D/W SG re: handback. SG feels MH is still unwell as not engaging and refusing meds. Crisis team would like to handback as no longer giving oral meds, no problems reported from Hazelmead – MH often not in and does not engage. Agreed crisis team will continue until Tuesday (06/06/06) when we can discuss it at team meeting. Depot due on 6th also, crisis team can do it or (If MH prefers a male or refuses) SG can arrange for (Name) to do it on the Thursday (previously refused it from SG).’*

No Crisis Team visits on 3, 4 and 5 June 2006 are recorded. On 5 June 2006, AG entered the date but no other information. .

On 6 June 2006, Crisis Team records stated *‘T/call to SG regarding handing back SG saw MH today he is refusing to go to Windswept, he wants to go to B&B, also intimated will refuse Depot tonight she is doing referral to homeless & Housing Association we to inform outcome of visit tom (?tomorrow). She is also considering referral to ORT (Assertive Outreach Team)’.*

On the same date, SG recorded *‘T/C received from JM (mother) she is extremely concerned for MH, he continues attending her home and demanding money and tobacco whilst he’s there he makes no attempt to interact and only engages in minimal conversation. As MH has refused to leave on several occasions (sic) JM has had to call the police. She is worried due to his increase of alcohol use, which makes his behaviour erratic and impulsive. Advised to contact the Crisis team over the weekend if needed – support given. She is extremely concerned that he is going to be evicted from Hazelmead from 19/6/06 informed that we will try and organise a placement for him if Windswept doesn’t go ahead. T/C to DB (Manager of Crisis Team) informed of current presentation and risks. RISK – 19 yr old male – Accommodation problems – psychotic – auditory hallucinations – use of alcohol – Past history of self-harming behaviour – serious suicide attempt – Poor personal hygiene – Poor dietary intake/fluids – No insight – Poor engagement with CMHT/Crisis Team – Medication – poor compliance. DB will feed this back to Crisis Team who will take on his care and accommodation problems’.*

Commentary: Our view is that the concerns expressed by JM should have triggered a psychiatric assessment by a Consultant Psychiatrist. This did not happen.

On 6 June 2006, later Crisis Team records stated (as pm) *'Visit at Hazelmead House. MH refused his Resperidal Consta (sic) injection which was due today. C/T will try again tomorrow'*.

On 7 June 2006, the Crisis Team records stated *'am Visit made to MH at Hazelmead. MH initially accepted his injection, but when informed it has to be in the buttock MH refused and started to become hostile towards us. He did not believe that consta cannot be given in the arm, as he wanted. MH then said he would talk it through with SG. (Name) (who works at Hazelmead) expressed her concerns about MH's mental health. She believes he has deteriorated in the last week. Hazelmead have asked MH to leave by the weekend.'*

We telephoned SG (his Care Co-ordinator) and told her of the concerns with MH and that he refused his depot from us.' A following note states *'T/C with SG. MH accepted his consta from her. SG also expressed her concerns of (sic) MH's mental health. He also refused to go to the council with SG to seek new accommodation.'*

There are no records of visits by the Crisis Team for 8 June 2006, but on 9 June 2006, the Crisis Team records stated *'Visited MH at home this afternoon. Spoke with him briefly. MH made no eye contact at all (looked at the floor) asked him if there was any reason for this – he said there wasn't. He said he was "fine", was abrupt and as if he wanted me to leave. Denied any strange thoughts or odd experiences. Accepted medication although at first said he would take it later. Said it's better to visit am. Spoke with Hazelmead staff who said MH does not engage with them in conversation'*.

On 10 June 2006, the Crisis Team records stated *'Visited MH @ Hazelmead, but he refused his medication MH claims that it makes him feel weird'*.

The next day, on 11 June 2006, the Crisis Team records stated *'Visited MH at Hazelmead. Again no eye contact. Accepted medication – no problems slightly warmer in affect but still guarded and non communicative. Said he is going to Windswept tomorrow to look around. Crisis Team to call SG in morning to see who is providing transport. Conversation with staff at Hazelmead who reported no problems but cannot believe the change in MH. Staff reported previously he was a jovial person with good rapport. Change since O/D.'*

On 12 June 2006, AG recorded *'Visited MH at Hazelmead. He was concerned about having to leave Hazelmead on Friday. Discussed Windswept – had missed opportunity to go to visit with the Crisis Team – agreed that he would go if I fixed it. MH was concerned that he was drinking more'*. On the same date, Crisis Team records stated *'Attempted J/V (Joint visit) to Windswept. MH informed me he is arranging to go tomorrow (symbol for with) AG (Psychologist) at 4.30. This has been confirmed by AG. Windswept have been informed'*.

There is no record of a visit by the Crisis Team on 13 June 2006 but on that day, SG recorded *'T/C to JM, no changes in concerns, MH feels food is contaminated and he won't eat anything if it's already open. Informed we are currently looking into accommodation'*. (SG's records show that negotiations in respect of Windswept continued until MH eventually took up residence there in August 2006).

On 14 June 2006, Crisis Team records included reference to MH having visited Windswept with AG the previous day and a second entry at 12.30 states '*Visited at Hazelmead MH was out, staff report been settled. S/W (Spoke with) SC this morning*'. There is no reference to medication in this record. The information about the visit is supported by a record made by AG of the visit but this, however, is embedded in her records between the dates of 12 June 2006 and 3 July 2006 but dated 13 July 2006. AG subsequently confirmed that her record had been wrongly dated and that the visit did take place on 13 June 2006.

On 15 June 2006, the Crisis Team records stated '*T/call to SG she is taking to Windswept for assessment 3.30 Monday 19/6 the day he is due to leave Hazelmead. She has back up plan to Accommodate in (name of B&B) but would require daily visit from C/Team. Agreed and she will advise dates when CMHT and AG are visiting as MH doesn't like too many visits. Agreed to S/W MGMT about situation and any help in getting MH into Windswept. Oral meds to be discontinued and SG will S/W Consultant regarding (symbol for increase) Depot. S/W PC re above*'.

On 19 June 2006, SG recorded '*Attended Hazelmead as MH was evicted today. We have had to place him in the (name of B&B). Guest Hs due to problems of alternative accommodation. (Name) assisted us in packing his belongings and taking them to the (name of B&B). MH moved out, during the process he was very quite (sic) and subdued, no eye contact, uncommunicative. As we were due at Windswept at 3.30 pm I stayed with him, we went to his mums*'. Whilst there MH spent most of the time in the next room, occasionally pacing in and out. JM and SH (sister) are still extremely worried they feel his behaviour has returned to what he was like when he first came into the service. Continues demanding money and tobacco, he looks withdrawn and inappropriately laughs and smiles. MH was reluctant to go to Windswept however he eventually agreed. On arrival we were told the app was cancelled. Re-booked for 21/6/06 at 2 pm.'

On 20 June 2006, SG recorded '*D/W Dr PS, informed of current presentation and symptoms etc. Advised to inform C-Team. T/C to C-Team, informed of current plan*'.

On 21 June 2006, SG recorded '*T/C to JM to see how things had been and to see if MH was there. She reports he has been there for several hrs, refusing to go he is outside the front door, shouting, being verbally abusive, kicking the door, punching the wall, she doesn't know what to do, it was 12 pm and our app at Windswept wasn't until 2 pm. I attended JM's home at 12.30 pm, MH was sat on the stairs outside the front door, he had grazes all down his knuckles, when asked he stated "I done it on the wall" he was then sat with his head in his hands, stating he "Wants to be left alone". There was no eye contact, he had his hood pulled up and refused to move. JM then let us in asking as he agreed to leave when asked to go to Windswept to which he did. MH has now been drinking alcohol the majority of the time and continues to report auditory hallucinations. We attended Windswept. View assessment in correspondense (sic). PLAN (1) Windswept feel that MH is too unwell at present to go to Windswept and the structure would be to (sic) challenging and stressful for him, however they do feel that when he was more stable, he would be a very good candidate. (2) I will contact Crisis Team. Throughout the assessment MH was extremely pre-occupied ?responding to external stimulus, hearing voices. MH went to Hazelmead after. T/C to Crisis Team, D/W KO due to the (symbol for*

increased) risks she will D/W the team with ?admission. T/C to JM to inform her of the outcome’.

On the same date (17.00) Crisis Team records stated ‘Seen at his mothers as requested by SG (Care Co-ordinator) as she stated he was restless, agitated, hearing voices, and wanted an assessment for hospital admission. MH was seen and stated he was “upset” (sic) due to stress at not being allowed to visit his mother. He said his voices had gone, (but “they were voices that made him laugh”). Now that he is at his mothers he say (sic) his stress is OK now. His voices have gone. And he said he was going back to the (name of B&B) at 8 pm. He agreed to take his depot tomorrow and consider his medication in general. He offered limited eye contact and appeared more spontaneous than previous visits. Handed over to Duty Manager, DB, who agreed that he needs to continue (symbol for with) depot and discuss medication with his consultant and care co-ordinator. It would also appear that there are elements of behaviour regarding MH’s needs. It did not appear at time of visit that MH warranted a hospital admission’.

On 22 June 2006, SG recorded ‘T/C to Crisis Team they are seeing him today to carry out a full assessment’.

On 22 June 2006, the Crisis Team recorded ‘Risperdol consta giving (sic) 25mg. MH appeared slightly warmer in affect than I have previously seen him. Still has dipped head and no eye contact giving (sic) to us. Next consta due 6/07/06’.

Another entry on the same day marked ‘pm’ stated ‘T/C from SG – CPN – really concerned re MH – feels MH is very unwell, feels that (Name of B&B) B+B accommodation is totally inappropriate and hugely increases MH’s risks. SG reported that MH was seen by Windswept yesterday but they stopped the assessment after 10 minutes as they felt that MH was too unwell to continue. They felt MH would possibly be suitable following acute admission to Sandalwood once better. Discussed situation with PC – who will visit MH tonight i/c KHu (on call) + assess whether hospital admission is appropriate.’

There is no record that PC made the agreed visit.

On 23 June 2006, the Crisis Team records stated ‘Home visit (symbol for with) AB – MH was pleasant in manner – clean + tidy in appearance + engaged well (symbol for with) Crisis Team – apart from non eye contact whatsoever. MH reported that his mood is “fine” as well as sleep + appetite + he likes staying at (name) B+B. MH’s rate + content of speech was fine – but monotone and quite flat. The only time he expressed any emotion was when saying about currently relationship (symbol for with) C/C – SG was “shit” – did not want to talk to CT about this, but said he would discuss it (symbol for with) AG later when she visited. CT tried to talk to MH regarding problems earlier in week at his mother’s home, but MH said this was sorted out + fine now, but he would have a break from seeing mum today. MH indicated wanting to change to oral meds – olanzapine, but C/T advised to discuss (symbol for with) C/C and AG, although pointed out there would be concerns particularly due to serious overdose. MH told C/T that overdose was to get attention which it did – served its purpose, no feelings of wanting to do that again. Plan – daily visits to monitor as appears MH is very changeable currently’.

Commentary: This entry was made by the same person who made the entry on the previous day but records give no indication that the very real concerns expressed by SG were taken into account. Nor do records indicate the reason for the failure of PC to visit to assess whether hospital admission was appropriate or why this was not followed up.

On 24 June 2006, the Crisis Team records stated *'Home Visit (symbol for with) DB – MH was pleasant + corteous (sic), but impatient for us to leave as going to visit his friend at Hazelmead. Denied any problems + when asked what time would be best to see him tomorrow – asked why we would be coming – explained just to check that things are OK. MH agreed we could come about midday tomorrow. No eye contact by MH at all during visit'*.

On 25 June 2006, the Crisis Team noted that a visit was made at 12.20 and stated *'Visited at (name of B&B) no answer from MH's room, S/W staff they have not seen MH today.'*

On 26 June 2006, SG recorded *'T/C to Crisis Team, they have seen MH they report that he was co-operative and there were no psychotic symptoms. They did note that he wasn't giving any eye contact. He has accepted his medication and he has agreed to an apointeeship (sic). He will see me next week'*.

There are no records of Crisis Team visits or of the above telephone call on 26 and 27 June 2006, but on 27 June 2006, Dr MS saw MH and recorded *'Seen - today at his Mothers flat. At present living at (name of B&B) but spends great deal of time – with Mother. Drinking ++ (Followed be brief indecipherable entry) Aud – hallu – of 3rd Person – talk about (Brief indecipherable entry) both male and female voices. Denies – dellu, passivity feeling – speech – N – rate and tone – Mood – euthymic – insight – NIL. Plan (symbol for increase) Risp. Consta – 37.5mg IM. 2/52 – start activities in the community eg. Gym – Agreed to have appointee'*.

On 28 June 2006, the Crisis Team records stated *'Attempted HV @ (name of B&B) – MH did not answer the door. Note pushed under the door to inform him we will pick him up for the gym tomorrow at 10.30 am.'*

The Crisis Team records for 29 June 2006 states *'Visited MH at home at (name of B&B) to pick up for the gym. Eventually answered the door. Would not retain eye contact, and did not want to come to the gym. Said he had had a late night and had been drinking. Said he had a hang over, adimately (sic) would not come with us, became quite Brittle the more we pushed, so we decided to leave it'*.

On 30 June 2006, the Crisis Team records stated *'Visited MH at (name of B&B), he was not in but left note for him to call. Manager there is concerned about MH, said he is drinking heavily in the evenings and wondered if his money is being looked after and believes he is spending all his money on alcohol. He is worried that something may happen to him and compared him to another resident he had there'*.

A further entry on the same date stated *'T/C to MH, he asked what was wrong, explained just calling to see how he was, he said he was fine, didn't sleep as stayed up all night, said he had been drinking – only 3/4 drinks though. Had not eaten today,*

encouraged him to get something asked if he would attempt gym next week, said he would. Explained would be out to see him tomorrow'.

Commentary: In June 2006, four of the most senior members of the Crisis Team had contact with MH. Features at that time were non-compliance with medication, active refusal of medication, significant consumption of alcohol, recognition of psychotic symptoms by SG and Dr MS, escalation of concerns by his mother and by his Care Co-ordinator, who was clear that an assessment for hospital admission was appropriate. During this period the Crisis Team failed to keep to the daily appointment regime and a planned visit by PC to assess MH was not made and no reason was recorded in the notes for this failure.

From early April until the end of June 2006, MH was assessed on four occasions. On 12 April 2006 the Crisis Team referred to risks as did SG on 17 May 2006. There was no reference to risk factors in Dr MS's notes of her interviews with him on 22 May 2006 and 27 June 2006. No formal Risk Assessment had been undertaken as part of his overall care planning, although risks were clearly identified and MH had been subject to Enhanced level ICPA since first referral to the service.

July 2006

This month shows a similar pattern of presentation and reluctance to engage. It should be noted that the records made by AG in this month are not all consecutive. We have assumed the dates recorded as being correct albeit recognising that notes were not contemporaneous.

On 1 July 2006 the records of the Crisis Team stated *'Visited at (name of B&B) with K. MH opened the door but said he did not want us to come in (even after asking twice). MH was visibly agitated (moved his hands around which appeared to be due to agitation not tremor) MH was aware of this and attempted to put his hands behind his back or hold them. MH denied any odd experience or stress and at this point. laughed inappropriately. MH said he was eating and sleeping but incongruent with yesterday's T/C. MH said he was out drinking yesterday and plans to watch the football today. At one point, MH made a fist with his hand but then pulled it away with his other hand. MH appeared keen for us to leave and gave no eye contact throughout. Plan to visit tomorrow to continue to monitor MH'.*

On 2 July 2006 the records of the Crisis Team stated (noon) *'Seen at the (name of B&B) appeared slightly brittle and offered no eye contact. He responded to questions states he's "OK", "eating OK", "sleeping OK". "No thoughts that are worrying him" He was dressed in a thick top whilst the temperature was quite hot'.*

On 3 July 2006 the records of the Crisis Team stated *'Seen at the (name of B&B) . Concerns raised by staff ie drinking White Lightning but no other behaviour issues. Concerns from staff about alcohol (symbol for with) medication. MH appeared slightly warmer in effect (sic) than yesterday he declined offer of the Gym as he was about to meet with AG psychologist. He did agree to attend Sandalwood Gym tomorrow'.*

On the same date AG recorded *'Went to see MH at (name of B&B) – he said he didn't want to talk, but let me into his room to make another appointment. I asked him how he had been coping with the heat, and reminded him it was important to drink lots of water (and not just alcohol) He said he had been drinking a lot of alcohol lately. MH was wearing a thick sweat shirt in spite of the heat – he said this was because he needed to do some washing and had run out of clothes. I suggested he talk to (Name) about washing facilities. MH asked if I could give him a lift to his mum's. I asked him to phone first, which he did, so I ran him round. Once there, he went into his sister's bedroom, lay on her bed and was occupied with his mobile phone. I talked a little with JM, MH's dad and (JM's ex partner). They expressed their concern about MH and related how last week he wouldn't leave, so JM had eventually called the police at which point he had left the flat. Dad had arrived some time later to say that MH was hiding in the bushes across the road. He was swearing to himself and making strange barking noises. Mum called the crisis team....'*

On 4 July 2006 the records of the Crisis Team stated *'Visited MH at home to collect him and take him to the Gym. MH refrained from coming to the Gym saying it was too hot today. Asked MH if he had any worries or anything we could do for him but he said he was fine'*.

On 5 July 2006 a record of the Crisis Team visit included *'he made no eye contact and occasionally had an incongruent smile as if something was amusing him. He would not let us in and half hid behind the doorSG his Care Coordinator will liaise with the EI team as to days of visits as it is felt that he will disengage if he is visited more than the agreed once a day'*.

On 6 July 2006 the records of the Crisis Team stated *'Visited MH at the (name of B&B) this morning MH answered the door but said he did not want us to come in his room. MH refused his depot saying this was because he did not like needles. Explained the importance of having his depot but MH again refused and said he was willing to take oral meds. Discussed previous attempts to offer to MH when he has refused in the past and that he had accepted his depot in the past. MH laughed inappropriately during the conversation..... although denies any voices or odd thoughts. MH said he would accept oral meds if he had to take one tablet a week. Explained this was not possible which he agreed he knew anyway. Agreed Crisis Team would come back another day to see if he felt differently about taking the depot. MH was a little more talkative than when I have seen him in the past and said that he plans to go and visit his mum today'*.

On 7 July 2006, SG recorded *'T/C to MH as I had arranged to see him, he declined my visit stating he will see me next week'*

On 7 July 2006 the records of the Crisis Team stated that it had been *'reported by CPN, SG, and Support Worker, R, that attempts to visit MH were to no avail as he wasn't in'. However the next day, the records of the Crisis Team state 'Visited MH at (name of B&B), he opened the door. Initially refused his depot but asked again, asked if he could have it in his arm, we said it couldn't be. He just had to pull his trouser band down slightly. He agreed to this. Did not maintain eye contact but said he was fine, had been down for breakfast. Was not seeing mum today was going to*

try and do some washing. Agreed we would not see him tomorrow but would see him Monday, he said he would come to the gym.'

On 10 July 2006, AG contacted MH who indicated that he did not wish to see her.

On 11 July 2006 the records of the Crisis Team stated 'Visited MH at the (name of B&B). We asked him if he would like to either come in town for a coffee or come to the gym at Sandalwood. He declined both of these options saying he had washing to do. He asked about SG and when he was going to see her then he told us he was going to see SG on Thurs. Made no eye contact throughout and at one time appeared to be responding to voices.'

A further entry (undated but deemed to be on same date because of positioning) states *'Visit to MH at 12.15 pm at (name of B&B) but MH was out and staff were not aware where he was.'*

On 12 July 2006 the records of the Crisis Team stated 'MH's mum paged us to visit her house as MH had been there for 5+ hours, coming in + out, refusing to leave, sitting outside the flats in the bushes. Mum was tearful and reporting that MH had been barking like a dog. MH had left the property by the time we arrived. He'd called himself + taxi and neither his mother or father knew where he was going. Both parents expressed their concerns about MH + their disappointment that he is not in hospital as they feel it is the only place where he will get better. Explained re MH Act + difficulties ie unable to detain if presenting ok at assessment etc. Mum really concerned about impact on her 7 year old son. Assured parents that we are actually trying to engage with MH and they could page if MH turns up there - then we would be able to see him. MH's parents both report that MH has been very different since the O/D of olanzapine – no eye contact, inappropriate giggling etc. Plan - continue daily visits to attempt to engage with MH + continually assess mental state'.

On 13 July 2006 the records of the Crisis Team stated 'Visited at (name of B&B), MH had to be persuaded by staff to leave his room so they could clean it but otherwise they report he has been settled this morning. S/W MH, No eye contact, guarded body language he was reluctant to engage – he is seeing CPN at 2 pm today. He has had his hair cut and was clean and well presented he agreed to use the Gym tomorrow around mid-day'. On the same day, SG recorded 'Appointment cancelled due to unforeseen circumstances'.

On 14 July 2006 the records of the Crisis Team stated 'Visited (name of B&B) with student nurse. MH was not in his room. Manager of (name of B&B) stated that he was up in the morning came downstairs and collected his sandwiches and left'.

On 16 July 2006 the records of the Crisis Team stated 'Seen at the (name of B&B) he appears slightly warmer in effect (sic), ie smiling at times and gave some eye contact. When asked about his thoughts & voices he said he wasn't troubled. It was put to him that its (sic) has been some time since he had those symptoms he said he is troubled by them now and again but couldn't be more specific. He denied cannabis/drug use but admitted to using "Belgian Beer", which he says has strong content. He said he was staying in today. He declined offer of Gym tomorrow as he is seeing (Name) from early intervention so agreed not to be seen by us'.

On 17 July 2006 the records of the Crisis Team stated 'T/C received from MH's mother who is concerned about MH as she believes he has been smoking cannabis which has a detrimental effect on his mental health. MH also had to be removed from his mother's house by the police as he was refusing to move from his sister's bedroom'.

On 17 July 2006, SG recorded 'Seen at the (name of B&B) BEHAVIOUR AND APPEARANCE – Inappropriately addressed to time of year, v – hot but had a thick jumper with the hood up. No eye contact throughout visit. Appeared restless and appeared to be trying to grab something. Spent all my visit staring at the wall or head down. Laughing & smiling. SPEECH – No spontaneous conversation, yes or no answers when not needed. Slowed rate (symbol for decrease) volume monosyllabic with closed answers, would not elaborate. MOOD –sub – "Feel OK. CBJ –flattened affect, lack of motivation, denies any suicidal ideation, no plan or intent expressed, however he stated he has been going to the Railway Station frequently. This is of great concern as he has in the past spoke about "throwing" himself in front of a train. He states at present he just goes and sits there. HALLUCINATIONS – Reports to experience auditory hallucinations however would not elaborate. Appears to be responding to external stimuli. DELUSIONS – Difficult to assess (sic) due to communication problems. Appeared pre-occupied. CONCENTRATION – Poor, had difficulty engaging. SLEEP – Reports is good. DIET/FLUIDS – Poor diet X1 meal a day reports to be drinking a lot of alcohol x10-12 cans of lager a day. INSIGHT – Poor. MH requested I give him some money when asked what for he indicated for alcohol, to which I declined. Support given throughout. I will contact Crisis Team. TC received from MH the staff at the (name of B&B) (sic) had given him my mobile no. He rang at 5.45 pm telling me to visit and give him money when I declined he hung up.'

On 18 July 2006, SG recorded 'D/W Dr PS and the Crisis Team. Informed of MH's presentation and his behaviours. He has now had x1 dose of Risperdol Consta 50MG IM. E (CT Member) will feed back to the team.' There is no corresponding record of that discussion in the Crisis Team records.

On 19 July 2006, AG recorded (with no introduction) 'When I got to the (name of B&B) (name) (Manager) expressed concern that MH had been very restless the previous evening, walking between his room at (?and) the office repeatedly. Had eventually spoken to MH and asked him to stay in his room. Arrived at MH's room just as MH was sending me a text to ask when I was next coming. He said he was OK but very restless – I suggested we went on a walk, which MH agreed to, so we went round the Lawns. MH walked very quickly, paying little attention to his surroundings. However he was able to slow down a bit when I asked him to, and did stop to look at the fish when I suggested it, and was happy to tell me a bit about the fish. MH appeared a little better than when I have seen him recently. He was able to answer questions, and asked me one or two things. MH said he had drunk heavily yesterday. He had borrowed money from his mum to do this. When I asked him about it he said he had been hearing voices but wasn't currently. He denied having any bothersome or unusual thoughts. He told me that he had been spending time at the railway station – he said that this was because he could get a cup of coffee there, and because there was a girl called (initial) that he liked. However, he could understand that his mum was concerned because he had previously had ideas of throwing himself under a train – he denied that this was the case at the

moment..... When we got back to the car, MH said he would walk to him (sic) mum's. I suggested he phoned first, which he did but JM said she did not want him round there today. JM asked to speak to me on the phone and said that she was at the end of her tether; she was very concerned about MH.'

On 19 July 2006 the records of the Crisis Team stated 'Tried to visit MH at the (name of B&B) but he was not in. Warden at (name of B&B) said that he had gone out with someone ? earlier'. On the same day, SG recorded 'x8 TC received from MH between 6 – 9pm. On answering he informed me he had drunk x1 bottle of white rum and was at the train station, he denied any suicidal ideation. He became irritable and verbally abusive at times. I ended the call. TC to Crisis Team spoke with AB. They will make contact'.

A further entry by the Crisis Team at 21.00 on the same day recorded 'Pager message to contact SG she informed us that MH has gained her mobile number & has made several calls demanding that she takes him money. She says he reported he has drunk a bottle of White Rum & is currently at the train station begging. SG states that the staff at the (name of B&B) told MH off for begging & he became a little irritable & and began pacing up + down corridor. She says he denies any suicidal thoughts or hallucinations. SG offered to access some emergency money & take MH shopping which he refused. He has broken his mobile & phoned her from a telephone box. She has advised him to return to B+B & drink some coffee and get some sleep. Team to visit (name of B&B) & check MH has returned'.

A further Crisis Team entry at 22.30 on the same day recorded 'Attended (name of B&B) spoke (symbol for with) staff who confirmed he had been drinking and was agitated, coming to their office, at one point staff reported MH chatted for about 15 minutes but was unable to explain his agitation. He did ask the staff for £5-00 but was refused. When he came back he was asked to go to his room as the staff were eating their dinner. MH obliged (sic) and he spent the last hour in his room. Staff advised to utilise police if MH was a management problem ie aggression or hostile. Advised to use crisis line if advice required'.

On 20 July 2006 the records of the Crisis Team stated 'Visited MH at the (name of B&B). He had just woken up. He did agree to speak to us but made it clear that he did not want to see crisis team but would see AG and SG. Told us that he had earned £2.00 begging last night which he had spent on drink (alcohol). Declined offer to come out for a tea – drink or go anywhere with us'.

The same day, SG recorded 'Professionals meeting arrange for 21/07/06'.

On 21 July 2006, AG recorded 'meeting at the Mall with JM (mum), myself, SG, RG, A (Crisis Team) and (name) (with the Crisis Team for that day) Agreed: that RG would discuss the possibility of a mental health act assessment with JD. That Crisis Team would reassess. That we would ask Windswept to assess him. That AB and SG would review the risk assessment'. SG recorded 'PLAN (1) Reassessment (sic) by Crisis Team (2) Reassessment by Windswept (3) SG+AB to formulate risk management plan (4) meet again 28/7/06 @ 8.45 am'.

On 21 July 2006 the records of the Crisis Team stated (am) '*Seen MH he accepted the risperdal constana (sic) 50mg IM without any problems. He did however state that he thought he would no longer be involved with the crisis team and SG would be administering his injection. Agreed that his next injection would be given by his CPN SG. MH was very polite and made superficial conversation. He still is unable to make good eye contact. He did not present as being preoccupied or guarded – noted to have had a haircut. He plans to remain in doors for the rest of the day. AB attended multi professionals meetings awaiting feedback regarding further input from the crisis team as MH no longer wishes to engage*'.

On 24 July 2006, SG recorded '*Rang Windswept they can see MH today at noon. Went to see MH however he refused to attend Windswept today. No change in presentation has agreed to go tomorrow*'.

That day the records of the Crisis Team stated '*Incorrect dose of Risperdal consta given. Given 50mg IM instead of 37.5mg IM. Adverse incident forms completed informed (Name) Pharmacist who stated that MH will not notice the effects until 3 weeks later. Major effect may be postural hypotension. He has previously had 37.5mg IM. Good practice is to change two doses of 37.5mg before administering 50mg IM or Risperdal consta. Also possible effects are E-P-S symptoms but this is more likely to be more gradual than sudden – more noticeable after 3 weeks. Dr (Name) Duty doctor informed of the drug error she agreed with pharmacist – no further action to be taken. MH was made aware he was receiving 50mg IM of Respirdal was told about the increased dose however does not know he should have had 37.5mg. Will be notified tomorrow*'.

Commentary: This relates to the dose given on 21 July 2006. This important information was not conveyed to MH because he was not in when visited the next day and the clinical notes indicate that this matter was not picked up at the next visit in 26 July 2006. These were serious breaches of the Trust's Medicines Management Policy requirements.

On 25 July 2006, SG recorded '*Collected MH from (name of B&B) (sic) and accompanied him to Windswept. View form for assessment details. After the interviews, they still feel that MH's mental state has not improved and that he would find the structure etc to (sic) demanding. However they will review again in 1/12*'.

On 25 July 2006 the records of the Crisis Team stated '*Visit made to (name of B&B) but MH was not in. Later informed at Dr PS's ward round that MH was being assessed at Windswept. Appointment made for MH to see Dr MS at 12.30 pm*'.

On 26 July 2006, SG recorded '*Attended the Crisis Team base. Risk assessment and plan formulated*'. The plan indicated that it was completed by her and AB of the Crisis Team but was not signed by either. At that time, MH was under the care of the Crisis Team and SG told us that she believed that responsibility for signing the plan lay with AB. It contained a detailed record of much of MH's history of risk as known to either/both the CMHT and the Crisis Team, including threats in 2005 to kill a named individual (CJ); comprehensively recorded the current category of risk as self harm and risk from others as low; risks of suicide moderate and substantial; and risk to others, children and self neglect as moderate. Future risk was assessed as low

for self-harm, risk from others, risk to others and risk to children; with moderate risk of suicide; and low and moderate for self-neglect. In categorising the risk currently applicable it was recorded *'MH took an overdose in Feb 06 of x56 Olanzapine tablets; he made no attempts to seek help currently he denies any suicidal ideation however there are concerns as MH is attending the train station frequently and he has previously had thoughts of throwing himself under a train.'* In respect of future risk, it was recorded *'If MH's mental health remains unstable and he continues to use excessive amounts of alcohol this leads to erratic and risky behaviours and poor personal care'*. Under the heading Service User Concerns/Comments, is recorded *'MH currently denies any suicidal ideation, plans or intent or any thought disturbances however he does intermittently has reported to experience auditory hallucinations'*.

Under the heading Concerns expressed by Family/Significant Others is recorded *'MH's mother, JM at present feels his mental state has deteriorated and his alcohol use has increased. She reports he is uncommunicative, agitated, poor eye contact, pre-occupied and spends his time at her flat pacing with his hood pulled over his face. He has also been verbally aggressive and had a major row with his father. JM has observed MH's fears of food contamination. In the past he has spoken about throwing himself in front of a train and he is now spending a lot of time at the train station.'* The Management Plan recorded *'Daily visits by the Crisis Team. Weekly visits by CPN. Weekly visits by AG. Weekly visits by Early Interventions worker T. Dr. MS to review on 26/07/06. Re-assessment at Windswept on 25/7/06. Professional meeting on 28/7/06. Administration of depot every 2/52. and Continue attempts to engage MH in therapeutic activities'*.

Commentary: There is apparently no corresponding record in the Crisis Team notes nor a record of any review of MH by Dr MS on 26 July 2006 at the appointment referred to in the Crisis Team's note dated 25 July 2006. Whilst the Crisis Team recorded on 25 July 2006 that an appointment had been made for MH to see Dr MS, she herself advised that no appointment had been made.

On 26 July 2006, AG recorded *'Went down to (name of B&B) but MH not in. (Later learnt that he was being assessed by Dr MS at this time) (Name) (Manager) said that he hadn't been quite as restless recently'*.

On 27 July 2006, SG recorded *'T/C to JM, she feels things have remained unchanged continuing to have problems with MH at her home. She stated she had tried contacting the Crisis Team for x4 hours on an off and had no response so ended up calling the police. JM requested I contact her tomorrow after the meeting'*.

On 27 July 2006 the records of the Crisis Team stated *'Visited MH at the (name of B&B) this afternoon. MH invited us in and was drinking bottles of stella when we arrived. MH refused our offer to take him to the bank saying that he had drunk too much (4 bottles) but later said this was his first drink. MH also said he would like to sort it out himself. Talked about the objectives of current crisis team input to engage him in activities so he could shortly move on to Windswept, oral medication oversee (sic) and to help him with the bank. MH said he was happy living where he is and did not really want to go to Windswept although he later said he liked it there. MH agreed he felt more comfortable with male member of the crisis team and mentioned*

(Name) MH agreed to try not to drink tomorrow and that he would allow (Name) to take him to the bank tomorrow between 10 – 11 am. MH said he was annoyed with people at Hazelmead especially (name) MH again presented as eager for us to leave, v. limited eye contact. Appeared to be responding to auditory hallucinations as he laughed inappropriately (sic) at times when we asked him why he remained quiet. He also said “Stop being silly” but was unable to explain why he said this. Despite the above MH was slightly warmer in affect than when I last saw him (asked how I was, said “Take care” etc.).’

On 28 July 2006 the records of the Crisis Team stated ‘Visited at (name of B&B), MH was warm in affect, denied any hallucinations over last few days but appeared distracted. MH was Angry with the Team over late appointments & breaking agreement. Explained our concerns which he denied. MH looked tired & drawn & refused to go anywhere – he accepted oral meds but then opened a can of lager, he admits starting drinking early most days - no eye contact throughout’.

There is a further Crisis Team entry that day (unsigned and in the notes after 29 July) which stated ‘Decision made following joint meeting to commence referral for Mental Health Act assessment for Monday.’

On 28 July 2006 AG recorded ‘Meeting at Sandalwood Court with myself, SG, RG, SS, PC and DB’. AG’s records provided no further detail about this meeting. Neither of the Consultants (Dr PS and DR MS) was recorded as being present at the meeting. Also that day SG recorded ‘Professionals meeting view minutes. PLAN – (1) To organise a Mental Health Act Assessment for 31/7/06.’

On 29 July 2006 the records of the Crisis Team stated ‘Home visit with DQ. MH not home not answering door. Staff reported MH drinking alcohol + will try again later’. There is no record of a later visit that day, but on 30 July 2006 the Crisis Team recorded ‘Visited MH at the (name of B&B) in (Street name) Road, he took his medication but not once did he give us any eye contact’ and on 31 July 2006 the Crisis Team recorded ‘T/C from Mum – MH is with her now and she will keep him today for assessment’.

The Mental Health Act assessment was held as planned and in the evening of 31 July 2006, MH was admitted to Sandalwood Court under Section 2 of the Mental Health Act. With JD (an Approved Mental Health Professional), Dr MS and Dr P (Section 12 approved doctor) undertook the assessment. Following admission, the hospital notes record ‘.....Currently admitted under sec 2 of MHA as there was a noticeable deterioration of mental health since April – May 2006 and no improvement since being started on Risperidone and depot injections. Known to be intrusive, paranoid, withdrawn at times and noted to be irritable, angry and pacing around..... Came pacing in into the room dressed in black jacket; no eye contact. Sitting at the edge of the chair. Appear agitated and didn’t want to take or answer any questions. Plan (1) To continue with PRN medication and to be reviewed by team regarding antipsychotics (2) Needs detailed physical examination as he refused to have physical examination currently (3) routine admitting bloods.....’ On the evening of same day, nursing notes for Sandalwood Court confirm the above actions.

Commentary: Between 15 April 2006 and 31 July 2006 MH missed 11 appointments with the Crisis Team and there were recorded 12 instances when MH missed or was non-compliant with medication. There were 2 occasions when Hazelmead staff reported to SG that MH was not compliant with medication. In July 2007, the Crisis Team missed daily visits to MH on 8 occasions.

August 2006

On 2 August 2006, Dr V, SHO in the in-patient unit, recorded in the medical in-patient notes 'D/D (Diagnosis) Paranoid schizophrenia. Multiple substance dependence – currently detained on a protected environment'.

Commentary: This was the first occasion when there is any record in AWPT notes of potential diagnosis of schizophrenia. This was almost 2 years into MH's engagement with the service and some 8 months prior to the homicide. There is no evidence in the AWPT medical notes to show that a diagnostic formulation was actively pursued following the record made by Dr V until after the homicide. Dr V's record appeared to be comprehensive and we endeavoured to transcribe the whole record but the legibility of her handwriting was such that we could be certain only of the entry quoted above, together with the fact that her record refers to MH hearing voices, to his having auditory hallucinations, to his level of drinking, to his use of cannabis and brief family history. This differential diagnosis was not followed up and the opportunity to confirm the diagnosis and to consider more appropriate treatment and medication at this stage was missed.

On 2 August 2006, AG recorded in the nursing in patient notes '16.45. Brief chat with MH. He was smiling and laughing inappropriately during our conversation, and at one point said something totally unrelated. (Responding to voices?) He said he didn't want to be here and was cross with JD (AMHP) for saying that he had to be. He is wanting a drink and says he is shaky because he hasn't had a drink. Also that he won't be able to eat unless he does. I recapped that he was here because people were concerned about him, and that once he was a bit settled he would be able to start doing things like gym etc. Also encouraged him to talk about the voices, should he be experiencing them. Will visit again after my leave (21/8)'.

On 7 August 2006, Dr AW (SHO) recorded in the medical in-patient notes 'W/R Dr PS.? autistic behaviour'.

On 7 August 2006, nursing notes recorded in a ward round stated 'S/B Dr PS (Cons Psych) Dr AW (SHO) Dr C (SHO) St/N LG (RGN) O/T (HI) SG (Care Co-ord) According to SG, MH presented i/c psychotic episode 2 yrs ago. There was some debate as to whether MH had suffered any signs of Neuroleptic Malignant syndrome. Poor eye contact terse answers. PLAN (1) SHO to ascertain Neuroleptic malignant syndrome (2) Consider changing depot on Dr PS' return (3) SG to liaise BDI (Becks Depression Intervention) (4) SHO to search school history and depending on outcome – IQ test (5) for escorted leave up to 1 hr daily at nurses discretion (6) Mother also attended. Admits MH has been in care. Also, MH was investigated for petit mal seizures during primary school. Had previous EEG'.

On 14 August 2006, Dr AW recorded in the medical in-patient notes ‘ still some evidence of ? autistic behaviour..’ and on 20 August MH’s Named/Associate Nurse recorded her view in a ward round preparation form ‘? Change of Medication ?Assessment of possible Autistic/Asperger (sic) Traits’.

On 23 August 2006, Dr AW interviewed MH’s mother and recorded in the medical in-patient notes ‘Relationships. MH has had one proper relationship with a girl named (Name) at the age of 16. This was whilst his mother was living in Cardiff, and MH met (name) there. He would visit her on weekends, and they would go out with another couple, the boy being a friend of MH. (Name) broke off the relationship, and MH started to use Cannabis heavily at this time. JM now thinks this marks the start of MH’s illness..... ..PPsych H: After the break up with his girlfriend, mother reports that MH became initially paranoid and suspicious that his friend was sleeping with (name) (who had another boyfriend anyway), and then became frankly deluded that he was raping her. MH also believed that he was being abused by this friend and by his mother. When she came to visit and bought him new clothes, he cut them up into small pieces and disposed of them saying that they belonged to his friend. Mother reports that it took time initially to get MH to see his GP, but once MH did agree to go (sentence ends here) ‘Current illness. MH’s mother believes that his current illness started when he took an overdose of Olanzapine in Feb 06. Prior to this, he had been attending MIND regularly and participating in a number of activities and themed evenings. He had a number of friends through MIND. He would visit the pub regularly, but did not get drunk and only had 1 or 2 drinks. She says that he had a life, even though he didn’t work, and would see her 1 - 2 times a week. She says that there was no warning of the overdose, except that the day before he gave father a birthday card which he never normally does. MH had not given any indication of his intention, nor did he leave any note. He was unconcerned and nonchalant about the fact that he had survived the overdose. MH has repeatedly insisted that he was simply trying to attract attention, rather than commit suicide. Since the overdose, MH has become increasingly withdrawn and disengaged from his friends and from MIND. His alcohol intake has increased dramatically. He has become increasingly intrusive into his mother’s home – visiting numerous times each day, often at inappropriate times, as well as phoning and texting up to 100 times per day. His appetite has decreased, and he has expressed beliefs that his food was being contaminated. He started wearing his hood up, and performing repetitive shaking of his hand, and hiding in the bushes opposite his mother’s house. He has expressed extreme concern and anxiety about irrelevant things, such as Iraq. Since being an inpatient, MH seems significantly calmer and less agitated’.

Commentary: MH was not made the subject of section 3 of the Mental Health Act 1983 and he was discharged from detention on 28 August 2006 but it was agreed with him that he would remain in hospital informally.

On 24 August 2006, the hospital nursing notes recorded- ‘MH this am has been bright & positive in mood today, seen by Dr PS second opinion, & ASW they have decided there are no grounds at present to convert to a Section 3. MH has agreed to go out 4 times a week for 3 hours to consume no Alcohol & no drugs he will go to visit his friends & not to go to his mothers too much. He wants to go to Windswept says that he will comply with all conditions to go there. If things become a problem

then he has been told that we will have to consider possible re assessment for a Section 3. This is to start from when his Section runs out this was at Dr PS' request'.

On 25 August 2006, Dr AW recorded in the medical in patient notes *'Telephoned by mother. Having spoken to MH's sister, she realises that there are many aspects of MH's upbringing that she is not aware of. Sister called would like an interview discuss these issues further'. On the same day, AG recorded 'Session with MH planned but not there when I called. Rearranged for Tuesday'.*

Commentary: MH's section 2 detention was due to lapse on 31 August 2006 and on 25 August 2006, a Mental Health Act assessment took place on the ward. An order for 'discharge from detention' indicated that MH would be discharged from detention on 27/8/06 and would remain in hospital informally.

On 29 August 2006, AG recorded *'Ward phoned to cancel apt. However MH phoned later and I met with him at 4 pm anyway'.*

Commentary: AG's next record in her notes indicate that she did not see MH until 30 October 2006, although MH left Sandalwood Court to move in to Windswept on a trial basis on 15 September 2006. In fact, she signed an entry in Windswept nursing record on 21 September 2006 (Included in following).

September 2006

On 1 September 2006, SG saw MH in Sandalwood Court and recorded *'MH appeared slightly agitated, restless. His speech content was sexually inappropriate making comment about myself and other staff members. It was apparent that he believes "he is a mighty soldier" and that he has a job to do which is to save the world from all the terrorists and bombings. Not engaging in the activities based on the ward. Appeared preoccupied at times. Medication remains unchanged: Risperdal Consta 50MG IM 2/52 Respiridone 2MG CD. No compliance problems at present. Due to be re-assessed by Windswept. I will visit again on 18/9/06'.*

On 4 September 2006, Dr AW (SHO to Dr PS) recorded in the medical notes *'Off section now. P – appropriate. Takes leave sensibly, negotiates (symbol for increase) respects boundaries. Eating well. Speech – tone normal, trying to do & or not group work as possible – walking/snooker/cooking. Taking Px (prescribed drugs) under supervision – has talked about not taking when goes home. Px: respiridol const (sic) 50mg 2/52, Respiridone 2mg Zopiclone 7.5mg reports being well. Attending MIND drop-in 3 times..... seeing his mother (MH) abstaining from alcohol drug use 2-3 ys (cannabis) believes he is more open, relaxed, calm & active. MSE – head down, better eye contact but somewhat restless. S (speech) – normal tone, rate, volume. Appropriate in content. M (mood) – is euthymic. ??responding to hallucinations... I – insight into coping skills required..... none into his current illness. P (Plan) – C/W (Continue with) current plan – activities Windswept to assess can increase leave'.*

On 11 September 2006, a Dr (*undecipherable*) (GP Registrar with Dr PS) recorded in the medical notes in respect of a ward round - (From the nursing staff) *'Went for*

visit to Windswept but no assessment been done.....started to kick doors and impatient in general. Assessment for possible Asperger's/Autistic spectrum still pending.....' Then records discussion with MH:- 'Went to bed at 5 am last night..... been to Windswept twice last week, been have (sic) also started having some shandy. Like Windswept & would like to go there. Thinks Windswept is like hospital but more independent and MH will learn and expected to do daily.....said that he has been a bit "hyper" in last few days – more talkative, pacing around/want to move a lot, maybe annoy people..... Mood or body do not speed up during this "hyper2" time. Maybe experiences this about 4-5x a month for about 1-2 hr each. Doesn't do any drugs, used to do cannabis but not anymore. P (Plan):- to establish of SG re: mood swings..... To get assessment for possible developmental probs eg – Asperger's/Autistic spectrum – continue'.

On 15 September 2006, Windswept nursing notes recorded that MH had moved in and did not settle well immediately. They stated '*.... he was overheard speaking to (name) at Sandalwood about ? a patient there called (Name) "getting his head kicked in" He went out from 6 pm to 8 pm, returned in good order reported having "two shandies" and visited his mother. He asked staff "What he had got" meaning diagnosis; he stated he used to smoke weed on a daily basis and to drink rum so he thinks he has a "drug psychosis". He added that he "acts like a child" and "needs to grow up".*

A summary document completed by Windswept and covering the period 15 September to 29 October 2006 contains the following entry for 15 September '*MH was transferred from Applewood to Windswept for a period of trial leave over that weekend. On Applewood, he had been compliant with medical treatment but was drinking alcohol and displaying verbal aggression, sexually inappropriate behaviour and generally bizarre behaviour and speech.*'

On 16 September 2006 Windswept nursing notes recorded that he made '*Comments of a sexual nature about a female member of staff at times his speech was bizarre, he asked staff "Who blew up the World Trade Centres" he also talked about the pop singer "W" saying that the singer "worried him".*'

On 17 September 2006, Windswept nursing records stated '*MH was noted to be walking around with his hood up (something that was observed on initial assessments prior to admission to hospital, when he was troubled by "voices") At times his speech content has been quite bizarre, interrupting others conversations with unrelated comments. Making reference to dogs on occasion. Asked staff if they'd ever seen boys making faces (these MH demonstrated as people mouthing words but not actually speaking...'*

On 18 September 2006, SG recorded '*Went to see on Applewood, I was informed MH has been transferred to Windswept, it was on a trial basis, he is now an informal patient.*'

Commentary: As MH's Care Co-ordinator, SG should have been informed of the transfer and of his discharge from Section 2 over three weeks previously.

On 18 September 2006, Windswept nursing records stated *'Risk – Whilst out at snooker MH stated he was going to finish with his current girlfriend because he was going to go out with female members of staff S/N (Name). Advised this was not possible and totally inappropriate'*.

On the same day, a further record in the evening stated *'MH left the Unit to go to the local shops –on return to unit, staff commented on the strong smell of alcohol on his breath – MH claims to have had 2 shandies – when staff suggested he had consumed something stronger, MH laughed but didn't deny it. MH has been behaving quite childish throughout shift but this has not been a management problem. He attended for tea but declined to attend Community Meeting'*.

On 19 September 2006, Windswept nursing notes recorded *'PC has been contacted he agreed that the plan was not for MH to be formally admitted as yet. Said that he was going to ward round @ Applewood to see if some clients can be discharged from there to (indecipherable word) later that day. TC received from PC (CT) – no vacancies today at Applewood, maybe tomorrow. MH has spent time off the ward this afternoon – admitted to drinking "shandies" – and went out again after the evening meal to "visit his mum". TC received from Hazelmead to report that MH had been there this afternoon, carrying a pint glass of beer and being disruptive. Staff to be aware that MH is banned from Hazelmead premises. MH returned to Windswept at 8.25 p.m.'*

On 20 September 2006, Windswept nursing notes recorded *'13.10. TC Received from PC, he is still trying to clear a bed, no success as yet, updated on incidents at Hazelmead, also MIND's intention to ban him as of today because they feel he's too unwell at present. MH was up early, requested and received routine medication, attempted to walk away without having taken tablet, however did take it once staff prompted him to do so in their presences (sic). MH left the unit prior to planning meeting, despit (sic) staff's attempts to encourage him to remain and attend. Prior to leaving MH was reminded that he was no longer welcome at Hazelmead..... whilst MH was out, phone call received from MIND saying that they were planning to send him a letter banning him, due to his rude/abusive language/behaviours'*.

On 21 September 2006, SG recorded *'TC received from JM, she informs me that MH is now in a relationship with fellow patient (G/F). He has been spending all of his time with her. Informed JM I am on leave for x2 wks but will contact her on my return.'*

On 21 September 2006, Windswept nursing notes recorded *'... T-call from PC still looking into a bed, said may have to be next week. He agreed that Windswept nor acute is suitable prominent difficulty is the Asbergic (sic) element, will get (XX)(CMHT CPN) to visit for a meeting with PC.....'* In the same record, AG entered and signed the following *'Brief chat with MH – he told me he was very well and happy to have a girlfriend. Said his life is good at the moment. Seemed much chattier than usual, speech faster, gestures (which have been unusual for him in the past). Said he's not drinking much and not smoking cannabis. Will see next week'*. There is no record in either her own notes or those of Windswept that she did see MH the following week.

On 22 September 2006, the Windswept notes showed that MH initially refused to give a urine sample but then did so and the consequent drug screen proved to be negative.

On 24 September 2006, Windswept nursing notes recorded *'Telephone call from JM saying she is concerned that MH is staying at the house of (G/F) a lot. He is asking his mother for money as he has spent all of his – she is refusing these requests. He has also told her he wants to move into (G/F)'s accommodation, & mother is concerned about this due to the fact that they are both ill people.... she asked if there is anymore (sic) we could do. I explained that at present there is little we can do as MH is an Informal Patient. Reminded her that if MH continues this behaviour, he is missing his medication & his mental health may start to deteriorate. At 09.05 hrs tel-call received from MH. He said he is going to lunch with his mother, & he agreed to return to Windswept at 3 p.m. so we can discuss his plans for the future. MH said he would like to move out of Windswept & live with (G/F). He says he has discussed this with her & she is in agreement. He said he has no money. I reminded MH he is missing his medication & this will not help him. He was pleasant & polite on the telephone with no evidence of intoxication, slurred speech or psychotic thought content.'*

A further record in the notes on the same date recorded *'MH returned to unit around 14.15 hrs no evidence of Alcohol. As soon as he returned he announced that he was leaving/moving out to live with his girlfriend (G/F) asked to wait and speak to staff which he agreed to do. Staff asked MH if he thought he was ready to take such a big step, and had he really thought how he would manage with rent, council tax, buying food, paying bills, especially as he had no money at present. MH responded by saying (G/F) was due back pay on her benefits this tuesday (sic), reminded this would be her money and not necessary (sic) for his use.*

Staff encouraged MH to remain a resident at Windswept so that proper attention can be paid to addressing his needs i.e. CPA, discussed with medical teams etc. MH was also reminded that the relationship was very new and if he moved in what would he do/go if they had an argument or found they couldn't live together. MH agreed that it would be in his best interest (sic) to remain at Windswept, and go out on leave rather than being discharged until this can be arranged. MH stated he was going to (G/F)'s for the night, he agreed to return tomorrow. He was given Respiridone (quicklet) 2mgs for his morning medication which he said/promised he would take. Request for Zopiclone denied with the explanation that if he was well enough to be going out, as he said he was then he didn't require night sedation.'

On 25 September 2006, Windswept nursing notes recorded *'13.25 hrs. Remains absent from the unit. Contacted PC who has agreed to discuss the situation with Dr PS. Also mentioned that MH's girlfriend (G/F) may be returning to hospital in which case MH would have nowhere to stay. At the time of report, still awaiting to hear back from PC about this.'*

A later entry at 17.05 hours on the same day recorded *'P/C (phone call) to PC of Crisis Team, he was not available, spoke to KHu (CPN) no feedback re PC discussing this situation with Dr PS. KHu informed us (G/F) is not returning to hospital at present. They visited her at home today and MH was present. MH has made no contact with unit at time of writing.'*

On the same date at 19.05 hours was recorded *'Attempted to contact MH on his mobile to ascertain what time he would be returning and the need to be on the unit tomorrow morning for medication. There was no answer no message left'*. And at 20.25 hours recorded *'MH has not returned at time of writing and no contact made with unit'*.

On 26 September 2006, Windswept nursing notes recorded *'13.15 hours. MH remains absent from the unit. Message left for PC to update us on management plan, which he intended to discuss with Dr PS yesterday'*.

A further entry on the same date at 15.40 recorded *'Staff contacted MH via his mobile phone, MH answered briefly, stating he was on a day out with G/F to Bristol, stated he had had his medication today, when I asked where he had obtained it from as he had only been given one 1x Respiridone 2mg (quicklet) on Sunday, and that was for Monday, he reported that he had forgotten to take it yesterday so took it this morning. Advised he needs to be taking it every day. I asked MH when he intended to return as it was important for staff to see him and check on his wellbeing regularly. MH has agreed to return tomorrow (Wednesday 27/9 by 10.00 hrs am).'* At 20.25 it was recorded *'No further contact, unable to get feedback from PC,'* and a further entry that evening states *'No contact made this shift'* (apparently referring to PC not MH).

On 27 September 2006, Windswept nursing notes recorded *'13.10. MH has made no contact with the ward. Dr AW will be in contact with SG regarding MH being at Windswept.'*

A further entry later the same day at 20.05 hours recorded *'T/C to MH's mobile requesting he contact us somehow, even if it is via the Crisis Team; & to remind him of his depot due on Friday 29-9-06. It is unlikely MH is receiving these calls as he has no money, hence no credit on his telephone. T/C to CMHT, message left for RG (Manager) requesting him to contact us. No phone call received today. If he phones, please discuss the following: (1) MH's presentation & absence since transferred to Windswept (2) MH's non compliance with oral medication (3) Depot due on Friday 29-9-06 – who is covering for SG's caseload whilst on leave? And could they visit him in community to administer depot? (4) Arrange CPA A.S.A.P. to discuss accommodation & discharge liaising with PC (Manager, Crisis Team) (5) Ensure Consultant Psychiatrist is aware of all this information (A note in the margin of this entry states:- 'SG on leave until 9/10/06).'*

On 28 September 2006, Windswept nursing notes recorded *'10.05. P/C from RG to discuss issues discussed yesterday ... he was updated as to MH's presentation since being at Windswept. RG feels that from this description feels that is still unwell at present and needs to be returned to hospital. Advised RG Windswept had liaised with PC re management of MH. RG will contact PC & Crisis Team for a referral to be made whilst in the community. RG was informed that MH's Respidal Consta was due tomorrow, as SG is on leave he will liaise with his team for one of them to give this. RG is aware we have ordered the consta and will be available here from tomorrow a.m. RG assured staff he will discuss this issue with Dr PS and contact us regarding further management. RG feels that because of MH's probable mental state & that SG is on leave he would like to wait until her return before CPA & discharge*

planning goes ahead. RG is aware of our concerns re management of MH at Windswept.'

At 12.00 hours the same day it was recorded 'P/C received from MH's mother JM. She reported she is concerned for MH as he appears as he was prior to admission to Sandalwood. She reports that he is drinking heavily, has spent all the benefits he received is not looking after himself. She reports he is visiting her but only to borrow money and tobacco. She is concerned for MH at present. Informed the unit would contact her when we had more info re plan for MH. P/C to RG – message left will call back. P/C to Crisis Team to see if RG has contacted them re management. AB will speak to PC and get him to call back.'

A further entry on the same day at 13.25 hours recorded 'P/C from RG he has arranged for two members of his team to visit MH to persuade him to return to Windswept, if he does not agree RG will request assesment (sic) from Crisis Team. Dr PS is aware and is happy with this. Expressed concern should MH return to Windswept of his presentation due to non compliance with meds + alcohol intake and whether MH could be managed here. RG said feedback could be obtained from the team members who will visit and report back, however RG feels he will not want to return here'.

At 20.15 hours it was recorded 'T/C received from RG. CMHT have been unable to locate MH in the community. They are aware of mother's concerns ie deteriorating mental health. RG will refer MH to the Crisis Team – as they are visiting the address at which he is residing. He says either CMHT or Crisis Team will attempt to administer depot in the community. RG will liaise with PC (Manager, Crisis Team) regarding the need for re-admission for MH. RG said MH's mother knows MH very well & he appreciated her concerns about MH. He reports MH has also been texting SG (Care Co-ordinator) inappropriately on her mobile phone'.

On 29 September 2006, Windswept nursing notes recorded '13.30. MH returned in the company of DM (Community Support worker) and (G/F). Initially MH stated he was here to take his own discharge, and move in with (G/F). Making reference to Dr PS's name as Super..... Dog, very restless unable to sit still, for any length of time, gesticulating constantly with his hands, muttering to himself, quite unsettled in presentation unable to concentrate on conversation. MH refused to accept his depot (Respirdal Consta 50mg/im) saying he doesn't want the needle but would have a tablet. Respiridone 2mg (quicklet) given and a further tablet given for tomorrow. Staff liaised with PC and Dr V (SHO) as Dr AW was unavailable (Dr PS's SHO). Attempts to keep/persuade MH to stay until seen by a doctor or allow staff to establish relevant management plan. Shortly after leaving the unit MH rang back to say that he would return and have his Depot. Returned to unit again at approx. 11.30 hours. Agreed to have Depot, same given Respirdal Consta 50mg I.M.

S/B (Seen by) Dr V- assessment made, she feels he is still much improved than when MH was in Applewood, he reported, no Auditory Hallucinations, and she felt there was no evidence he was being troubled. No reports of disturbed thinking presented. MH reports he is sleeping well, and believes he has a Mental disorder but not Schizophrenia, some borderline probably. Staff conveyed there (sic) concerns re the deterioration they were observing, but Dr V feels he is much better than when she'd previously seen however understood staff's concerns of MH's non

engagement missing medication etc. PC contacted, informed of MH's presentation, that he has now accepted his Depot and oral medication. PC is aware further assessment required at the concerns re placement suitability, he is going to liaise with DB. Plan at present, seeing as MH had accepted/received his Depot, he could return on leave to (G/F)'s, he has 1x 2mg Respidone for tomorrow (30/9) He has agreed to return on Sunday for further medication. Crisis team aware. MH has once again left the unit in company of (G/F)'. A later entry at 20.00 hours on the same day recorded 'No contact made this evening'.

On 29 September 2006, Dr V recorded in the medical notes 'Asked to see MH as he had been refusing his oral medication & didn't want to take his depot this morning. He was restless & agitated though he agreed to take his oral respidone. He went back but did agree to come back (word undecipherable) to take his respirdal consta. He is living with (G/F) at present and is very (word undecipherable) about it. He seems to have been sleeping well & that he doesn't hear any voices. He had been hearing them in the past but felt they were childish & reassuring + quite liked them. He feels he has a mental health problem therefore not schizophrenia. He feels it is a border line disorder that he knows is not quite schizophrenia. He said that he doesn't need any medication but he agreed to take it as it helps things to settle. He denied abusing any substances eg cannabis. MSE –PMA (symbol for increase) was restless and kept walking around. Was very communicative made good eye contact though was smiling inappropriately sometimes. Talk – relevant & coherent R/T/Q (response to questions) Mood – inappropriate occasionally.... feeling fine. Denies delusions. Said he got afraid last night when (G/F) and he were talking about ghosts..... Plan – to continue on respirdal consta + oral respidone – Crisis Team will cover liaison over the weekend - for team review of situation on Monday.'

On 30 September 2006, Windswept nursing notes recorded '11.10 hours. MH attended the unit at 11.00 hrs. He requested medication for tomorrow & assured me he had taken today's dose. T/A given for tomorrow – he intends to stay out tonight + tomorrow night + will return for further medication 2/10/06..... he was extremely reluctant to engage, only to reassure me he is "alright", he prefers living in the community'.

On 30 September 2006, Crisis Team records stated '8.30 am. Seen this morning at M Ave, appeared relaxed and polite. Appropiarate (sic) in manner plans to visit his Mum today'. Prior to this entry, there is a blank sheet in the Crisis Team notes, which has not been struck through, followed by the above entry, after which the page is blank and not struck through, followed by a further blank page which has not been struck through.

Commentary: We considered that the clear and comprehensive notes recorded in Windswept nursing records indicate a growing level of serious concern about MH's presentation, mental state and home circumstances. These were supported by several telephone calls from his mother. These concerns were communicated regularly to PC of the Crisis Team and, to a lesser extent, to RG. Whilst the latter shared these concerns and is reported in Windswept notes to have taken action to try to expedite matters, this was not recorded by him. PC indicated to Windswept on a number of occasions that he

would be taking action but there is no record by him, or by anyone else, that he did so.

The concerns of Windswept staff and of RG did not result in a Mental Health Act assessment taking place or referral by PC to Dr PS or Dr MS for Consultant review. There is no record in the medical notes of discussions with Dr PS or any action taken by him. We were concerned that these circumstances had not prompted a review by either Consultant, given that MH's presentation, engagement, home circumstances and poor compliance with medication were of such concern and so clearly recorded by Windswept staff.

October 2006

On 1 October 2006, Windswept nursing records stated '*am MH remains on leave for the morning period*' and Crisis Team records state '*8.30 am. Home visit to (G/F) – MH was there. They were dressed but lying on the floor downstairs with all the bedding..... (Details of (G/F) excluded here) I explained the need to make their own choices, reiterated with them there (sic) relapse signs and for them to take their medication. Both agreed to continue to do this*'.

Commentary: We were concerned to find explicit detail about (G/F)'s presentation and difficulties clearly recorded in MH's records and consider this to be a breach of patient confidentiality. ¹

On 2 October 2006, Crisis Team records stated '*Visited at (G/F)'s taken to Windswept who gave morning meds, & tom (tomorrow) AM's meds, informed has had depot, MH was settled made Good eye contact & chatted happily*'.

On the same day Windswept nursing records stated '*13.00 hrs. MH attended the unit this a.m., accompanied by JE of the Crisis Team. MH would only engage in conversation so far as to say he was "Doing alright". He appeared dishevelled but stated he had been washing his clothes at (G/F)'s. He took his medication here for this am and was given a TTA for tomorrow a.m.'s dose. JE asked if there was any reason why MH had to attend here for his meds, as the Crisis team were delivering meds for (G/F) at home on a daily basis and could take his to him. It was suggested that this was discussed with both teams before a decision was made regarding his meds. Team to phone crisis team tomorrow*'.

A further entry on the same date stated '*Nocte 06.50 a.m. MH returned to the unit at 23.45 hrs. He rang the bell and when answered he just walked into the building he was offered staff time to discuss any problems and assess his mental state – he was briefly engaged in superficial conversation. No overt signs of psychosis or alcohol use. MH immediately went up to his room. At 6 am MH came downstairs and engaged in conversation with staff. He stated that he had fallen out with his girlfriend because she had been seeing someone else. MH wants to try to make up with*

¹ The Panel sought to see the witness, who made the 1 October 2006 entry, but were told that she was no longer employed by the Trust.

her. He then told staff he was going upstairs to shave his head but wouldn't say why. MH was pleasant & appropriate in conversation.....'

On 3 October 2006 Windswept nursing records stated '13.05. MH this morning was encouraged to attend planning meeting + complete chores. He had a bath + attended for meds without prompting(Here MH gave some detail about his relationship with (G/F) Phone call made between JK & PC (crisis team), current plan is to monitor MH's intentions and if he requires Windswept advice engaging in a relationship leading to increase his vulnerability to stress.'

A later entry on the same date stated '19.45 hrs. T/C from MH's mother this evening, enquiring whether he had returned to the unit last night. She said he had arrived at her house at 11.30 pm last night due to "falling out" with (G/F), but mother had encouraged him to return to Windswept. I advised that MH had indeed returned. Advised that MH has agreed to maintain contact with us, & we are awaiting the return from leave of SG, to plan future interventions. Mother appreciates that MH can only help himself to make changes, but he appears reluctant. She says MH keeps going to her house & demanding money from her which she cannot supply. RISK She says if she did then MH would spend it on alcohol. She also said MH is verbally abusive towards herself + his younger brother, calling him "a bastard".

On 5 October 2006, Crisis Team records stated 'Visited MH at (G/F)'s flat. MH was drinking a can of "stella" (8.45 in the morning) and was awake since 6 am (reported by him). MH was warm in affect, cheeky in manner and talkative. MH said he is waiting for £400,000 which his grandfather apparently "owes him".....When I asked further questions MHseemed as though he didn't want to talk about this further. MH also talked about how.....' (blank page here, followed by entries for 13, 14, 15 and 19 October) continuing on the next page with the above quote from 5 October... 'and be the toughest man in the county so he can get the most pretty girlfriends and be a celebrity and have lots of money and take a lot of illicit drugs. MH also reported smoking cannabis last night with PD. MH asked if the crisis team could bring out his medication said I would discuss with team + Windswept.'

A further entry by the Crisis Team on 5 October 2006 stated 'D/W with Windswept fed back earlier visit. JK informed me they are planning to organise urgent CPA when SG back (Mon) as MH not engaging. They are expecting MH to attend Windswept today and if he doesn't will call CT to discuss course of action'.

On that day Windswept nursing records stated '13.00. T/C from Crisis Team – they have been to see their client (G/F) & MH was there. He asked them to bring him some medication. They say he has been drinking heavily (10 cans of "stella" seen) & he + (G/F) were using cannabis last night. They also say that MH is expressing some strange ideas around being a Gangster, expecting huge sums of money in "inheritance from his Grandfather..... He would not elaborate on what he meant by this. MH has not attended the unit for medication – if he hasn't by 2 pm then we should contact Crisis team to make them aware of this. I have informed the Crisis Team that the plan is to arrange an urgent CPA when his CPN returns from Annual Leave on 9/10/06. Currently MH would not be able to engage in rehab here due to his presentation at the moment.'

A further entry on the same date stated '20.30. Crisis Team arrived at 14.30 to (indecipherable word) them to deliver meds (indecipherable) however Crisis Team did not write up his prescription chart as requested'.

On 6 October 2006 Windswept nursing records stated '10.20 hrs. P/C to PC, Crisis Team to enquire about MH receiving his medication in the community. PC has said someone will call by to collect his prescription charts & Respiridone Quicklets and give them to him in the community. PC also said there may be a bed available after the weekend on Applewood, and could be admitted on Monday should it be necessary. If so urgent CPA in a ward round'. A further entry in Windswept notes on the same day states 'Crisis team collected MH's treatment card and the remainder of Respiridone Quicklet tablets.'

Commentary: Our understanding of the advice recorded as having been given by PC is that a Mental Health Act assessment was dependent upon bed availability rather than on the current mental state, which in our view demanded an urgent MHA assessment. An assessment did not, in fact, take place until 17 November 2006, some 6 weeks later. We heard from the Trust that its current (at time of this report) policy explicitly addresses the fact that a Mental Health Act assessment is not dependent upon bed availability.

On 7 October 2006 Crisis Team records stated 'Visited MH at G/F's. Took meds no problems, said he was going to 10 Downing Street, when I asked why he said he was friends with the government. MH says everything was fine and that he was happy. He asked where the bottle of vodka was we took away. There was a lot of beer can remains and rubbish about'. However there is no record in Crisis Team notes of a bottle of vodka being removed.

On 8 October 2006 the Crisis Team records stated 'Visited MH at (G/F). MH accepted his medication stated that he would be going out to his friend's house for a haircut. Was bright in mood. Plan is to visit again tomorrow'.

On 9 October 2006 the Crisis Team records stated 'Medicated MH this morning, he was up and dressed, very talkative, good eye contact and smiling a great deal. MH looked better than I have seen him for a long time'.

On 9 October 2006 Windswept nursing records stated '13.5 hrs. Attempted to contact SG (Care Co-ord) as the phones at the Mall are out of use. Attempted to contact by E Mail – with no reply, phone call to PC for update re MH and probable admission to Applewood. Informed us that following ward round he will know whether MH will be admitted today and due to difficulty in contacting Staff at the Mall the CPA could wait until decision is made about his admission'.

A further entry on the same day states '20.20. message left (symbol for with) PC to chase up the plan for MH did not call back, nor did SG'.

Commentary: There is no entry by PC in Crisis Team records of any of these discussions with or contacts from Windswept.

On 10 October 2006, Windswept nursing records stated 'SG arrived on unit & spoke to JK (manager) Staff informed her that MH wasn't on the unit. Half hour after SG left MH returned to the unit. MH has spent the morning in evidence. Making bizarre comments to others no serious conversation made.'

On that day, SG recorded in her notes 'Attended Windswept spoke with LL about the current situation. MH has hardly been at Windswept over the last 3 wks spending possibly 1-2 nights. He is drinking excessively and smoking cannabis. He is spending all his time with (G/F) staying at her flat, not engaging in the Rehab programme, staff feel he continues to show signs of psychosis, delusional beliefs also that he's agitated. They have had a lot of contact with JM who is extremely worried about him, she feels he's very unwell, there was an incident when MH hit his younger brother. Due to MH not returning to Windswept Crisis + Home Treatment Team are visiting him daily to deliver medication. Due to current situation Professionals meeting booked for 13/10/06 at 9 am. As I was leaving MH was walking down the street. APPEARANCE AND BEHAVIOUR – unkempt, dishevelled, dirty clothes, appeared agitated, pacing, unusual movements. SPEECH – Rate – increased, rambling at times, volume – heightened. Speech content sexually inappropriate. MOOD – MH reports that at times he feels "depressed" however, ok now, MH appeared elated, flight of ideas grandiose. HALLUCINATIONS – Denies, although appeared preoccupied ?responding to external stimuli. DELUSIONS – MH believes he is a mighty soldier (sic) and has a task to carry out. A/c of his beliefs pattern around sexuality. He told me that "I haven't raped you, I can tell by your eye". He believes that (name of famous rapper (FR hereafter)) & (name of famous female singer (FS hereafter)) are his half brother and sister. APPETITE – reports to be eating however looks like he's lost a lot of weight. ALCOHOL+DRUGS – drinking spirits at present ½ of vodka. Smoking Cannabis daily unable to obtain quantity. He stated he may go on to use LSD, speed, Heroin. Since I last saw MH there was a dramatic deterioration of his mental state. Advised him about the possible effects of Cannabis could do and that he is putting his placement at Windswept at Jeopardy (sic), however he seemed oblivious to this. D/W Dr PS, informed of current presentation, Dr AW has been attempting to see him however to no avail. Dr PS has recommended that when he is seen to possibly commence Depakote'

A further entry in the Windswept notes on the afternoon of that day stated 'MH went out to snooker with (staff name) this afternoon. He did state that he didn't plan to return back to the unit and his meds were being given to him. Co-client (Initials) stated that he didn't go to snooker but went to a friend's that lived nearby ?(G/F)'s house. MH didn't return back to the unit this period'.

On 11 October 2006, Windswept nursing notes stated 'Crisis team contacted this a.m. to remind them of MH's depot this Friday & stating due to them having the chart they would have to order it. They called us back stating no dose/frequency is written on chart SHO has been contacted and asked to call Windswept'.

On 12 October 2006, Windswept nursing notes stated 'SG contacted the unit stating that a professional meeting is being held at the Mall at 9 am tomorrow staff from Windswept will need to attend'.

On 13 October 2006, Windswept nursing notes stated '10.45 hrs. *Attended Professionals meeting at The Mall. Present RG (Team Manager) AG (Psychology) SG (Care Co-ordinator) SD (Crisis Team) TE (Windswept) to discuss future management of MH in the community. SG expressed concerns over MH's current mental state, and his current relationship with (G/F), which the MDT felt is detrimental to MHs mental health. It was also reported that MH has been drinking to excess smoking cannabis and has mentioned to SG about using other illicit substances. It was fed back to the team that since MH has been transferred to Windswept he has spent only short amounts of time on the unit, at these times his mental state has been difficult to assess. MH has on 2 occasions wanted to take his own discharge, as he feels he no longer needs to be at Windswept as he had accommodation at (G/F)'s house.*

It was felt by the team that MH needs a further assessment by a medic, with possibility of considering a Mental Health Act Assessment. Although Crisis Team reports he is currently compliant with their interventions + taking medications and may not be detainable. The matter is complicated further by his involvement with (G/F). She may be taken back into hospital, which could complicate matters should he need readmitting to the acute ward – this will be managed by the crisis team + ward staff if this matter arises.

As MH is currently informal and has not been engaging with Windswept it was felt he should be discharged when emergency accommodation can be found. It was also felt that MH has not responded well to Risperdal and his team may suggest a review of current medications. He continues to receive his medication daily from the Crisis Team and they are aware his depot is due today. MHs vulnerability was discussed, also the potential to be easily led. Felt that should (G/F) be readmitted may be the opportunity to re-establish a treatment regime and be seen by care co-ordinator & AG for Early Intervention work.

PLAN: MH to remain on leave from Windswept til Monday to allow for short term emergency accommodation (B+B) to be arranged following liaison with RG on Monday if goes to Plan to be discharged from Windswept.

To be referred to Assertive Outreach Team.' ²

For MH to be reassessed for Windswept in the future following improvement in mental state

Crisis Team to continue to administer medication.'

On 13 October 2006, SG recorded in her notes '*Professional meeting. View letter in correspondence. PLAN – (1) Placement at Windswept to be terminated (2) Look at MHA assessment (3) Reviewed by Dr MS on 16/10/06 (4) Community support to remain in place (5) Crisis team to visit daily (6) Emergency placement to be found.'*

On the same date, there are two records (unattributed) as follows:- A handwritten note taken on the day and filed in Crisis Team notes (used thereafter for continuation records from 14 October 2006) and typewritten notes of the meeting apparently derived from the former and undated. This latter document is filed in the Correspondence section of MH's notes.

² In evidence the Panel heard that the AOT was not taking any new referrals at this time and that care co-ordinators had been informed,

The note contained in the Crisis Team records stated '13.10.06 Multi professional meeting RG/SG/AG/T. MH is not making any progress no improvement on risperdal consta. Long term concordant (sic) issues – possible review of meds – depixol injection. To be reviewed by Dr MS on Monday. If MH's partner goes into hospital CMHT will arrange B&B – RG will be doing this.'

The record contained in the Correspondence section of the notes records is headed 'Professionals meeting for MH on 13/10/06' and recorded 'Those present: SG – care Co-ordinator RG – CMHT manager AG – Early Interventions Team T – Windswept SC (now SD) – Crisis Team.

T commenced the meeting be (sic) sharing the input that Windswept have had with him since he moved in mid September. There (sic) contact has been extremely brief it has been very difficult to engage in any conversation with him. He has only spent at the very most 6 days out of a month there, the remaining of the time he has spent with G/F at her home. It is proving a job to obtain an assessment of MH's current mental state but they feel he is unwell at present and unable to engage in the structure at Windswept. Also he is not spending any time there and is taking up a bed which someone else could benefit from.

SC (Now SD) – the Crisis team have been seeing MH daily to deliver his medication and monitor his mental state. He has been smoking Cannabis and drinking heavily.

SG – last saw MH on 10/10 06 after being on leave for 2 weeks. She noticed a dramatic change in MH he was unkempt, agitated, laughing inappropriately, flight of ideas, grandiose (believing he is a mighty soldier (sic) and is going to save the earth from bombs), sexually inappropriate and disinhibited.

Every body (sic) at the meeting was extremely concerned for MH's well being AG has also seen a deterioration in his mental state and his engagement and compliance is sporadic.

RG stated that the best and safest option was to take him into hospital; whether this is on an informal or formal basis. This is due to the risk to MH and others. Plan 1. Current placement at Windswept to be terminated 2. Look at Mental Health Act assessment 3. To be reviewed by Dr MS on 16/10/06 4. Community support to remain in place 5. Crisis Team to continued visiting daily 6. To be discharged from Windswept 7. Emergency placement to be found possibly The (name of B&B)'

Commentary: There was no medical presence at this meeting. Also, although the CMHT team leader attended, the Crisis Team manager (PC) was not present.

On 13 October 2006, Windswept nursing notes stated '13.00 hrs. P/C from SG, informed us that (G/F) is going to be taken back into hospital this p.m., and therefore SG will ask MH to return to Windswept until Monday – SG is unsure whether MH will return here if not may have to consider emergency homeless accommodation. The forms have been completed for B+B accommodation from Monday. Staff still to contact RG on Monday a.m., should MH remain here over the weekend. Asked SG to ensure that should MH return here we would need his med chart from the Crisis Team: and to ensure he has had his depot due today as we do not have it available here. SG assured the above would happen and that either her or the crisis team will contact Windswept to update us if MH will be attending. SG is on leave from this evening for one week.'

There is a further entry on the same day '20.00. Call from crisis team, they will give depot tomorrow due to time constraints today + they will speak to MH + girlfriend about his plans if (G/F) has to go back to hospital NB crisis team will call tomorrow with a more certain idea of MH's intentions'.

On 14 October 2006 Crisis Team records stated 'Saw MH today at his girlfriend's flat (G/F) he became quite hostile towards (name and I) at times. He agreed to go to the (name of B&B) if his girlfriend came into hospital. Informed the (name of B&B) that MH may arrive there and that funding was agreed. Negotiated that he would have his depot tomorrow'.

On 14 October 2006, Windswept nursing notes stated 'P/C to Crisis Team for an update of information regarding MH returning to Windswept. AS informed me that both MH & (G/F) were not home for their visit this a.m., but will let us know if we are to expect him'.

On 15 October 2006, Windswept nursing notes stated 'P/C from PC stating that they are planning (G/F) admission to the ward today or tomorrow thus MH will be homeless. He will be offered B&B or Windswept so we are uncertain at present what his plans are'. On the same day Crisis Team records stated 'MH not in unable to give his depot.'

On 16 October 2006, Windswept nursing notes stated '20.25 hrs. MH has made no contact with the unit, and remains on leave. Unit to contact RG tomorrow'.

On 18 October 2006, Windswept nursing notes stated '15.10 hrs. P/C to RG CMHT Manager re MH. Informed that (G/F) will hopefully be readmitted to Applewood tomorrow a.m. RG informed me that the community team feel that MH is more unwell than he has been but showing symptoms of elation, disordered thought as opposed to previous depressed presentation. PC informed RG that MH is to be offered to come back to Windswept as the first option, with a chance to reengage, but feel that he may be too unwell to engage with our service. Informed me that should MH return here, attempts should be made to assess his mental state. If this occurs before the weekend perhaps contact AG (Early intervention team to attend, as she knows MH well with a good rapport and may help with assessment. If MH felt to be too unwell to be managed at Windswept Crisis Team are to be contacted as RG feels he may need acute admission rather than B+B and this may not be appropriate. However, MH may refuse to call to Windswept. Contact Crisis team for more info tomorrow a.m.'

On 19 October 2006, Windswept nursing notes stated 'Contacted Applewood – (G/F) re-admitted this morning. Contacted Crisis Team – they are attempting to contact MH re. Where he will be staying ie. at (G/F)'s flat/returning to Windswept. Should he return to Windswept, Crisis Team have been asked to bring MH's drug chart + meds'.

On 19 October 2006 Crisis Team records stated 'Windswept have a bed for MH. Unable to get hold of MH to inform him as he has no fixed abode. Made contact with MH's mother she will attempt to make contact and ask MH to contact the crisis team'.

A further Windswept record on the same date stated '19.52 hrs. T/C from JK (Crisis Team) to say MH had been removed from Applewood at approx. 17.30 hrs, as he was intoxicated & possibly carrying a knife. I tel'd. Applewood to enquire whether incident had been reported to police. I spoke to "K" who says MH had arrived on the ward, supposedly to bring some clothes for (G/F). On arrival he was very intoxicated, his ?speech/behaviour escalated & he was requested to leave. CT had been contacted but they were unable to attend at that time. K says that after MH left, another patient says they believe MH had a knife in his pocket although this was not observed by staff. She said she would liaise with the Crisis Team regarding informing the police. No contact made here with MH'.

A further entry on the same date was noted in the margin with Drug & alcohol and stated '21.00 hrs. MH returned to the unit at 20.15 hrs. He smelt strongly of alcohol & said he had been drinking lager throughout the day. He also said that he & (G/F) had been smoking "green" (some form of cannabis) all last night, & so he was "a bit giggly". MH says the cannabis "can make you a bit paranoid", but then said the respiridone tablets & injection had made him paranoid as he used to "see little bits" when he had to have them. He does not want respiridone any longer & said he wants to change back to olanzapine. I advised he would need to discuss this with the doctor tomorrow a.m., to which he agreed. Mental State) MH presented with elated mood & some underlying irritability & grandiose ideas – he repeatedly said he will save the world, that he personally will capture Osama bin Laden he made racist remarks about Iraq people & the trouble they have caused. MH referred to "wanting to smash a room up", but would not elaborate on this. MH talked of his sadness at (G/F) being taken back into hospital, & said he feels stressed & upset about this. (annotation in margin here Mental state) He agreed that he does feel elated in mood, he said he could not stay here as he "needs to get out & go on buses". When MH went to his room he played extremely loud music although did turn it off after being requested to turn it down. I asked MH if he had brought any drugs to the unit – he said, "No". I asked if he had brought anything else with him that he should not have – he immediately said, "What, a knife? Or what....?" I explained alcohol or weapons of any kind. He denied this. MH was able to sit & drink a cup of tea for approx. 10 mins. with staff. He says he has eaten today. He went to his room. At approx. 20.45 hrs MH knocked on the door & said he had to leave, he could not remain here for the night. He said he was returning to (G/F)'s, he would get the bus & needed "to get out on the buses" Despite attempts to persuade MH to remain here, he still left. I felt he could not be detained at that time due to the level of intoxication. He said he might return to see a doctor, tomorrow but he also might not. Earlier, whilst talking to Support Workers (2 names), MH had implied that if any other man goes out with (G/F), that man will be killed by MH.'

A further entry on the same day stated '9 pm. Telephone Call to crisis team to inform them of MH's departure and that he was going back to (G/F)'s house. Also advised them that MH may have a knife, they were already aware of this. JS (Crisis Team) later phoned to see if MH had returned and was informed no'.

On 20 October 2006, Windswept nursing notes stated '14.55 hrs. T/C to CMHT requesting RG to contact us. Also left the info that it is suspected MH was carrying a knife yesterday, for if community staff should attempt to contact him today. No call received from RG as yet. No contact with MH today'.

On 21 October 2006, Windswept nursing notes stated '13.00. MH arrived at Windswept at 9 am, looking tired; said he had not slept last night and had not had any medication for a few days. He had a wash, changed his clothes and made himself tea and toast. Crisis Team were contacted and H brought up a daily dose of medication, which MH accepted. He agreed to a visit from Crisis Team tomorrow morning – at (G/F)'s flat. MH consented to staff (SB and GC) conducting a personal search when he arrived at Windswept for illicit substances/weapons – none found. MH was pleasant + co-operative with staff. He expressed troubling thoughts on a range of subjects, including drug abuse and tried to communicate how he was feeling, but with great difficulty in organising his thoughts. He indicated he was unhappy & sad but this did not manifest in his behaviour. He was somewhat flattened in affect and restless in behaviour. MH left the unit at approx 10.30.' A further entry later that day stated '20.00 hrs. No contact with MH this afternoon'.

On 22 October 2006, Windswept nursing notes stated 'T/C received from Crisis team, they have been out to see MH this morning but he wasn't at the flat, if he attends the unit please can staff contact crisis team'. A further entry on the same day states '20.10. No contact made with Windswept'.

On 23 October 2006, Windswept nursing notes stated 'T/C received this morning from JK crisis team, to enquire if any contact had been had with MH over the weekend, informed none since Saturday. Advised staff will contact them should he attend. T/C received from MH's mother expressing concern about his presentation, she had just spoken to him on the phone and he was at "the flat". JM feels that MH is deteriorating rapidly, almost to the point that he is a bad as prior to admission, he tells her that he's got knives, and is going to kill himself, (G/F) and any other man who (G/F) goes out with. JM enquired if she could request a Mental Health assessment advised she could. Also reassured that I (LL) would be contacting Crisis team and would also relay her concerns. Attempt made to contact crisis team, all staff out at present message left'.

On 23 October 2006 Crisis Team records stated 'MH attended ward & was brought down to Crisis Team as unable to be allowed on ward due to previous behaviour (Knife & threatening) it had earlier been reported he was violent to his brother – hitting him & that this was reported to police. MH was restless, over talkative & had pupils like pinpricks, he spoke about being "depressed" & lonely since (G/F) was brought into the ward & spending his day wandering around his friend's house for company. Admitted having 1 small drink & spoke about using cannabis & threatening to use crack cocaine if didn't see (G/F). Informed unable to visit on ward but arranged to bring to Sandalwood in morning for 1 hour visit. Given 2mg Lorazepam by AS & went home happy'.

A further entry in Windswept notes on the same day stated '15.00 hrs. Contact made with JK Crisis team informed of JM's concerns about MH's mental health, and her voiced desire for Mental Health assessment. JK reports that following our conversation this morning they had made contact with MH at (G/F)'s flat, he had presented well dressed, sober, appropriate in manner. Accepted his medication. JK will inform other members of Crisis Team of JM's concerns. Crisis team have arranged with MH to see him tomorrow'.

Commentary: Although Windswept reported from information received from the Crisis Team that MH had received his medication the Crisis Team record indicated that the only medication he had been given was 2mg of Lorazapan rather than the prescribed medication of Risperidone on a daily basis and Respirdal Consta every fortnight.

The risks presented by MH now included frank references to knives, violence towards his brother and threats of self-harm at a time when he was variously described in the records as angry, threatening to others, agitated, and presenting flight of ideas. A thorough Risk Assessment involving all of the hospital and community teams was not undertaken, although MH's behaviour clearly involved risks to himself and others wherever he was.

A further Windswept entry on the same day stated '15.10. Contact made with MH's Mother (JM) to inform her that I had made contact with Crisis team and passed on her concerns. I also reassured her that crisis team had made contact with MH and found him well and he had received his medication. JM appeared quite distressed and informed me that MH had just been around to her flat, being verbally abusive to her and her 8 year old son thumped the 8 year old and had been shouting obscenities to him and his friend (also 8 years old). MH had been demanding money as well as being abusive. JM stated that she doesn't know what to do anymore, because he presents one way with her and when Crisis team see him for a short while, he can present a "calm" front for a short period of time. She reported feeling unsafe when MH is around and fearful for her younger son. Staff (LL) advised her that as MH had actually physically assaulted her 8 year old, she could report it to the police, this would give the message to MH it was not acceptable. Obviously JM feels this is a drastic measure, but feels she is left with no other option and needs to protect her other sons (sic)'.

A further entry on the same day stated '4.20 pm. MH arrived on the unit and headed straight to the fridge where he made himself a sandwich. Staff tryed (sic) to engage with him he talked of wanting to topp (sic) himself and believed he's the black man from the crying game. He is angry with Applewood because they are keeping (G/F) in He then started shouting for support worker (initial) at the top of his voice. Staff unlocked his room, where he requested medication "Lorazapam". He stated he feels depressed when he doesn't use weed. He stated all he's had for drink is one bottle of becks and he hasn't used weed today. He has eaten ++ and has been very unsettled (agitated and restless). He left the unit at 4.40 pm stating that he planned to visit (G/F) in Applewood. Crisis team called (by recorder) message left. Applewood called (By recorder) (to inform them of his plans. Spoke to JP. She states that he is banned from visiting Applewood.

Crisis team called back they have stated if MH goes there he is to be diverted to Redwood so he can be seen by a medic there. Dr AW called the unit after message left on his pager and stated that he doesn't feel MH is a suicide risk and this is something he says. Just at that point MH walked on to the unit approx 5 pm then walked out again refusing to engage with staff. Dr AW stated to contact the crisis team if he enters the unit again. Staff nurse (name) went after MH and he was way up the road and ignored her calls'

A further record on the same date stated:- '8.15. At time of writing staff have not heard anything else regarding MH. Ward manager (JK) has stated that MH should not remain on the unit as he appears too unwell and if he returns to unit Crisis Team are to be informed'.

On 24 October 2006 Crisis Team records stated '10.00. Visited at home & brought to Ward to see (G/F), arranged room on Sandalwood, MH was again talkative speaking about being on Applewood as child, knowing (G/F) as child, dealing SPEED as child. Angry towards fellow patient (initials) as he had relationship with (G/F), very immature in behaviour & outlook & again asked for Lorazepam – agreed would visit Crisis Team after seeing (G/F)' A further entry on the same day stated '11.00. S/W SG reported concerns of that drug use & when he last had depot she will arrange urgent review with Dr PS.'

On 24 October 2006, Windswept nursing notes stated '15.00. Message left at the Mall for SG – what is the management plan for MH'. On that day SG recorded in her notes 'T/C received from Windswept, MH has not been discharged from there. They are concerned over his mental state he continues not to stay there and engage. I will D/W Crisis Team. Attended Sandalwood, spoke with AS who informs me Dr PS is still RMO for MH + Dr MS hasn't seen him. I will book a review. Saw MH outside Applewood. He has now been banned from the ward due to unacceptable behaviour, threatening to others. MH's presentation remains unchanged, he was agitated, elated, flight of ideas, unkempt. He also informed me he was carrying a knife. He wanted to hurt (initials) as he had had a relationship with (G/F) which he didn't like. MH refused to give it to me. Very difficult to follow conversation. Support given'.

A further entry in Windswept notes on the same date stated '17.45. MH returned. Joined others for tea, spoke of nearly getting into a fight but went away due to feeling too tired. They came back to Windswept for "a couple of hrs" Crisis Team aware. Spoke to H from Crisis Team (indecipherable) he has been seen several times + has had his respirdol consta. There is no need to further assess at Windswept'.

A further entry on the same date states '19.30. MH had staff time twice. Spoke of the following – The fight he had nearly he was commended for not engaging – Asked several times if he was well when this question was posed to him he said he was – Spoke of drinking a bottle of stella since Saturday – Spoke of only smoking cannabis 1/12 – Spoke of not wanting to go to hospital outside of area, has been told that if he requires hospital admission he can not go to Applewood currently due to (G/F) being there – Spoke of the incident re his mother said that he was angry he was warned that this position significant for her too – Spoke of having no strange thoughts nor voices but has been feeling sad – Having had injection today + is now on Lorazepam. NB MH spoke to fellow client (Overheard) that he got smacked around the head during the previous mentioned night'.

On 25 October 2006, Windswept nursing notes stated '9.45 am. T call from SG to JK (Manager of Windswept) SG is going to sort out a MHA assessment for MH and manager JK who spoke to her has advised her that he need's admission into an acute unit due to him being so unwell and unable to engage in the rehab'. A further

Windswept entry apparently on the same day (but may be following day as date not clear) stated '*Nothing heard from or about MH during the shift.*'

On the same date, SG recorded in her notes *T/C to JM, she continues to struggle with MH's behaviour, he continues to ask for money etc. Since (G/F) has been in hospital, he has been staying at her flat visiting her daily. He is discussing (personal matters) with her which she's finding increasingly distressing support & reassurance given++. Referral to Outreach + Recovery Team completed. D/W Dr PS and team as the Crisis Team are visiting daily and they are offering care then it appears Dr MS would be RMO. RG contacted the team and this was confirmed.*

In addition a further Crisis Team entry apparently on the same day (but may be following day as date not clear) stated '*Visited & observed taking morning meds x 2mg Lorazepam appeared more settled, spoke about smoking whole bag of "GRASS" to himself last night, visited Mum & spoke about being placed out of Swindon if needed hospital, he doesn't want this so took depot & will comply with Crisis Team. Taken to Sandalwood to visit (G/F) for 1 hour.*'

On 26 October 2006 SG recorded in her notes '*Attended Windswept, situation unchanged due to lack of engagement and deterioration in mental state it was agreed to arrange a CPA discharge meeting as MH is not making use of the bed. Booked for 1/11/06. Relevant invites sent.*'

On 27 October 2006 SG recorded in her notes '*T/C to JM, inviting her to the meeting. MH's behaviour continues to be problematic. She was very distressed and worried about MH's wellbeing. Support given.*'

On 27 October 2006, Crisis Team records stated '*11-00. Visited at (G/F)'s house observed taking meds, MH was restless & spoke of childhood – Dating (FS) admits using cannabis, brought to S/Wood for visit with (G/F) then taken to Mum's. MH spoke of unhappy childhood & delusions around this "bombs" and "(indecipherable)" etc otherwise settled in presentation.*'

On 27 October 2006, Windswept nursing notes stated '*Spoke to SG, she believes that MH is unwell and will speak to the crisis team regarding this. She has been update (sic) on our input into MH care and T calls with mother. She is trying to get him assessed by Dr MS who is now his consultant. I have spoken to her regarding our situation on having him under our care and would only be able to discharge him to B+B or in patient acute care. We have arranged a discharge CPA for next week. Wednesday 1st November here at 9 am.* On 28 October, the notes stated '*Nocte (06.46 hrs) No contact with MH.*'

On 29 October 2006, Windswept nursing notes stated '*Nocte (07.066 hrs) No contact with MH.*' A further entry on the same date stated '*MH appeared on the unit at 12.45 pm stating he wanted a bed here at Windswept. Crisis team informed & they state that MH does not have a bed here & was being managed in the community by Crisis team. He is currently living at (G/F)'s house but he states he has no electricity or food. MH asked whether he could stay here for a few hours before leaving, same granted. Crisis team to be contacted if MH present as a management problem.*'

A further entry on the same date stated '16.00. MH requested that he be able to take his belongings back to (G/F)'s flat, Crisis team contacted to see if anyone would be to (sic) collect him and his belongings, same agreed but MH would need to wait a while, same relayed to MH, he was happy to stay. MH and belongings left the unit with the Crisis team member. Shortly afterwards T/c received from MH's mother saying he had contacted her saying he was homeless and penniless. JM was reassured that he was staying at (G/F)'s flat and Crisis team were remaining in contact. JM expressed concern about how much money he has spent over the last week, and was worried if he should turn up and become threatening, advised if this should happen to involve the police'.

On the same date, Crisis Team records stated 'Visited MH at (G/F)'s house MH was listening to rap music and said that the song playing was his and (FS's). MH accepted his medication, has been collected from Windswept with his belongings and taken back to (G/F)'s house'.

On 30 October 2006, Windswept nursing notes stated '20.00 hr. No contact made by MH or his mother today', but on the same day AG recorded in her notes 'Saw MH for 15 minutes.' This entry contains no further detail.

On 31 October 2006, Crisis Team records stated 'Home visit today, MH was warm and pleasant in effect (sic) joking with myself and (name), asked if we could take him to see (G/F). Check with ward but (G/F) was out with (initials) and phoned him to say he could join her at snooker. MH asked for lift across the road which (initial) was going to do til he realised it was around the corner from where we were, so MH ran round on his own after more joking with us. Medication taken with no issues'.

A further Crisis Team record for 31 October 2006 was located in Crisis Team notes after the record for 21 November 2006. The November notes included blank pages, which had not been struck through and, until well into the Independent Investigation process when additional notes came to light, represented the final entries made by the Crisis Team prior to the homicide.

The misfiled entry for 31 October 2006 stated '12.00. Seen at (flat of G/F) MH was compliant (symbol for with) meds. Some bizarre features ie said he is friends (symbol for with) (FS) & she has his pictures in her house. He kept the visit short as he was attending I.DS, snooker (symbol for with) DM'.

Commentary: This is coincidental with the other report of the same date which did not accord with regard to MH's presentation as respectively 'joking' and 'bizarre features' and differed in other key aspects. We could find no reason for there to be two records or for the differences between them.

Between 11 and 25 October 2006, when Dr MS became Responsible Medical Officer (RMO) for MH, there was no clarity as to whether Dr PS or Dr MS was in fact the RMO.

Following the professionals' meeting on 13 October 2006, the Crisis Team failed to visit MH as agreed on 9 of 18 days during the balance of this month

and when there was documented evidence of serious and shared concerns about further deterioration in his mental state.

November 2006

On 1 November 2006 Windswept nursing records stated '*10.00 am. CPA cancelled due to people not turning up other than mother + CPN. Additionally phone call made by CPN to PC of crisis team who informs that there will be a MHA assessment + poss transfer from Swindon to another hospital poss Devizes. MH is now discharged from Windswept*'.

On 1 November 2006, SG recorded in her notes '*Attended CPA discharge, (Name) plus JM present. I contacted the Crisis Team to see who was attending it appeared no one had been allocated. T/C to PC, he has requested a MHA assessment so he felt there was no need for the meeting and for MH to be discharged from Windswept*'.

Commentary: The Mental Health Act assessment did not, in fact, take place until 17 November 2006.

On 2 November 2006, SG recorded in her notes '*T/C to Crisis Team requesting outcome of MHA informed that it has not taken place yet*'.

On 2 November 2006, Crisis Team records stated '*MH paged asking when he would be picked up to come here, as trying to arrange MHA. I tried to get him to come here at 2 pm but was already on his way. MH came and saw (G/F), he seemed bright, initially asked me if I thought he was "a lose (sic) cannon" He came and got his meds, accepted – had been to HMV and bought some Cds, asked for a lift as he has an Autism Assessment at his mums at 1 pm. DM agreed to take him back if he would wait. MH agreed*'.

On 3 November 2006, Crisis Team records stated '*10.00. Visited at (G/F)'s No answer, key in door, no sign of inhabitants, visited at mum's & medicated. MH expressed some bizarre thoughts & admitted (NB time 1.30 appears in margin beside 'smoking') smoking £80.00 Grass yesterday asked for lift to TOWN, to sell bracelet he had found, Given House Key (these last 3 words appear to have been crossed through)*

A further Crisis Team entry for the same day stated:- '*Visited MH at (G/F)'s flat. MH was listening to music when I arrived. He appeared slightly agitated underneath his superficially bright speech. He looked confused and said he is worried about his friend who he thinks knows (FR) the rapper. MH agreed to take his Depakote in my presence after a little persuasion + discussion. CT to visit tomorrow morning*'.

On 4 November 2006, Crisis Team records stated '*Visited MH at (G/F)'s flat this morning. MH took his medication in my presence but again needed reminding what it was for, and gentle persuasion. MH reported he is still smoking £10 worth of cannabis per day although he hadn't had any this morning. He could not explain how he could afford it but said he uses it to help him relax. He says he has problems relaxing at present and uses happy hard core music to help him. MH said he had*

had a thought yesterday that he might need heroine (sic) to help him relax, but had since realised this was not a good idea and appeared offended when I asked him if he had ever tried it, saying "No, I know what that does to people" He said he is eating and sleeping ok and no longer drinking alcohol. At times MH appeared confused in his thoughts and seemed to hold back on saying things that he started to say. MH told me he believes he had a brain tumour in the past but no-one talks about it, which he finds strange. MH asked for a lift to Applewood to visit (G/F), which we did. MH was able to remain calm during the journey but slammed the car door when he got out. Crisis Team to visit this evening.'

On 5 November 2006 (believed to have been 4), Crisis Team records stated 'Seen this evening outside of (G/F)'s flat was on his way out, he said that the electric (sic) had gone out and the flat was all in the dark. Medication was taken by MH who then went on to say he was waiting to get some cannabis and with that disappeared of (sic) round the corner. To be seen at (G/F)'s flat tomorrow'.

On 5 November 2006, Crisis Team records stated 'Visited & observed taking morning meds, warm in affect spoke of knowing all about (FR's)s life brought to Sandalwood to visit (G/F), supervised visit MH

A further record on the same date stated '1900. Seen at M Avenue flat (home of (G/F)) MH had consumed approx one glass of wine. Said "smoking £10.00 worth of cannabis per day" declined rationale for not smoking it. Took meds as prescribed. Stated "Iraq war didn't really happen. Review care option (symbol for with) his team on Monday.'

On 6 November 2006, Crisis Team records stated 'Visited at (G/F)'s house. MH accepted his depot accepted his medication. The front door glass was smashed, informed the council, council unable to board the front door but because they wanted us to report to police – tried to inform the police with no response will try later. Plan is to medicate him tonight'. A further record on the same night stated 'Visited at home window boarded up, MH was settled, he had been visited by (G/F) so upbeat, observed taking medications'.

On the same day, JM telephoned the PALS service and she received a full response dated 9 November 2006. (This is dealt with in more detail in Chapter 7)

On 7 November 2006, SG recorded in her notes 'Contacted C/T assessment has not yet been carried out. T/C to JM, situation unchanged MH's behaviour continues to be disruptive drinking and using cannabis. Support given'.

On 7 November 2006, Crisis Team records stated '12.00. JM – MH's mum called the office. Stated MH had been dropped off at her house today and had punched (and marked) his 25 yr old sisters arm. JM gave him £5 to leave. JM has requested that MH is NOT dropped off at her house any more or she will call the police. Info passed on to JE & EC.'

The next entry in the records is for the same date but relates to actions one hour earlier. It stated 'Visited at (G/F)'s observed taking meds some evidence Flight of

Ideas brought to ward to see (G/F) & then given lift to Mum's House. Visited at (G/F)'s MH not in meds left through

On 8 November 2006, Crisis Team records stated *'Seen at flat appeared boisterous (sic) in manner in a jovial adolescent way. He said he was buying cannabis tomorrow. When asked say (sic) he doesn't need to carry a knife – took meds. Went to fish shop for his meal.'*

On 8 November 2006, AG recorded in her notes *'Visited MH in (G/F)'s flat. MH seemed in a good mood and happy to talk to me, though much of what he said didn't make sense. He told me that he had changed – he had been round at mum's by himself in his sister's bedroom when he started shaking – it was a happy state – a tear come (sic) out of his eye – this was healthy, a release – it got the anger out – he had been angry with himself after all he's experienced. He referred to some words on the cover of a CD – Hardcore Euphoria – which said "Shaking forever". He is washing and changing. MH started tapping his chest – told me he was checking for cancer – he asked if he would be able to spot it by doing that – I expressed some doubt about this. He said he is lonely without (G/F). He is spending time walking, or around mum's. He is seeing (name) and his other mates quite regularly. Still keen on DJ) – has the same expressions. Currently not drinking much but is smoking cannabis. He wants some money – wants to go away because he would feel good. Also would like to buy stuff – furniture.'*

The door to the flat got kicked in – thinks it was probably (name) He kicked the cupboard over and broke it. He wants to go crazy – bonkers – and smash stuff. He is pretty certain he has autism – when he was little he smoked pot and went slow and paranoid – when in foster care. Autism slows things, makes you see things, and is associated with genius. I said we could get that checked out. He would like a job – as a music producer – old school jungle stuff – you don't hear much of it at the moment. He thinks he will be able to do this because of what happened – "Me and a few lads will get out". He wanted to study science and biology – would like to study the body. "I'm going to look like (DJ) and (name) – I just know things" Worried about testicular cancer – he says he doesn't want to die. He is not getting on with his family – they just shout – especially SH – "I'll just hit her if she shouts again" The record then refers to unusual views by MH about racial incidence of cancer. Agreed I'd talk to Mind to find out procedure for getting un-banned. Also said I'd talk with SG about whether or not we can do anything to get his money paid weekly. Arranged to visit next week. MH told me that he is taking the tablets but doesn't think they do anything'.

On 9 November 2006, Crisis Team records stated *'Am. Seen at home stated he smashed a bottle outside the shop below his flat, because he thought the shop assistant was accusing him of rape which she denied. He said he felt foolish afterwards.'* A later entry on the same date stated *'9.00 Visited & observed taking meds, again witness'd (sic) bizarre thought content mainly of a sexual nature but warm in affect, very child like in outlook agreed to visit circa 8 AM tom'.*

On 10 November 2006, Crisis Team records (unsigned but believed to be completed by Dr MS) stated *'Seen to – get - unkempt, good eye contact – Giggley (sic) Said spends £50 a week on Cannabis, remaining goes for shopping, Gets £100 a week*

on benefits – Happy for us to set up appointeeship – Not keen to see DAT (Drug and Alcohol Team) – said often gets anxious. No structure to the day, agreed to attend IDS – no overt Psy sympt at Present – Thinks – he has got Autism. Sleep (symbol for tick), Appetite (symbol for tick) Affect – (indecipherable) Plan – (symbol for increase) Depakote – 750mg OD, 500mg Nocte – Respidal consta – 50mg IM 2/52 – Respidone – 2mg OD. C-T – Twice a day. Review by me’.

A further Crisis Team entry that day stated ‘Visited to night at G/F’s flat, MH was pleasant in effect (sic). Medication was observed being taken with no problems and MH reported to no problems. Crisis team to visit in the morning’.

On 11 November 2006, Crisis Team records stated ‘AM. Seen in flat said he hasn’t been able to gain access to cannabis. Asked to go to Applewood to see (G/F) declined to offer as no facility to see patients off the ward at weekends. Said he might go out and damage cars to get himself into hospital. Rationale given to MH’s compliance (symbol for with) medication’.

A further entry on the same date stated ‘HV. Brief due to MH being dressed only in jeans (no top). Fairly calm + lucid, talking about Driving and not having any food or cannabis. Took meds no problem’.

On 12 November 2006, Crisis Team records stated ‘HV. MH animated and pleasant – a little bizarre at times asking to be taken to Mum’s house – agreed to drop ½ way up (name of street). Talking about being a DJ. Able to hold appropriate conversation. Meds given’.

A further entry on the same date stated ‘H/V MH. MH not in. Meds left through the door. Got call later on from Applewood reporting that he had been out drinking with (G/F)’.

On 13 November 2006, Crisis Team records (unsigned but believed to be completed by Dr MS) stated ‘Seen today – Worried – in case his anger comes back later said – he has got Ca –..... responded to reassurance. Still waiting for appointeeship – to be done – Gave unrealistic explanation – to check his anger – bizarre lip movement – No change in management Plan. Review in 2 days’.

Commentary: Dr MS did not undertake a psychiatric review of MH on 15 November 2006 in accordance with her recorded intention.

On 13 November 2006, AG recorded in her notes ‘Visited MH at (G/F)’s flat – he was there waiting for me. I stayed about 40 minutes. The flat was very messy. There was a dessert bowl of cigarette ends on the sofa. Throughout my visit MH fluctuated between being fairly jovial and appearing sad/negative about life. Much of what he said didn’t make sense. He said he had been thinking about anger – (Picking up on what he told me last week that he had cried and that the anger had gone from within him) – he thought it had come back today – he had been very stressed about cancer and about (G/F). Someone started on him yesterday – he tried to hit MH – MH said he didn’t respond, though he thought about it. MH said something about words on a CD and the Government – I asked him to tell me a bit more about this – he smiled and said that now I would be thinking he was schizophrenic. He said I didn’t seem as

relaxed as I had last week. MH asked "Is my hair OK?" I said "yes- why?" MH explained that signs of not being angry were that your hair looks good, you've got to be able to stick your eyes out without looking schizophrenic, and got to keep your bottom lip relaxed so it hangs down. If he is angry he can't relax in the daytime. I did say that these weren't signs I'd associate with anger.

(G/F) is still in hospital (Name) at MIND made him angry – he thought she was out to get him – getting angry helps him to be at Mind as it helps him in the flat. FR has got the same problem – but MH doesn't think it's come back for him (I think relating to the anger) MH said the anger is with ourselves – for example, he used to be angry with himself for not making people laugh. Some people get trained to do it – (What?) – Cry it out. MH doesn't want to get labelled as a schizophrenic. He would like to be seen as a DJ. He would be earning money, though he will be rich anyway. "I can't keep my bottom lip down for long – I need some green" MH told me that there was someone in MIND that he was going to talk to – they knew about his past – he thought that they were going to set things in motion.

He is not happy – he misses the past – something is not right – it is too good to be true. MH told me that he and (G/F) were sort of engaged. – they are not rushing things. MH showed me two hip hop magazines he had bought how is he spending his time? – visiting (G/F), mum's, MIND, lying in bed. (Name) has the same problem He nearly had a drink yesterday. (G/F) – he wants to keep her for himself – would hit anyone else who made a move on her – it says on CD cover (Title of track which I didn't manage to note)

MH told me that he had been banned from the shop downstairs – he had gone in there and thought that the woman was accusing him of raping her – so he smashed a bottle down onto the ground from outside the upstairs flat – he did sweep it up afterwards. He told me that he had been accused of rape – he had been tortured (what happened?) – don't know "I just know it – I love it because I can do it to myself – I don't want to talk about it – it makes me special" Mum has told (G/F) about it – lies. Schizophrenia – I asked MH what he understood by this – he said it meant someone can't use expression, it shows in their eyes, they get fidgety and angry. MH said he had to change this, got to stop snitching and lying (Showed me page from magazine that had that last phrase on it)

He thinks it will help if he smokes loads of cannabis. He has been getting a bit on edge. He is half brother to (FS). He wakes up feeling good – and then the Crisis Team are late in coming round and he gets on edge – he smashes things up – like the small cupboard in the flat. It's hard to see the good things in life – (What are the good things?) – "night time – I love night time lying in bed and listening to the radio and (G/F). Elite – he is one of the elite – it is to do with the way you look – most people are the elite. MH said he fantasises about knocking people out – it feels real – he thinks it helps get rid of his anger. I gave MH a lift to Sandalwood to see (G/F) – on the way he was asking why people bothered to live'.

On 14 November 2006, SG recorded in her notes 'T/C to Crisis Team, PC inform me that they are looking for an out of area bed, as (G/F) has now been taken into Applewood so it would be inappropriate for them to be on the ward together. T/C to JM to inform her of this'.

On 14 November 2006, a Care Plan (Form eICPA8) was formulated by CS as Care Co-ordinator (identifiable from a Crisis Team entry 2 days later as a Student Nurse) This Care Plan was then updated on 22 and 30 November 2006 (By Green Lane Hospital). These updates were countersigned on 5 December 2006 by a member of staff believed to be Crisis Team but unidentifiable by signature. The Care Plan showed that on 14 November 2006:-

People involved in your care	Role/Service and contact details	Invited	Present	Copy
Crisis Team	Monitor mental state and home treat, give MH and observe him take his medication.	Y	Y	Y
SG	Care Co-ordinator	N	N	N
Windswept Team	Residing there	N	N	N
Dr MS	RMO, prescribe and review medication	Y	Y	N
GP: Dr B Kingswood Surgery				

Commentary: In the Plan it was recorded the Windswept team was involved in MH's care because MH was residing there. This was incorrect, nonetheless they were not invited to attend nor present when it was believed that they were still involved.

The Care Plan records under the heading Details of your care plan, sub heading Your strengths: *'Willingness to engage with Home Treatment Team. You are willing to express how you are feeling and try to get your point across. You understand the importance of taking and adhering to your medication plan'* and continues:-

Your needs	How these will be met	Person responsible	Start date and how often
Your mental state has deteriorated (<i>sic</i>)	Crisis team to monitor MH's mental state and to ensure he is taking his medication over weekend.	Crisis team	29 – 9 – 06 Wkend
Not staying at Windswept going to friends and staying at hers	Crisis Team to locate MH and assess mental state and administer his medication and observe him take them.	Crisis team	5 – 10 – 06 Daily
Suitable accommodation	CMHT (RG) to arrange	RG (MHa)	13 – 10 – 06
Medication review	RMO Dr MS to assess	Dr MS	10 – 11 – 06
Deterioration (<i>sic</i>) in your mental state	Crisis team to continue with home treatment and increase visits to twice a day	Crisis team	10 – 11 – 06 2xdaily

Updates on 22 and 30 November are included on the next page but reproduced in due date in this section. The heading Current medication states *'Respiridone Quicklets 2mg once daily. Risperdol consta Depot Deep IM every 2/52. Depakote 750mg am, 500mg pm'* and recorded as *'Prescribed by Dr MS'*.

The plan continues under the heading, Summary of Risk Factors *'If you do not continue with your current plan ie taking medication and agreeing to home visits you*

are likely to suffering (sic) from a relapse in your mental state-psychosis. Risk of not engaging with mental health teams. Risk of sever (sic) self care. Risk of becoming aggressive – MH has stated that he is angry with certain people. Withdrawal from social networks – ie (G/F) his girlfriend. MH has also been to (sic) known to carry a knife’.

Under the heading Crisis and contingency the plan records ‘Heading: You have a risk of developing episodes of: *‘Paranoid psychosis’*’.

Heading: This is more likely to happen if you are experiencing particular stresses. Potential sources of stress are: *‘Excess alcohol and cannabis use’*

Heading: Other things that could go wrong with the plan: *‘Non-engagement with mental health team and non-compliance with medication’*

Heading: Early warning signs that things are not going well: *‘Experiencing hallucinations and paranoia (sic)’*

Prior to the signature of CS is stated:- *Not appropriate to ask him to sign due to MH’s lack of insight and fears of him not engaging’.*

On 14 November 2006, Crisis Team records stated *‘Home visit today me and KHu CPN. MH presented as bezarre (sic) in his thoughts and what he was saying. Suspect “visual hellusions (sic) with MH talking to or about a Gary. MH kept repeating that he is a nice person and we are nice. MH accepted his medication’.* This entry is unsigned.

A further entry on the same date stated *‘Attempted to visit today. No-one at home. Later ward contacted crisis team to say that girlfriend (G/F) had not returned from leave. Later police contacted ward to say that there have been reports made of MH & (G/F) kicking (G/F)’s ex partner’s door in (Name) St’.*

On 15 November 2006, Crisis Team records stated *‘No one at home. Police came there in search of (GF). (Name) and me went to c MH. Left a message that Crisis team visited’.*

A further entry on the same day stated *‘Pm. Attempted to visit 2x. MH not in. Did not leave the meds try again tomorrow’.*

On 16 November 2006, Crisis Team records stated *‘Am. Attempted to see MH today to assess how he is and give him his medication. MH was not in. O/C to try and make contact and give meds’.* A further entry on the same day stated *‘Visited at home. MH was in. Initially behaviour bizarre but then accepted medication. MH stated he had no food & no money to buy any. Advised we could possibly get food tomorrow for him but there was little we could do tonight. When we left threw the plastic cup across the ground’.*

On 17 November 2006, SG recorded in her notes *‘MHA assessment carried out it was felt that MH was not detainable it was felt he should be given the opportunity to take some responsibility + remain in the community with Crisis Team support’.* This is endorsed by the record completed by the ASW (addressed in Chapter 5 of this Report).

On 17 November 2006, Crisis Team records stated *‘11 AM. Home visit, house very chaotic, MH accepted routine medication, very agitated, thought disordered has no*

food & no money, made threats to trash flat & threats to kill KHu & myself. Clearly MH very disturbed mental health rapidly deteriorating. Informed manager PC, who will follow up In Patient placement out of area.'

Commentary: There is no subsequent entry by PC of any follow up action and no record of a report being made to the police of the threat to kill.

A further entry on the same date stated 'Visited MH at flat this evening. Flat was very dishelled (sic). MH was expecting us to come with food as someone said they would bring him food. Gave meds – took no concerns but kept saying he wanted LCD (sic). He asked if he could go to hospital tomorrow and see (G/F). Said we didn't know, he said if he couldn't he would saw his arm off and this was a warning to us all. We gave him £1 so he could go and get some chips'.

On 18 November 2006, Crisis Team records stated 'HV. Gave medication, took MH to shop and bought him a roll crisps + a drink. Acting quite bizarrely, poor eye contact, little paranoid and garrulous (sic) Plan/Visit am.'

On 19 November 2006, Crisis Team records stated '09.00. Home visit, key left in door pointed out the dangers of MH doing this. Medication accepted and taken. MH had still been sleeping when I arrived. Was appropriate in manner gave MH some tined (sic) food, very little eye contact made. C/T to visit on call tonight'.

Commentary: Two days after a threat was made by MH to kill members of the Crisis Team, a female member of staff was apparently allowed to visit MH unaccompanied at a time when he could be expected to be alone in (G/F)'s flat.

A further entry on the same date stated 'Visited at home, the flat was in total darkness but MH came to the door. Stated he had no electricity. MH was very giggly but would not elaborated (sic). Took medication and asked if he could come to the ward to see (G/F) tomorrow, we said that we didn't know but asked if he could wait in. He has to go and get money at 10 am, asked him if he could be back by 12. MH said some odd comments about ghosts and continued to giggle throughout visit'. This entry is followed by a blank sheet which has not been crossed through.

On 20 November 2006, AG recorded in her notes 'Went to visit MH but he was not there. Couldn't get him on his mobile either'.

On 21 November 2006, Crisis Team records stated 'Visited MH at home. Allowed us in and accepted medication. Asked him if okay to collect him for his appointment with Dr tomorrow. He said this is fine. He informed us that he thought he was becoming unwell though said to not tell. Asked him how he said little things, won't go into detail, but said about predicting things. Said he didn't want to go to hospital yet as wants to go to Applewood and can't as (G/F)'s there currently, and doesn't want to go out of town. He also felt that (Name) was uptight and asked him if he wanted cannabis. MH stated he was coming into some money soon from granddad and would like to buy a car, particularly a Rover 75. He will need to learn to drive first though. Also spoke about a Porsche but decided on a Rover. Has eaten today, flat was very dishevelled and was sitting in front of small heater on the floor. There was the lounge door on its side in the hallway'.

Commentary: The Crisis Team notes provided by AWPT to the Investigation ceased at this point. We believe that copies of later entries provided to us by a witness to the investigation allowed us to complete this chronology in full but we cannot be certain that we had the complete Crisis Team records.

On 22 November 2006, a Mental Health Act assessment was undertaken. The record completed by the ASW stated in related paperwork *'Assessment under MHA had been indicated by the Crisis Team since the beginning of this week but a bed had not been available at Green Lane Hospital: MH could not be admitted to Applewood House because (G/F) (girlfriend) was also a detained in-patient and there were other relationships with in-patients which were likely to generate conflict. There had also been difficulties in obtaining either S12 Doctor/GP with knowledge to take part in the assessment'*. The outcome of this assessment was that MH agreed to informal admission to Green Lane Hospital.

On 22 November 2006, SG recorded in her notes *'Liaised with Crisis Team, MH has agreed to an informal admission to Green Lane hospital, he will go in today. T/C to Green Lane spoke with SC (staff nurse) Gave her some background information and my contact details if needed + current medication of Risperdal consta 50MG IM 2/52. Risperidone 2MG OD. Depakote 500MG BD'*.

At this point the Care Plan dated 14 November 2006, was updated at Green Lane Hospital as follows:-

Your needs	How these will be met	Person responsible	Start date and how often
<u>Update</u> 22 – 11 – 06 review of mental state deterioration in psychotic symptoms, medication does not appear to be holding him.	MHA Assessment Informal admission to Greenlane hospital Imber Ward	Crisis – Lds Greenlane hospital – with liaison with Swindon crisis team	22 – 11 – 06 22 – 11 – 06

On 22 November 2006, Green Lane Hospital notes recorded *'Admitted at 1 pm with no notes or information or consultant cover here at Green Lane (Under Dr PS in Swindon) After discussion, Dr DS has taken consultant responsibility and has spoken to Dr PS to express his unhappiness at way admission was arranged..... Notes should be coming over tonight – we need to check when his depot is due (social worker says it was given on 21 11 06)'*.

On the same day, another junior doctor recorded:- *'schizophrenic disorder ? schizoaffective disorder'*

Note: Whilst Dr PS undertook the Mental Health Act assessment, MH's Responsible Medical Officer (re-titled 'Responsible Clinician' after November 2007) at the time of admission was Dr MS of the Crisis Team.

On the following day is recorded *'..... Swindon team have sent previous risk assessment, so can this be looked at, and utilised..... Risk assessment updated..... MH talked about being the "hardest man in Swindon". He said he had*

the ear of Bin Laden & the whole of Iraq & could summon "help" at any time if anyone got on the wrong side of him..... seems a bit volatile in nature nothing too serious noted. Says he hates Swindon and that it is a hole. He managed to contact his girlfriend on the phone & seemed satisfied that he had spoke (sic) to her'.

On 24 November 2006, Dr N (junior doctor) recorded:- '(symbol for diagnosis) Schizophrenia – exacerbation of psychosis, (symbol for increased) cannabis use, carrying a knife, hit little brother, verbally abusive to mother, put a knife to girlfriend's throat.'

Between 24 and 27 November 2006, Green Lane Hospital notes recorded variously '*.. denies having thought disturbance ... denies audit/visual hallucinations... abrupt appeared trying to be intimidating (to staff) ... bizarre speech content ... grandiose delusions ... visit by parents... bit hostile.... said he wanted money or drugs from them but later said he'd been jokingpresents as a little bizarre in speech content...*'

Commentary: This appears to present not only a conflicting picture but also willingness by staff to accept denials by MH when questioned about features of his presentation, a theme that recurs throughout his engagement with the service.

On 27 November 2006, Dr N, SHO, recorded in Green Lane Hospital medical notes '*feeling much better. – feels more settled & not paranoid. – Wants to go home now – He believes that he became ill says that he smokes cannabis occasionally, feels a little paranoid at 1st but then it settles him down. – lives (symbol for with) girlfriend & survives on incapacity benefit. – sleeping well – appetite ok. MSE Good eye contact. Calmer. Cleaner. Mood – (symbol for objective) euthymic and (symbol for subjective) (ditto marks). (Symbol for Plan) need to discuss case (symbol for with) Dr PS & create POC'.*

Commentary: Nursing staff continued to believe that Dr PS was MH's RMO when MH had been under the care of the Crisis Team immediately prior to admission and the Crisis Team, including Dr MS, should have been involved in arrangements for discharge.

On the same day, the nursing notes recorded '*SG (CPN) phoned to see how MH was doing -. She will try to visit next week with MH's mother. Crisis team gave MH his last depot Respiridone Consta 50mg on 21st November its every fortnight and next due on 5th December. Apparently MH is NFA as he been (or being) evicted due to non payment of rent from current accommodation. SG says they may try to get MH placed at Windswept, Swindon?'*

A further entry on the same day recorded '*Seen by Dr DS who would like the ward to liaise with Swindon team re: where MH is to go when discharged. He would like a plan before discharging him, and perhaps the Swindon team (SG) could come and assess MH to see how close he is to his normal self – this week. After speaking with Dr DS MH agreed to stay a while on the ward as he wanted to go earlier in the day. Can we contact SG tomorrow please re above. Dr DS will review Friday.'*

On 28 November 2006, Green Lane Hospital nursing notes recorded '*..... MH came into the office at lunchtime and said he wanted to get out, and if he couldn't he would smash the place up. MH advised that this is not a good idea.*'

The next entry on that day recorded '*Liaised with MH's mum when she rang this morning re MH's progress. MH then spoke with her himself. Liaised with SG & it appears MH is still presenting as elated in mood compared to his normal presentation. SG said that MH's girlfriend (G/F) is being discharged next week & plan is for Swindon crisis team to assess MH with a view to him returning to the ward in Swindon & then on to Windswept when ready – MH then spoke with SG.*'

A further entry on the same date recorded '*Nocte. MH appeared to have a settled evening staying mostly in his room, slept from 10.30 pm until approximately 4.30 am. Since being awake MH has been noticed to be laughing to himself and appears agitated. At 5.30 am asked to leave the ward to go to a cash point. When refused he said he wanted to go now. Explained that this was not possible at this time but could be discussed later in the day. Offered PRN Lorazepam 2mg at 06.10 am as MH appeared to be getting more agitated saying he wanted to leave. Seems to have had a good effect. Is sleeping in bed at time of report 7 am.*'

On 29 November 2006, Green Lane Hospital notes recorded '*Still wanting to go to town in morning. Spoke to Dr DS who said we need to check with Swindon team to check re risks. SG said she knows of no threats/dangers to general public, just his family/just girlfriend. The incident re a knife was a cutlery knife, and threat to an ex of girlfriend. He later said he'd only been joking. Has been quite patient waiting for staff to be available to take him to town. Dr DS has said Swindon don't consider him a risk public that he could go on his own but he was happy to wait for a lift in morning. Reportedly polite & settled in town with nurse.....*'

On the afternoon of the same date is recorded '*T/C Dr DS coming to see MH on the ward in the morning to assess risks with him. Returned from the pub, states he's had a shandy – has gone off the ward a further 2 times, returning both times within 40 minutes however does smell of alcohol – on the whole remains settled & pleasant, but on one occasion was rather abrupt & rude to staff*'

On 29 November 2006, SG recorded in her notes '*T/C to Imber ward to see how MH had been. Spoke with Staff Nurse whom (sic) reports he has been settled, compliant with prescribed medication although continues to have delusional beliefs. Spoke with MH, he wants to come home he has heard G/F has been discharged so wants to find accommodation. Some evidence of thought disorder believing he's a "mighty soldier (sic)" + has to stop the terrorist. Support given ++'. On the next day, SG recorded 'T/C to JM to see how she was, support given.*'

Also on 30 November 2006, Dr DS recorded in the medical notes '*MH appears calm and friendly. He was willing to see one without question. He denies any auditory hallucinations, thought insertion, withdrawal or broadcast. He denies that he feels he is being threatened or wishes to harm others or himself. He wishes to go back to Swindon ? has acc. He is not concerned if he lives (symbol for with) his g friend. Plan. I have had to contact SG (Care Co-ord) I have contacted the Swindon CAHT*

(Crisis Team) and they will phone back. MH is fit to return to Swindon. He is voluntary and thus can go on his request. I have no reason to stop him’.

On the same day, the nursing notes recorded ‘Dr DS reviewed MH, he feels he doesn’t need to be here and staff are to liaise with crisis team. His mother contacted ward and she is aware of this’. It was later noted ‘Contacted Swindon CAHTT they will liaise with ward this afternoon and are aware that MH does not wish to be in GLH. And wants to return to Swindon. MH has been appropriate on the ward, pleasant in manner’.

A further note in the nursing records that day recorded ‘T/C received from PC from CAHTT in Swindon to say they will support MH in community. PC agrees MH can be discharged. MH is currently off the ward at present so does not know the decision. Copies of medical notes and drug chart faxed to the CAHTT in Swindon’.

Another note that day recorded ‘Returned to ward and informed of plan. MH was keen for d/c taxi has taken MH to girlfriend’s address. Given TTAs for 2 days and discharged as planned’.

On 30 November 2006, MH was discharged from Green Lane Hospital. The Care Plan dated 14 November 2006, was updated on discharge as follows:-

Your needs	How these will be met	Person responsible	Start date and how often
Update 30 – 11 – 06 Monitor mental state	Discharge from Greenlane Twice daily visits from crisis team medication administered x2 daily + fortnightly depot medical review with Dr MS – weekly	crisis team crisis team Dr MS	30 – 11 – 06 X2 daily X2 daily weekly?

Note: Records relating to the Crisis Team from December 2006 to January 2007 were absent from the file of NHS notes provided by the Trust. They came to our attention part way through our investigation following discovery of copies. We cannot be certain that we had access to the complete set of Crisis Team records. (This is addressed in more detail in Chapter 9)

Commentary: There are no records of any subsequent reviews by Dr MS.

December 2006

On 1 December 2006, a Crisis Team contact sheet recorded 3 entries timed at 1100, 1215 and 1430 respectively. The first recorded ‘Visited at (G/F)’s x2. No sign of Activity, Telephoned ward & asked if here (sic) from him to ask him to report to Crisis Team at Redwood’ The second recorded:- T/call to mum on (telephone number) MH was there agreed to wait & give lift to (G/F)’s then ward to visit’ The third recorded:- ‘Seen at mum’s settled in presentation warm in affect observed taking meds, given lift to (G/F)’s to drop stuff @ home then brought to ward to see (G/F), MH spoke of needing to be calmer, internal frustration & anger & wanting to help (G/F) give up Alcohol he also alluded to having used cannabis today’.

On the same date, SG recorded in her notes *'T/C received from JM, MH has been discharged from Green Lane. Informed I will contact the Crisis Team to find out what's happened. T/C to Crisis Team, they did not discharge MH he self discharged and at that time was not detainable. Due to ongoing problems and past difficulties meeting arranged for 7/12/06 at 9.30 am at The Mall. T/C to JM to inform of meeting. She requested that AB (PALS) also be present'*.

On 2 December 2006, a Crisis Team contact sheet timed at 10.00 recorded *'Visited & observed taking morning meds, taken to shops for (indecipherable) settled in presentation & warm in affect No Delusional thought evident'*,

And later that day, *'Attended the friend's flat to administer medication but received no reply. Further attempt to be made tomorrow'*.

On 3 December 2006, the Crisis Team recorded *'Visited MH at friend's flat where he is currently living. Accepted meds + reported he was asleep in bed last night when we visited but later stated he had been out clubbing + had found (G/F) in bed on his return'. A later note timed at 18.00 recorded 'Seen MH very bright and animated. He made polite generalised conversation and accepted his medication. He did however have incongruous laughter'*.

On 4 December 2006, Crisis Team records stated *'Visited at home & accepted medication as prescribed. Initially appeared low & flat in affect but seemed to brighten up during visit'. A further entry on the same day stated 'Attempted to visit at home this evening. MH not in'*.

On 5 December 2006, Crisis Team records stated *'(AM) Home visit – Risperdal consta administered to ® side – 50mg as prescribed. Spoke of jaw pain but vauge (sic) about where the pain was, when it started and if he had experienced it before. Spoke of experiencing anger 'inside him'. Meds taken whilst staff were present. Reported to have been to the pub last night and got drunk. Spoke of meds + alcohol being a negative mixture'*.

Also that day the Crisis Team records *'Visited MH at the flat, was there with (G/F) and there was a strong smell of what seemed like cannabis. Also large crate of Beer on the floor. MH took medication. (G/F) asked us if we could help find MH find somewhere else to live as she has been told that flat could be at risk if he stays there. Explained MH would have to go to homeless section, we would discuss in handover tomorrow'*.

On 6 December 2006, Crisis Team records stated *'Visited MH at home this morning. MH reports he slept well last night + "am OK." MH was quite kaotic (sic), starting sentences + being unable to finish them as if he realised he did not want to tell me what he started to say. Although he did say he could talk to an old friend from the past. He started to say he could hear voices but did not elaborate further when asked although did say they have been muffled compared to what they used to be like. MH agreed to go to the (name of B&B) so I agreed to call them + call him with a time he could move in later today'*.

A further record on the same day noted '1745 T/call to (name of B&B) they are full tonight but expect vacancies tomorrow we to call V' (name). That same evening the Team recorded '19.00 Visited MH at flat informed of above. Observed taking meds. No psychosis evident pleasant & cheerful in manner noticed crate of lager in hallway'.

On 7 December 2006, Crisis Team records stated 'T/call to (name of B&B) they have vacancy but need fax from paying Authority – S/W CPN they plan to try YY St 1st so not booked. Visited MH at home & observed taking meds & informed would let him know about Accommodation tonight. Settled in presentation but a little childlike in attitude'.

On the same date, SG recorded in her notes 'Meeting attended by:- SG – CPN. AG – Early Interventions. PC – Crisis Team manager. AB - PALS. Apologies from – JM. The people involved in MH's care were (sic) under the impression that once G/F was no longer on Applewood that MH would return there however it was felt by some that this would not improve the situation.

Problems identified (1) Accommodation (2) Psychosis/erratic & bizarre behaviour (3) Non compliance with Prescribed medication (4) Therapeutic Activities.

The above issues were discussed at length and the current plan to be put in place. (1)SG to refer MH to YY Street. (2) Crisis Team will visit x2 a day to deliver medication. Current medication Risperdal Consta 50mg IM 2/52. Risperidone 2mg od, Depakote 500mg BD. (3) For JM's confidence to be restored in the Crisis Team so that she will contact them when needed. (4) PC to D/W AD the ongoing referral to the Outreach Team. (5) AG to take MH back to MIND (6) SG to refer to New Dimensions (7) Screening for Autistic Spectrum disorder'.

Also on that day, AG recorded in her notes 'Meeting with SG, AB (PALS) (on behalf of mum) and PC. 1. YY Street – SG is to phone C. 2. Mind – AG will pursue MH having access to Mind again. SG will explore the possibility of his attending New Dimensions 3. Currently on Depocote (sic) and Risperdal – to be reviewed at end of January. 4. Aspergers – AG will arrange to do questionnaire with mum 5.SG will continue to support mum. We discussed that it was appropriate for her to phone Crisis when there was a problem, but that it would be useful to agree with her what response she would hope for. This will be related to PC, who will put it in a care plan 6. Crisis Team – they are currently delivering his medication once a day but feel they are doing nothing else particularly with MH. They will continue this for two weeks. 7. Referral to Outreach – we all agreed this was the level of support MH needed though their capacity is limited – PC will call AD and speak to her 8. MH continues to smoke cannabis and there are lots of empty cans in the flat.'

Crisis Team records for that day stated 'Visited MH at (G/F)'s this morning. Took his medication in my presence. Reported no voices unless he wants them + he controls the voices - Again appeared to be responding at times (laughed to himself) Reported he was "fine". MH said he doesn't want to move in to YY Street because he knows someone there + finds him annoying. He reports he used to live with him at Hazelmead and then he left and MH wonders if he left because of him. However, after some discussion MH agreed to come to YY Street'.

A further entry on the same date stated '*Seen tonight at (G/F)'s flat, observed medication being taken. No problems reported by MH told us (G/F) was upstairs and was alright as well, no plans for tomorrow. C/T will visit in the morning*'.

On 8 December 2006, SG recorded '*Referral made to YY St and to New Dimensions*'.

On 9 December 2006, Crisis Team records stated '*Seen at (G/F)'s flat with her present, Medication accepted and observed being taken. MH was chatty talking about his nightmare at times giggly, reported to being alright, although appeared thought disordered going off in different directions with his conversation and not making sense telling me he was "just being silly". On call visit tonight*'. There is no record of an on call visit.

On 10 December 2006 a Crisis Team Contact Sheet (unsigned and not part of the continuous record) stated '*Took medication out to MH this morning, but he was not in or asleep. Medication Put through the door*'.

A further entry, but now on the continuous Crisis Team record stated '*Home visit this evening to MH at (G/F)'s flat, no answer or lights on. Medication posted through door for MH with C/T slip informing I had called*'.

On 11 December 2006, Crisis Team records stated '*Seen at (G/F) flat pleasant and appropriate in speech. Queried his move to YY St - took meds from a previous envelope in presence of staff*'.

On 12 December 2006, Crisis Team records stated '*HV. MH warm and appropriate in presentation, dressed, took meds, agreeing to move to YY St when sorted. PM meds left. T/C to SG who is sorting this*'.

On 13 December 2006, Crisis Team records stated '*Visit to MH, he was not there so put meds through the door. We had a couple of pages through but the telephone no. left did not work. Tried another no. on File but this also did not work. MH was under impression that he was moving into YY Street today, we called SG to see if she could get hold of him before he goes there*'.

On 14 December 2006 Crisis Team records stated '*AM. Seen at M Avenue, appeared bright and appropriate in mood, he wants to know when he's moving to YY Street. Took meds w/out issue*'.

On the same day, AG recorded in her notes '*Visited MH in (G/F)'s flat. MH was smiling a lot of the time. He told me had drunk 4 pints of alcohol that day. He said his old symptoms were coming back – I asked him what this meant – he said he was being too sweet/too shy. He didn't want to talk more about this. He said he'd had a stressful night but generally things were fine. Cannabis – has been smoking it – makes him cry which he sees as good as it gets the anger out. He apologised for "my stupid laugh".... We talked about going back to Mind – MH said he realised he needed to be quiet, not run about, not stupid, be sensible. He thought he could do this. YY Street – was supposed to go yesterday but it was cancelled – they will let him know.*

Has been frustrated which has been making him angry. Has been looking in the mirror and checking himself – he thinks the alcohol shows in his lips and face – “shows if you have the anger come back” He is a bit scared – I asked about this – he said it was an inside nerve thing. Famous people – “I feel famous” He thinks he has a lot of built up anger and that this is a serious problem. He said that he thought his eyes were nice and open and clear. He had had two bad nights – last night he was awake 2 – 10 am, and the night before he was awake most of the night. He had been watching an Indian film. Went to a party on Saturday. Plans to go to mums for Christmas. Life is fine’.

On 15 December 2006, Crisis Team records stated ‘Seen MH very bright and animated Mood euthymic. No evidence of any psychotic symptoms. He accepted his medication without any problems. No side effects reported. Will be seen again tomorrow’.

On 16 December 2006, the Crisis Team recorded ‘Visited MH at home this morning. He was eating lasagne for breakfast + reported he was smoking cannabis last night. Took his am meds in our presence, left night meds with MH. MH had forgotten to take last nights meds. MH feels he has “improved greatly” which we agreed with, no obvious signs of psychosis observed. MH reported he is frustrated sexually + that he is having a party tonight with people from MIND. CT will visit tomorrow evening. CT need to chase YY Street + let MH know when he can go there’.

On 17 December 2006, Crisis Team records stated ‘Seen at (G/F)’s flat this morning, warm and pleasant in effect (sic). Medication accepted with no problems. Had party last night which MH enjoyed said “it was a nice social gathering of friends”. MH appeared relax (sic) and his manner was appropriate’.

On 18 December 2006, Crisis Team records stated ‘Visited @ (G/F)’s flat. Observed taking meds left evening meds. MH was settled & warm in affect’.

A further entry on the same date at 16.30 stated ‘Attempted t/c to SG to see how referral to YY St going. No answer. Message left to contact CT’.

On the same date, AG recorded in her notes ‘Tried to visit MH but he was not there. Couldn’t catch him on the phone’. On the next day she noted ‘T/C to Crisis Team, MH at present is complying with current plan’.

On 20 December 2006, Crisis Team records stated ‘Seen at flat of (G/F). Appeared warm & appropriate in mood. Took meds & requested a lift to MIND’.

On the same date, AG recorded in her notes ‘Visited Mum and sister SH to go through questionnaire about Aspergers. After having gone through the questionnaire, we agreed that although there were aspects of his behaviour that now fitted an aspergers profile, there was no evidence of this when he was growing up’.

On 22 December 2006, the Crisis Team recorded ‘AM. Home visit, MH appeared quite happy and relaxed. Medication taken with no issues, asked if I could drop him into town, was wanting to go Minds dropin. MH was warm and pleasant in effect (sic), asking if I thought he was getting better, telling me he used to feel angry but felt

he didn't have that problem anymore with his angry (sic). Good eye contact made. Will need meds tomorrow am.'

On 23 December 2006, Crisis Team records stated '*10.30 Visited & observed taking morning meds. MH was settled in presentation & warm in affect. He requested lift to MIND and plans to spend Xmas with (G/F) @ His Mum's*'.

On 24 December 2006, Crisis Team records stated '*AM Seen at (G/F)'s flat appeared bright. Some psychotic thoughts present i.e. felt he was "famous" and had a "....." (indecipherable) where he was the only one in the world. Compliant with meds but admits to being forgetful i.e. never took meds on the 20/12/06 nocte*'.

On 26 December 2006, Crisis Team noted '*Went to see MH this morning with medication, but he did not answer the door/light (sic) were on, medication put through the letter box*'. Similarly on 28 December 2006, Crisis Team records stated '*Visited @ (G/F)'s No Answer put meds thru' door*'.

January 2007

On 2 January 2007, Crisis Team records noted '*Visited MH this evening to give him his consta depot but he was not in, we will try again tomorrow*'. That same day SG also recorded in her notes '*T/C to YY St, no answer message left*'.

On 3 January 2007, Crisis Team records stated '*Visited MH this morning, MH has not taken any of his medication for the last couple of weeks, consta depot given and excepted (sic)*'.

On the same day, SG recorded '*Seen at (G/F) home. MH appeared unkempt, restless. DW (G/F)'s CPN was present who informs me that MH has not been taking his oral medication and that he is still very unwell (psychotic). The Crisis Team then attended to administer his depot which he accepted. They took away all the brown envelopes containing his medication approx x20 envelopes. When asked why he hadn't taken them he stated "because they haven't been to see me every day". MH then went upstairs to have his injection*'.

Commentary: The RCA minutes of a meeting with members of the Crisis Team on 25 July 2007 refer specifically to 28 envelopes – all dated. There is no reference in the Crisis Team notes for January 2007 of any envelopes having been retrieved.

On 5 January 2007, SG noted '*Message received from R from C/Team requesting I contact them. T/C to R, unavailable message left*'. The next day she recorded '*Spoke with AS, they want to hand MH's care back to the CMHT. I voiced my concerns over this due to his non-compliance with medication, poor engagement and symptomatology however JV arranged for 11/01/07*'.

On 9 January 2007, SG recorded in her notes '*D/W Dr PS (Fax also received from Vulnerable Adults Team view fax in correspondence dated 8/1/07). Informed of meeting arranged on 11/1/07. Voiced my concerns that I feel MH's mental health remains unstable that his behaviour continues to be erratic, unpredictable and*

aggressive in manner towards his family. I feel that there has been no improvement in mental state and there are external factors (symbol for increasing) his symptoms, alcohol & cannabis use. Also he has no fixed abode and he is non-compliant with prescribed medication: Dr PS felt that a further admission maybe beneficial in order to change his depot medication to stabilise his mental health. He has suggested I discuss this with C/Team, if not he will talk to PC. T/C received from New Dimensions visit arranged for 17/1/07 at 12 pm'.

On 11 January 2007, Crisis Team records stated 'Seen this morning with SG, MH appeared pale and tired, he reported to having problems with (G/F) and living in the flat with her. MH kept good eye contact throughout visit, he did say he was getting voices but felt more able to cope with them and it wasn't as frequent, but still thinks he's a rap singer and talked about this in detail. MH reports to not smoking cannabis for 3 weeks because it got boring, he had no problem with his attention or concentration. But did appeared (sic) to be low in mood and unhappy at present. SG was going to feed back to Dr PS and contact PC later'.

On the same date, SG recorded her notes of this joint visit with RK (Crisis Team) 'Seen at G/F flat, he had just woken up. APPEARANCE and BEHAVIOUR – Casually dressed, dirty clothes, unkempt. Appeared restless. SPEECH – Rate – slowed volume/tonne – unremarkable. MOOD – MH states he sometimes feels sad but smoking cannabis allows him to know himself. Some signs of flight of ideas present, erratically changing subject, sleep disturbed. HALLUCINATIONS – Reports to hear voices 3 days ago, can't make out what there (sic) saying. DELUSIONS – believes Bin Laden has given him Schizophrenia, that he's got to stop the terrorists. Felt his jumper had alternate meaning. Laughing inappropriately. SLEEP – Initial insomnia, 4 hours sleep a night. DIET – Reports to be fine no evident recent weight loss. CONCENTRATION – Didn't appear to take in/understand questions, flitting from one thing to another, not answering questions asked. DRUGS/ALCOHOL – Drinking lager x 4 – 5 cans a day. Has smoked cannabis for a while. Informed RK of my concerns over handing MH's care back to the CMHT due to his support needs as the CMHT's haven't the resources for this also due to his presentation + his mother's concerns. Despite this care handed back to CMHT, RK will get PC to contact Dr PS. Informed MH of New Dimensions App - I will collect him. T/C to JM, she's still extremely worried about MH, he's calling her a rapist and being abusive. Support given +++'

Commentary: At the handover meeting on 11 January 2007, the notes recorded by the 2 people involved (RK, Support worker with the CT and SG, a CPN) contain significant differences which may be explained by one being unqualified whereas the other is a qualified CPN.

On 17 January 2007, SG recorded in her notes 'MH DNAd (did not attend) his appointment today. I will try again on 19/1/07'.

On 19 January 2007, SG recorded in her notes 'Seen at (G/F) home. Reluctantly agreed to have depot, depot given as prescribed. HS (name) OT (Occupational Therapist) also present. MH's presentation remains unchanged, clearly thought disordered, laughing inappropriately, auditory hallucinations, preoccupied, showing no remorse over 'hitting' his younger brother. T/C to LM review booked with Dr PS

on 30/1/07 at 11.30 AM. Due to housing needs I will take MH to the homeless dept. on 24/1/07'.

On 26 January 2007, SG recorded in her notes 'T/C to JM, continues to voice concerns over her son's mental state. Would like to attend meeting with Dr PS on 30/1. I will collect her'.

On 30 January 2007, Dr PS saw MH and recorded in the medical notes 'Notes not available. G.P. Dr E. Current medication Risperdal 50mg 2/52. Currently living with (G/F) (G/F is moving out and MH will have to find his own accommodation)

Said he has given up cannabis for the last 3 weeks - previously admitted to using £20 worth a day before. Alcohol – 'rarely' and only '1 can only'.

Admitted to feeling stressed at times and to fluctuations of mood. Didn't want to elaborate on his beliefs and experiences but hinted at 'influences' and things going wrong.

Denied any ideas/plans of harm to self or others.

Was previously on Depakote but stopped taking it.

Doesn't want to be referred to DAT "I can do it on my own"

Didn't think needed any help with accommodation issues.

O/B Guarded, at times preoccupied, distracted, smiling incongruously on occasions.

Agreed to (1) have a change of Depot as Risperdal consta has only led to partial improvement.

? To go back on Depakote.

Px (1). Depixol 20 mg im test dose

(2) Depakote 750 mg BD

Follow up (1)CPN (2)support worker (3)Review as arranged'

Commentary: The Crisis Team recorded that MH was not seen or present on 8 occasions and that medication was left in envelopes (put through the letterbox) on 6 occasions. They recorded also that MH reported not having taken his medication for 2 weeks. CT visits were not always in accordance with the care plan. There are no notes of any reviews being carried out by Dr MS as indicated in the updated care plan.

In the absence of SG (planned sick leave) (XX) was to take over as Care Co-ordinator. We were unable to find evidence that any record had been made by (XX) in January 2007. In addition to his clinical notes we had access to statements made to the police on 4 April 2007, following the homicide, which we draw on hereafter.

We noted that the police did not interview members of the Crisis Team.

SG stated to the police 'On 17/1/07 MH dna an appointment'. She also stated that on 19 January 2007 'MH did attend an appointment and reluctantly took his medication,(this was a depot injection). Whilst I was with MH I noticed there was no improvement in his mental state and arranged an appointment for him to see Dr PS. MH then failed to keep an appointment with me on 24/1/07'. She also stated that 'I contacted JM on 26/1/07, she continued to express concerns and wanted to attend the appointment between MH and Dr PS'.

She also stated that *'On 30/1/07 I collected MH from (G/F)'s flat in order to attend the appointment with Dr PS. On the way we went to collect JM but she did not come with us. At the appointment with Dr PS it was decided to discontinue the Risperdal Consta and commence new medication (Depixol). The stat dose (test dose) of 20mg was given by way of injection. Other medication was discussed with MH but not administered at this time. The agreement was that (XX) would supply this medication in my absence. After this meeting I introduced MH to (XX) who would be taking over MH's care in my absence. Due to my sickness absence I did not record my last meeting with MH and Dr PS. I have recalled this from memory. This was my last contact with MH.'*

February 2007

The first entry in the CMHT records for this month is on 19 February 2007 when (XX) recorded in his notes *'DNA for appointment which I made for him via his mother. I have been asked to follow up for SG while she is off sick. Phoning his Mother is the only way I have apparently of getting in touch. I have attempted to see him before this but he calls into his mother's most days but at no particular time. Is apparently staying with another patient (G/F) but this is to end, consequently I have referred him to YY Street. A vacancy should materialise soon. Today, I was hoping to give him an injection of Depixol 50mg Px by Dr PS. He has already had a test dose which was well tolerated. Phoned his mother – MH said he hadn't turned up because he was 'depressed'. She is going to try to find out if he's now got a phone and, if so, she will let me have the number. She told me he's living over some shops in (name of street) but she doesn't know the address. She tells me that he's still with (G/F) and I could get the address by finding out what hers is. She has given me his Mobile Number which is new, but he often doesn't answer it. I will continue to try to see him.'*

On 21 February 2007 (Three weeks after SG's handover to him) KL recorded in his notes *'Having found the address: (address) – above the shops, I called round with an injection. There was no answer. Phoned him on his Mobile which he answered – he has agreed that I can do the injection tomorrow at M Ave.'*

On 22 February 2007, (XX) recorded *'Called to see. Depixol injection administered. Mental state appeared reasonable. Living in total squaller (sic) – (G/F)'s flat. I told them that he was referred to YY St. Attending MIND regularly. D/W Dr PS'*.

Commentary: At this date, MH was not, and had not been, attending MIND, due to the depth of that organisation's concerns about his mental state. (XX's) entry was inaccurate and demonstrated apparent reliance on MH's self-reporting. He appeared to have made no check of its veracity.

On 27 February 2007, (XX) noted *'D/W Dr PS. Px Depakote 750mg BD. Px sent. See again on 8th March.'*

Note: There are no other clinical entries for February.

In his evidence to Wiltshire Police, (XX) advised that he was approached by SG in early February 2007 about the injections for MH. He stated *'My understanding was*

that MH was of no fixed abode'..... 'contacted MH's mother, who I since found out was called JM'.

Commentary: SG recorded in MH's notes on 29 September 2006 that MH was living with (G/F) at her flat and the address thereof was recorded (albeit somewhat unclearly) in November 2006 in a Front sheet/personal information record in the front of MH's notes. (G/F)'s address was recorded in the notes as MH's place of residence. MH's (G/F)'s address was available to (XX) in that it was recorded in the appropriate record in MH's notes. We were concerned that (XX) apparently did not take the obvious step of reviewing the file.

We have noted that (XX's) file note of 19 February 2007 followed on immediately from an entry by SG on 28 July 2006 and was filed immediately before her next entry on 1 September 2006. Albeit that the file for MH was in a somewhat chaotic state, we were concerned at such a significant discrepancy. Whilst it was open to us to consider possible reasons for this, we were not able to substantiate any such as we were not able to hear from (XX) either in writing or in person.

A further entry by (XX) on 21 February 2007 is followed by a blank page in the notes. Again we were unable to raise this with (XX). In addition, we were not able to explore with (XX) the reasons why he stated that he could not locate MH, when the information was included in current records available to him, nor why he apparently failed to make any entries in the notes for a period of some 3 weeks, when he should have been recording any abortive attempts to locate MH. We considered the possibility that this section of the notes might be missing but were unable to reach a clear conclusion as we were unable to interview (XX).

March 2007

On 4 March 2007, MH killed CJ.

No clinical records for this 4 day period were provided to us although we made every attempt to obtain a complete record of MH's engagement with the service. Clinical records would have indicated what care, if any, was being provided for MH during this critical period. The service might have been alerted to MH's mental state, which might have lead to assessment and admission in accordance with the Mental Health Act. We were not able to establish whether there were any records for this period.

Chapter 4

Clinical Diagnosis and Treatment

Introduction

Schizophrenia is a diagnostic term for a major mental disorder, which is characterised by an alteration in an individual's perception, thoughts, affect and behaviour. The constellation and pattern of symptoms experienced by an individual vary and are influenced by their individual personal circumstances and the presence of any co-morbid conditions, particularly the misuse of psychoactive substances.

Assessment

The process of assessment of an individual presenting with psychotic symptoms is a multi-faceted procedure and has four major components:-

- Develop a diagnostic formulation.
- Establish engagement and therapeutic alliance.
- Understand issues relevant for families and carers.
- Identify needs (psychiatric, psychosocial and physical) for which specific treatment interventions are required.

Diagnostic Formulation

Assessment to develop a diagnostic formulation is a fundamental part of the role of the psychiatrist in relation to patients for whom they have responsibility. Whilst a junior psychiatrist may put forward a differential diagnosis for a patient, making a 'formal' diagnosis of a particular disorder relies on the skills and competencies of the more experienced and senior psychiatrist within a team and most usually falls to the responsibility of a consultant psychiatrist. In order to undertake this task, a consultant will need access to a wide range of information for the patient and is often reliant on this process of information gathering being undertaken by members of the multi-disciplinary team, particularly members of nursing staff. National Institute for Clinical Excellence (NICE) guidance specifically states that diagnostic formulation should include assessment by a psychiatrist as part of the process.

Significant clinical information was collected and recorded in relation to MH by DB (Crisis Team Manager), AG (psychologist) and SG (community psychiatric nurse).

Commentary: No formal diagnosis was made until after the homicide, although three differential diagnoses were noted for MH. On 2 August 2006, Dr V noted (*'Paranoid Schizophrenia. Multiple substance dependence'*). This was subsequently repeated and expanded by two other junior doctors after MH's admission to Green Lane Hospital on 22 November (*'Schizophrenic disorder. ??schizoaffective disorder'*); and on 24 November 2006 (*'Schizophrenia – exacerbation of psychosis, cannabis is up, carrying a knife, hit little brother,*

verbally abusive to mother, put a knife to his girlfriend's throat'). We saw no evidence to indicate that either Dr PS or Dr MS formally undertook an assessment or formulation process of MH in order to formalise or dismiss a diagnosis of schizophrenia.

International Classification of Disease (ICD-10)

The International Classification of Disease (ICD-10, World Health Organisation) sets down the following diagnostic guidelines for schizophrenia:-

For each symptom cluster, the first references within MH's records are noted in bold italics as follows:-

- (a) Thought echo, thought insertion or withdrawal, and thought broadcasting.
Feb 2005 noted by AG ***'sometimes seems like people can hear his thoughts....'***
- (b) Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions or sensation; delusional perception. Ideas of reference noted on initial assessment by DB ***'believes that a DJ on the TV is pointing at him.'*** Notes from review on 4 October ***'he started saying that there is a (sic) news about him on the TV and people look at him in a special way that only he can understand'***.
- (c) Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient amongst themselves, or other types of hallucinatory voices coming from some part of the body. Noted in medical notes by Dr MS 27 June 2006 ***'Aud - hallu - of 3rd Person - talk about him (brief indecipherable entry) both male and female voices.'***
- (d) Persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. Being able to control the weather or being in communication with aliens from another world). This was a major feature of presentation noted from MH's contact with primary care. It was later summarised in statement by Dr PS ***'His presentation at that time (2004) was characterised by delusional thinking centred round three alleged incidents of sexual abuse, two against him and one against a youngster'. This set of beliefs is noted consistently in the records made by Crisis Team, SG and AG in 2004 and early 2005, which include references to MH believing he was a mighty soldier, he had to stop all the terrorists, Bin Laden and Iraq , getting a 'Crown' and going to Downing Street.***
- (e) Persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, when occurring every day for weeks or months on end. ***'None of the clinical staff recorded information that fell within this cluster.***
- (f) Breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms. It was noted on initial assessment by DB on 17 September 2004 ***'His thinking appears very disordered and he is unable to be coherent at times. MH is obsessed by these abuse allegations but is vague and disjointed in his explanations.'***
- (g) Catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism and stupor. ***These were not noted in the records.***

(h) 'Negative' symptoms such as marked apathy, paucity of speech and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication. **Staff did record evidence of negative symptoms by MH, including flattened affect and lack of motivation.**

(i) A significant and consistent change in overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude and social withdrawal. **These aspects were noted in records made by SG and by Crisis Team staff.**

Commentary: The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear cut) belonging to any one of the groups listed as (a) to (d) above, or symptoms from at least two of the groups referred to as (e) to (h) should have been clearly present for most of the time during a period of one month or more.

References to the range and the complexity of the symptoms presented by MH were sufficient at this point in time (end of 2004) for it to be appropriate to formulate a working diagnosis of schizophrenia. This did not happen.

Care and Treatment

Reference to the NICE guidelines at this stage would indicate the following components required for appropriate care and treatment of patients with schizophrenia:

- Reach a diagnosis.
- Develop a psychological formulation.
- Identify strengths and needs.
- Develop a risk assessment and management plan.

In addition, the guidance recommends that

- Where co-morbid conditions such as substance misuse are identified, specific assessments and care plans are developed with regard to this.
- When a diagnosis has been made, it should be fully explained and discussed with the patient and if appropriate with their family.

Establish Engagement and Therapeutic Alliance

Following diagnosis, it is important to acknowledge specifically the requirement to engage with the patient and their family. This process of engagement is a fundamental component of the successful treatment and support of patients with schizophrenia. Both the short and long-term engagement of the individual are the foundation of any specific intervention including pharmacological interventions, psychosocial interventions and interventions aimed at addressing physical health.

For MH the major element of his care and treatment in relation to engagement and the development of a therapeutic alliance was provided to a degree by his contact with SG as his Care Co-ordinator within the CMHT and the series of sessions provided by AG.

Assertive Outreach teams and Early Intervention services have been developed to address this need. However, in MH's case, the opportunity for his care to be managed within the framework of an Outreach team or an Early Intervention service was not possible due to the stage of the resourcing and development respectively of these teams within the Trust. (Chapter 7 addresses this in more detail)

Observations on the Treatment of MH and the Management of Schizophrenia

Pharmacological Treatment

Anti-psychotic medicines are the primary treatment for schizophrenia. There is well-established evidence for their efficacy in both the treatment of acute psychotic episodes and relapse prevention over time.

MH was not prescribed medication at the time he presented to primary care. This was an appropriate strategy given there was no emergency indication for anti-psychotic medication and the referral process in place enabled an immediate specialised mental health assessment to be undertaken by the Crisis Team.

The core assessment dated 17 September 2004 completed by DB stated under 'Next Steps/Management Plan:- *'commence Home Treatment, - Daily visits, - 10 mg Olanzapine velotabs – administered by crisis team.'* The records of the Crisis Team indicate that, with some recorded exceptions, they visited daily and provided MH with medication although they often noted that they did not see him or always see him take his medication.

MH was prescribed a number of different anti-psychotic medications:

Olanzapine (Trade name: Zyprexa) Max daily dosage 20 mg.

Risperidone (Trade name: Risperdal) Max daily dosage 16 mg.

Flupenthixol Decanoate (Trade name: Depixol) Max dosage 400mg weekly; usual maintenance dose 50 mg every 4 weeks to 300 mg every 2 weeks.

During the course of MH's care and treatment by the mental health services, he was prescribed anti-psychotic medication for the treatment of schizophrenia. Olanzapine and Risperidone (atypical anti-psychotic drugs) were prescribed as oral treatments and both were prescribed within a recognised dosing regime. In addition, to respond to difficulties with compliance with oral medication, MH was prescribed two anti-psychotic drugs in the form of an injectable, slow release preparation, Risperidone Consta and Flupenthixol Decanoate. Both were prescribed in accordance with recognised dosing regimes.

The anticipated therapeutic effects of these drugs are:-

- Reduction in the experience of hearing voices (hallucinations).
- Reduction in intensity of belief in delusional ideas.
- Improvement in thought disorder.

Supervision of Medication

The notes of the Crisis Team record that they should have visited daily to support MH taking this medication but it was clear from the records that they did not always visit as required. There is also limited information noted during visits to demonstrate the monitoring and assessment of the effect of introducing this medication, specifically as noted within the NICE guidelines for treatment with anti-psychotic medication:-

1. Prescription of anti-psychotic medication should be considered as an individual therapeutic trial.
2. Expected benefits and risk should be explained to the patient.
3. The dose of medication should be carefully titrated with reference to recording of the efficacy, side effects experienced, adherence to regime and physical health of the patient.

Commentary: Throughout MH's treatment by the mental health services there is very limited evidence that these principles were adequately adhered to.

Recommendation 5: The Trust should ensure that all staff adhere to the principles set out by NICE for the treatment with anti-psychotic medicine. The Trust should ensure that all staff are provided with appropriate training to ensure their understanding of these responsibilities and to develop competence to discharge these responsibilities.

Clinical staff judged that MH did respond positively to treatment with conventional anti-psychotic medication. However, it is notable that Dr SB (Fromeside), who is currently responsible for MH's care and treatment, noted in her statement:- *'At the present time MH continues on a very high dose of Clozapine, an anti-psychotic medication known to be particularly effective for service users with treatment resistant symptoms.'*

Review of MH's Medication

In terms of anti-psychotic medication, MH was commenced on an appropriate medication, Olanzapine, and this was altered to an appropriate alternative, Risperidone, at his request. A lack of understanding by clinical staff, including consultant staff, of the severity of his illness meant that a treatment trial with Clozapine was not implemented in the period where he was under the care and treatment of either the CMHT or the Crisis Team.

Commentary: Dr MS' last recorded involvement with MH was on 13 November 2006 and there is no record that Crisis Team staff or SG sought her advice in respect of concerns about MH's ongoing presentation thereafter.

Following an overdose of Olanzapine, MH was recommenced on Olanzapine on 22 February 2006. However, he was reluctant to continue with the Olanzapine due to his complaints that it made him feel tired (a recognised side effect). In April 2006, Dr PS therefore initiated treatment with an alternative anti-psychotic, Risperidone, and in his written statement recorded:- *'It was therefore decided to start him on oral*

Risperidone with the view of establishing him on depot injection of Risperdal consta in view of his erratic adherence with oral medication.'

Commentary: There is lack of clarity in the content and completion of drug charts by the Crisis Team. Some entries are blank and one indicates that MH refused medication. There is inconsistency in the recording of administration of medication in respect of MH, given his history of non-compliance.

MH's compliance with oral medication was inconsistent and the switch to a depot preparation was appropriate.

It is unclear why records in the drug charts in respect of the oral doses of Olanzapine are left blank. Similarly in respect of the dose of depot Risperidone due on 18 June 2006, there is no entry in the Crisis Team notes in relation to this date and event.

Recommendation 6: The Trust should ensure that staff complete drug charts in accordance with its own stated policy and report any errors or omissions without delay.

Medication Record Keeping

The AWPT Drug Prescription and Administration Record is a pro forma designed to support the prescription and administration of medication to patients in a hospital setting and its format is consistent with that seen in very many hospital establishments. In this context the responsibilities of the registered practitioner in signing the chart to confirm that they have administered a particular drug are very clear. These responsibilities are established at a national level within the Nursing and Midwifery Council (NMC) standards in relation to the administration of medicines. These responsibilities are similarly reflected in the Trust 'Medicines Management Policy'

Difficulties arise in MH's case where the same chart has been used in relation to the Crisis Team actions regarding their interventions to 'support MH' with his medication whilst in the community. The available information indicates that there is a lack of clarity and consistency within the approach of the Crisis Team as to whether staff were 'administering' the medication prescribed to MH whilst he was in the community or whether they were 'delivering' the medication prescribed to MH.

Commentary: We were unequivocal in our view that the stated policy of the Crisis Team to 'provide home treatment' included the administration of medicines.

In addition, medication prescribed by the Crisis Team consultant in July 2006 was not dispensed. One chart is signed as having given a 50 mg dose of depot Risperdal on 21 July but this is before the date that the prescription for the increased dose was authorised.

In January 2007, when (XX) took over responsibility of MH's medication during SG's sick leave, the drug chart indicates:-

30 January 2007 A test dose of depixol is prescribed as a once only prescription. There is no signature to indicate that it was given.

30 January 2007 Depakote 750mg bd is prescribed but no record is given of it being dispensed. A single dispensing 'box' is dated 22/2.

19 February 2007 Depixol 50 mg im 2 weekly is prescribed but there is no record of it being given.

Commentary: If the Crisis Team were administering the medication, then there were clear breaches in the NMC standards, particularly in relation to Standard 8, sub-section 2.1 and 2.10 (Standards for the Practice of Administration of Medicines) and also Standard 17 (Standard for Delegation). These breaches related in particular to the dropping of envelopes and the recording of information although this is difficult to establish in the possible absence of a comprehensive set of the Crisis Team records during the critical time period. We were able to review the Trust's Medicine Policy written in February 2003, which is marked as having been revised in August 2006, although the initial policy provided to us was the Medicines Management Policy dated 2008. The section of relevance is Appendix F, '*Policy and procedure for the storage, carriage and administration of medicines in the community*'. In regard to the administration of medicines, the policy gives guidance in relation to the supervision of a patient, who is self medicating, and the direct administration of medicines (Sections (4) and (5)):-

'4. Administration of medicines

In addition to the AWP trust policy and procedure for the management and administration of medicines, the following guidelines apply:-

Supervising a patient who is self medicating

This guidance relates to the patient who is administering his or her own medicine under the supervision of an employee, or individual working on behalf of, the Avon and Wiltshire Mental Health Partnership NHS Trust

- The role of the practitioner is to encourage and support the patient/service user in the self-administration of his or her own medication.
- Any member of the team who is deemed competent by the team manager can supervise this practice.
- The medicine can be kept at the patient's home, unless there are concerns over the risks this may pose to the individual e.g. significant risk of overdose.
- At each visit, the practitioner should ensure that they have the correct medication for that patient before returning it to them.
- If the patient is unable to self administer, then a registered practitioner must be involved in the administration of the medicine i.e. measuring liquid medicine.

5. Direct Administration of Medicine

For the administration of depot medication, please see additional guidance, entitled 'guidance on depot medication'.

- A clinical team may decide that a patient is unable to self-administer medicine independently, without the assistance of a registered practitioner. If direct administration is considered appropriate, then the discussion and plan for this must be recorded in the clinical notes and the following steps taken. Please discuss with the patient or service user where they would prefer to take their Medication.
 1. The team member administering the medicine must be a registered practitioner.
 2. They must adhere to the Trust policy and procedure for the management and administration of medicines.
 3. A valid prescription must be taken along with the medicine to the patient's home. This is to ensure that the correct dose is given to the correct patient, as this direct practice is deemed administration and as such must be viewed, as any other administration of medicines would be.
 4. The registered practitioner is responsible for this practice.'

We noted that the policy states that the role of the practitioner is to 'encourage and support' the patient/service user in the self administration of his or her own medication' The policy does not make reference to the 'delivery' of medication.

Recommendation 7: The Trust should ensure that all members of the Crisis Team adhere to their remit and professional responsibilities in respect of the administration of medication and monitoring of compliance and that failure by a patient to comply is formally escalated, including an appropriate report to the Responsible Clinician, so that any necessary actions can be determined and implemented.

Working in Partnership with Carers

NICE guidance, '*Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care, National Institute of Clinical Excellence 2002*', emphasises the importance of working effectively with the family and carers of patients with schizophrenia, including.

- Provide written and verbal information on schizophrenia and its management, including how families and carers can help through all phases of treatment
- Offer them a carer's assessment
- Provide information about local carer and family support groups and voluntary organisations, and help carers to access these
- Negotiate confidentiality and information sharing between the service user and their carers, if appropriate
- Assess the needs of any children in the family, including young carers

From the records it is clear that both SG and AG met regularly with MH's Mother, JM. In her evidence to us, JM stated that:- *'They did a lot of family work with us, with MH. He went to Hazelmead and for a period he was quite stable.'*

Commentary: We neither saw nor heard any evidence to indicate that the NICE guidelines in respect of working with families were fully or comprehensively adhered to in MH's case. SG and AG did see MH's mother and sister for sessions and these were helpful but this seems not to have been connected in an appropriate way to information sharing with, and by, the wider care team. SG was also in contact with JM and advised us that she regularly fed back information within the multi disciplinary team meeting and that she kept professionals updated by telephone with the work she was doing

Recommendation 8: The Trust should ensure that staff are aware of the process and need for partnership working with carers and adhere fully thereto.

Referral and Diagnosis Factors

In the initial referral letter from GP dated 10 September 2004, it was noted *'MH presents with depressive symptoms and the crisis team were telephoned as he was making suicidal suggestions and talking about past abuse. No immediate risk was foreseen so an appointment was made with J, our clinical psychologist. J was very concerned as MH appears to have symptoms of a psychotic illness and his stories of abuse, apparently only just remembered, were difficult to disentangle from some apparently paranoid thoughts. We have not commenced any medication.'* There was a Referral for urgent review by Dr PS, of the CMHT, which was subsequently and appropriately referred to the Crisis Team. .

Commentary: On initial presentation, MH was noted to have some depressive, paranoid and psychotic symptoms and was talking about abuse. It was appropriate, given the presentation, for a consultation to be arranged with the Practice Psychologist to explore these issues further. As additional information emerged, importantly the concern that MH had symptoms of a psychotic illness, an appropriate urgent referral for psychiatric review was made.

On 17 September 2004 there was a telephone call from the GP Practice to the Crisis Team, which was recorded by the latter as MH having:- *'thoughts of suicide and murdering person he believes abused him.....TV speaking to him.'* MH was assessed by DB, Crisis Team Manager, later that day.

Commentary: A significant constellation of psychiatric symptoms is noted in the record of this assessment. In summary:- included were bizarre behaviour; suicidal and homicidal ideas; very disordered thinking; unable to be coherent at times; obsessed by abuse allegations; poor eye contact; quite guarded; nervous and suspicious; wants to gouge out eyes of the abuser; strange and unexplainable delusions; suspicious of taking medication; use of cannabis; frightened and confused; paranoid; ideas of reference and low mood. It is

also evident that MH was acting on his beliefs, avoiding food and residents at the hostel; and visiting the police station with regard to report of abuse.

The interventions of support from Crisis Team and commencement of anti-psychotic medication were appropriate immediate interventions. However, of concern is that we found no evidence of any structured plan for a more detailed assessment to be undertaken following these initial interventions.

In October 2004, there was a review by Dr Ra (Locum Consultant Psychiatrist). He recorded that:- *'MH talked most of the time about his sexual molestation and wants something should be done to the person who he (illegible word)done it. He did not express suicidal ideas. On MSE MH was casually dressed. Eye to eye contact was poor. He gave very brief answers and muttered to himself at times. Mood is a little angry. His thoughts were preoccupied by his sexual abuse ideas (delusional ideas). His orientation, memory and concentration were normal. He lacked insight'* Dr Ra also completed a Treatment Plan:-

'To continue Tab olanzapine (20mg) daily for 2 weeks. Crisis team to visit daily to administer medicine. To contact CMHT as he is going to be under treatment for a long time. Social Services involvement'

Commentary: No formal diagnosis was made or differential diagnosis suggested.

Throughout October 2004 there was a series of appointments with AG (Psychologist), who recorded details of continued disclosure by MH of information regarding alleged abuse and the expression of unusual beliefs, about incidents, which he believed showed on his face. On 20 October 2004, AG made a referral to the Vulnerable Adults Unit (VAU).

Commentary: MH's beliefs about the alleged abuse were explored extensively including referral to VAU. The content of other 'unusual' ideas e.g. regarding (TV) and incidents 'showing on his face' appear to have had less exploration and emphasis.

The extensive range of psychotic symptoms and experiences was not regularly assessed by conducting a detailed mental state examination. This does not accord with best practice when commencing treatment with an anti-psychotic drug for the first time and represents a missed opportunity, which we consider to be significant.

Recommendation 9: Comprehensive Mental State Examination should be undertaken on a regular basis, particularly in respect of commencement of treatment with an anti-psychotic drug.

On 26 November 2004, there was a review by Dr Ra, at which he noted MH's mental state as showing no hallucinations or delusions and that his mood was normal. His Plan stated:- *'To continue Olanzapine 20 mg daily. He already has an appointment with CMHT so Crisis Team can hand him over to CMHT.'*

Commentary: The Mental State Examination at the appointment indicated that MH's mental state had improved. Limited but crucial information, regarding ongoing psychotic symptoms, which could have further influenced Dr Ra's decision, had not been transferred from the Crisis Team. Crisis Team records for the previous day show that AG made contact with the Crisis Team on 25 November 2004 to say that MH's medication should be reviewed, as he still had delusions.

The range and complexity of symptoms presented by MH were sufficient at this point in time, for it to be appropriate to formulate a working diagnosis of schizophrenia. Reference to the NICE guidelines at this stage would have indicated the following requirements for appropriate care and treatment:

- Reach a diagnosis
- Develop a psychological formulation
- Identify strengths and needs
- Develop a risk assessment and management plan.

In addition, the guidance recommends that:-

- Where co-morbid conditions such as substance misuse are identified specific assessments and care plans are developed with regard to this.
- When a diagnosis has been made, it should be fully explained and discussed with the patient and if appropriate with their family.

At this stage, MH's care and treatment fell significantly short of that recommended within the NICE guidelines, specifically

- A clear diagnostic formulation was not made and recorded.
- Although AG did develop a psychological formulation, this was not explicitly shared with MH and his carers or with the other clinicians involved in MH's treatment. AG advised us that in October and November 2004, she was developing a formulation but that this was too tentative to be recorded and shared with MH, JM and others. However there is no evidence that this tentative formulation was developed further. This omission is of particular concern in relation to subsequent decisions by the Consultant Psychiatrists, Dr PS (CMHT), Dr MS (Crisis Team) and latterly, Dr DS, Green Lane Hospital, Devizes.
- MH's strengths and needs were not explicitly assessed and recorded
- No specific care plan was developed to manage co-morbid substance misuse.

Recommendation 10: The Trust should ensure that clinical staff are aware of and implement relevant NICE guidelines.

Decision Making

December 2004 saw the transfer of MH's care to the CMHT and on-going family work sessions with AG and SG.

In February 2005, AG recorded disclosures by MH 'Sometimes seems like people can hear his thoughts'. And 'I don't hate CJ but I'm going to kill him and demonstrating to his mother and sister with a kitchen knife how he would cut CJ.'

Commentary: The significance of the additional psychotic symptoms and continued actions on the basis of his thoughts does not appear to have led to action in respect of these heightened risk concerns.

On 1 March 2005, MH was seen by Dr PS for the first time in Community Review Round. No overt psychiatric symptoms were noted. Dr PS recorded:- 'Continue with medication. To support/monitoring Hazelmead staff'

Commentary: Dr PS noted MH's presentation and had information available to him at the meeting from MH, SG and the staff from Hazelmead hostel. The management plan agreed at this meeting was in response to this information. However, it is not evident whether Dr PS was aware of the number and nature of continued notes of psychotic symptoms made during the sessions with AG. Without this additional information the continuation of the same care plan was reasonable. This was MH's third contact with a consultant psychiatrist but again no diagnostic formulation or working diagnosis was recorded following this meeting. This was a serious omission on the part of Dr PS.

In July 2005, MH was evicted from Hazelmead due to unacceptable behaviour (getting drunk and threatening towards others – throwing bottles and assaulting residents).

Commentary: These events appear to have been interpreted by AWPT staff in the context of 'inappropriate social behaviours' rather than as possibly reflecting or arising from psychotic experiences. This possibility was not explored despite information from previous sessions with AG.

On 31 January 2006, at a CPA review, MH's mental state was noted by SG to be apparently stable and no psychotic symptoms were noted or recorded. The record includes:-

'Plan

CPN to visit 2/52. Continue current medication – Olanzapine 20 mg nocte. MH to continue visiting family weekly. Socialising with others. Attending MIND/Fishing. Engagement with FLEX's (name). Work on budgeting skills with (name). Monitor mental state. Benefits to remain at £120 Incapacity 1/12 DLA £32.20 a week. Support/advice/encouragement.'

Commentary: This would have been an appropriate care plan given the apparent stability of MH's mental state. However, the assessment of his mental state was based on inadequate information, albeit that other information was available. Had that information been accessed, then it is probable that a more appropriate Care Plan would have been developed.

Reference to NICE guidelines in relation to comprehensive service provision recommends that care for individuals with schizophrenia should include the following elements:-

1. Social, group and physical activities.
2. Working in partnership with carers.
3. Appropriate assessment and management of consent, capacity and treatment decisions.
4. Pharmacological interventions.
5. Psychological and psychosocial interventions.

At this stage, the care provision for MH consisted of some of the above 5 major elements, or parts thereof. However, it did not accord with the recommendations within the guidelines in relation to assessment and management and recording of consent, capacity and treatment decisions and working in partnership with carers. Although MH was prescribed an appropriate anti-psychotic drug, the management of this drug lacked key elements of the NICE recommendations in terms of titrating, the dosage of the drug against improvements in mental state monitoring of efficacy and consideration of alternative drugs. A key element of this failure is that the prescribing doctors did not appear to have all the information regarding MH's mental state over time available to them on the 3 occasions he was reviewed and thus relied on the Mental State Examination conducted at the interview in making treatment decisions.

Recommendation: (Repeat of recommendation 9) Comprehensive Mental State Examination should be undertaken on a regular basis, particularly in respect of commencement of treatment with an anti-psychotic drug.

Overdose

On 11 February 2006, MH took a serious overdose of Olanzapine, although there is dispute regarding the amount. The records indicate that MH developed neuroleptic malignant syndrome as a consequence of the overdose. He was admitted to Great Western Hospital for treatment.

Commentary: Apart from one note to the effect that MH had once attempted to conceal medication, there is no contemporary evidence prior to the overdose that MH was considering taking an overdose. However, he had spoken about self-harm earlier in his illness at the time of presentation. Admission to a general hospital was appropriate.

On 13 February 2006, there is a Great Western Hospital ward round note which states:- *'took ?48 tablets of olanzapine. Took them for attention. 1st time taken overdose – never done it before. Would not do it again. Feels has a bad leg - hurts when he moves. Obs stable. Plan/- continue to monitor. - psychiatry R/V (psychiatric review).'*

Commentary: It was an appropriate intervention to refer MH for a specialist psychiatric review. This note was made by a junior member of medical staff but the signature is unclear. Notes made by the Crisis Team (*addressed in*

fuller detail in Chapter 9) were generally not attributable as full signature and titles were not used. Confirmation of many entries made by staff of this team was by initials only or unreadable 'signatures' (one consisting of a single long line followed by two lower case letters). In some cases there was no identifying entry at all after the clinical note recorded. Designation of the recorder by job title was rare. Registered staff in the Crisis Team are covered by the Codes of Conduct for their professions. For registered nurses, the Code of Conduct issued by the Nursing and Midwifery Council includes a section on keeping clear and accurate records, which includes the following requirements:-

42 You must keep clear and accurate records of the discussions you have, the assessment you make, the treatment and medicines you give, and how effective these have been.

43 You must complete records as soon as possible after an event has occurred.

45 You must ensure any entries you make in someone's paper records are clearly and legibly signed, dated and timed.

Whilst the times and dates of entries were generally appropriately recorded, the above three requirements were frequently not.

Recommendation 11: All entries in clinical notes must include in capitals the name and title of the person making the entry and the name(s) of any others involved in/present at the matter being recorded.

On 14 February 2006, a record was made by CM (Mental Health Liaison Nurse) stating that she had:- *'liaised with SG - MH's Community Psychiatric Nurse, she has arranged that MH be collected from hospital today by his mother with whom he will stay the night & SG will see and review him again tomorrow thus he may be discharged to his mother's when medically fit.*

Commentary: We could find no evidence that a psychiatric assessment or review was undertaken by anybody as a result of the overdose. This was confirmed during interview with CM. This was contrary to Trust policy and a clear and potentially critically important missed opportunity in MH's case.

The acute medical management of MH's overdose was appropriate and he made an effective recovery from the effects of the medication taken in overdose and was appropriately referred for a psychiatric review, albeit that this did not take place.

The Trust Policy dated 2001 *'Operational Policy: The General Hospital Management of self-harm'* makes the following statement:

'Patients referred for specialist assessment following and (sic) episode of self-harm will receive a full psychosocial assessment by designated clinical staff, within 24 hours of referral'

Full details of the requirement of this assessment, including a detailed risk assessment, are given within the policy. This Policy meets the criteria set down within the NICE guidelines for the requirement of a psychological and risk assessment to be completed following an episode of self-harm.

The Trust Policy also states:- *'Every patient who presents to the Emergency Department following an episode of self-harm will receive an initial assessment immediately upon arrival in the department'*

This is to include the completion of the 'SAD PERSONS' assessment scale which is included within the policy. (The SAD PERSONS scale was developed in 1983, to aid the assessment of suicide potential. It does not, however, remove the need for clinical judgement)

Note: In the event, this was not possible because of the level of physical aggression presented by MH when in hospital. However, no attempt to complete this important assessment at a later point in time when MH was more settled was made.

Commentary: There were significant failings in the management of this episode of self-harm. Critical assessments and actions that are clearly set down in both Trust Policy and NICE guidance were not undertaken.

A decision to discharge MH was taken on the basis that he was medically fit but no assessment of his psychiatric fitness for discharge was made and no understanding of the psychological precipitants and causation of the overdose was developed. There was no psychiatric assessment after his discharge and he next saw a consultant psychiatrist in May 2006. This was a critical missed opportunity and, in our view evidence of both failures in systems and individual failings by AWPT and its staff.

Recommendation 12: There must be a psychosocial assessment prior to, or as soon as possible after, discharge of a patient who is admitted to hospital following a self-harm episode.

Deterioration in Mental Health

During March and April 2006, recorded entries in notes indicated that MH's mental health was deteriorating with re-emergence of suspiciousness, thinking about abuse, appearing pre-occupied, inappropriate laughing and refusing medication. He agreed on 20 April to commence on Risperdal consta.

Note: During 2006, there were four Mental Health Act assessments of MH, two of which resulted in in-patient admission. (This is dealt with more fully in Chapter 5)

Commentary: There is clearly substantial evidence that MH's mental state was relapsing without consistent treatment with anti-psychotic medication. The

prescription of an alternative anti-psychotic in the form of an injection was appropriate and took account of the previous difficulties with compliance.

During May 2006, records showed continuing evidence of relapses in MH's mental state, including non-compliance with medication. However, when Dr MS saw MH on 22 May 2006 and conducted a Mental State Examination, her record (reproduced in Chapter 3) did not reflect in full the concerns and behaviours noted by other clinicians throughout May 2006. Whilst recognising that the notes made by AG may not have been accessible (as AG did not always incorporate these into the main notes in a timely fashion, an issue addressed in more detail in Chapter 9) we were concerned that Dr MS appears not to have reviewed the records of the Crisis Team, of which she was the clinical lead, or those of the CMHT. Her assessment of MH was, therefore, not fully informed by key information.

Commentary: Continued attempts to provide medication by depot injection were appropriate particularly given MH's noted prior inconsistency with oral medication compliance.

In June 2006, varying accounts of MH's mental state were recorded; at times, he was reported as relatively settled and at others there were clear reports of psychotic symptoms. Assessment was started for admission to Windswept but the assessment and admission were not completed as Windswept Staff considered MH too unwell to continue.

In July 2006, MH was variously described as intermittently self-reporting auditory hallucinations. The clinical factors recorded included:- paranoia related to food contamination; auditory hallucinations, of which he would not disclose content; a previous psychotic episode; erratic and bizarre behaviours; preoccupation; guarded when communicating; poor eye contact; difficulty in engaging in conversation; neglecting eating/poor nutrition/fluids; neglecting personal care; irritable, agitation, restless; responding to hearing voices although will not disclose thought content; poor insight; alcohol abuse; past history of cannabis misuse; reports from JM that she has heard MH talking to himself and barking like a dog. As part of a Risk Assessment, a Management Plan, unsigned, but confirmed as being completed jointly by SG and AB of the Crisis Team, included:-

'Daily visits by the Crisis Team. Weekly visits by CPN. Weekly visits by AG. Weekly visits by Early Interventions worker, T. Dr MS to review on 26/07/06. Re-assessment at Windswept on 25/07/06. Professional meeting on 26/07/06. Administration of depot every 5/52. Continue attempts to engage MH in therapeutic activities.

Commentary: This Management Plan appears to have been predicated on the basis that MH was capable of giving consent to it and of maintaining his compliance. Although there is presumption that all adults have the capacity to consent, given the degree of documented disturbance in MH's mental state, we considered that the question of his capacity should have been considered as part of his ongoing assessment and management. MH's capacity to give consent was not formally assessed and in any event, he did not sign the plan. However, SG advised us that this was an interim plan as MH's mental state

was to be assessed by a Consultant and the professionals meeting was to take place, then a Mental Health Act assessment would be organised.

Recommendation 13: Formal assessment of capacity to consent to treatment, including medication, should be undertaken and recorded on the patient's first contact with the service. Thereafter, new assessments should be undertaken where there are changes to the treatment regime. In addition, where there is evidence of, or concern about, actual or potential non-compliance, the issue of capacity to consent should be reviewed as part of the process of managing compliance.

Admission under Section 2 of the Mental Health Act

On 31 July 2006, a Mental Health Act assessment took place and MH's admission to Applewood as an in-patient under Section 2 of the Act took place. The hospital admission record shows:- *'...noticeable deterioration of mental health since April – May 2006 and no improvement since being started on Risperidone and depot injections. Known to be intrusive, paranoid, withdrawn at times and noted to be irritable, angry and pacing around'*

Commentary: The Section 2 admission was an appropriate intervention.

During the period of MH's in-patient stay, Mental State Examinations were recorded which demonstrated a gradual reduction in psychotic symptoms. On 23 August 2006 a Mental State Examination was recorded by Dr AW:- *'A+B (Appearance and Behaviour) Still very head up. Makes eye contact when he is asking for leave otherwise not. Appears to be distant + preoccupied. S (Speech) normal in T/V/R (Tone, Volume and Rate). M (Mood) S/O (subjectively/ objectively) - N (Normal) O - not much variation - flat. T (Thoughts) No evidence of delusional thought..... A+C (Attention and Concentration) – able to engage in conversation, but appears bored & distant.realises need to engage in activities. Denies being ill.'* The decision was made not to complete section 3 and MH was discharged from detention on 28th August 2006, but agreed that he would remain in hospital on an informal basis.

Commentary: MH had made a positive response during the admission to hospital. The decision not to apply for a Section 3 was finely balanced and he agreed to remain in hospital as an informal patient. In the circumstances, this decision was not unreasonable.

However, when MH was seen by SG on 1 September 2006 at Applewood, she noted his psychotic beliefs:- *it was apparent that he believes that he is a 'mighty soldier' and that he has a job to do, which is to save the world from all the terrorists and bombings'*

Commentary: These observations are recorded in the community notes of SG and not in the clinical file held on the ward. It is uncertain whether this clear evidence of active psychotic symptoms was available to Dr PS when he conducted his ward round on 4 September. Notwithstanding, Dr PS should have assured himself that he had access to all relevant information, given that the decision not to apply for a Section 3 was finely balanced.

During October 2006, substantial difficulties were experienced with MH's placement at Windswept. On 10 October 2006, SG recorded that MH's mental state was very disturbed. She described him as *'...unkempt, dishevelled, dirty clothes, appeared agitated, pacing, unusual movements. SPEECH - Rate – increased, rambling at times, volume – heightened. Speech content sexually inappropriate. MOOD – MH reports that at times feels "depressed" however, OK now, MH appeared elated, flight of ideas grandiose. HALLUCINATIONS – denies although appeared preoccupied ? responding to external stimuli. DELUSIONS – MH believes he is a mighty soldier (sic) and has a task to carry out. A/ct of his beliefs pattern around sexuality. He told me that 'I haven't raped you, I can tell by your eye". He believes that (Name of famous rapper hereafter referred to as (FR) & (Name of famous singer hereafter referred to as (FS)) are his half brother and sister..... Drinking spirits at present ½ of vodka. Smoking Cannabis daily unable to obtain quantity.... may go on to use LSD, speed, Heroin. Since I last saw MH there was a dramatic deterioration in his mental state. Advised him about possible effects of Cannabis.D/W (Discussion with) Dr PS, informed of current presentation'*

Commentary: At 10 October 2006, Dr PS was aware of the nature and level of concerns expressed by SG, MH's Care Co-ordinator.

On 13 October 2006, a Professionals meeting, was held and was attended by SG, RG, AG, T (Windswept) and SD (Crisis Team). SG recorded the agreed action plan:- ' 1. Placement at Windswept to be terminated.

- 2. Look at MHA assessment.**
- 3. Reviewed by Dr MS on 16/10/06.**
 - 6. Community support to remain in place.**
 - 7. Crisis team to visit daily.**
 - 8. Emergency placement to be found'.**

Commentary: There was marked deterioration in MH's mental state, characterised by a return of thought disorder and delusional beliefs. This should have prompted an urgent review of the risks he posed to both himself and others. It is probable that his concurrent use of cannabis and alcohol had a major negative impact on his mental state but specific actions to address and manage this were not formulated.

November 2006 saw continued entries in the records indicating MH's poor mental state.

Informal Admission to Hospital

On 22 November 2006 a Mental Health Act Assessment was undertaken. JD, the ASW, recorded:- *'I felt MH was relatively open and direct in the way he responded to the process of assessment; he acknowledged psychotic experiences and negative impact of cannabis and alcohol; he was direct about physical aggression towards siblings and placed it in context of longstanding sibling conflicts. He was not convinced about efficacy of medication but did not refuse and himself identified he was approaching point where he would seek admission; he recognised how anxious and unsure/confused he was. There are clear concerns and some increased risks indicated for MH's health, self-neglect and the protection of others; these were*

acknowledged by MH who agreed with very little demur to a voluntary admission and there were no indications for compulsory admission at this point.'

Commentary: At this assessment, admission to hospital as an informal patient was offered to, and accepted by, MH. It was appropriate, therefore, for an informal admission to occur.

On 22 November 2006, MH's informal admission to Green Lane Hospital occurred. The Mental State Examinations conducted thereafter show some improvement and do not describe any of the psychotic symptoms noted prior to his admission. However, nursing records include reference to those symptoms.

On 30 November 2006, MH was reviewed at Green Lane Hospital by Dr DS, Consultant Psychiatrist, who elicited from MH no psychotic or abnormal symptoms and formulated a plan: *'I have had contact with SG (Care Co-ord) I have contacted the Swindon CHTT (Crisis Team) and they will phone back. MH is fit to return to Swindon. He is voluntary and thus can go on his request. I have no reason to stop him.'*

Commentary: The decision to discharge MH was not unreasonable on the basis of the apparent rapid resolution of his disturbed mental state. However, Dr DS and other clinicians at Green Lane Hospital were unaware of the longitudinal picture of MH's illness and were not able to take this into account. Notwithstanding, Green Lane Hospital is part of AWPT and the information should have been readily accessible to Dr DS and colleagues.

Recommendation 14: The Trust should ensure that, whatever system it operates for the recording and collation of patient notes, the complete record is readily available to those seeing the patient, particularly on transfer of care between teams, including in-patient admission, and Mental Health Act assessments.

Recommendation 15: Whatever system of clinical records is in use, all available information should be passed to the lead clinician where an admission or discharge takes place.

Further Deterioration in Mental Health

From December onwards, there is a series of entries in the files suggesting that MH's mental state was again deteriorating but there is no medical intervention recorded.

Overall Commentary: MH had continuous contact with mental health services from September 2004 to March 2007. The pattern of his illness was that of a fluctuating mental state with episodes of deterioration leading to a return of the florid psychotic symptoms. It is evident that, at times when he was taking cannabis or significant amounts of alcohol, this would precipitate a very rapid negative deterioration in his mental state. The risk that MH presented to both

himself and others was also fluctuant and related to his mental state. The deterioration of MH's mental state was recorded throughout his notes during 2006 and 2007 up until the time of the homicide.

Recommendation 16: The Trust should ensure that clinical supervision, and monitoring by Team leaders, include regular review of all current cases to ensure that concerns and/or deteriorating mental state are responded to speedily and appropriately and then monitored continuously. The Trust should develop a system which includes some form of visual marker for notes files, which highlights for staff concerns about changes in presentation and actual/potential risks, including compliance with care plans.

Commentary: From a diagnostic point of view, a diagnosis of schizophrenia (ICD10 F20) would have been appropriate and MH was receiving treatment compatible with this diagnosis. His compliance with medication was inconsistent and prescription of a depot preparation was appropriate to assist with issues of concordance. The lack of a formal diagnosis and the lack of full awareness by the Consultants of the range and severity of psychotic symptoms experienced by MH may have contributed to the continued prescription of conventional medication for schizophrenia without consideration that MH's illness might be treatment resistant.

There was no recorded discussion of MH's case between Drs PS and MS and no record of any medical engagement with MH after Dr PS saw him on January 30 2007. We were clear that both Dr MS and Dr PS should have had a very clear awareness of the recorded and reported concerns about the deterioration in MH's mental state from early 2006, on the basis of information from the respective teams and from their own records and observations of, and engagement with, MH.

Recommendation 17: Where a patient's care moves between different care teams, consultant medical staff should have a formal, recorded process of handover of responsibility to ensure that all relevant clinical information is shared. This process of transfer of clinical responsibility should be managed within the framework of the Care Programme Approach. However, reliance on this process does not necessarily entirely discharge the individual professional responsibility for each consultant to ensure that they are adequately informed regarding the key clinical issues relating to each patient for whom they have RMO responsibility.

Commentary: Discharge planning is a key aspect of care planning but in MH's case, each discharge appears to have been undertaken without any effective involvement of the receiving team, including the relevant Consultant Psychiatrist, to ensure that the discharge plan and ongoing care plans were fully informed. Whilst we acknowledge that a consultant is very much reliant on feedback from members of the team engaged with the patient on a day to day basis and, in particular, the Care Co-ordinator, the length of MH's engagement with AWPT services and the apparent intractability of his mental health problems, exacerbated by poor compliance with medication and the increasing use of drugs and alcohol, should have alerted Drs MS and PS to the

need for a closer medical overview of MH's health and to the need for discussion between them to ensure that ongoing care was fully informed.

Dr PS was made aware in early January 2007 of SG's very serious concerns about MH's deteriorating state and himself saw MH on 30 January 2007. He should have been aware, from weekly CMHT meetings, of the difficulties subsequently reported by (XX) in locating MH and ensuring that the medication regime prescribed by Dr PS, was adhered to. There were several key points in MH's care at which a full Mental State Examination and a formal diagnosis by a consultant are likely to have led to formulation of very different care plans for MH, including close consultant involvement in his care and progress. For emphasis, we feel it appropriate to repeat the following extracts from chapters 2 and 3 of this report:-

From Dr C that MH was: *'..floridly psychotic ... one of the most profoundly psychotic men I have treated..'*

'Just over one month since first referral, the service had the following information (about MH): thoughts of murdering and or harming his alleged abuser, thoughts of suicide, concern about food contamination, fears of taking medication, preoccupation/obsession with sexual abuse, lack of insight, delusional ideas, speaking to himself when engaged with others, family history of psychiatric problems, unhappy childhood, use of illicit drugs, TV speaking to him (thought broadcasting), scar on face invisible to others, people 'looking at him', social isolation and introvert, delusional ideas about sister and girlfriend, frightened and confused, thought disorder, psychotic symptoms, paranoid and bizarre symptoms.

In addition, during MH's ongoing engagement with the service, there were clearly recorded incidents of his having:-

- engaged in anti-social and aggressive behaviour.
- acquired knives.
- threatened to kill two members of the Crisis Team.
- held a knife to his girlfriend's throat whilst on Applewood Ward.
- made threats that he would kill any man, who associated with his girlfriend.

This is additional to his having demonstrated to his mother and sister the way in which he would 'cut' CJ.

In following chapters, we highlight the systems and culture within which clinical staff were working and acknowledge the impact thereof on both service provision and the effective working of teams and individuals, including Consultant Medical staff. Notwithstanding, we consider that Drs MS and PS were in a position to have mitigated the impact of these difficulties on the care and treatment afforded to MH.

Chapter 5

Mental Health Act assessments

Approved Social Workers

Mental Health Act assessments (MHA assessments) are conducted by Approved Mental Health Professionals (AWHPs) (Previously Approved Social Workers (ASWs)). In Swindon, these personnel were seconded to the Trust but continued to be employed and paid by Swindon Borough Council so as to preserve their independence in their decision making under the Act.

At the time of MH's engagement with the mental health services, the team of ASW's was based in the same building as the CMHT as was the Early Intervention Service. PC had been seconded from the Borough Council to the Crisis Team as an Approved Social Worker and was on the rota of ASW's for MHA Assessments and paid by Swindon Borough Council. He became involved with the management of the Crisis Team in 2006 and ceased to be on the rota. He was subsequently appointed substantively as Manager of the Crisis Team in 2008. (This has been addressed in detail in Chapter 7 of this report.)

Two ASWs, namely JD and HQ were involved in arranging and conducting Mental Health Act assessments on 4 occasions for MH as follows:-

31 July 2006 when MH was detained under section 2 of the Mental Health Act 1983
25 August 2006 when it was determined not to detain under section 3 of the Mental Health Act 1983 and MH agreed to remain as an informal patient
17 November 2006 when MH was judged to be not detainable
22 November 2006 when MH agreed to informal admission to Green Lane Hospital, Devizes.

A further MHA Assessment was proposed by the CMHT in January 2007 but following initial investigation by the Crisis Team it did not proceed.

First Admission under Section 2 of the Mental Health Act 1983, 31 July 2006

At a Professionals Meeting on 28 July 2006, it was planned to organise a Mental Health Act assessment on 31 July 2006. On that date, JD made application for admission for assessment under Section 2 of the Mental Health Act. Her social work assessment report states, *'This report is based on contact with SG and AG, brief telephone call with mother, update from Crisis Team and access to health and social care record.'*

The appropriate forms are dated 31 July 2006 and show MH as living at (*name*) Bed and Breakfast, Swindon, that JM is MH's nearest relative, that JD last saw and interviewed MH on 31 July 2006 and that she signed off the printed statements in the application form.

Medical Recommendations

The joint medical recommendation for admission for assessment was by Dr MS (Crisis Team Consultant Psychiatrist) and Dr P, GP. Dr MS certified that she had previous acquaintance with MH before she conducted the examination on 31 July 2006.

In the application for admission both doctors stated that they were of the opinion, *'(a) that this patient is suffering from a mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment AND (b) that this patient ought to be so detained (1) in the interests of the patient's own health, (ii) in the interests of the patient's own safety (iii) with a view to the protection of other persons AND (c) that informal admission is not appropriate in the circumstances of this case for the following reasons.....'*

Dr MS wrote, *'Patient is suffering from psychotic illness, experiencing auditory hallucination of 3rd person, incongruous affect and troubled by intrusive thoughts. Said he is feeling depressed and there is recent history of self-harm through overdose. He has no insight in his condition. So far he has not complied with treatment in the community and is refusing admission on an informal status.'*

Dr P wrote, *'The patient is reported to be suffering from Paranoid Psychosis, he is not complying with the treatment, has relapsed with a psychotic state, has no insight into his illness and is refusing treatment on a voluntary basis'*.

The Social Work Assessment report provided in conjunction with the application dated 31 July 2006 shows the outcome of the assessment. *'Admitted; Time 6.15 p.m. Section 2 of Mental Health Act 1983'* and reports (inter alia) *Admission therefore indicated in the interests of his health, safety and to a lesser extent for the protection of others; only achieved through use of MHA S2; appropriate because no previous admission and need to re-assess care plan.'*

Social Work Report relating to the Admission

Another Social Work Assessment Report showing the date 31 July 2006 but actually dated 4 August 2006 appears in the records. This is a much more comprehensive report which shows that MH was admitted at 6 pm on 31 July 2006. It also shows that JD obtained information from MH's Care Co-ordinator, psychologist, mother and father; had an update from the Crisis Team; and had access to health and social care records. There is no reference to MH's threats to kill and JD lists the 'Risk Factors Influencing Decision' as *'Young man with history of homelessness. Now living in temporary accommodation. Use of cannabis and alcohol from early adolescence. Has had to leave Hazelmead House because of increased use of alcohol and cannabis. Has now had to have restricted access to mother's house because of increased incidents of verbal aggression and some incidents of physical aggression towards siblings. Difficulties managing finance; demanding food and money from mother. Previous police involvement on at least one occasion in removing MH from family home following conflict. Previous poor concordance with medication. Recently accepted depot medication but current medication does not*

appear to manage psychotic symptoms. Previously experiencing psychotic beliefs about self/others. Serious unexpected overdose of prescribed medication for which he did not seek help. Has expressed idea he might throw himself under a train. Difficulty in him understanding impact of mental health experiences on his behaviour. Reported as currently using alcohol and cannabis. Evidence that treatment regime prior to overdose had been effective in managing symptoms'

Second Mental Health Act Assessment on 25 August 2006

This assessment was conducted by HQ on 25 August and was signed and dated that day. MH was still an in-patient at Sandalwood Court and his MHA assessment under section 2 was due to expire on 31 August 2006. The assessing doctors were Dr PS, Consultant Psychiatrist to the CMHT and the in-patient team under whose care MH had been during the period of his section; and Dr K. The outcome of the assessment was, *'Not detained under a Section 3. Will remain on Applewood Ward for further treatment.'*

Dr PS had earlier recorded, *'Due to fact that his diagnosis was still unclear, he was still showing signs of psychosis, was expressing a wish to leave, it was felt that an assessment to consider a Section 3 was required'*.

HQ spoke with MH's named nurse on the Ward, who reported that further investigation was needed to make enquiries into the possibility of MH having an Autistic Spectrum Disorder, and with MH's mother, as nearest relative, who stated that she felt that MH had been calmer this week and felt that he needed a clear diagnosis before he was discharged. She (JM) felt that a period at Windswept and then looking for appropriate accommodation would be appropriate. JM stated that MH could not return to live with her as he had been physically and verbally aggressive to his seven year old brother. In addition, MH's sister was at home and there was not room for him in the flat. There is no note of any consultation with SG (Care Co-ordinator). The two doctors considered that MH did not meet the criteria for detention under Section 3. HQ felt that MH should be given the opportunity to take some responsibility and remain at Applewood as an informal patient. She recorded also, *'However it may be helpful for the staff to ask him to sign a contract and be very clear of what is expected of him.'*

The ASW's Assessment Report

'Risk Factors' were shown as, 'MH will not return to the ward and become vulnerable and at risk from others. MH will spend long period of time at his mother's house and put her under stress. MH may use alcohol and cannabis. MH may be abusive towards his younger brother.'

'Any other comments – need for further actions' were shown as, 'MH to have 3 hours leave every few days. MH not to drink or use cannabis when he is on leave. MH to agree leave times with staff and return on time. MH to engage in activities/groups and take medication. MH not to spend to (sic) long at his mother's house. Referral to Windswept to be made'.

Commentary: Following this assessment, reference to enquiries about suffering from autistic spectrum disorder is shown in the clinical notes of SG and AG on 7 December 2006; and, on 20 December 2006, AG completed a questionnaire which excluded the possibility of this diagnosis. MH had disclosed to a visiting member of the Crisis Team on 2 November 2006 that he was 'going for autism assessment.'

As to lack of a clear diagnosis, Dr V (Senior House officer) recorded on 2 August 2006 a differential diagnosis of paranoid schizophrenia with multiple substance dependence had been made. This was some 3 weeks before the second assessment. But there is no reference by the ASW to threats to kill and alleged sexual abuse.

Third Mental Health Act Assessment on 17 November 2006

According to the clinical notes, a Mental Health Act assessment had been called for on 1 November 2006. We were unable to ascertain the reason why an assessment did not take place until 17 November save to say that HQ did not consider that any delay would have been on her part. We did note that, although the assessment took place, the report is dated 23 November 2006, which we understand is outside the timescale expected. There were no handwritten notes to support the assessment and we were informed that contemporaneous notes taken by HQ had been destroyed.

The outcome of the assessment is shown as, '*Not detained*'.

HQ had received information from MH's mother who reported MH's erratic behaviour and aggression towards his then 7 year old brother and to her (his mother); and expressed concerns about his carrying a knife and smoking cannabis. The Social Work assessment report does not disclose explicitly consultation with any other persons. Although HQ subsequently advised us that this had been undertaken, such consultation was not clearly recorded in line with the approach in the previous assessment on 25 August 2006.

Commentary: In hindsight, HQ acknowledged that she did not consult with Dr MS (MH's RMO) or SG (his Care Co-ordinator).

Under '*Recent Events*', HQ reports (inter alia) that MH had not been concordant with medication, that he had been carrying a knife, and that he had made sexually inappropriate comments to SG. Under '*Interview with the patient*', HQ records that MH said that he was aware he needed to, '*.... sort himself out*'.

He denied carrying the knife and explained that he bought it because he liked knives, but that he did not carry it around, although he admitted that he had held the knife to (GF's) throat. However, he said that this was a joke. He also admitted hitting his younger brother and being irritable with his mother. He said that he would come into hospital if it was Applewood as he wanted to be with (G/F) but would not go into any other hospital.

Medical Assessment

The assessing doctors were shown as Dr PS and Dr K and HQ noted, '*Dr PS felt that although MH did demonstrate some slightly unusual and irritable behaviour he could not elect (sic) any psychotic features and he was able to negotiate with him a management plan.*' Dr K agreed with Dr PS and felt that MH should be given the responsibility to stay out of hospital and to keep himself and others safe.

It was agreed with MH that he would keep to the following plan, '*To give the knife to the Crisis Team. To see the Crisis Team x2 (twice) a day and to take medication. To limit his time with his mother and to avoid seeing his younger brother. Not to smoke cannabis. To engage with AG.*'

Under the heading '*ASW's assessment/recommendations – decision making*', the first paragraph is a repetition of the first paragraph of her previous assessment report which HQ informed us had been cut and pasted across from the previous assessment.

The second paragraph of this report reads, '*Therefore I felt that MH should be given the opportunity to take some responsibility and remain in the community with Crisis Team support.*'

'Risk factors' are shown as, '*Risk to others and to MH if he carries a knife. Potential risk to others if MH uses the knife inappropriately. Risk to MH becoming further unwell. Risk of MH neglecting himself. Risk of MH's cannabis use increasing. Risk to MH's younger brother. Further stress for MH's mother.*'

HQ did note that '*MH has recently been assessed for autistic spectrum syndrome; however this has not yet concluded*'.

Commentary: It does not appear that HQ was fully informed of recent events and MH's presentation, which had been causing much concern and it was not clear whether she had access to the records.

And, in those records there are numerous references to smoking significant amounts of cannabis on a daily basis, being agitated, confused and deluded, of assault on family, bizarre thoughts, threats to others, and allegations of rape. HQ's interview with MH for the assessment on 17 November 2006 is timed at 3.00 and yet she had not been informed that at 11 am that morning MH had been seen by 2 members of the Crisis Team when he accepted routine medication and he was described as being very agitated, and thought disordered. He is recorded as having threatened to trash the flat and making threats to kill both members of the Crisis Team involved in the visit that morning. It was also noted that the Crisis Team Manager was informed and recorded that he would 'follow up in-patient placement out of area'.

No record of these events and his agreed action was made by PC, which we consider to be a serious breach of Trust requirements.

MH was seen again by the Crisis Team the same evening. He took his medication. It is recorded in the notes that he *'Said he wanted to go to hospital to see (G/F) and if he couldn't he would saw his arm off and this was a warning to us all.'*

Commentary: On separate occasions on that same day, MH had threatened to kill and to self-harm, one prior to, and one after, the Mental Health Act Assessment.

Final (Fourth) Mental Health Act Assessment on 22 November 2006

This assessment was undertaken by JD with the assessing doctors shown as Dr PS and Dr E (MH's GP). JD stated *'Assessment under MHA had been indicated by Crisis Team since the beginning of this week but a bed had not been available at Green Lane Hospital: MH could not be admitted to Applewood House because (G/F) was also a detained in-patient and there were other relationships with in-patients which were likely to generate conflict. There had also been difficulties in obtaining either S12 Doctor/GP with knowledge to take part in the assessment.'*

The outcome of the assessment is noted as *'Admitted to Imber Ward, Green Lane Hospital, Devizes as a voluntary patient at approximately 2 p.m. on 22nd November 2006'*.

The ASW's Assessment

The assessment report is dated 24 November 2006 and signed by JD. Her Social Work Assessment report is comprehensive and is supported by her contemporaneous handwritten notes which she was able to produce at the time that she attended to give evidence to the Investigation. She was in possession of information, having completed a referral form commencing at 11 am on 20 November 2006. She made notes of her discussions with JM (MH's mother), with Dr PS and Dr E, and with the Crisis Team, who had seen MH on 21 November. She had session notes from the Early Intervention Service and spoke with AG. She had a copy of a letter from Dr MS to Dr B (GP) and a copy of the Risk Assessment and Management Plan completed by SG and AB (Senior Nurse Practitioner in the Crisis Team) dated 26 July 2006; and a report completed by nursing staff at Windswept dated 31st October 2006. She also spoke with Dr MS. There is a note as to the lack of availability of a Section 12 doctor and that the assessment had been re-arranged for a day later. Also that a bed at Green Lane Hospital had been lost but that one was expected to become available the next day.

Medical Assessment

Neither of the assessing doctors considered that MH met the requirements of the Mental Health Act but felt that he would benefit from admission and was clearly agreeing to this. Both felt that MH was experiencing the effects of a psychotic illness which was only partially responding to medication. Dr PS felt that Depakote (mood stabiliser medication), which had only recently been introduced, might still be building up efficacy. He also felt that MH had been generally consistent in keeping to undertakings in the past. For example, he was currently concordant with medication with the Crisis Team and Dr PS therefore felt a degree of confidence in

MH's undertaking to accept voluntary admission to Green Lane Hospital. There had been some concern that MH would have an interest in admission to Applewood House in order to be with (G/F) but he did not object to Devizes despite its unfamiliarity and increased distance from (G/F).

Commentary: We have noted that in the second half of 2006 it became necessary on four occasions to consider compulsory assessment and/or treatment under Mental Health Act provisions and that a further Mental Health Act assessment was proposed in January 2007. We consider this was an accurate barometer of MH's fragile and unstable mental health and a reflection of the need to contain the risks he presented to himself and to other people.

Despite the comprehensive nature and content of her assessment report and the notes she had taken as a prerequisite, it does not appear that JD was fully informed of the full history of MH's involvement with psychiatric services. Specific threats to individuals, including members of the Crisis Team on 17 November, had not been reported to her nor his stated intention of a desire to kill his alleged abuser. Nor was she aware that the assessment had been expected to take place much earlier in November.

In her evidence to us in response to a specific question regarding the Crisis Team note that on 17 November 2006 MH had made threats to kill two members of the Crisis Team, JD stated *'I don't remember threats to kill people in the Crisis Team. I think I would have remembered if there were threats to kill staff because I had stuff from mother.....I did have a summary, and I put it in, of what the Crisis Team had told me....I put down on my form a list of the concerns that the Crisis Team had told me following HQ's assessment. I was aware that he had held a knife against his girlfriend's throat because I asked him about that in the assessment and he laughed it off as if it was a joke.....you should be able to cross reference this with the Crisis Team notes as to who was contacting me and I know I should have written down and I clearly in writing the story down I didn't write the person who was telling the story.'* We were unable to discover any notes of such a cross referral. Notwithstanding, our Independent Advisor commented favourably on the quality of JD's work.

Recommendation 18: All handwritten notes made at the time of a Mental Health Act assessment should be retained and filed in accordance with NHS policy.

Recommendation 19: Application for assessment for admission under Mental Health Act Sections should be conducted without delay and should not be conditional upon the availability of a bed.

Chapter 6

The families and the relationship between MH and CJ and family views on services provided to MH

The Families

There are two families on which the homicide directly impacted, the effects of which have changed the lives of all their members. These are MH and his family, and the family of his victim, CJ, including his partner at the time of his death, who is also the mother of his child.

The two families lived relatively close together on a large and run down housing estate on the outskirts of Swindon, described by EP, partner of CJ, in her evidence to the police '*...you get people that hang out in flats and just doss and smoke*', and '*...kids get bored and they just hang out on the streets, and smash things up...*'

The estate is close to Great Western General Hospital where CJ was taken after the stabbing. . MH has a sister and also a half brother, who is considerably younger than MH and lives with their mother, JM. CJ's eldest brother, AJ, and his wife, MJ, had their own home in another area of Swindon but were regular visitors to the family home. MH did not live with either of his parents after the age of 17, when he moved into the first of a series of temporary accommodation. He did, however, remain a frequent visitor at the home of his mother and returned there immediately after the homicide to tell his mother what he had done.

Both families came across to us as warm and caring, despite the fact that there were health issues in each family. We were advised that MH's father was too unwell to meet with us but his mother and sister did so and evidenced articulately their concerns at the deterioration in MH's health from 2004 up to the time of the homicide. They expressed also their growing frustration at what they considered to be both an inadequate response to the concerns expressed to AWPT by JM and a superficial approach to MH's state of health when visited at her home by some members of the Crisis Team.

The Relationship between CJ and MH

It appears that CJ and MH were the common link between the two families. They had known each other since junior school although we heard evidence of tensions between them at different times in their relationship. (*These issues are dealt with in later paragraphs in this chapter*) They had been part of a group of young people on the estate, which included also MH's sister, SH. CJ's partner, EP, told us that '*CJ had loads of mates.....This is where MH came in ... I have known MH since he was about 14 ... part of CJ's group*', and '*MH was a friend but not CJ's best friend*'.

This latter was endorsed by MH's sister, SH, who told us '*..but they were not best friends, by any means, no way*', and by CJ's brother, who said '*.. there was not really*

I would say a friendship.... CJ knew him, CJ would not class him as a real friend'. MH's mother was also clear that MH and CJ were not 'best friends' although they knew each other.

But HJ told us that in terms of CJ's best friends *'It would have to be MH. They were good friends right to the end'*. But she also stated *'they fell out with each other. Something happened between them, 2004 and 2006, and from that January things were not the same. My son did not want to go home, he stayed in my house and he would not tell us.... He was getting depressed, he was getting psychiatric help....'*

Note: Concerns about CJ's mental state are addressed later in this Chapter.

MH was reported by HJ as spending significant time at CJ's house and was welcomed by CJ's parents even when CJ was not there. CJ's mother prided herself on her welcome for CJ's friends.

Contact Prior to the Homicide

The evidence from CJ's parents is that their welcoming MH to their home apparently continued throughout his acquaintanceship with CJ even at times when the J family believed that MH was involved in some acts of vandalism against the family property. We were made aware, however, that there were other views on the source of the vandalism. At Christmas 2006, MH visited the J home and HJ reported that MH also visited the house on the Thursday and Friday before the homicide, wanting to speak with her husband, KJ. KJ also said of MH *'He was on about Bin Laden'*.

The Homicide

The homicide took place less than three months after MH was reported by CJ's father as having said, on 26 December 2006, that he would kill another mutual friend.

KJ described that MH came to see him on Boxing Day of 2006. This was agreed by other members of the family but it appears that they were unaware of the matters discussed. KJ said that before coming to the door, MH had been walking up and down outside the house, looking *'not well'*. KJ said that MH told him in that visit that Osama Bin Laden wanted him to kill somebody called (*name*) whom KJ described as MH's best friend.

On 1 March 2007, the Thursday before MH killed CJ, JM (MH's mother) saw MH and described him as *'.. really shot away ... he could not even string a sentence together hardly, get nothing from him at all.'*

JM also reported to us the following conversation with (G/F), who was present on that Thursday when she met with MH *'I said "Has anybody been to see him?... Anybody, Crisis Team, the Mall, anybody?" and she said "He has just been left." That was her exact words, "he has just been left"'*.

HJ told us that she saw MH on the Thursday 1 March 2007 and Friday 2 March 2007 preceding the homicide and described him as *'I think from that Friday until he (CJ)*

got murdered, he was not the same as I had seen him'. CJ's brother told us that his parents had told him that MH had visited their home on the day of the homicide but that they did not let him in.

The homicide occurred on Sunday 4 March 2007 in the communal hallway in the block of flats where EP lived. MH had announced his arrival on the intercom and CJ went down to the hallway to talk to him, apparently with no concern about his safety, albeit that verbal evidence indicates that CJ had some concerns about changes in MH's approach to him and had been suffering increasingly from panic and anxiety symptoms. The latter may be endorsed by CJ's GP and general hospital records, addressed in more detail in later paragraphs of this chapter.

We heard from EP that after she had their baby '*CJ severed his links with MH*', and '*We banned him – after once when we were in the flat and MH was sitting on the sofa. This was when (the daughter of CJ and herself) was two. MH said funny stuff, "I feel I want to throw something at children"..... We agreed a plan..... When CJ told me about MH's problems, I got a bit wary.... I would answer the buzzer and say that CJ was not there. If CJ was there then he would go down. They would just be nattering*'. She added '*...from Christmas 2006 to March 2007, MH was buzzing at the door every day.... It felt like pestering in the end.*'

EP described a comment from a friend (some time in 2006) that MH wanted to kill CJ. She described to us CJ's reaction when she told him of this conversation. '*CJ said, "I don't know why". He was not worried then. Then there was a stage when CJ stayed indoors. He was staying in, not always going out.... He wouldn't go out. I don't know why. Then he started anxiety attacks and was seeing a psychiatrist and was put on the sick. This was 2006. I felt like he was keeping something from me. Everyone says he was protecting me and the family. CJ would tell me everything about the family and his mates but not about this*'.

Commentary: MH's mother, JM, referred to aggression in MH at the start of his illness and that he was saying then that he wanted to kill CJ.

General Practice Notes for CJ

The concerns reported by EP may be further underlined by evidence from CJ's GP records, which indicate a series of visits by CJ to his GP and to Great Western Hospital from mid 2006 into early 2007 with a range of concerns and reported symptoms which would appear to indicate a rising level of anxiety and depression.

There is no evidence in the records to indicate whether there were clear issues driving this change in CJ's mental state but, if these were, as his partner indicated, linked to the threat from MH, then either they were clearly not such as to prevent his meeting MH when he presented at the flat on the evening of the homicide; or his wish to protect his daughter overrode his concerns.

CJ the Person

CJ appears to have been a charismatic character, who was variously described by his partner EP as *'Happy go lucky', 'Chubby', Jack the Lad but bubbly'*. She told the panel *'CJ did not want to grow up and wanted to go on meeting his mates, being 'chappy'*. By his immediate family, CJ was described as generally happy, although unwilling to undertake formal training to support his interest and expertise in computers.

In her statement to the police, EP described CJ as someone who preferred to stay up at night and sleep in the day and linked this to his being anxious and afraid (not specifying of what). *'He just said that he liked being up all night, he felt safe being up all night, he got into a habit of it, off his Mum's'*.

In terms of work history, CJ was reported to have worked at a Retail Store for 6-7 months and to have been dismissed when he took time off for the birth of his daughter. Then that he had the odd jobs but kept walking out. This included a job in Devizes in the summer of 2006 but without further detail given.

EP stated that thereafter *'He never worked then but he did not claim benefits He was then laid off.....sacked He found it hard to get back. In town, he was always looking in windows for jobs'*.

One of CJ's brothers was of the view that MH's relationship was based on jealousy in that MH did not have the family relationships and support that CJ did. CJ's mother also felt that MH might have been jealous of CJ's nice home, nice flat (actually that of his partner), his little daughter, his relationship and his and EP's plans to become engaged. In her evidence to Wiltshire Police, EP stated *'I think he was jealous of CJ for having a family and he didn't CJ had everything that, CJ didn't have everything, but I just think in MH's eyes he was doing, using as an excuse to kill CJ'*.

There is no evidence in clinical notes or other evidence to support this theory of jealousy although JM's description of MH's beliefs about CJ's behaviour towards MH's girlfriend in Cardiff could give some credence to this theory.

MH's Personal History

MH's family life was characterised by broken relationships and a range of health problems on both sides of his parental families. MH and his sister were twice put into foster care, once when MH was seven and again when he was nine. One of these was particularly difficult for MH as the foster parent provided food and entertainment that were strange to him.

JM reported that when MH was ten, the children's father moved back into the house and cared for the children. JM moved out and then spent some 7 years between Dorset and Cardiff maintaining regular contact with the children. After leaving school aged 16, MH then moved to Cardiff to live with his mother. At one point, he lived with her and her then husband for three months in Yeovil.

JM moved from Cardiff back to Swindon. MH stayed on in Cardiff for some 3 months and was reported to be talking in a delusional way. He moved back to Swindon in 2004 when he was 17, with assistance from a Support Worker and then moved into Culvery Court Hostel. It was at this time that MH told his mother that CJ had abused him.

In her evidence to Wiltshire Police on 4 March 2007, JM described MH prior to his diagnosis with schizophrenia as '*.... a quiet boy, who could interact quite normally and had quite a few friends*'. From at least 2004 up until the time of the homicide, MH was a regular visitor to JM's home and she felt it necessary to call the police on a number of occasions because of MH's behaviour and his refusal to leave.

There appear to have been only two significant relationships with girlfriends in MH's life. The first was with a girl in (*place name*) , with whom he was described to be '*totally smitten*' and the other with (G/F) a user of the mental health services in Swindon, with whom he lived from late summer in 2006 until the homicide. In her evidence to Wiltshire Police in March 2007, MH's mother stated that after a visit to her in (*place name*) when MH was 16, he told her that CJ had been phoning (*girl*). That in a subsequent visit to her, MH made allegations about a relationship between CJ and (*girl*) and about CJ's actions towards (*girl*) . JM interpreted this to mean that '*....something was not right with MH*'. MH then began making threats to her that he would kill CJ.

However, in her evidence to Wiltshire Police, EP (CJ's partner) said that she had asked CJ why (*name*) in (*place name*) was phoning him on his mobile, which indicated some form of communication between them.

Mental Health

In 1994, when MH was 7 years old, his GP referred him to Great Western Hospital Paediatric Department, following concerns expressed by MH's teacher that MH he would '*switch off in class*'; had '*vacant episodes*'; and then '*would not respond*'. Also that MH had a poor attention span and needed input from the teacher. The GP questioned whether these reports were symptoms of petit mal (epilepsy). The Paediatric Registrar found that MH '*would not establish eye contact and was very, very shy*' but that an EEG test was normal. In a letter of 21 10 1994 to MH's GP, the Registrar advised '*.....we are going to get in touch with the class teacher to get a better idea of what the vacant episodes involve and also how frequently they occur. Once we have a better picture we can make a plan and then write to mum about starting any medication. Mum was quite happy with this plan.....Review will be arranged at a later date*'.

There is no record of any follow up action nor any indication that MH's mother pursued the matter further. Thereafter, until the time of referral to AWPT, there is nothing unusual in MH's primary care (GP) history.

In terms of health issues, MH was reported to have started smoking at the age of about 14, and later to have become a regular user of Cannabis (including Skunk Cannabis) and consumer of quite significant amounts of alcohol.

Commentary: MH's childhood was clearly not an easy one in many aspects. He and his sister were fostered on two occasions, one of which was outside MH's cultural experience. His mother later handed over care of the two children to their father. Until he was 17, when he moved into a Hostel in Swindon, MH spent time variously with his father, his mother and his stepfather. His first significant girlfriend relationship ended and he was said to be hard hit by this. His smoking, use of cannabis and drinking all started at a relatively early age. He had one period of employment and he had had difficulties in school. It is probable that these experiences impacted negatively on both his social interactions with others and his ability to develop stable relationships.

Increasing Family Concerns about MH

In March 2006, JM reported to AG, Consultant Clinical Psychologist in AWPT's Early Interventions Service, other matters of concern to her, including MH's being cruel to cats. This was recorded in the Early Intervention Team records on 23 March 2006 as *'When there (Mother's house) he chases the cats and attempts to strangle them'*.

Commentary: We felt that this was an issue of significant concern and an indicator of a need for further investigation. We believe that AG should have communicated this issue formally and speedily to the wider team. This is considered to be one example of major weakness in the overall approach to the management and communication of information to inform care and treatment decisions for MH. Different teams were aware of different pieces of information about MH's behaviour, his threats to others, his possession of knives and his increasingly fragile mental state throughout 2006 and early 2007. In our view, each of these pieces of information was a matter of concern in its own right which should have prompted urgent joint team discussions. When considered in their entirety, they provide a strong indicator of a possible crisis impending, which should have prompted immediate action.

On 6 November 2006, MH's mother, JM, rang ABi at the PALS (Patients Advice and Liaison Services) office to register her concerns about the care MH was receiving.

Commentary: The PALS Website states that *'PALS was introduced to ensure that the NHS listens to patients, their relatives, carers and friends, and answers their questions and resolves their concerns as quickly as possible. PALS also helps the NHS to improve services by listening to what matters to patients and their loved ones and making changes, when appropriate'*.

All NHS mental health services were required to establish a PALS service although AWPT delayed in doing so (*the evidence of AWPT Chief Executive in Chapter 9 of this report refers*). The decision to delay implementation of PALS pre-dated the appointment of LMCM.

On 9 November 2006, ABi responded to JM. Her letter (which was copied with JM's consent to PC, Crisis Team Manager; SG, MH's Care Co-ordinator; and RG, Manager of Swindon East CMHT) included the following *'You explained that MH is currently very unwell and behaving in a very disinhibited, violent and frightening*

manner towards you, your daughter and your young son...and is threatening to kill other people as well as himself..

It was a great shock when MH took an overdose of his medication and nearly died. It remains your fear that he may act again to kill himself – he has described how he might do this by throwing himself under a train.

.... (MH) is now technically homeless but is living at a girlfriend's flat whilst she is in Sandalwood Court herself (i.e. as an in-patient) You are aware that MH himself has tried to regain access to both Hazelmead and Windswept but that when he has been collected by the (AWPT) Crisis Team he has been returned to the flat.

On top of this, there appears to be a conflict of opinion amongst the professionals involved in MH's care and treatment about where and how he should be treated. You feel that resolving this conflict is critical to both MH's safety and that of the rest of your family. You were extremely disappointed last week when a round the table review was not attended by the Crisis Service and you are left feeling frustrated that the more ill he has become, the less help that there appears to be available.

Commentary: We found that ABi had acted in accordance with her role and that her approach was commendable. The involvement of PALS and consequent actions by AWPT staff are addressed in more detail in Chapter 7.

JM's Views on the Care and Treatment MH received from the Trust

In general terms, JM was not always sure which team was providing MH's care. She said in her evidence 'It was all so confusing. I did not know who he was under half the time. They made decisions and changed their minds and not inform us. So a lot of the time I did not know what was going on really'

Commentary: JM's evidence indicated a failure to comply with NICE guidelines in respect of family and carers (Chapter 4 of this Report refers).

JM's view was that the organisation had largely failed her son, although there were some notable exceptions. She was clear that, after he took an overdose on 12 February 2006 'He never really got up to speed after that. He rapidly went downhill that last year (2006/07)the family work stopped, everything ground to a halt. I was calling the Crisis Team a lot because he (MH) would come round and get very abusive ... but the Crisis Team would not help. They would just say, "Phone the police" which I did not want to do and that is what I ended up doing a lot of the time.....When it came down to it, I needed some help with MH, and MH needed help – it was just not there.'

JM was critical of MH's treatment in Great Western Hospital following his overdose in February 2006, although she did not attribute that treatment to any particular organisation, and she felt there was a significant mismatch between what she was told about MH's recovery and what she herself observed. She was also shocked that MH was not admitted to a psychiatric hospital following discharge from Great Western Hospital. Regarding MH's emergency in-patient stay she said 'It was not long we thought it would be straightaway hospital, straight back to Hazelmead.....

a psychiatric hospital and he was not.....He was sectioned eventually for a month and we were under the impression that they put on six months after they do the month and the CPN thought that was going to happen. We thought it was going to happen and they let him out. What they did was send him to Windswept for a weekend for an assessment and they said he was too ill for Windswept ... the bed was gone and he was sent back to the flat (G/F) with no water, no gas, no electricity.'

Commentary: This is endorsed by a summary prepared by Windswept, and included as a copy in the AWPT notes and thereby available to AWPT Crisis Team staff, including two entries:-

'23.10.2006 MH's mother called Windswept in a distressed state, reporting he is 'deteriorating rapidly', saying he claims to have knivesWhen informed the Crisis Team finds him behaving appropriately when they visit, she states that he can present a 'calm' front for a short period of time. MH then arrived at Windswept, agitated, restless, delusional and talking of wanting to kill himself.

29.10.2006 MH visited Windswept requesting to stay overnight. There is apparently no electricity or food at (G/F's) flat. Crisis Team was informed, however they came to collect MH and his belongings and took him back to (G/F's) flat'.

Commentary: We were concerned by these reported actions of the Crisis Team on this occasion, when there appeared to be considerable evidence to show that MH's mental health was deteriorating but, regardless, the Crisis Team returned him to (G/F's) flat and the unsuitable conditions there.

JM felt that MH's Care Co-ordinator, SG, and the Early Intervention Service Psychologist, AG, had been supportive of both MH and her and had ensured, as far as possible, that she was engaged in the care process and that SG, in particular, kept her up to date on developments in so far as she herself knew them. She stated that SG *'..tried and tried and tried as did AG. They always had the time. If you rang them, they would always ring back.....He was getting a lot of input from SG and AG'.*

She advised us that, when she had told SG that MH had a knife, SG had told Hazelmead and that they had then taken the knife away. But her overall assessment was that MH *'Just that he did not get the treatment that he should have had'.*

JM's experiences and perceptions of the Crisis Team were markedly different from those relating to the Community Mental Health Team (in the person of SG) and the Early Intervention Service (AG). Of the Crisis Team interventions, she stated *'I think that they like the easy ones (patients) I just get this feeling ... MH you could not get a section put on him.*

I used to say to them that he (MH) has got one agenda, which is to get rid of you as quickly as possible – as quickly and painlessly as possible. I said that he will agree to anything, he will not do it but he will agree to it.

Every time I phoned the police with MH what they do is get hold of the Crisis Team and more often than not the Crisis Team never got back to MH to see how he was or anything'.

JM was disturbed also that, after MH was discharged from Green Lane Hospital in November 2006, he was not sent back to Sandalwood on discharge but to the flat of his then girlfriend, herself a service user. JM had wanted him hospitalised and believed that she made this clear to the Crisis Team but reported that MH told her that he went back to Sandalwood and then *'They paid for a taxi, the Crisis Team, and sent him back (to G/F's) flat'*.

In addition, JM advised that no carer's plan had been developed for her, which was a breach of a key requirement under the Integrated Care Plan Approach (ICPA). (This is dealt with in fuller detail in Chapter 9 of this report). Despite her positive view of the care provided by SG of the CMHT, JM was critical about what she saw as failings by (XX) of the same team who took over the CPN role on a short term basis in February 2007 when SG had a planned absence from work for medical reasons. However, JM's assertion that (XX) did not know MH's address clashes with evidence from SG.

JM was clear that SG was aware that MH was living with (G/F) at the time (XX) took over MH's care in a period of planned absence for her, as SG had expressed her concern at the arrangement. SG also recorded in MH's notes on 29 September 2006 that he was living with (G/F) at her flat and the address thereof was recorded, albeit somewhat unclearly, in November 2006 on the front sheet/personal information record in his notes.

JM stated that it was three weeks before (XX) saw MH, during which period MH did not receive his medication, adding that, after two weeks when MH had not been seen by (XX), he rang her to ask her to get MH to go to the Mall but MH did not do so. This was consistent with his 'engineering' of his engagement with the service and his poor compliance with medication. (XX) then rang JM to obtain MH's address because he had not got it, telling her that he thought that MH's records were still at Green Lane Hospital.

JM expressed very real concerns about the actions and approach of the Crisis Team, including the fact that initially she did not know anything about the Team albeit that this was a new service, which should have been well publicised, and which should later have provided her with relevant information and literature as MH's main carer. In her evidence, she stated *'Had I known they existed, I would have phoned them but I did not have any knowledge about how mental health worked.'*

And in respect of MH's later engagement with the Crisis Team and confidence in that team, JM told us *'The police have not got a lot of confidence, you know, they have told me. There are a lot of people who have not got a lot of faith in the Crisis Team.'*

And in respect of the care MH received from the Crisis Team *'Because they never helped. They would say that they were coming round in the morning for his injection and they would not arrive until the afternoon. Well MH is up and gone by then..... And they arrived one day and said, "We have run out".'*

JM also described an incident when the Crisis Team was arranging for MH to relocate to YY Street. She said that she had a call from the Crisis Team saying that

someone would call her in five minutes because there had been a problem with YY Street. She waited a week for the promised call then rang them herself. She told us *'They just said that it was not happening..... He (MH) is back with SG and it is up to her to find him accommodation. Well, I rang SG and she did not know anything about it'*.

Of concern to us were JM's reports of the brevity of Crisis Team visits to MH and her view that they never sat and talked with him. She said *'They would see him for two minutes and then they would be gone. They never spent any time with him. If they had sat and talked to him for a while and questioned him, they would realise that he was not well. The Crisis Team that was always short visits. They never spent a significant amount of time with him, not even ten minutes, no. I would say that I am worried about him, he is not well, and they would come out of my bedroom (where they always gave him his depot) after two minutes and say that he was all right'*.

JM told us that MH could probably *'hold it together'* when visited by the Crisis Team *'...for ten to fifteen minutes, but then he is just sitting there agreeing with everything, isn't he?'* Visits were *'As long as it took to drop his trousers, stick the needle in and come out, basically'*.

Commentary: The brevity of visits as described by JM is endorsed by the views of his sister, SH, except that SH refers to visits being of around 20 minutes in duration.

SH's Views

MH's sister, SH, also expressed concerns about the treatment MH received from the Trust and, in particular, the Crisis Team. SH said, in response to a question whether things began to go wrong in 2004 *'Yes, he was not eating, he was not going out, he was not communicating with me and my Dad..... He caged himself in his bedroom, 24/7 literally and would not speak to anybody.'*

Of the Crisis Team she said *'I know when I was living with my Mum, things were bad, we were not getting any answers, nobody seemed to want to look after MH and there were times when medication was not brought out..'*

I tried to help my Mum with MH as much as I could to get him the help that he needed but we were not getting anywhere. We even told them that something was going to happen, he would either take his own life or whatever, and still we got nowhere. He was hanging around the train station night after night, after night, after night, and we told them that and they did nothing. He was not eating, he was banging his head against the front door, smashing his head against the window and he had a knife on him.

Sometimes it was three or four days before anyone came out from the Crisis Team and my Mum spent all her time on the phone trying to get his medicine out.

When the Crisis Team eventually came out they would say, "We will assess MH and see how he is." We were not allowed in the living room when he was assessed. We had to go to another room and MH had to talk his way through this assessment.....'

They would be there 20 minutes, tick the boxes and they would go and that would be it if they had stayed for more than 20 minutes and monitored him for a bit longer, they would see.

..... three to four day gaps. Too busy, cannot come out. You could never pin MH down. If he knew they were coming out to give him medication, he would run. He used to spit it out and all sorts. She (My Mum) could ring them up in the morning and they would turn up the next day and he has gone. It was constantly like that It was days on end, two or three days, four days. It was, "Oh, we cannot find him, Oh, we are busy, or We have not got the medication" when he is schizophrenic and he needs his medication, you cannot go on like that.

We wanted him sectioned. We wanted the assessments to get him sectioned before this happened, but it never did.....The assessors I just gave up with it in the end, to be honest, because they just came out, signed a sheet and went again. The attitude to me was that they could not be bothered with it. MH was known as a difficult patient when he was in Sandalwood.

.. we did tell the police, we told the Crisis Team, we told everybody that he needed help... even they (the police) knew things were not right.'

Of SG and AG she said, 'They came round several times and they were very good.....They would come round all the time for family meetings and talk about MH, to talk to MH...'

In respect of (XX), she stated, 'There was even one case when they did not even know where MH was. They did not even have (G/F's) address, where he was staying. This person we spoke to did not even know where MH was....These people were supposed to be looking after him. This was not just once, this was going on and on. It was just passing the buck.'

With regard to MH's treatment following the overdose, SH said 'they just literally threw him out of the hospital and said we have done our bit, we have dripped him, and my Mum was saying he is schizophrenic but they said it is not our job.... ' She added, 'I think once he was in Sandalwood for 4 weeks and he told them he was feeling violent and they let him out.'

Commentary: The Assertive Outreach Team (AOT) was visiting (G/F) and was aware that MH was living with her from late summer 2006. We appropriately had no access to (G/F's) notes and do not know what was recorded in them but there was no evidence in the records available to us that the AOT conveyed to the Crisis Team or to MH's care co-ordinator that MH was living with (G/F). However, the CMHT notes make clear that SG was aware of this from MH's mother before she handed over MH's care to (XX) on a temporary basis on 30 January 2007. Although that handover was not recorded, we found SG's description of the handover to be convincing and in line with her generally systematic approach. We concluded that (XX) would have been aware that MH was living with (G/F) and that he had, or could readily have accessed, her address.

MH's own Views on the Care and Treatment he received from the Trust

MH was clearly still unwell at the time he met us in the Medium Secure Unit, but was able to speak coherently, expressing his remorse about what had happened. He described a difficult and fairly chaotic childhood, which accorded with what was in the written records available to us, and referred to his single episode of employment in a warehouse. He said that by the time he had been diagnosed as schizophrenic in 2004, his being unwell had been creeping up over a long time. He described his concerns that his food had been touched, or breathed on, by others and referred to his history of use of alcohol; and of cannabis daily at the age of 15.

In terms of his treatment in Sandalwood Court, MH said '*... they only kept me in for four weeks but they should have kept me in for longer, I think because I was still unwell.... I think Sandalwood made me well for a short time*'.

In respect of the Crisis Team, MH said (they were) '*Pain in the arse*' and '*I don't think they helped me at all really but, never mind, they didn't see what was happening inside my head..... They didn't see that I was unwell, you know, that's what I think*'.

In respect of his admission to Great Western Hospital following his overdose in February 2006, MH said that he had not been seen by a psychiatrist but that '*SG came to see me. I think she said to me, 'Was you trying to kill yourself' and I said, 'Yeah' but they didn't question me about it*'.

In general terms, MH was unable to recall that any clinical staff had spoken to him about the drug, Clozapine, when he was being treated in the community.

Support for the Families after the Homicide

AG and SG had no further contact with JM after the homicide, although the latter had trust in, and a good relationship with, both.

JM also reported that the Crisis Team were '*Brilliant with me when it all happened and I went to pieces ... I won't tell you what she (my daughter) said to them but they were tripping over themselves after all this, the Crisis Team. But they were good with me, I will be honest. They did help me and got me some (medication)*'

On 18 February 2010, almost three years after the death of her son, HJ received a letter from the Trust which contained the following statement '*For reasons of confidentiality to our patients, it has not been possible for us to make contact with you to discuss the incident that lead to your son's death*'.

Commentary: This letter was not sent as a matter of course but in relation to a matter raised by the Investigation Manager. We received Trust evidence throughout the Investigation to the effect that patients and their carers were at the centre of the services provided but felt that the comment made in the letter did not reflect this stated value and, in addition, was a misapplication of the duty of confidentiality. In any event, the court proceedings had taken place in July 2007 and had identified MH by name and as a user of mental health

services and there seemed to be no reason for the Trust to maintain its stance on confidentiality some three years thereafter.

Recommendation 20: The Trust should put in place a mechanism for early support for, and communication with, the families of the perpetrator and victim of a homicide (or families affected by any other incident of similar impact) albeit that this might be through the services of another NHS organisation or non NHS organisation.

Other Information received

CJ's sister-in-law reported attending a study day run by Swindon Adult Mental Health Services some six months after the homicide, at which the case of MH was raised. She felt that she had to leave the session because of this but spoke first to the person running the training who, she said, told her that the Trust '*.....had made a 'cock up'..... should not have let him (MH) out*' and said '*that it was a real mess from start to finish*'.

The AWPT was approached for details of this training session but was unable to provide us with any information. The Trust's spokesperson advised that there was no record of the training event.

Commentary: we were concerned that the Trust was unable to locate a paper or electronic record of this event.

Chapter 7

Trust and other statutory services

Note: The actions and decisions of AWPT staff are, where appropriate, recorded in Chapter 3 and some are dealt with in more detail in Chapter 9.

The Community Mental Health Team (Swindon East)

At the time of the homicide, there were 3 CMHTs in Swindon - North, South and East. The East CMHT was engaged in the care and treatment of MH, together with the Crisis Team and the Early Intervention Team.

The consultant aligned to the East Team was Dr PS, a very experienced clinician, who qualified in 1972 and was appointed as Clinical Lead Consultant in Swindon in 1981. In addition to his duties to the CMHT, he was (inter alia) Responsible Medical Officer (now Responsible Clinician) for his CMHT patients admitted to Sandalwood Court (Psychiatric in-patient Unit). During any absences (such as annual leave) Dr PS's colleague, Dr Rm (Consultant to the South CMHT) was available to advise the East Team and vice versa under a reciprocal arrangement. Included in the team were:-

RG: Team Leader for both the East and South CMHTs and a Community Psychiatric Nurse (CPN) with some 35 years experience including 21 years with the CMHT and 10 years as Team Leader.

SG: Community Psychiatric Nurse (CPN), was appointed as Care Co-ordinator to MH in December 2004. She had fairly recently qualified (September 2003) but was appointed Care Co-ordinator on the basis that she had the workload capacity to take on MH. She was related to RG and, whilst he remained her team manager, her clinical supervision was allocated to (XX), a senior CPN, although we were told that due to prolonged absences by (XX), her supervision was, on occasion, undertaken by other senior members within the team. The family relationship between RG and SG was not considered to be a problem within the CMHT. Their working relationship was reported to us as being entirely professional and SG was highly regarded within her team; by Crisis Team members whom we interviewed; by AG, a member of the Early Intervention Team; and by MH and his mother JM. We found that SG was generally most assiduous in her duties. She is to be complimented on her delivery of and attention to her role as Care Co-ordinator, despite her recent qualification and lack of specific training.

Commentary: At that time, AWPT did not have a policy in respect of the employment of members of the same family, although such policies are common in the NHS as it is not unusual for members of the same family to be employed.

(Senior CPN) (Referred to as (XX) in the remainder of this report) within the East and South CMHTs had a high caseload. It was he, who took over the Care Co-

ordinator role to MH when SG went on sick leave (planned surgery) in early 2007. We were unable to interview (XX) because he had left the service.

With the exception of RG, the above named were all interviewed by the police following the homicide in April 2007 and gave statements under Section 9 of the Criminal Justice Act 1967. Although these documents did not come to our attention until late into the Investigation process, given that these statements were effectively made under oath and made soon after the homicide, they provided us with some corroboration of key facts.

DQ: support worker in the CMHT, shared an office with SG. She also worked shifts in the Crisis Team as and when requested and had an insight into the working practices of both teams.

The Advent of the Crisis Team

In 2003, as part of a Government imperative, the Crisis Team was set up (a later section in this chapter provides detail on the operational policy, structure and system of working for the Swindon Crisis Team).

Commentary: Information provided to us indicated that the decision to establish a Crisis Team in Swindon was approved by AWPT Trust Board in 2001, (although the need for such a service was first mooted in 1999) and the service was established within the proposed two year timescale. We heard from clinical and other staff that funding of the service came from two sources:- 1. Savings from the reduction in the number of in-patient beds in Swindon and 2. Transfer of resources from the CMHT. We were advised by the Trust that the establishment of the new service was not considered by the Trust Board as it was part of a national move to establish Crisis Teams. We were, however, told in evidence that in-patient beds were significantly reduced in number (an expected outcome of establishment of a Crisis Team); that CMHT staffing resources were reduced by half (although the workload remained unchanged); and that the Crisis Team did not initially have sufficient staff to deliver the new service. And that the AORT faced a situation in 2006, where their staffing was depleted because they were not authorised to recruit to vacant posts; and that this meant that the AORT could not accept transfer of MH's care from the Crisis Team in 2007, although they were the most appropriate service to manage his ongoing care and treatment. Our view was that the two year implementation period should have been used to develop robust financial provision for the new service, without detriment to services provided by other teams.

The advent of the Crisis Team was to affect the long established practices of the CMHTs. Whereas hospital admissions had previously been consultant led, the Crisis Team took on a 'gate keeping' role whereby all decisions on in-patient admissions, or whether it was more appropriate to offer home treatment, were taken by them. The Crisis Team was also involved in facilitating the discharge of in-patients, including immediate follow up and treatment in the community post discharge. At the time of inception of the Crisis Team, there were 3 psychiatric wards at the Sandalwood Court in-patient facility, namely, Applewood, Rosewood

and Redwood. Both Rosewood and Redwood were later closed, leaving 18 inpatient beds available in Swindon.

Evidence heard by us indicated that within the CMHTs, there was a feeling of disempowerment over decisions to admit patients and also that their professional opinions were not taken into account, not least because decisions were taken and/or communicated by unqualified staff in the Crisis Team to qualified staff in the CMHT. These feelings were also reported to be apparent in teams outside Swindon. There were strong feelings by some that the Crisis Team members were elitist.

We were informed that, at the time of MH's engagement with the mental health services, the East CMHT had a dedicated day on Tuesdays for review of Community patients and in the afternoon the whole team met to discuss patients' presentation; and treatment and clinical advice was available. Community patients who needed to be seen by the consultant were seen with their Care Co-ordinator. Reviews could also take place where appropriate and include patients and their families. Urgent issues could be discussed within the team at any time. All members of the team would have developed knowledge of MH and the concerns of SG and of MH's mother, JM.

Within the CMHT, the changes consequent upon the establishment of the Crisis Team were not considered to be well managed by the Trust. Within the team itself, staff did feel well supported and valued, and communication within the team and with the Early Intervention Service was believed to be good and effective.

Changes to Referral Procedures

Consequent upon the establishment of the Crisis Team a new referral process was applied

- A referral marked 'urgent' by a General Practitioner and indicating a risk to self or others was passed to the Crisis Team for assessment and engagement. This is the method by which MH came to the attention of psychiatric services. (The initial letter from the GP was addressed to Dr PS and was passed to the Crisis Team).
- Any non-urgent referrals were allocated to the CMHT.
- After assessment by the Crisis Team and/or the crisis had been managed, the patient would either be discharged back to their GP for follow up and treatment or, if it was felt that the patient required input from secondary services (including Assertive Outreach services), then the person would be referred to the CMHT. This happened in the case of MH, who was referred to the CMHT.

Medical responsibility and the RMO role lay with the consultant psychiatrist of the team involved in the management of the patient at the time and these roles would normally shift from one team to the other with the transfer of patient care to a different team. Thus treatment (medical treatment and care co-ordination) remained with the CMHT when the patient was receiving treatment through the CMHT in the community or as an in-patient. But when the patient was receiving input from the Crisis Team the medical responsibility moved to the Crisis Team and to the consultant aligned to that team, although care co-ordination remained throughout

with the allocated Care Co-ordinator. On 26 October 2006, there were discussions as to who the Responsible Medical Officer for MH would be and it was decided that as the Crisis Team were visiting daily and offering care that Dr MS would be RMO

The Responsibilities and Actions of Individual Members of the CMHT

Dr PS

Dr PS summarised his role and responsibilities within the CMHT and also provided a description of the running of the team in terms of forums for communication between team members and himself as the Consultant Psychiatrist. 'I am currently the Consultant Member of the East Community Mental Health Team (CMHT) which provides assessments, treatment and management for individuals suffering from a psychiatric disorder in the working age group of 16-65 in the Eastern sector of Swindon. The East Team accepts referrals from this sectorised area and provides comprehensive assessments, clinical management, review and follow up for individuals requiring secondary health inputs. In my role as the Consultant member of the ECMHT I am actively involved in assessment, allocation, clinical supervision, giving clinical advice, medication management and general support to all members of the CMHT. In addition I am involved in liaison with GPs as and when required, or clinical in the Great Western Hospital for psychiatric advice, as well as having the Mental Health Act role as Section 12 approved Doctor.'

Dr PS summarised the chronology of consultant responsibility in respect of MH as follows 'Referred to the Psychiatric services by his general practitioner in September 2004 and remained under the treatment of the Crisis Team until 8 December 2004.

From the period between 8 December 2004 and 18 May 2006 MH's treatment and management was with the ECMHT with SG as the Care Co-ordinator and myself as the RMO.

I saw him for a review in the community review round on 1 March 2005.

From 18 May 2006 until 7 January 2007 he was under the CHTT (Crisis Team) who were in charge of his clinical management and the CHTT (Crisis Team) Consultant was his RMO.

This was the case except for the two periods of inpatient treatment in Applewood in Swindon from 31 July 2006 and transfer to Windswept on 15 September 2006 as well as an episode of inpatient treatment in Green Lane Hospital from 22 November 2006 till (sic) 30 November 2006'.

Dr PS stated that in respect of any consultant to consultant communication between him and Dr MS of the Crisis Team 'No there is not anything in the records. I am just trying to wrack my brain. I am sure there was some informal exchange like how is he doing and how things are getting on, so I think there was informal contact. But neither giving any shape or direction for the treatment'.

In a meeting held with Crisis Team staff as part of the RCA process, Dr MS said that she had talked with Dr PS about MH on one or two occasions.

Commentary: It is a matter of concern that there was no record of direct consultant to consultant discussion or liaison on any occasion, particularly when there was a transfer of care between teams. This is of particular significance in January 2007 when the transfer for MH was made from the Crisis Team to the CMHT, concurrent with recorded deterioration in his mental health.

Recommendation (Repeat of recommendation 17): Where a patient's care moves between different care teams, consultant medical staff should have a formal, recorded process of handover of responsibility to ensure that all relevant clinical information is shared. This process of transfer of clinical responsibility should be managed within the framework of the Care Programme Approach. However, reliance on this process does not necessarily entirely discharge the individual professional responsibility for each consultant to ensure that they are adequately informed regarding the key clinical issues relating to each patient for whom they have RMO responsibility.

Consultant responsibility for MH reverted to Dr PS when MH was admitted to Applewood on 31 July 2006 under Section 2 of the Mental Health Act. MH was reviewed by Dr PS in a ward round on 7 August 2006 and a plan was noted in MH's records. As the admission progressed, MH's mental state improved and his presentation on the ward became more settled. Dr PS said that he attributed the improvement in MH's mental state to a number of factors. One of these was that MH was under a controlled situation and so he had no access to alcohol and cannabis at that time, together with the fact that his medication was supervised.

Dr PS formulated a plan for MH in response to this pattern of improvement *'This was something that was discussed with MH and the plan was that he would come to me for treatment as an in-patient, come to me to engage in the activities. He would be granted short periods of leave initially or he would have a period of leave with his mother, and once we were confident that he would stick to his commitment of not using substances the leave would be gradually increased, and I had discussed with him the idea of going to Windswept which was our rehabilitation unit so that he could have a longer stay supervised'*.

In practice, due to bed availability issues, the transfer to Windswept was made over the period of a weekend and not in the gradual manner intended by Dr PS, who said that *'He (MH) was sent off over a weekend and I think that this was to get a bed for another patient that was the situation'*. He added that permission for that lay with: *'The managers decide, because first of all, even if there was any consultant, I would not have been aware if it was over the weekend, unless I was on call.....but usually they would make a decision and sometimes the consultant would hear in retrospect the decision that had been made'*.

Commentary: It was evident from the records at Windswept that MH's mental state once again deteriorated and his behaviour gave cause for concern. This is endorsed by notes made by SG from mid-September to early November

2006. However, a return to an in-patient facility was not possible due to the non-availability of a bed.

The transfer to Windswept was not made in accordance with the plan of care that had been made by the clinical team responsible for MH. The opportunity to test MH's commitment and ability to manage within the lesser structured environment of a rehabilitation environment was provided for MH but the unanticipated speed of his transfer militated against this. Furthermore it is evident that there was a lack of clarity regarding who had consultant responsibility for MH during the 6 weeks he was resident at Windswept.

Dr PS explained 'Normally if he had been on Windswept I would have been the responsible consultant. Now within a very short period of going to Windswept he started missing and he went to this other patient's house, he started living with her, so it became a situation whenever my SHO used to go to see him, because it was their duty to go and review patients there, and I would also attend for a Ward Round – it was agreed that we would do it every fortnight, unless there was a need for them to call me – so, whenever he went, he could not find MH there.'

In respect of whether MH was technically under his care in the six week period he spent at Windswept, Dr PS said *'No.....Windswept reported to, well it was the acute services it was the Applewood crisis team and home treatment team.....I had to say to them that, if you are looking after him and this is what is being done and he is not an inpatient on Windswept, and then I cannot possibly have the consultant responsibility. That was passed on to Dr MS'*.

We received no evidence to indicate that Dr MS consulted Dr PS about the transfer of MH's care back to the CMHT in January 2007.

MH was reviewed by SG on 19 January 2007. She noted distinct abnormalities in his mental state *'clearly thought disordered, laughing inappropriately, auditory hallucinations, preoccupied showing no remorse for hitting his younger brother'* also *"reluctantly agreed to have his depot which was given'*.

Commentary: MH's mental state was clearly deteriorating further. His next dose of Risperdal consta would have been due in 14 days on 2 February 2007.

MH was reviewed by Dr PS on 30 January 2007. Dr PS's observations include *'Admitted to feeling stressed at times and fluctuations of mood. Didn't want to elaborate on his beliefs and experiences but hinted at 'influences' and things going wrong. Denied any ideas/plans of harm to self or others'*.

In terms of interventions Dr PS noted:

'1. Doesn't want to be referred to DAT (Drug and Alcohol service' "I can do it on my own"

2. Didn't think he needed any help with the accommodation issues.....on examination guarded, at times preoccupied, distractible smiling incongruously on occasions. Agreed to have a change of depot as Risperdal consta has only led to partial improvement. To go back on Depakote. Px depixel 20mg in test dose, Depakote 750mg bd.

Follow up CPN, support worker Review as arranged'.

Commentary: In terms of MH receiving the medication agreed between him and Dr PS, the test dose of depixol, (ie. not a treatment (therapeutic) dose), was administered that day. The therapeutic dose was administered by (XX) on 22 February 2007. It should have been given 8 days earlier.

Recommendation 21: Where a member of the clinical team is unable to undertake the prescribed administration of medication in a timely manner, (s)he should refer this immediately to the RMO to agree what action is to be taken.

Commentary: We have concerns as to the extent to which Dr PS is considered to have discharged his responsibilities as consultant. He clearly had a good understanding and formulation of MH, although it is noted that there is no evidence in the medical records that he explicitly recorded any diagnosis or his contact with, or discussion about, MH. However, whilst it appeared to us that, at each point, the interventions in which he was involved for MH were appropriate, he failed to engage with Dr MS for the overall monitoring and direction of MH's care and treatment. In particular, when MH was discharged back to the CMHT in 2007, reports of his mental state and obvious deterioration should have alerted Dr PS to the need for an urgent psychiatric review to inform changes to the care plan.

We were unaware in our interviews with staff, including Dr PS, that he kept a register of every patient discussed at the CMHT meetings. We subsequently heard from Dr PS that this register contained only the names of clients discussed in team meetings.

The decision to continue to manage MH without extending the Mental Health Act Section 2 to Section 3, was a finely balanced decision and if the plan articulated by Dr PS for the period of rehabilitation at Windswept in the manner he described had been provided for MH, events may have unfolded differently. Dr PS' view was, in any event, contrary to that held by Dr MS, who considered that a Section 3 admission was appropriate. Formal liaison and discussion between himself and Dr MS that could have facilitated better sharing of knowledge between the two consultants.

Dr PS stated that, in terms of how much knowledge he had of the contents of the therapeutic sessions MH had with AG, and how that was communicated to him *'I was used to attending meetings with the community mental health team to give us some feedback on people who were involved with the Early Intervention Team and they did not have a consultant. So what happened was that the Consultant who was looking after that sector became the Consultant and the Early Intervention Team would come and talk to the community health team So SG was the care co-ordinator, AG, was doing work through the Early Intervention Team and I think the communication between the two of them was excellent. They were regularly sharing, communicating and they had set up a family work with MH and his mother, so they had a very broad view of what was happening not only in MH's life but also in relation to MH's case provided by the CMHT.'*

Dr PS felt that this was communicated appropriately with him as well *'I think SG used to keep me informed. AG used to come to the Community Mental Health Team meeting once a month just to give some feedback saying "He is doing better" or "They are more settled" or "I have some concerns". But as far as SG is concerned, I think she was in regular touch and would keep me informed.'*

RG

RG advised us that the CMHT was friendly and supportive and that, prior to the establishment of the Crisis Team, had been adequately resourced but that following the implementation of the Crisis Team, there was a 50% reduction in resources. The caseload for the Crisis Team as a whole he believed to be 50 whereas the average caseload for each team member of the CMHT was 50, with (XX) carrying a caseload in excess of 70 at one time and SG having a caseload of over 40, when the expected caseload would have been 25 - 30. Although RG remained her team manager, in view of the fact that they were related, arrangements for SG's professional supervision were delegated to and expected to be undertaken by (XX). We were told that in addition to clinical nursing supervision, SG also had access to support and advice from Dr PS.

SG

SG gave a statement to the police dated 4 April 2007, the homicide having taken place on 4 March 2007, in which she stated that she was Care Co-ordinator for about 46 patients. Her evidence to the Investigation was that she had a workload in excess of 40 which was above the Nursing and Midwifery Council (NMC) Guidelines of 25 - 30. She further stated that she qualified in September 2003 and that from September 2003 until April 2004 she was employed as a Link Liaison Nurse by AWP Trust until she was appointed as a CPN. She advised us that she had received no formal training as a Care Co-ordinator.

In general, she kept clear and comprehensive records but it was noted that she failed to maintain some records in January 2007, to which she had admitted in her statement to the police. SG advised that she did not record the review on 30 January 2007 because Dr PS took notes and recorded the plan. Nevertheless, her record keeping should have been reviewed during her clinical supervision, primarily by (XX) or by other senior members of the team as necessary. SG advised us that workload pressures within the team meant that on occasion supervision was 'put off'. Further evidence indicates that there were no records of supervision sessions for SG, which is contrary to Trust policy.

MH was on an enhanced level care plan due to his complex needs. (*Chapter 9 of this report sets out the required process and arrangements for the Integrated Care Planning Approach in mental health services*) SG worked closely with AG, Clinical Psychologist in the Early Intervention Team, participating in some Family Work sessions and in other discussions with AG with regard to MH. She also worked closely with the staff at Hazelmead supported accommodation in Keywork sessions with MH and otherwise as to the provision of prescriptions for MH's medication, including assisting him to fill his dosette box and activities identified for his participation.

She considered the relationship between the CMHT and the Crisis Team to be difficult and challenging, and that communication was problematic; that her concerns were not listened to; that her professional assessment was not valued; and that patient care was thereby compromised. SG maintained contact with MH throughout 2004–2007, including the periods when he was the responsibility of the Crisis Team and their aligned consultant.

SG could not recollect having been involved in any of the Mental Health Act Assessments or in-patient admissions, which she considered to be unusual given that she was MH's Care Co-ordinator. We found no evidence in any of the notes by her to indicate that she had been consulted in these matters or on discharge arrangements.

At the time of the initial handover from the Crisis Team, SG observed that there were no notes available. She was not told when MH was moved from Sandalwood Court to Windswept Rehabilitation Unit and she was not told officially that MH had been discharged from Green Lane Hospital. On 29 November 2006, her record shows that she telephoned Imber Ward at the hospital and spoke to a staff nurse, who reported that (MH) had been *'settled, compliant with prescribed medication although continues to have delusional beliefs'* and SG also spoke with MH, recording *'He wants to come home, he has heard (G/F) has been discharged so wants to find accommodation. Some evidence of thought disorder believing he's a 'mighty soldier & has to stop the terrorist. Support given'*.

In his notes, Dr DS, Consultant at GLH, recorded *'I have had to contact SG (Care cord). I have contacted the Swindon CAHT (Crisis Team) and they will phone back. M (MH) is fit to return to Swindon. He is voluntary and thus can go on his request. I have no reason to stop him.'*

SG's records show that she was told by JM (MH's mother) on 1 December 2006 that MH had been discharged. In her evidence she told us that, as Care Co-ordinator, she should have been told officially that MH had been discharged.

SG also endeavoured to follow up on reports to the Vulnerable Adult Unit with regard to a knife, which had been confiscated from MH whilst he was resident in Hazelmead, but without success and had also followed up with the Crisis Team on issues regarding Mental Health Act Assessments in October and November 2006.

She expressed to the Crisis Team her very serious concerns about MH's presentation, especially in January 2007 but in her evidence to us said that she believed that her concerns were not listened to by senior personnel in the Crisis Team.

SG said in evidence to us that she did not know that MH was hoarding medication at Hazelmead, which allowed him to take an overdose in February 2006, when monitoring of medication had been delegated to staff at Hazelmead, where the then temporary manager was a Registered Nurse in Mental Health and learning disabilities (RMN).

Commentary: We were satisfied that SG probably did not know that MH tried to conceal medication given by the Crisis Team while he was resident at Culvery Court, and that she did know that MH was partially non compliant with medication at Hazelmead.

SG knew about knives, one a confiscated oriental knife was put in the safe at Hazelmead, another in MH's possession was a penknife. SG advised us that she did not know that MH was reported to have held a knife to his girlfriend's throat and she did not know that he had acquired another oriental knife which he used to kill CJ.

She did not know who CJ was, or that he was an actual or (supposed) friend of MH and that he lived a short distance away.

She says she gave information to (XX) on handover which would have included MH's current known address, which she knew to be (address) , where he lived with (G/F). She believed that (XX) would have known about MH from his supervision of her, from team meetings and from other occasions when he covered for her during her annual leave. In fact, she noted on 16 May 2006 that, after one absence between 8 May 2006 and 16 May 2006, *'On my return from leave informed that MH had refused his injection of Risperdal consta 25mg IM. (XX) had gone out to see him.'* This aligns with her police statement following the homicide, when she stated that (XX) had gone out to see MH at Hazelmead when MH had refused his injection. Her note continues *'D/W Dr PS, informed of situation, advised to try again, discussed referral to Crisis Team if unsuccessful'*.

(XX)

At the time of the homicide, (XX) was a senior CPN in the East and South Swindon CMHTs. He was a Registered Mental Health Nurse having qualified in 1983. (XX) did not provide a written statement nor attend to give evidence to the Investigation Panel. This was a most regrettable situation given the differences highlighted between his written statement to the police and the evidence we adduced from other witnesses as to his involvement in patient care, particularly as it related to MH; together with our concerns about the inappropriate location of (XX's) records in the notes.

Having regard to the fact that both RG and SG advised the Panel that (XX) was SG's clinical supervisor, it is remarkable that that fact was not recorded by the Internal Investigation, or within the Root Cause Analysis report (notwithstanding that reference to his supervision role was included in the notes of a meeting between the RCA panel and CMHT members). Nor was that fact apparently recorded in meetings with Trust Solicitors, or in (XX's) police statement. In these interviews and meetings, (XX) claimed to know little about MH although he would have been present at team meetings on Tuesdays when all patients were discussed.

Furthermore, SG's clinical notes on 16 May 2006 show that in her absence on annual leave, MH had refused his injection and that (XX) had gone out to see him. (XX) refers to having been introduced to MH briefly by SG. SG informed us that her procedure for handover would be to give (XX) MH's drug chart, his address, the reason why he was on medication, any risks posed at the time, information about ease of engagement and any other relevant information. In his police statement,

(XX) refers to having obtained MH's case notes but that they appeared incomplete. The clinical notes passed to the police were complete insofar as they related to the CMHT but were incomplete as to the Crisis Team.

In his notes of 30 January 2007, Dr PS recorded that he prescribed Depixol 20mg IM test dose and Depakote 750mg BD. In his statement to the police, (XX) stated that on 27 February 2007 Dr PS told him that he would like MH to have a mood stabiliser in the form of Depakote, that Dr RT (SHO) made a prescription which he (XX) posted to MH. In his record in the clinical notes of 27 February 2007, (XX) notes *'D/W Dr PS. Px Depakote 750mg BD. Px sent. See again on 8th March.'*

Commentary: It would appear that (XX) did not appraise himself sufficiently to appreciate from SG's notes at the time of the handback from the Crisis Team that MH had not been compliant with oral medication and that to post a prescription to MH for a mood stabiliser would have been ineffectual in the light of his history of non-compliance with the Crisis Team.

Recommendation 22: Where there is a transfer of care between teams (or between members of the same team), this should be done within the framework of a Care Programme Approach and include a written record indicating the written documentation available; the information transferred, including known risks and other historical information which would indicate the potential for risk; and immediate action to address risk. This document should be signed by all parties to the discussion in respect of the action to be taken, including the need to review the care plan.

In her evidence to Wiltshire Police, SG stated *'On 30 January 2007, I collected MH from (G/F's) flat (For a meeting with Dr PS) Other medication was discussed with MH but not administered at this time. The agreement was that (XX) would supply this medication in my absence. After this meeting, I introduced MH to (XX) who would be taking over MH's care in my absence. Due to my sickness absence, I did not record my last meeting with MH and Dr PS. I have recalled this from memory. This was my last contact with MH.'*

In his evidence to Wiltshire Police, (XX) stated that he was approached by SG in early February 2007 about the injections for MH. He stated *'My understanding was that MH was of no fixed abodeI contacted MH's mother, who I since found out was called JM.'*

However, JM 's understanding and (XX's) own record clash with evidence from SG to the effect that *'But with regard to injections and things like that, I would have given (XX) his drug chart and explained where he lives and the reason why he is on the medication..He ((XX)) would also have been involved in the entries that I put in "Discussed with Dr PS". The majority of those occasions were always on a Tuesday which are when we had our team allocations review meetings which in the afternoon all the team are present and that is when we discussed ongoing cases, existing cases, any concerns and any issues and, although MH's care was under the management of the crisis and home treatment (sic), I would still liaise and inform Dr PS of what had been going on and (XX) would have been present for quite a few of those as well, so would have had an understanding from that as well'*

(XX) made the following entries in the CMHT clinical notes:-

19 February 2007 '*....phoning his mother is the only way I have apparently of getting in touch (JM) has given me his Mobile Number ... I will continue to try to see him*'.

21 February 2007 '*Having found the address: (address)*'

Commentary: (Address) was clearly recorded as MH's address in MH's notes on 29 September 2006 by SG. This information was readily available to (XX).

(XX's) record of 19 February 2007, comprising a single completed page, was filed between entries by SG on 28 July 2006 and 1 September 2006. His later entry on 21 February 2007 was appropriately located in the records. We were very concerned at this apparent discrepancy at this stage in MH's treatment but were unable to come to a clear conclusion about this.

We were unable to further our enquiries with (XX) in respect of these critical events and the Trust was unable to provide any records of clinical supervision for (XX).

DQ

As a member of the CMHT at the time, DQ was then a support worker (now known as an Associate Practitioner). She has 27 years experience of work within the NHS, of which 16 years are in the field of psychiatry; and for the last 9 years with the East CMHT. She also has worked 'bank' and 'agency' shifts, including shifts with the Swindon Crisis Team.

Commentary: DQ's evidence provided us with information about different working practices in the Crisis Team and the CMHT.

DQ's first dealings with MH as a patient were when she made an early visit to him on behalf of the Crisis Team on 25 September 2004. She noted in the records on 8 October 2004, when MH was seen at Culvery Court, that he only took 10mg of Olanzapine and attempted to hide the other 10mg, which he said was for his friend. According to her statement to the Investigation, she was present on 6 occasions between 25 September 2004 and 23 October 2004 when the Crisis Team saw, or attempted to see, MH.

Sharing an office with SG enabled DQ to be aware of facts relating to MH's presentation. Whilst she was aware that MH was very 'paranoid' at times she never felt at risk but advised us that, within the Crisis Team, nothing was shared about risks. She knew that MH and CJ were close neighbours. She advised us that the Crisis Team did good work but did not like visiting patients where drugs and alcohol (Dual Diagnosis) were involved. Commentary: If this information is correct, then the approach of the Crisis Team did not align with good practice, its own operational policy or national policy. NICE guidance (set out in full in Chapter 4) recommends that: 'Where co-morbid conditions such as substance misuse are identified specific assessments and care plans are developed with regard to this.' Both versions of the (draft) operational policy of the Crisis Team state that the service is considered unsuitable for people who present with a primary diagnosis of substance abuse. This is in accordance with Department of Health guidance but the reference is to a primary diagnosis of substance abuse, not cases where the primary diagnosis is

mental health. The draft policies also both recognise that 'Individuals may use drugs/alcohol in an attempt to alleviate/cope with mental health problems'

Recommendation 23: Crisis Team staff should be trained in the recognition of Dual Diagnosis and its impact on existing mental health problems and the requirement to alert other agencies as appropriate.

DQ reported that they do not '*get the bigger picture*'; refused to see patients; and indeed overlooked concerns expressed by JM (MH's mother). Her view was that the Crisis Team saw a difference between illness and dual diagnosis; and that their visits were of short duration. That in the Crisis Team 'gatekeeping' role, it was felt that CMHT opinions did not count and the Crisis Team did not have the same respect for Dr PS as the CMHT did. In her view, whilst the overdose by MH was unpredictable, it should have been highlighted as a risk.

DQ acknowledged that she was not a qualified clinician when working in the multi-disciplinary team but on the basis of her evidence, we concluded that she was experienced and very competent in carrying out the work she was required to do. She was not trained in Risk Assessment and did not have a Risk Assessment Certificate. Such is her interest in her work that she sought the opportunity to have Risk Assessment training but this had been denied her. (This is dealt with in more detail in Chapter 9 of this report)

The Swindon Crisis Service (The Crisis Team)

The Department of Health document '*The Mental Health Policy Implementation Guide*' (30 March 2001) sets out clearly the expectations of a crisis resolution/home treatment service. This addressed in considerable detail the four phases to crisis resolution:- assessment, planning, intervention and resolution. It stated that a Crisis Resolution/Home Treatment Team '*should be able to*

- *Act as a 'gatekeeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service.*
- *For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week.*
- *Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible.*
- *Remain involved with the client until the crisis has resolved and the service user is linked into on-going care.*
- *If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge*
- *Reduce service users' vulnerability to crisis and maximise their resilience.*

Experience indicates that the following principles of care are important

- *A 24 hour, 7 day a week service.*
- *Rapid response following referral.*
- *Intensive intervention and support in the early stages of the crisis.*

- *Active involvement of the service user, family and carers.*
- *Assertive approach to engagement.*
- *Time-limited intervention that has sufficient flexibility to respond to differing service user need*

Commentary: The decision to set up a Crisis Service was in response to national policy, as set out in Department of Health Guidance, rather than a local decision by AWPT, and we were advised that this decision was not therefore considered at a Board meeting.

The Swindon Crisis Service (also referred to as the Swindon Crisis Team and the Swindon Crisis/Home Treatment Team) was responsible for the care and treatment of MH at the point of his initial referral to the Trust in 2004 and during part of the critical period of his later deteriorating state of health, when his care was managed by the Crisis Team for a number of weeks from April 2006 until January 2007. In the interim period, he had been cared for by the Swindon CMHT back to which his case was transferred in January 2007. SG, CPN, remained MH's Care Co-ordinator throughout the time MH was being cared for by the Crisis Team. The Crisis Team appears not to have acknowledged this fact, which is normal practice, and this is evidenced, inter alia, by the production of an Enhanced Care Plan, signed by CS, (whom we identified as a Student Nurse), under the title 'Care Co-ordinator', on 14 November 2006

Commentary: We consider this to be a matter of concern in two respects. In this instance, a student nurse was allowed to develop a key document for a young man with serious mental health problems, apparently without guidance or counter-signature and when she was not the Care Co-ordinator (and, as a non-registered Mental Health Nurse, could not have held that role). In addition, that SG was not involved in the development of this Care Plan and was not provided with a copy to inform her role of Care Co-ordinator and later continuing CPN role when MH returned to the care of the CMHT. We sought to make contact with CS but were advised that the Trust had no records of her and that she might have been an 'agency' nurse. We believed that, albeit with some difficulty, it would have been possible to locate CS even if she were registered with an agency rather than assigned to the Trust as part of her training. In any event, a student nurse should not have been allowed to assume the role of Care Co-ordinator and complete such a key document. It appears that there was a serious failure to provide appropriate support and supervision for an unqualified member of staff attached to the Crisis Team.

Recommendation 24: The Trust must ensure that Care Plans are completed and signed off by the Care Co-ordinator and, where possible, the patient countersigns the entries.

At the time the Crisis Team took over MH's care, the service had been in place for approximately one year but clinicians in other teams continued to have reservations about its modus operandi, its philosophy, the attitude of some of its staff and relationships, both generally and between the Crisis Team and the CMHT in particular. (These issues and their impact on an integrated approach to care, including that offered to MH, are considered in detail later in this report).

Notwithstanding, the approach and culture, which the Crisis Team was widely reported to have adopted, was seen to disempower other care teams in the Trust, including medical staff.

We were, however, able to draw on the evidence of a number of NHS staff, who had been involved in the planning and implementation of the Crisis Service in Swindon, and were thereby clear in our understanding that, in setting up this new service, the Trust was acting in accordance with Department of Health requirements. Concerns expressed by other clinical staff about the Crisis Team were not about the fact of its establishment but about the way in which it was set up and apparently legitimised in the development of an excluding style of working. PC told us *'I can remember our Locality Manager at the time standing up on a stage on a day and saying 'Right. We've got 150,000, we've got three months; we need to put something in place by April that shows we have an extended service'.... 'In fact, it has taken the best part of three years for the Trust to decide what Crisis and Treatment means to it ... and the evidence of that, of course, is that we have seven different teams doing seven different things across the Trust'* (Evidence given March 2010)

MS, who had overall responsibility at the time for implementation of the new service, advised the panel that *'In my view, the introduction (of the CT) was well managed.'*

In contrast the current Executive Medical Director of the Trust stated *'So the assumption is that there is the CT (Crisis Team) and therefore you do not need the beds. Rarely do initiatives like that tie up'.*

We were provided with two documents setting out the Operational Policy for the Crisis Service, one in draft format, dated December 2003, and one in final format, dated 20 February 2007, less than two weeks prior to the homicide on 4 March 2007. Both were incomplete in that some pages were missing. The later (February 2007) Operational Policy set out the following service statement; service definition of a crisis; service aims and objectives; and service philosophy

'Service Statement -

The Crisis Service provides a 24-hour, 7 day per week service to people experiencing an acute psychiatric crisis, who require same day assessment. It also provides an alternative to acute hospital admission by providing intensive intervention in the community.

The Crisis Resolution Service is mainly based on the criteria set out in the Department of Health's Mental Health Policy Implementation Guide and fits within the local whole system for Working Age Adults.

Service Definition of Crisis -

Presentation of an individual whose normal coping mechanisms and resources have become overwhelmed by the onset or relapse of a severe mental illness, or through experiencing significant situational change. The crisis renders the individual and carer unable to manage their changed circumstances, presenting a risk to themselves or others, thus requiring a same day specialist assessment of their mental health needs.

Service aims and objectives -

- *Provide the earliest possible assessment to people who meet the service criteria.*

- *Provide immediate multi-disciplinary community based treatment 24 hours a day 7 days a week.*
- *Provide care in the least restrictive environment.*
- *Act as a gatekeeper by the prevention of avoidable admission to hospital of persons experiencing mental health crises.*
- *Work closely with involved and allied services ensuring efficient communication and service coordination*
- *Ensure a collaborative approach, which considers the contributions, needs and health and safety of service users, relatives, carers, general public and staff*

Service philosophy -

Crisis Resolution provides an alternative to hospital admission for people experiencing severe mental health problems/difficulties.

The Service allows the individual experiencing severe mental health difficulties to be treated in the least restrictive environment with the minimum disruption to their lives, which ultimately aids progress and recovery.

The Service encourages individuals and their carers to be actively involved in their plan of care.

Using a multidisciplinary team approach, the Service will provide each individual with a comprehensive needs/risk assessment to enable delivery of appropriate care that meets their physical, psychological, social, cultural and spiritual needs as far as possible and safely within their home environment.

The Service will provide a high quality service that is easily accessible to all within the Swindon locality of Avon and Wiltshire Mental Health Partnership NHS Trust.

The Service will provide flexibility in responding to changing demands by working in partnership with service users, their carers and other relevant agencies.'

From evidence we heard, it became clear that many staff considered the initial driving philosophy and purpose of the Crisis Team, as interpreted and implemented within AWPT, to be to facilitate both the reduction in the number of in-patient beds and the minimisation of the use of the remaining beds. The AWPT service as generally described to us was that the Crisis Team role became that of a 'gate keeping' role to discourage, prevent and limit admission to in-patient facilities rather than to assure the most appropriate and effective provision of care on an individualised patient basis.

Leadership of the Crisis Team

Following the decision by the Trust Board to set up a Crisis Team in Swindon the process of recruitment of staff to the new service commenced in 2003. We understand that the first appointment to the team was that of DB, Manager of the Crisis Service, who was recruited from another NHS organisation where he had set up their new Crisis Teams. We were not able to establish conclusively the selection process involved in this appointment and sensed that normal procedures may not have been fully implemented. A request was made to the Trust to provide a copy of the job description relating to DB's appointment and the response was to the effect that despite enquiries unfortunately it had not been possible to find the job description which applied at the time of DB's appointment to AWP.

Commentary: We understand that it is normal practice for recruitment documents to be destroyed after a set period has elapsed but a copy of the job description for the Manager post formed part of DB's contractual terms and should have been placed on, and remained in, his personal file. In addition, the records normally destroyed do not include non-confidential documentation relating to a selection process. NHS job descriptions are not confidential documents and are normally also retained on electronic systems.

Recommendation 25: Employee files should contain a copy of all prime documentation, which forms part of the contract of employment.

In the absence of a job description and in the context of an operational policy which reflected a subtle change in one of the Department of Health stated key roles for the Crisis Team, we found difficulty in assessing the degree to which DB was adhering to organisational requirements. Certainly, evidence given to us by others indicated that his primary focus was on the reduction of bed usage and this may have impacted on his ability to provide effective leadership for the new team. *'.. they were saying he attended every ward round and was making decisions about discharging patients which is what he was employed to do.'*

On 17 November 2003, an induction and training session was run for the new Crisis Team. We were provided with a copy of the programme for that single day event and with copies of key documentation considered at the event. The programme and associated paperwork, much based on the good work of the Sainsbury Centre³, appeared to provide for an effective induction but we did not have sufficient information (such as evaluation sheets) to determine how effective the session was in introducing staff to a new service underpinned by a new philosophy and very different ways of working. Evidence from staff who joined the Crisis Team after 17 November 2003 was to the effect that there was no formal or structured approach to induction, but rather 'on the job learning', which could involve visits with a member of the trained nursing staff in the team.

It appears that, with the exception of DB's appointment from outside the AWPT area in August 2003, all other staff at inception of the service were drawn from existing teams and this was believed to have had a substantial negative effect on those teams as resources were transferred to the Crisis Team without commensurate reduction in the workload of other teams.

In respect of later management of the service, we were faced with starkly conflicting evidence. PC denied being interviewed or appointed as Manager of the Crisis Team at any time before 2008 (after the homicide) subsequent to DB's move to new responsibilities in 2006. This conflicted with the weight of evidence from other staff. We heard from DB, JD, AD, The RCA team and a member of the Crisis Team their unequivocal views that PC was the manager of the Crisis Team, albeit initially on an 'acting basis', for the latter period of MH's engagement with the service. In addition, the notes of the individual meeting between the RCA panel and PC on 9 July 2007,

³ The Sainsbury Centre for Mental Health

record that he was acting manager of the Crisis Team which role he had held for 14 months, and that PC stepped into DB's role as Team Manager.

PC was asked to attend a second hearing with us and then advised that he had been appointed to the role of manager in 2008, when he and two colleagues were interviewed for the post. He also said *'I am not aware of any formal process to make me the manager of that team I did not go through any formal process to become manager of the Crisis and Home Treatment Team'*.

Commentary: We were unable to understand either this conflict in evidence or the conflict in PC's explanation of the role he held. The Trust was a Partnership Trust, reflecting the importance of and need for integrated working between health and social care services. It is common practice for staff seconded into NHS organisations to hold managerial roles, albeit that the contract of employment is held by the original employer. Even if PC was not, as he stated, the manager but just the clinical lead, he would thereby in the absence of any nominated manager have had responsibilities for such matters as record keeping; adherence to agreed clinical policies and procedures (including patient discharge and handover arrangements), professional practice, record keeping, and statutory training. Notwithstanding, we believed on the basis of the evidence of other staff that PC was the designated manager, albeit on an acting basis, for the latter period of MH's engagement with the Crisis Team and at the time that MH was transferred back to the care of the CMHT in January 2007.

The issue of PC's delivery in practice of his responsibilities in either the managerial role or the clinical leadership role is addressed in more detail in later paragraphs in this chapter.

The Crisis Team's Role and Purpose

We were presented with conflicting evidence about the approach, value and philosophy of the Crisis Team in its early stages and at the time of MH's engagement with the service, and it appeared that this was due as much to the speed and process of implementation of the service as to its modus operandi, in practice. Staff variously described the Crisis Team and interactions with its members as *'An elite, an elite band working within our teams and I believe that was encouraged.....I think that back then there was a feeling that the Crisis Team re-assessed, so if we (Windswept) assessed that someone was not well enough, they would say that' "Well, we will assess and see if they need an acute bed". It was always a secondary assessment.'*

'One day you can have a really good experience with the Crisis Team and you think that has worked really well and then another day your calls might not get returned or you have been chasing round the country looking for information on a patient when it turns out they have all the information sat on the desk and they have not let you know. It's really patchy.'

'It was a newly formed team ... and as there was no consultant before I went there the team was pretty autonomous. I am a clinician; I do have some say in the management. Although it is a multi-disciplinary team, I value everyone's opinion and give everyone space but I do carry some weight as well. To achieve this takes time because they were quite dominant people there ... at that stage it was very much a manager led team.....(The) Prime driver is to reduce the bed numbers, close the beds, one ward, close the ward...'

'One has to make sure that those (Crisis) teams are adequately resourced and adequately run to be able to take that extra pressure and I think that sometimes there is a temptation to close beds and immediately when you set up something like a Crisis team. Sometimes not as adequately resourced as it might be, to think that the new source can take the slack immediately, and I think there is a temptation to do that'

'....the sense about the Crisis Team in Swindon when it was set up, it was set up very speedily and it has had a fairly bullish 'gung ho' attitudeIt has left a legacy and it is a very difficult one.... They moved from being everything to everybody to being a gatekeeper of beds.'

'I would say (when told that the Crisis Team itself had to re-assess a patient) "With respect I have known this person for a long time. I have been qualified for a long time and I have kept up my training. You are not qualified and you have been in the job for five minutes, I think I would probably know better". But you still would not be listened to sometimes.'

The Crisis Team and MH

Witnesses extended these comments with particular reference to MH: *'I think their success rate was not great and patients were being discharged back to the Community teams in a state they should not have been really on more than one occasion.... (MH) was not a success (for the Crisis Team).'*

RG advised us *'I think PC and I probably argued more about MH than anyone else. I just could not get through to PC that this man was very poorly.... I found that the Crisis Team over MH were being very judgmental... I listened to all those people (AG, SG, Dr PS, MH's mother) and all those people were telling me that here is a young man who is not very well and that he is frightening his mother, he is turning up at his mum's demanding things and then there was the Crisis Team telling me he is a naughty boy, that he was not unwell – this is all behavioural stuff, he is not getting his own way and he is stomping his feet. I said to PC on one occasion, "This does not ring true, that what everybody else is saying is that this man is psychotic and he needs to be treated..." '...not just PC. It was actually several members of the Crisis Team that we just could not convince that there was a problem with this young man he was becoming more and more non compliant; he was being absent from Windswept. Windswept was saying that they could not contain this young man and that he needed at least to be seen..... people were saying that this lad was unwell and we could not get some of the Crisis Team members to see that....on one occasion, he was described to me as being a naughty boy and that I just felt was so judgmental anyway, but it was totally wrong as well.'*

'I felt that we should have been listening to MH's mother, who was saying that this lad is in crisis and things are escalating and I do not think we took enough notice of that.'

'I was consistently being told that (MH) was unwell and that he was increasing the use of drugs and alcohol and threatening his Mum and shouting and screaming and then be perfectly OK when he saw the Crisis Team for that two minutes. Anyone can actually be OK for two minutes, you have to dig and delve into these things.'

'I thought that reading all of the notes that it was quite obvious that MH had a lot of the negative signs of schizophrenia. I thought that was clear. But somebody said to me that, "Well, he is behaving like a naughty little boy".

'... the fact is that MH had come into the domain of what we call a malignant alienation with the Crisis Team. He was a difficult and complex case, leading to frustrations but then again I think that is part of our responsibility the Crisis Team had actually been attributing his behaviour more to drug use and what they call personality problems ... I think that gives some teams or people justification at times to not provide the type of care they are expected to, so there was that element there..'

And in respect of a question whether the Crisis Team would make their own assessment of the users of mental health based on their contact and would not always take into account the information from the community staff or from family and carers *'I think it was true of MH, yes, and it was true of other people as well and if somebody does not perform in the right way during a contact then the contact would be taken as the reality of how it is and any other things as it is not really.'*

Commentary: This would seem to align with both the reported view of the Crisis Team that MH was just a 'Naughty boy'; and with evidence from his mother and sister, his carers and those best able to report on MH's behaviour and deterioration, that MH could 'hold it together' when it suited him. It appears that the Crisis Team chose not to accept the advice and views of MH's family and other professionals engaged in his care and treatment but to continue to view him through the perspective of 'Naughty boy'. If this was a genuine view, then we question why the Crisis Team did not make this explicit and discharge MH back to the CMHT much earlier.

In respect of the proposal that MH should be given Clozapine as opposed to Olanzapine, RG told us *'I spoke to Dr PS And he said that, if you can arrange a bed for MH to go in, then so be it and he would agree that. I spoke to PC and the response was, "Not a chance" The consultants would unfortunately have no say in that matter. It was the Crisis Team's decision and the Crisis Team consultant to decide whether a person would go into hospital or not I believe (that not getting him into hospital to change medication over to Clozarel – another name for Clozapine) was a major miss I thought that was something that could maybe have helped this lad an awful lot. I think that this is a major missed opportunity.'*

Note: PC subsequently advised us that he would not have used the phrase, 'Not a chance'

Commentary: We were of the view that the witness involved was being truthful in this matter but were concerned that there was no record of this discussion; or of any subsequent discussion between PC and Dr MS, Crisis Team Consultant. It would appear that, if the matter was raised with PC as reported, he chose to make a decision without taking account of the views of the Crisis Team Consultant, the CMHT Consultant and a senior nursing member of the latter team. We are of the view that this was a key missed opportunity in the care and treatment of MH and that the appropriate action would have been for PC to ensure that Dr MS was aware of RG's and Dr PS's views and to convene a joint discussion to agree what action should have been taken. We do not believe that PC had the right to make such a decision without the agreement of at least the Crisis Team Consultant. Although the RCA interview notes indicated that PC had reported this to his manager, PC had made no record thereof.

Recommendations 26: All discussions concerning a patient must be recorded in notes in accordance with AWPT policy.

Recommendation 27: Key decisions relating to patients, including discharge, must involve discussion with the consultant(s) involved.

In response to the question as to whether there was a lot of missed opportunities as far as MH was concerned, RG told us *'Yes.....The Crisis Team are the Crisis and Home Treatment Team. There is no treatment in dropping pills through the letter box and we often said that there was no home treatment being performed anyway, it was a pill dropping service. Even our (CMHT) patients were reporting and they were saying that, "Well, they came in, put the tablet on my tongue and left as soon as it dissolved". That type of thing has been reported on numerous occasions from our patients.'*

In response to the question, *'Do you think that there are specific (Crisis Team) individuals who blocked MH's access?'* We were told *'Without a doubt... AS, PC, KH, some of the unqualified staff probably at the time..... quite a few of them ...have worked in the CMHTs and they know exactly what problems we are dealing with and as soon as they go to the Crisis Team, they are this elite group that can say, "No, not a chance, we are not going to see them, they have been drinking" Or "No, they are not coming into hospital because they have a personality disorder and we cannot offer them anything" and that is what you get from people who have actually worked in the CMHT, for years in some cases.'*

In respect of MH's alcohol and drugs use (Dual diagnosis) *'.. that has actually been a problem with the Crisis Team that, if anybody is drinking or anybody has been taking drugs, they very often refuse to do an assessment - but I believe that they are beginning to change now.'*

The Opinions of Other Colleagues

There were concerns about the Crisis Team's failure to take on board the views of other knowledgeable and senior clinicians in making decisions whether or not to admit patients to hospital. It appears that there was some misunderstanding of the

Team's processes and practice, arising from their overall approach. DB explained to us that *'Consultants used to think – or did think – that they had an allocation of beds and that was their beds and they could use them. And along came the advent of Crisis Teams, who suddenly had a remit of saying, "Well, actually, no you cannot admit, we have to check them out first and that is part of our gatekeeping function" That was what was quite controversial and a lot of staff found that every difficult to accept in the early stages.....it was particularly difficult for some psychiatrists to take that on board. They were losing some of their power base, for want of a better phrase, to the Crisis Team and, indeed, me heading that service losing some of the power base to me.....With any service, with any model, with any business, to be successful sometimes you have to assert yourself and the Crisis Team, in order to maintain the fidelity of the model at the time, had to challenge practice, at times had to be assertive to clinicians. It was difficult not to avoid being that way, particularly with some of the complex, contentious and difficult cases.....'*

In response to a question whether patient need became subordinate to the need to reduce admissions to beds, DB said *'I would refute that the need of the service user, the need of the client is paramount over and above any requirement of the service and we were trying to introduce this model. It was unpopular and on occasions we had to assert ourselves I think it took a good nine months, maybe almost a year, for services to start accepting the Crisis Team was here.*

In terms of the system of gatekeeping beds, DB said *'I do not believe that it had any compromise in patient care. I believe that the Crisis Team enhanced the care to the patient...'*

With regard to the principles of communication between the Crisis Team and other services, DB told us that he believed that these were set down in the operational policies and procedures. Review of these documents indicates that both the draft (9 December 2003) and the final (20 February 2007) Operational Policy documents state in this respect: *'Communication The Crisis Service communicates regularly with service users and care co-ordinators or referrers throughout their involvement.'*

Other parts of this section in the draft policy were not provided to us but the final version, agreed just under two weeks prior to the homicide (and some three and a half years after establishment of the Crisis Team) states also *'Urgent information regarding risk and/or dangerousness will be communicated immediately to care co-ordinators and any other agencies where this is indicated. It is the responsibility of the care co-ordinator to communicate with other involved agencies not known to the Crisis Team. The Crisis Team requires that all risk information is passed on to them as part of the referral and communication process'*.

Commentary: We noted with concern that there was no mention of carers in this key section of the Operational policy.

Recommendation 28: The Trust should review all Operational Policies on a regular basis to ensure that they are up to date and fit for purpose.

Commentary: We noted also that the threat made by MH to kill two members of the Crisis Team was not passed on within the Crisis Team or to other teams or to MH's Care Co-ordinator.

However, the service aims and objectives set out in the same document include *'Ensure a collaborative approach, which considers the contributions, needs and health and safety of service users, relatives, carers, general public and staff.'*

It is clear that these stated responsibilities for communication and collaboration were not met in MH's case and specific failures are set out in the relevant sections of this report.

The Concerns of Carers

In response to information that MH's mother felt that she was constantly dismissed by the Crisis Team, and they did not listen to her or her concerns, DB said *'Well, it is regrettable that JM feels that..... the views of carers are paramount'*.

This contrasts with the evidence of PC to the effect that *'I would say that looking back on it now that we certainly failed JM in terms of what she needed as a carer and as a vulnerable person'*, and in response to a question as to whether JM's criticisms of the CT were fair that *'Yes, probably. It's a difficult one, but yes.'*

In her evidence SG said *'Also because of the lack in confidence that JM (MH's mother) had in the Crisis Team I found it quite difficult, because obviously it is extremely important for carers and family for their opinions and sort of issues to be taken on board. I felt that this was sometimes not the case..... I do not think that they always – or if ever – took on board JM's concerns or some of the frustrations that I felt..... I just felt that JM many times in our conversations would say that they do not seem to listen to what I am saying, they do not take me seriously if somebody is not complying with their medication and will not engage they (Crisis Team) will hand them back sometimes to the CMHT.'*

Commentary: This is further evidence of a failure to adhere to NICE recommendations for the care of individuals with schizophrenia (Set out in detail in Chapter 4).

DB also advised us that *'There were a number of key functions that a Crisis Team needed to deliver on. Gatekeeping is just one of those functions. So it is not the raison d'être of a Crisis Service. The main focus is on being an alternative to hospital...'*

This accords with Department of Health guidance, but PC expressed a very different view of the situation *'I guess the aim was to reduce beds, so the more beds they reduced, then the more the Crisis Team was seen as a success in the eyes of the Trust or the managers involved at the time. Obviously, we went too far and we reduced it down to the fact that we have not enough beds now in Swindon and we have had to change the ethos of the team and the team has turned around now to a*

different way, a more person centred approach to the way we manage in-patient beds...

...I just think that probably the (Crisis) Team to a degree was in a bit of chaos really. ... the sort of unofficial ethos of the team was that there was a high level of bravado, a high level of sort of the team being maybe better than other teams. In terms of managing its risk it was slightly chaotic in terms of any formulation ... so there was a sort of ad hoc super hero kind of feel to it.... What we were lacking was that clear formulation, a clear idea of what we were doing and why we were doing it...

....the team as an ethos was one of really trying to stop people coming into hospital. If you keep focusing on that, it tends to have this major distraction to anything else you are meant to be doing when gatekeeping, when keeping people out of hospital is your number one criterion, then everything else slightly falls to one side...

....I think there was a lack of direction really from a management point of view about being clear on other things beside gatekeeping and that would look at, you know, the way we operate as a professional team.....the culture within the Crisis Team .. was that of gatekeeping as being the most important role so, therefore, keeping people out of hospital sidelined lots of other outcomes for people, which obviously clearly are available at any particular time.....When you make that kind of service level decision (ie. a blanket approach to admissions) then what you do is you put that ahead of any individualised care plan.'

PC said of the previous approach '*I guess the compromise was at the time that there were people who actually benefit from coming into hospital, maybe for a short period of a week or two weeks, and as part of a care plan that would be seen as beneficial. They maybe would have lost out because everyone had pretty much a blanket approach.'*

Commentary: This final point seemed to us to be in stark contrast to PC's own actions at the time of MH's hand back to the CMHT, which is addressed later in this Report.

PC also told us '*The staff (of the CT) were surviving without the clear policies and processes that keep them on the straight and narrow.....If, in my opinion, it was about providing comprehensive and holistic treatment to service users and carers in Swindon, I don't think it was fit for purpose.'*

Commentary: On the basis of the weight of evidence, we were satisfied that PC was the Manager of the Crisis Team. If this was his opinion, he should have escalated his concerns to a higher level of management.

Recommendation 29: The Trust should promulgate and facilitate the escalation by staff of genuine concerns and respond appropriately.

Competence of Crisis Team Members

We found considerable evidence that individual members of the Crisis Team failed to adhere to Trust policies and procedures, with particular reference to the quality and

comprehensiveness of information recorded by them; effective communication of information to others; inadequate or non-existent monitoring of MH's mental state; adherence to medication administration policy requirements; and follow up on agreed actions.

Commentary: Our view is that, whilst staff registered with professional bodies had obligations and accountabilities in respect of that registration, overall the operational staff in the Crisis Team were lacking the quality of leadership, which should have been provided sequentially by DB and PC. These issues are addressed in fuller detail later in this Report but, in this Chapter, we consider in particular the actions and involvement of Dr MS who also had leadership responsibilities as the consultant aligned to the Crisis Team.

A continuous theme heard from outside the Crisis Team was that untrained members of staff were taking decisions as to whether a patient should be admitted, thereby overriding the views of trained, and, in some cases, very senior, clinicians in other teams. However, contrary evidence was that the assessment and decisions were made by experienced and registered nursing staff in the Crisis Team but that, on occasions, they delegated the communication of the decision to non registered staff, who failed to make clear that the decision had been made at an appropriate level. We were told *'We would always be assessing a patient with a qualified person as the first on call..... I would not be expecting an unqualified nurse to be saying, "No."*

In complete contrast, PC told us, *'.. there was a culture within the team and one of the cultures was that you would have a bizarre scenario where a Band 3 support worker would tell a clinical nurse, a Band 6 nurse in the CMHT that "No, that person couldn't come into hospital". That was how the team was raised to have that kind of independent capacity without probably the clinical skills'*.

Another member of the Team told us in respect of whether assessments were refused by support workers in the Crisis Team *'It does happen, yes. Less qualified and you may get a qualified person (in another team) making a decision thinking they should be in hospital. I know it was happening with MH'*.

The Crisis Team final Operational Policy, February 2007, states unequivocally that *'The Service encourages individuals and carers to be actively involved in their plan of care.....Using a multidisciplinary team approach, the Service will provide each individual with a comprehensive needs/risk assessment to enable delivery of appropriate care that meets their physical, psychological, social, cultural and spiritual needs as far as possible and safely within their home environment.....The service user satisfaction questionnaire will be issued to each person coming into contact with the Service, once the initial feedback is obtained and modifications are made, as required.'*

In respect of the *'suggested information'* to be gathered by a referrer prior to contacting the Crisis Service it states *'Drug/alcohol use ... Levels of current use of drugs/alcohol may indicate underlying mental health problems.'*

In relation to the Crisis Team's responsibilities in respect of discharge planning it states '*Crisis Team practitioners identify the factors that resulted in hospitalisation of the service user, and through a collaborative process with the service user, carers, Care Co-ordinator, RMO and ward team develop a plan for early discharge. The plan identifies & clarifies the role of each key clinician.*

Whilst the service user is an in-patient, the responsibility for implementing the early discharge plan rests with the in-patient team. When the service user is discharged the responsibility is transferred to the Crisis Service'.

Commentary: Our understanding of the reference to a service user satisfaction survey is that, almost three years after being set up, the Crisis Team was only then proposing to consult on a service user satisfaction questionnaire. Clearly, if this questionnaire had been introduced earlier on in the service's history, it might then have impacted on decisions made in respect of MH's care and treatment.

The Crisis Team Operational Policy makes clear that use of drugs and alcohol is a factor for inclusion in any referral, which is in stark contrast with the reported practice of the Crisis Team choosing not to see patients with current substance misuse issues (Dual Diagnosis patients). In addition, the reference in its guidance on referral to the fact that levels of current use of drugs/alcohol might indicate underlying mental health problems should have alerted the Crisis Team to this possibility, particularly in the context of feedback from MH's mother and professionally qualified staff in other teams that challenged their view of his being a 'naughty boy'

It appears that the pressure to deliver on the reduction of admissions and thereby on the reduction of the number of in-patient beds led to an attitude and philosophy which alienated other staff of the Trust. There was sufficient evidence to indicate that the Trust's senior managers were aware of the tensions but took no action to address them. Issues concerning the Crisis Team appeared to arise from the implementation process and the unchecked approach taken by some of its members, rather than its intended role and efficacy therein. The effectiveness of the Crisis Team in achieving a reduction in bed numbers, whether or not as an intended outcome, appears to have overridden the consequential damage being done in other aspects of the Trust's services. Our view was that the team had lost its intended focus on 'alternatives to admission' to avoidance of admission in as many cases as possible. The Crisis Team's role is about appropriate responses to acute mental health problems, signposting to the most appropriate service, not the reduction in use of in-patient beds, albeit the latter may be a consequence.

Consideration of the evidence presented to us led us to conclude that there were significant failings in the care provided to MH by the Swindon Crisis Team. There were individuals within that team who were found to have acted in accordance with good practice and, where appropriate, with the Codes of Conduct aligned to their professional clinical registration. This included staff, who raised concerns about the failure to address the increasing levels of deterioration in MH's mental health. Overall, however, the extent of MH's

engagement with the Crisis Team appears to have been one of the most significant aspects of missed opportunity; that is, a circumstance where alternative actions would have led to a Mental Health Act Assessment, which might have resulted in a different approach to his case and thereby avoided the homicide.

The Crisis Team's approach to MH's treatment seemed to relate primarily to the delivery of medication (often by posting through the letter box); or the alternative administration of medication by injection; and brief observations of his mental state. In respect of the latter, his mother and his sister gave evidence to the effect that these observations were fairly perfunctory and allowed MH to 'hold it together' for the short period of any visit. Crisis Team notes and the evidence of MH's mother and sister indicate that there was no significant attempt by Crisis Team staff to test their concerns about MH's mental state or to explore deeper than the superficial presentation that MH was able to maintain for short periods of engagement with them.

Commentary: We consider that the practice of delivering medicine to MH through the letter box of the flat of (G/F), herself a user of the mental services and reported to us as being in a fragile state of mental health, was not an appropriate discharge of the Crisis Team function. We noted from the clinical records and from the evidence of the RCA panel, including minutes of a meeting on 25 July 2007, that the Crisis Team had allowed some 20 (or 28) envelopes of medication for MH to accumulate at the flat of his then partner. Whilst this is dealt with in more detail in Chapter 1 of this report, it raises three serious concerns:-

First, that medication for one patient was being delivered to the premises of another patient, with her own serious mental health problems.

Second, that the routine delivery of medication (through the letter box rather than in person) did not accord with the concept of crisis home treatment.

Third, that this was a young man with a history of non-compliance with medication and one, who had previously made a very serious suicide attempt using hoarded medication.

In addition, we were concerned that no positive action was taken when the situation was discovered. We sought to establish whether the matter was reported to the manager of the Crisis Team, PC, but there is no record thereof and no new care plan to reflect the situation. We noted also that the discovery of the envelopes was by SG and DW who then handed them to AB, Senior Nurse Practitioner. We had no evidence that AB escalated this matter. We found no evidence that the discovery of the medication was recorded in the Crisis Team notes and there was no record of any formal action taken as a consequence, in relation either to MH's own situation or to procedure within the Crisis Team. There was also no entry in the drug chart to indicate the retrieval of untaken medicine.

We received no evidence to indicate that regular formal assessment of MH's mental state by Crisis Team staff was undertaken or recorded. At best, the notes contain brief 'observations' rather than evidence that a structured process of Mental State Examination was undertaken. Apart from the initial assessment by DB in 2004, the only evidence available to us was of passive observation only, rather than formal assessments or interrogation of his mental state.

Witnesses described the modus operandi of the Crisis Team in general as '... part of the analysis was that the CT were getting a phenomenal amount of hours a week, like 80 or 90 hours a week just chatting to people, offering support and of course they are not seeing people in crisis when they do that.'

In terms of the system applying at time of contact of MH 'No risk screen or assessment. If it was provided, fine, maybe we will ask them but if not given, no problem, go and see the person... We were advised to read on a patient before going out on visits, so that was always said to us, do read on patients before I always read the last entry made.....'

... you get clips from different people, from shift to shift, but if that person has not seen them in that shift, obviously that will not be followed up, so there was not a clear chain of that information being held and word of mouth is not good enough, it needs to be documented, hence this weekly review is a point that everybody goes back to. We did not have that back then.'

MH's Discharge from the Crisis Team to the CMHT, January 2007

RK advised us (in respect of this discharge) that 'I was actually taking it back to PC and leaving that decision with him, because obviously I was in a situation there where I had to take on board what SG was saying and the concerns raised but being at the level I am, I cannot say, "Actually, SG, for these reasons this is why we want to hand back the care"... being put in that position, I would have to take it to the next level, which would have been PCI did not hand MH's care back to SG that day because like I say..... I was not qualified to make that decision. I was not qualified to have that resting on my shoulders. It needed to be someone above me and I did take that back to PC and said I did not do the hand back , these are my reasons, I presume the reasons I listed in my own documentation, it is back to you I do not know PC's reasoning behind the hand back and what reasons they were.....'

Looking at the cold hard facts right here now, I would say that where we were that day, hospital admission would have been a good thing for MH because at least then there would have been no hit and miss trying to find him and he did need to be medicated. I understand that the Manager of the Crisis Team said, "Just discharge him and the CMHT will have to deal with it".'

Dr MS advised us that 'It was discussed between the two managers.... RG and PC. As a Crisis Team, we are failing to treat him in the community and there is no point visiting twice a day. We are not making any headway and that was the reason I was told. I can remember these things. It is not documented. The team mentioned to PC

about it, he was the manager at the time, to hand it back to RG and there were some arguments about that as well but then he was handed back (My involvement in that decision was) None. Nil.'

In response to a question as to whether she felt that admission would have been most appropriate at this stage, she said *'Yes, I still believe that. I do not mean just an informal admission and I do not mean just a Section 2 admission.'*

Dr PS confirmed that, on 9 January 2007, he had advised SG that he felt that a further admission might be beneficial in order to change and stabilise MH's mental state and that he had tasked SG with discussing this with PC and that PC could ring Dr PS if he disagreed with that suggestion. PC did not ring him. Dr PS said in respect of SG's advising him that the Crisis Team had insisted on handing MH back to the CMHT despite her expressing her concerns *'... because I (Dr PS) expressed my own concerns about this – so one of the Crisis Team members had said that they would arrange for there to be a ring back to have a dialogue about whether he should be transferred or not. This did not happen.'*

The status of the Trust policy, *'ICPA and the Assessment and Management of Risk'*, which was provided to us, was unclear in that it was annotated that it had been reviewed in October 2006, with a further review date of May 2007. We have assumed that any changes made in October 2006 were immediately communicated to staff and, thereby, were in place at the time of MH's final discharge to the CMHT. The policy includes reference to the process for settling disagreements including those relating to the transfer of patients between teams. It states:- *'In such circumstances, there is a potential for the service user to fall between services, leaving them unsupported and at risk. Where these situations occur, it is the responsibility of the care co-ordinator to arrange an ICPA meeting to resolve the dispute and agree key actions to ensure that the service maintains its duty of care to the service user. It is the responsibility of the care co-ordinator's team manager to ensure the care co-ordinator is supported and that the dispute is resolved.'*

Commentary: Whilst we have concerns about the actions of those involved in this critical stage in MH's care and treatment, we also recognise the wider circumstances pertaining. It was not clear whether the discovery on 3 January 2007 of significant amounts of untaken medication prescribed to MH for administration by the Crisis Team precipitated the unexpected decision by PC to discharge MH back to the CMHT, a decision on which Dr MS (then RMO) was apparently not consulted and in which she apparently did not intervene. We accept that the appropriate referral by PC to the AORT was unlikely to succeed as that team was not accepting new patients because they felt that depletion of their staffing resources by the non authorisation to fill vacant posts made this unsafe. Notwithstanding, there is no evidence that PC tried to secure a meeting with AD, Team Leader of the AORT, to see whether scope existed for them to take on MH's care and treatment. Nor that he discussed the matter with Dr MS to obtain her support for the pressing situation. SG, as care co-ordinator, made clear at this stage her concerns about the lack of resources in the CMHT to manage MH's care and treatment effectively and did arrange an ICPA meeting with Dr PS on 30 January 2007. During this period, her line manager, RG, was reported to be trying to negotiate with PC on the basis of

his own and SG's concerns but records of these discussions were not kept. We heard no evidence that PC, RG, Dr MS or Dr PS sought to escalate this matter to a higher level for resolution. Equally, although Dr PS confirmed that he had advised SG on 9 January 2007 that he felt a further admission for MH might be beneficial, he told us that PC did not ring him back on this although a member of the Crisis Team had said that this would happen. Dr PS did not pursue the matter direct with PC. At this stage, Drs PS and MS indicated individual opinions that admission would have been appropriate but they did not meet to discuss the case or to exercise their rights to call for a Mental Health Act assessment. SG appeared to have exhausted avenues open to her and PC was not able to effect a referral to the AORT, which would have been 'the most appropriate service' (as stated in the Department of Health guidelines on the Crisis Team role) available. We accept that at this stage in MH's illness, none of the Crisis Team, the CMHT or the Early Intervention Service was able to provide an appropriate service to meet MH's needs. We believe that the managers and clinicians involved felt unable to resolve the situation in the absence of involvement of more senior staff, whom we know to have been aware at a minimum of the AORT position and whom we believed to be aware of the issues of staffing levels, high and excessive caseloads and tensions between the Crisis Team and the CMHT. Within the organisation was the knowledge also that neither Dr MS nor SG had received appropriate training to take on their respective roles of Consultant Psychiatrist to the Crisis Team and CPN Care Co-ordinator, albeit senior managers may not have known the detail of MH's position. We consider that senior managers of the Trust were in a position to achieve resolution to these issues but did not do so. In our view and in the words of the Trust's own policy, MH fell between services, with four teams unable to meet his needs for very different reasons and unable to resolve the dilemma they found themselves in.

When asked whether it was commonplace that the Crisis Team would return a patient to the Community Team without the consent of the senior clinician in the team Dr PS said *'Yes, I think it was ... I think it was a very common practice and still exists to an extent.....I felt like a peripheral person when he (MH) was with the Crisis Team. It is only when he engaged with the East Community Mental Health Team that one had a sense of ownership and control.'*

The RCA panel was clear that the Crisis Team had definitely handed MH back to the CMHT without any kind of CPA meeting or record. There was no recorded consultation between Drs PS and MS and no care plan was formulated by either the Crisis Team or the CMHT on discharge.

Commentary: The discussions between RG and PC at this stage should have been recorded in the Crisis Team notes by PC, as MH was at that point under care of that team. The evidence presented to us was that the discussions, and subsequent decision by PC to return MH to the CMHT, were undertaken without benefit of the presence or advice of Drs MS and PS, who both believed that admission to hospital was the proper course, or SG, who had her own concerns, supported by those of MH's mother, as to MH's deteriorating condition at that time. PC did not complete, or ensure completion of a discharge plan for MH, in accordance with standard procedure.

It concerned us also that Dr MS did not pursue her concerns with either or both of PC and Dr PS; that Dr PS did not raise his concerns with PC when the latter failed to telephone him; and that Dr PS did not exercise his own powers to arrange an admission for MH once he returned to the care of the CMHT on 11 January 2007. It appears that there was a tacit acceptance that the Crisis Team could make decisions which, at best, ignored the valid views of other clinicians and, at worst, overrode those views. We endorse the description by the previous Medical Director of the Trust that handover by the Crisis Team was '*poor practice*'.

Recommendation 30: The Trust should ensure that Team leaders understand and fully apply their responsibilities as managers and, where appropriate, as senior clinicians and are able to demonstrate competence, integrity and leadership.

Commentary: We identified as a matter of major concern that, once the decision had been taken to establish the new Crisis Team and the manager of the new service had been appointed, there appeared to be an absence of more senior management overview. It was our view that the Crisis Team was not acting in accordance with the ethos and requirements set out by the Department of Health but there appeared to be no monitoring of, or check on, the approach taken by the Crisis Team. Although individual clinicians involved in MH's care had duties and obligations to him in accordance with their own professional registration requirements, it is possible to see how the apparent condoning of the Crisis Team's approach by senior managers may have affected detrimentally the thinking and actions of staff at clinical operational level. We heard evidence from a number of operational staff to the effect that concerns they raised were not addressed and, in some cases, not referred upwards to the appropriate level of management. Such concerns, identified later in this chapter and in chapter 9, included a letter from the AORT about staffing levels; an analysis of the risks in disbandment of the Forensic Service; concerns about access to mandatory training; and feelings of not being listened to or properly involved in change processes.

Recommendation 31: The Trust Board should establish a process whereby it is appraised of and responds to the concerns of operational staff.

Commentary: We noted that PC had discussed the hand back with his manager, albeit there was no written record of this crucial discussion, but that neither had escalated the matter in the context of AORT's inability to take on MH's care.

Role and Actions of Crisis Team Consultant Psychiatrist

Dr MS is a Consultant General Adult Psychiatrist. Her first contact with MH was on 23 May 2006, as Consultant within the Crisis Team. On each occasion she undertook a face to face consultation with MH, Dr MS wrote a letter to Dr B, MH's General Practitioner (GP), summarising her observations and recommendations. In the main, these recommendations deal with the issue of medication. The management plans noted by Dr MS include communication of this information to the

members of the wider multi disciplinary team including both the Crisis Team and the CMHT. She sent letters to Dr B, MH's GP on:- 23 May 2006, 8 June 2006, 26 July 2006, 16 November 2006 and 17 November 2006.

In the letter of 26 July, she stated under the heading, '*Areas of Concern If his (MH's) mental state deteriorates any further due to non compliance with management plan described above and he begins to act out on his delusional beliefs, he will definitely require an urgent mental health assessment with a view to admission to Sandalwood Court.*' Copies of these were on file in the medical records for MH.

The Use of the Mental Health Act

The second doctor involved in the July assessment was Dr P and the Social Worker was JD. Dr MS made the detention in relation to all 3 categories of risk: in the interests of the patient's own health, in the interests of the patient's own safety and with a view to the protection of others.

She recorded that informal admission was not appropriate for the following reasons '*Patient is suffering from psychotic illness experiencing auditory hallucinations of 3rd person, incongruous affect and troubled by intrusive thoughts. Said he is feeling depressed and there is recent history of self-harm through overdose. He has no insight into his condition. So far he has not complied with treatment in the community and is refusing admission on an informal status.*'

No further details of the mental state finding on this assessment were provided by Dr MS who advised '*I did not do it because he was going into hospital. Normally when I do any form of Mental Health Act assessment, even 136, I write it in detail and dictate as well, but here because he was going to be admitted I might of taken a shorter cut.*'

Dr MS gave a clear exposition of her decision to admit MH under Section 2 and clearly expressed the view that, in her opinion, it would be 'extended' to a Section 3, based on her knowledge of MH and the difficulties of managing his care in the community. Although Dr MS advised that she held this clinical opinion, there was no record of any communication of this view point to the in-patient Consultant, Dr PS, which could have informed his decision making when a Section 3 was subsequently considered for MH.

Commentary: This omission on Dr MS' part, contributed to the missed opportunity of a more sustained period of in-patient treatment for MH at this critical point in his illness.

Ongoing Medical Review

Dr MS saw MH on two further occasions, on 10 and 13 November 2006 and recorded significant disturbance in his mental state '*I reviewed his mental state at Sandalwood Court on 10 November 2006. At the time of the interview he was rather unkempt and remained very agitated. He was giggling inappropriately said he was feeling very happy. Though on direct questioning I was unable to elicit any overt*

psychotic symptoms but his affect was incongruous and he had no insight into his condition. His mood was mildly elated but there was no change in his sleep pattern or appetite. He has no real structure to his day. Speech was normal in rate and form and thinking was clear.'

In her evidence, Dr MS responded to the question, "Your view with that knowledge was what?" with the answer 'Again, admit under Section 3.'

In respect of the later (January 2007) hand back of MH's care from the Crisis Team to the CMHT Dr MS said, '*And rightly so, because by this time just seeing the patient twice a day, not making headways in the management, proper management of the patient, how long can you go on doing it? There are the notes here as well. It was discussed between the two managers. RG was the manager there, PC was the manager and they both discussed it. As a Crisis Team, we are failing to treat him in the community and there is no point visiting twice a day, we are not making any headways and that was the reason I was told. I can remember these things. It is not documented. The team mentioned to PC about it, he was the manager at the time, to hand it back to RG and there were some arguments about that as well, but then he was handed back.'* In respect of her involvement in that decision making, she answered, '*None. Nil.'*

Dr MS did not contribute to the Mental Health Act assessment, which was undertaken by Dr PS on 22 November 2006 but it is recorded by JD (ASW) that she had a conversation with Dr MS.

Commentary: We were unable to determine the extent to which Dr PS was aware of Dr MS's specific concerns and views.

In the event, MH was not sectioned on that occasion (22 November 2006) but was admitted to Green Lane Hospital as an informal patient and Dr MS had no communication from Dr DS, the Consultant in charge at the hospital. However, Dr DS did record in the hospital notes that he had contacted the Crisis Team on 30 November 2006.

Commentary: No evidence was received to indicate that the details of this contact had been passed on to Dr MS. It was clear to us that there was a lack of communication between the three consultants, who played a role in MH's management at this critical period. Dr MS's knowledge and formulation of MH were apparently not made known to her colleagues, who were not able to take this important longitudinal information into account when they made an assessment of MH and determined the appropriate steps to be taken with regard to the Mental Health Act Assessment on 22 November 2006. This is of concern given the strength with which Dr MS articulated the view in July, August and November that MH should have been treated in hospital for an extended period under Section 3 of the Mental Health Act. It is of further concern, in the same context and in the light of production of new Care Plan on 14 November 2006, in which Dr MS was involved, that her last entry in MH's clinical records is dated 13 November 2006. We concluded that Dr MS did not see MH after that date, despite his reported deteriorating condition, and that she took no part in the decision to hand back MH's care from the Crisis Team

to the CMHT. Nor was there any evidence to the effect that she delivered actions agreed by her at the Care Plan meeting on 14 November 2006, relating to medication review and Mental State Examination.

Knowledge of Risk

Dr MS said that she had no knowledge of the disclosures made by MH to AG, Psychologist with the Early Intervention Team, with regard to threats to others and the specific information regarding MH's disclosures of wanting to 'kill CJ'. However, this information was not recorded in Crisis Team notes. Although these ideas had apparently receded when MH's mental state improved with initial treatment, it is very relevant that, at the time his mental state was deteriorating during November and December 2006, Dr MS was unaware of this past information, which was known to AG. Similarly it is of significant concern that Dr MS, as the Consultant within the Crisis Team had not been made aware by PC of the threats made by MH to members of that team.

Commentary: The medication recommendations recorded by Dr MS fall within acceptable treatment interventions for schizophrenia. Moreover, she took account of MH's poor compliance in terms of the switch from oral medication to depot medication. Because of MH's poor compliance with oral antipsychotic medication and his inconsistent compliance with depot antipsychotic medication, Dr MS herself never determined or recorded a formal diagnosis, although three differential diagnoses of 'schizophrenia; Paranoid Schizophrenia; and Schizophrenic disorder. ??schizoaffective disorder' were made. Because she failed to make herself aware by reference to the clinical notes, she was not, therefore, in a position to make the determination that MH potentially fell within the definition of having treatment resistant schizophrenia. Thus, consideration of Clozapine was not considered to be appropriate. We noted that there has been some positive response by MH to Clozapine prescribed as a form of treatment since the homicide, but we consider that, on the basis of the totality of the information held on MH's notes, it would have been appropriate for Dr MS to consider this alternative medicine during the period when she had consultant responsibility for MH. We consider this to be a missed opportunity and poor practice given Dr MS' concerns.

Dr MS' Involvement in the Crisis Team

Dr MS is a consultant with substantial experience of working within the NHS. Prior to joining the Crisis Team in March 2005, replacing a locum consultant, she was aligned to Swindon North CMHT. It is of concern that Dr MS had little experience or knowledge of the consultant role within a Crisis Team, when she took up this post. In her verbal evidence she stated in respect of the training the Trust provided for her so that she could understand the role '*Nil, nothing. I attended like national seminars and talked to people there about how they are working. It was just basically one or two seminars in London and speaking to colleagues all over the country on how they were functioning.*'

Dr MS explained that this training had been undertaken on her own initiative and that she basically worked to the method that she had been working all her life, and that it was helpful, but that no one knew exactly which direction to go and how to work (In a Crisis Service) and that there was no formal training because it was new all over the country.

Commentary: We received no evidence that the important contribution to be made by a consultant in setting up the new service was recognised by the Trust. Dr MS was an experienced consultant but had no real knowledge or experience of how the consultant role should be integrated into the working of a Crisis Team, leading to an absence of this element of clinical leadership. We believe that this was a significant contributor to the difficulties experienced by the Crisis Team and the services it provided during the early part of its existence. We are satisfied that Dr MS did not have the necessary competence or experience to discharge the clinical leadership role in a service new to her and that the Trust did not arrange appropriate training support.

Recommendation 32: When a consultant is appointed as clinical lead of a new service, (s)he should be afforded the appropriate support and training in order to fulfil the required responsibilities. Furthermore, the Trust should ensure that there is an appropriate process in place to ensure the contribution of consultant medical staff in the development and implementation of the new clinical service.

Commentary: Dr MS was clear that she was isolated her from the main team and from much of the team decision making processes. She subsequently advised us that she discussed the difficulties she was having in this relationship but that she had chosen not to take it further as this would have had an even more adverse effect. This appears to have been compounded by evidence reporting a history of failure to provide medical staff in Swindon with appropriate appraisal and supervision and lack of clear pathway for Dr MS to escalate concerns about the Crisis Team, which she had clearly identified, when she was unable to resolve them herself. The leadership role of a consultant is deemed to include the resolution of such problems or their escalation to a higher level where this is not possible.

In addition, we heard differing accounts of the relationship between Drs MS and Dr PS, albeit without specific instances. This may have been purely a reflection of the fact that they were the focal clinical heads of two services, the relationship between which was widely acknowledged to be poor. However, we heard no evidence to indicate that the two consultants took any positive action to attempt to resolve the tension between the two teams or to escalate the matter to a higher level of management.

Assertive Outreach and Recovery Team

As part of the National Service Framework the Swindon Outreach and Recovery Team (AORT) had been set up in September 2001 to deal with people, who were difficult to engage with services.

Assertive Outreach Teams were developed as part of the NHS Plan to provide intensive support for severely mentally ill individuals who are '*difficult to engage*' in more traditional services. Many will often have a forensic history and a dual diagnosis. Care and support are offered in their homes or some other community setting, at times suited to them. Workers can be involved in direct delivery of practical support, care co-ordination and advocacy as well as more traditional therapeutic input. The aim of the service is to maintain contact and increase engagement and compliance.

MH was referred by SG to the AORT on 25 October 2006 but AD, Team Leader, described how at that time the AORT were not taking on new patients for assessment due to poor staffing levels (staff had left and not been replaced) and the AORT Care Co-ordinators did not have capacity to take on new clients. Furthermore, at that time the Team did not have a regular (aligned) consultant psychiatrist and had to rely on numerous agency (locum) consultants who were there for short periods of time. The team considered it unreasonable to carry out further assessments and accept patients onto the caseloads as they would not be able to provide adequate medical cover or Care Co-ordination. All Care Co-ordinators from the CMHTs who had referred clients to the AORT were informed of the position, including MH's Care Co-ordinator, SG.

Commentary: The RCA panel found that the Swindon Service did not actively manage the capacity of the Assertive Outreach Service and that there was no over-arching approach to managing cases across teams in the area to ensure that those with the highest need were in the appropriate part of the service. Department of Health guidance states clearly that a Crisis Resolution/Home Treatment Team should be able to refer individuals with acute mental health problems to the most appropriate service. In normal circumstances, this would have been the AORT but that team was not accepting new referrals. Whilst faced with a difficult decision in January 2007, PC and his manager should not, in our view, have discharged MH to the CMHT without escalating their concerns and arranging a discussion involving senior clinicians in each of the three teams.

An assessment (of MH) was never undertaken by the AORT but, based on the referral and given his relatively short contact with services, there was nothing in the view of the AORT to warrant an urgent assessment at that time and ordinarily he would have been scheduled for a routine assessment. AD (Team Leader AORT) was asked by us '*Hypothetically speaking, if you had had the resources would he (MH) have been someone who would have been suitable for your team?*' She replied '*he would definitely have been assessed by our team without a doubt...I would have thought he is someone we would have tried to work with.*'

In any event the AORT considered that they had a lack of resources. This is set out in a letter dated 15 February 2007 from the AORT written to RT (Line Manager), who is reported to have conveyed it to the then Strategic Business Unit leader (AL). The letter set out concerns regarding arrangements for the provision of medical cover for the Swindon AORT, mentioning particularly that the team had been without a permanent consultant psychiatrist for at least 5 years. The letter stated that for the last 3 years, consultant cover had been provided by consultants from other teams

within Swindon, for 1 -2 sessions per week, with the option of additional contact for advice during the rest of the week. Since autumn 2006, cover had been provided by a series of agency consultant psychiatrists who had stayed for varying lengths of time, ranging from a day to several weeks. The letter set out in detail the concerns of the AORT. We were unable to obtain evidence of any response to this communication but were advised that it had not been considered formally in the context of the Trust's Risk Register.

Although MH was never accepted for assessment by the AORT, the team was aware of him due to his association with (G/F), who was a client of AORT and he was often seen at her accommodation when AORT attended to deliver medication for (G/F). On 3 January 2007 DW (CPN attending on (G/F)) reported to SG that MH had not been taking his medication (it was recorded that 20 or so envelopes containing medication for MH were handed to the Crisis Team). DW was not available to give evidence to the Investigation, having returned to Australia. The Trust was unable to provide a forwarding address although we understand that this information is recorded on the payroll record confirming termination of employment.

The AORT visited (G/F) on 1 and 2 March 2007 when they saw MH. These meetings were only for medication drops for (G/H) and were of short duration (5 - 10 minutes) and AORT had no concerns about MH. On 1 March 2007, MH was reported to be drinking beer at 10.15 a.m. when the AORT called and on 2 March when an AORT member attended (G/F), MH was recorded as having accepted medication for (G/F) who was taking a bath. On neither occasion did MH's presentation give AORT cause for concern.

This was the last known contact that MH had with mental health services prior to the homicide on 4 March. We were informed that members of the AORT had not been given any information about risks identified by the other teams and had not been made aware of the threats by MH to kill 2 members of the Crisis Team in November 2006. When questioned about knowledge of risks AD, Manager of the AORT, stated *'We were not aware (of history of threatening and difficult behaviours).'*

Her response to a question as to whether there was a mechanism for sharing information where two services users were cohabiting but being seen by different teams was, *'There is not but there should be. I would obviously say that if I thought there was a risk that I would not allow my staff to go there on a daily basis by any means whatsoeverI did not know his history at all.'*

AD was asked by us to comment on issues around the leaving of medication for service users. In response to the question, *'You say there are occasions when you do a job in that way, leaving medication with someone who you think you can trust to self medicate'*, she stated *'If it was safe to leave medication. If they were not in and we put it through the door we would make sure it was safe. But if we had been dropping medication for two days, and had not seen anybody we would not go again for a third drop.....We would not drop 20 envelopes through a door, we would not do three days without seeing somebody, dropping any more medication. I can honestly say it would probably be even two, we would not drop more than two days and by the third day we would want to see that person....If I was dropping medication*

through a door, and we had not seen someone for two or three days then we would stop putting medication through.'

Commentary: It is of considerable concern that members of the AORT were not alerted to the risks of threats made by MH and to his recorded history of possession of knives. The duty of care to staff in such circumstances overrides the duty of confidentiality to the individual patient, particularly given that all staff of AWPT are subject to the same requirements on confidentiality.

Recommendation 33: The Trust should put in place a clear process for sharing relevant information about actual or potential risk and for ensuring that appropriate training and protective measures are put in place, and that this process is monitored in practice.

Recommendation 34: The Trust should review its procedures in practice to ensure adherence to Trust policy in respect delivery of medications to patients' homes (or other residence). Where it is discovered that medication delivered in this way has been retrieved by, or handed to, Trust staff because it has not been taken, there should be a formal system for reporting the facts to senior staff and recording them in the Crisis Team notes and determining appropriate action in accordance with Trust policy.

Commentary: MH's constellation of needs and his presentation in 2006 fitted well with the type of patient whose needs could be best met by an Assertive Outreach and Recovery Team. It is clear that the barrier to MH being assessed and potentially supported by the AORT in Swindon was due to the decision of the AORT not to accept any patients for assessment during the relevant period due to resource and staffing issues. This was a key missed opportunity to work in different ways with MH including focusing on facilitating his engagement with services, including the Drug and Alcohol service. This is of particular note given that MH and his family did apparently engage with and benefit from the intensive period of support and intervention provided by AG as part of the Early Intervention approach in the 2004/2005 period of MH's care and treatment with mental health services.

Notwithstanding the impact for MH, we consider that the decision by the AORT was a responsible one. Concerns about medical cover had been escalated to a higher level with no reported action taken by those with the responsibility and authority for addressing such a crucial issue; and posts in the team were being held vacant as a consequence of decisions at an Executive level. We felt that, in the circumstances, the team had two choices, each invidious: to take on new patients, thereby compromising the safety of both new and existing patients and potentially compromising their professional codes of conduct by which they were contractually bound; or not to accept new patients. We were advised by the Trust that the Recruitment Scrutiny Panel procedure ensured that key clinical posts were authorised for recruitment but that the Panel had not been made aware of any recruitment issues within the AORT. The Trust advised us that this was because the appropriate senior manager had not referred the matter to the Recruitment Scrutiny Panel. We were told in

evidence that the AORT letter of 15 February 2007 was referred to the level of Strategic Business Unit Service Director.

Recommendation 35: The Trust should establish a process whereby clinical and operational deficits are addressed at senior level so that more junior staff are not faced with making decisions outside their sphere of authority and ability.

Mental Health Liaison Service - Management of Episodes of Self-harm

For at least 25 years it has been NHS policy that everybody who attends hospital after an episode of self-harm should receive a psychosocial assessment (Department of Health and Social Security, 1984). While psychosocial assessment includes several components, the most important are the assessment of needs and the assessment of risks. The assessment of needs is designed to identify those personal (psychological) and environmental (social) factors that might explain an act of self-harm; this assessment should lead to a formulation, based upon which a management plan can be developed.

The National Institute of Clinical Excellence (NICE) has published a comprehensive guide to the management of self-harm. The guidance uses a definition of self harm as 'self-poisoning or self-injury, irrespective of the apparent purpose of the act'. Clear recommendations are made in the NICE guidelines in relation to triage and assessment for an individual who has experienced an episode of self harm and all the key elements are reflected in the Trust Policy, 'Operational Policy: The General Hospital Management of self harm' dated 2001.

The Trust Policy states 'Every patient who presents to the Emergency Department following an episode of self harm will receive an initial assessment immediately upon arrival in the department.' This assessment is to include the completion of the 'SAD PERSONS' assessment scale which is included within the policy.

Note: The acronym 'SAD PERSONS' relates to 10 major demographic, social and clinical factors that are known to be associated with an increased risk in terms of potential suicide. This is a nationally recognised tool for the assessment of risk of self-harm and suicide.

The Trust Policy dated 2001 includes the following statement 'Patients referred for specialist assessment following episodes of self harm will receive a full psychosocial assessment by designated clinical staff within 24 hours of referral.' Full details of the requirement of this assessment, including a detailed risk assessment are given within the policy.

The physical consequences of MH's overdose were significant and led to his admission from the Great Western Hospital Accident and Emergency Department to the Acute Assessment Unit. Review of the notes indicates that MH's physical condition was regularly assessed and a range of interventions undertaken to monitor his physical wellbeing and to treat the physical

consequences of the drug overdose. All elements of the physical management were in place and effective.

Commentary: No psychiatric assessment of MH was undertaken following the overdose. There was apparently a superficial acceptance by AWPT that the overdose was 'for attention' and the services failed to provide the safeguard of a psychosocial assessment in accordance with Trust Policy. A decision to discharge MH was taken on the basis that he was medically fit but no assessment of his psychiatric fitness for discharge was made, and no understanding of the psychological precipitants and causation of the overdose was developed. This was a significant missed opportunity.

Recommendation (Repeat of recommendation 12): There must be a psychosocial assessment prior to, or as soon as possible after, discharge of a patient who is admitted to hospital following a self-harm episode.

Mental Health Liaison Service

We were advised that the Mental Health Liaison Service was based in Great Western Hospital in Swindon but that it was a part of the overall Crisis Team Service, albeit with a specific function and its own dedicated location. However, the Trust subsequently confirmed that these were two separate services, albeit managed by the same person. The service was provided by the Liaison Team between 9 am and 5 pm, Monday to Friday and by the Crisis Team or the duty SHO (doctor in training) at all other times. We sensed that there was some disconnection between these two services (Mental Health Liaison Service and Crisis Team) and this was certainly manifest in respect of MH's experiences after his admission to the Great Western Hospital on Saturday, 11 February 2006, following a major overdose of prescribed medication, which he had hoarded over some time. At the time of MH's emergency admission to the hospital, there were 1.6 whole time equivalent nurses employed in the Mental Health Liaison Service. We heard also in evidence that the need for training in Mental Health Liaison for junior doctors had been provisionally agreed but not implemented. We heard that the two services have now been amalgamated to overcome the difficulties caused by separation.

MH was brought in by ambulance and the hospital notes completed by the Emergency Department SHO state '*Known psychotic patient, apparently fitting on amb arrival not fitting (on arrival at hospital) but not co-operative. Unable to get rest of obs (observations) due to being unco-operative. Was agitated and uncooperative on admission. Patient now drowsy and confused. Unable to do full examination as patient abusive at this stage. Unable to communicate as patient became uncooperative.*' The Hospital record of admission to the Acute Assessment Unit states '*apparently distressed and agitated, hitting nursing staff.*'

The Mental Health Liaison Service provided us with a copy of the Emergency Department Mental Health Assessment Matrix Form, which should be completed in respect of every patient with a suspected mental health problem. This comprehensive 10 page form facilitates establishment of a risk weighting, which would be used to inform decisions about the patient's terms for discharge and future

support from local health services. This form was not completed in MH's case although an entry in the Great Western Hospital notes on 12 February 2006, relating to a doctor's (or nurse's) discussion with MH's parents states clearly that they '*understand that he will need an assessment in due course, prior to discharge.*' There is no record of a psychiatric assessment and a Risk Matrix form was not completed.

Commentary: It is probable that MH would have been rated as High Risk, had the Risk Matrix Form been completed and that, had a full psychiatric assessment been undertaken on discharge with the benefit of reference being made to his AWPT notes and the views of his family and Care Co-ordinator, then an appropriate new care plan could have been developed.

The next entry of note is by CM (Mental Health Liaison Service Nurse at Great Western Hospital) on 14 February 2006 to the effect that '*I have liaised with SG – MH's Community Psychiatric Nurse, She has arranged that MH be collected from hospital today by his mother with whom he will stay the night & SG will see and review him again tomorrow thus he may be discharged to his mother's care when medically fit.*'

CM did not have any interaction or contact with MH and advised us '*I see myself as somebody that undertakes the assessment if that is required and that is what I am asked to do, not just asked – if I see somebody there and this is what they need, then I would do that assessment. But then if somebody has been handed over to their own care team, then I do not go and check.*'

Subsequent entries on the same day by a member of the hospital medical staff state, '*CPN happy for him to go home to his mother's house and to be reviewed there..... Can go home. GP to repeat CK. Psychiatry RV (review).*' The related hospital medical Discharge Information document notes, '*Post Discharge Plan GP to repeat CK and U&Es.*'

Assessment of Risks

The Hospital Multi-Disciplinary Communication record makes no reference to Risk Assessment but endorses the medical comments about MH's aggression and lack of co-operation.

NICE guidelines set out the clear expectation that all patients who have been admitted following an overdose should be offered a psychiatric assessment on discharge. This did not occur in MH's case. However, it appeared that this was not an exceptional situation as we were advised by CM that '*People are discharged probably every day of the week from Great Western Hospital at some point during the day without a full psychiatric review or even being offered one*' (That is, those whose score on the matrix form is HIGH).

If you come in during the week, you get more chance of getting a full psychiatric assessment, as you should have At the weekend, if you were a Swindon resident, then it would fall to the Crisis team and they will only come to see people who come out red (HIGH) on the matrix..... it is almost a two tier system. If you are

coming in over the weekend, you probably do not get as good a service as you get if you are there during the week and there is dedicated liaison there spare.'

The Operational Policy dated August 2001, was authorised by AWPT and by the Director of Operations for Princess Margaret Hospital NHS Trust. We were advised that this was still extant and used by the successor hospital, Great Western Hospital, at the time of MH's admission in February 2006, although the policy was due to have been reviewed before that date.

Points of note in the policy are '*That all relevant medical and nursing staff will receive appropriate training in the assessment of patients following deliberate self harm. All self-harm patients receive an initial assessment, utilising the SAD PERSONS scale. The SAD PERSONS assessment will be clearly documented in the clinical notes. The SAD PERSONS scale is an aid to clinical decision making. It does not remove the need for professional judgment, or the importance of accessing the duty psychiatrist or psychiatric liaison nurse when planning interventions or making disposal decisions.*

All self-harm patients will be offered a full psychosocial assessment:-

Once admitted as a hospital in-patient – within 24 hours, medical condition permitting.

In the Emergency Department, within 3 hours.

If the patient is discharged home prior to a full psychosocial assessment, then contact will be made with the patient, in writing, by the psychiatric liaison nurse within 5 working days.

Appropriate training, supervision and support is (sic) provided for all general medical and nursing staff who routinely undertake initial assessments of self-harm patients. Training sessions will include SAD PERSONS assessment tool.....Risk assessment

Commentary: In MH's case, the stated policy was not adhered to in several important aspects and it would appear that, to a degree, this was because the policy was unworkable in practice. It appeared not to accommodate a patient like MH, who was unco-operative and aggressive. The Liaison staff did not work at weekends and would not, therefore, have become aware of MH's admission until the Monday, two days after he was brought to the Emergency Department and one day before he was discharged.

The doctor seeing MH did not complete the Risk Assessment process, which might have led to MH being scored as high risk, but it is acknowledged that his presentation made this impossible. Had a high risk score been the outcome of completing a Risk Assessment, the Crisis Team would have been called in over the weekend. CM believed that MH's Care co-ordinator, SG, would arrange the necessary psychiatric assessment required under Trust policy and recommended by the hospital doctor in MH's notes. However, the Operational Policy for the Psychiatric Liaison Service appears to intend that this responsibility should be undertaken by the Psychiatric Liaison Nurse on discharge from hospital but the wording of the policy leaves this open to interpretation.

In the event, there was no psychiatric assessment undertaken and AWPT systems denied MH the appropriate care and treatment because they failed to respond to the particular circumstances of his case. A proper assessment might have alerted staff to the fact that MH was someone who did deliver on his threats as he had spoken about throwing himself under a train, ie. intending to kill or harm himself before he had taken a very significant overdose of drugs, which he had hoarded without the knowledge of those caring for him. Had this been identified, it is possible that greater credence would have been given to MH's threats to kill CJ.

In the event, it appears that the only person who felt that MH needed to be admitted to specialist mental health in-patient care was his mother, JM, who reported to us that her concerns about MH were not taken seriously by the Crisis Team. Whilst SG is deemed to have had some responsibility as Care Co-ordinator for alerting the Crisis Team to the fact that a psychiatric assessment of MH was not completed either when he was an in-patient at Great Western Hospital or on his discharge, we were unable to determine from policies whether the overall responsibility for this serious omission lay with the Crisis Team or the Mental Health Liaison Service.

In addition, we were advised that it had been provisionally agreed in the past that there should be a dedicated liaison consultant and that SHOs should see patients in hospital as part of their training but that this had not been implemented.

We heard from LMc (Chief Executive of AWPT) that *'I am not convinced that always we are taking enough of a longer term view into the past of the person's history, whether the risk factors have changed between the last time we saw the person and the person that we are seeing now this concern that I have all the time of did we really get that risk right, that recurring thing that was going on in this young man's head about this other young man. Did we really get that right? Were we ever going to be in a position to say that the risk has completely gone away? That is the thing I keep coming back to.'*

Commentary: We are satisfied that the status of the risk factors for MH had changed dramatically at the point that he took the overdose, in that past threats to harm himself had become a reality. A full psychiatric Risk Review and discharge assessment would have addressed these important questions posed by LMc as well as a reassessment of reality of risk of his repeated threats to others and would have led to a different course in MH's care and treatment by the Trust.

We were provided with a report regarding clinical and operational risks in the Mental Health Liaison Service, raised with senior managers of AWPT in April 2009. This highlighted some of the factors, which applied at the time MH was admitted in February 2006, over three years earlier. The purpose of the report was stated as being to *'Appraise Adult SBU Integrated Governance of risks associated with the operation of the mental health liaison service to the Great Western Hospital, Swindon.'*

The key risk areas set out therein relate to
*'Non adherence to the mental health acute pathway. (Identified as high risk).
Ineffective arrangements for ensuring availability of mental health practitioners to attend the general hospital out of hours. (Identified as high risk).
Non adherence to all current national guidance and good practice recommendations. (Identified as medium risk).
Ongoing risk to AWP's reputation as the local provider of mental health services. (Identified as high risk).
Increased levels of staff sickness absence, staff dissatisfaction and staff grievances. (Identified as high risk).'*

Commentary: Our remit does not include review of the Rapid Improvement Plan per se but we were concerned that the Plan identified that failures to follow some procedures in respect of MH in 2006 remained an issue at 2009.

Recommendation 36: The Trust should undertake an audit of episodes of self-harm and compliance with the objectives set down in Trust Policy for the General Hospital Management of Self Harm; and the associated actions of clinical staff whom the policy covers.

Recommendation 37: The Trust should review the policy and amend it to include more specific guidance in relation to the completion of the SAD PERSONS risk screening tool when patients are admitted to Accident and Emergency and for medical reasons it is not possible to complete the tool whilst the patient is under the care of the Accident and Emergency Department. This is to ensure that an appropriate risk assessment and psychiatric assessment are undertaken as soon as practicable.

Recommendation 38: The Trust should review the process of 'joint' management of patients by the Crisis Team (Including Mental Health Liaison Service) and CMHTs to ensure that there is clarity regarding the responsibility and accountability for ensuring that an adequate assessment is completed for all patients following an episode of self-harm.

Recommendation 39: The Trust should implement the agreement for the training of junior medical staff in respect of patients presenting with self-harm.

The Swindon Early Intervention Service

AG was the Consultant Clinical Psychologist attached to this team and she worked with MH from 25 September 2004 until the date of the homicide on 4 March 2007. She saw MH on 53 occasions.

There were 7 components in relation to AG's involvement with MH as follows

- Memories of abuse.
- Sexual matters.
- Challenging his thoughts about CJ.
- Understanding psychosis and schizophrenia.
- Be focused toward recovery.

- Develop his social skills and confidence.
- Develop a relapse prevention plan.

AG placed a major emphasis on the need to engage with MH and she was able to develop and maintain a therapeutic relationship with him. This was entirely in keeping with the strategy of Early Intervention services in schizophrenia and forms an important platform for working with patients such as MH. After an initial positive period of engagement, the frequency and quality of contact between AG and MH deteriorated, following MH's overdose on prescribed medication in February 2006.

In her evidence AG stated *'My contact with him in that latter period was not as good, he was not engaging as well and it was quite difficult to get hold of him and see him. He was much more all over the place in terms of his conversation. It was hard to explore any idea in particular. He would just go off in other directions.'*

Psychological Formulation

AG had elicited a substantial amount of information disclosed by MH which she summarised within her written statement to us under 5 headings:-

'Statements about killing C (CJ)

History of MH's relationship with C

The incidents

Motive for killing C

My understanding.'

AG had used this information to inform her therapeutic approach to MH and in her statement summarised her understanding of these issues

'That, rightly or wrongly, MH believed CJ to have been responsible for sexually abusing (initial) when MH was 9 years old.

That this influenced the development of his assumption that he (MH) had himself been raped by CJ when he was 16 years of age, which I (AG) judged to be a delusional belief.

That MH had valued having CJ, who he also saw as a bit intimidating, as a mate, although he had been beginning to see this friendship in a different light.

That given his belief that CJ was responsible for these two incidents he understandably felt confused and angry and had a normal feeling of wanting justice to be done.

His feeling of wanting justice to be done, in the context of someone with low self esteem and lack of confidence, developed into a number of ideas that gained him recognition, a sought after career, popularity and respect.

That as a result, thinking about killing CJ made him feel stronger and more powerful - which was a positive feeling in the context of his illness and the way in which this had affected his life.'

This formulation led AG to support MH in making contact with the Police in relation to the events reported by him as occurring when he was 9 years of age.

In regard to MH's disclosures regarding his thoughts of wanting to 'kill CJ', AG acknowledged that some of the thoughts surrounding the idea were of a psychotic nature and she engaged in a variety of psychological interventions in relation to these thoughts. These were '*Exploring the possible consequences in some details: MH wanted to know how long a sentence he would get for murder, and how likely it would be that the police would be able to identify the person that had committed a murder.*

Through acknowledging the validity of his concerns through involvement with the Police Child Protection Team.

Through encouraging him to question his assumption that C had raped him.

Through working on involving him on other occupations as distraction from his thoughts.

Through trying to build his confidence, occupation and social skills, so that he could see himself beginning to achieve without the need to kill CJ.

Through the 'pros and cons of killing CJ' exercise.'

Commentary: We were satisfied that AG recognised that MH had developed a psychotic illness and that this, in combination with increased substance misuse, had a negative effect on his willingness and ability to engage with psychological work. However, we were concerned that there was limited recognition of the relationship between the content of the psychological formulation developed by AG, MH's psychotic illness and the resultant risk he presented to others, in particular to the individuals who formed part of his internal psychotic world.

In her statement and oral evidence to us AG described the psychological interventions with MH and the theoretical basis for them. From her responses to questions she appeared less aware that, whilst there is a significant evidence base for this type of intervention being of benefit in the early stages of the development of schizophrenia, it is well recognised that the detail of this work needs to be comprehensively understood within the multi disciplinary team working with an individual patient. Due to a failure by AG to communicate fully with the wider group of professionals involved in the care of MH, it is clear that other clinicians failed to develop this understanding and more importantly, a precise knowledge of MH's delusions and threats of harm to others.

Whilst some of AG's records contained full details of her involvement with MH, we found that there were significant shortcomings in other of her records, where there was little, if any, detail and in that respect AG's record keeping did not accord with the standards laid down by Department of Health Records Management: NHS Code of Practice, AWPT Policy on Records Management, or the British Psychological Society's, Division of Clinical Psychology, Record Keeping: Guidance on Good Practice.

We noted that the purpose, content and outcome of AG's psychological work undertaken were not made fully available to other clinicians who had contact with MH. In particular the two consultant psychiatrists, who had responsibility for MH's care (excluding some hospital admissions), when questioned had a very limited awareness of the details of AG's work and relied on others to raise

concerns. (Reference to the knowledge of the two consultants is dealt with in earlier sections of this chapter dealing with the CMHT and the Crisis Team)

Cognitive Behavioural Therapy

Commentary: A key outcome of the psychological work was to develop a response prevention plan in which AG supported MH to gain an understanding of his thoughts and avoid action by developing a '*Good and bad points about killing CJ*' formulation. AG adopted a Cognitive Behavioural Therapy (CBT) approach to address MH's statements and thoughts about killing CJ.

CBT is based on the concept that there is a relationship between thoughts, feelings and behaviour; and specific models of CBT have been developed for use with patients with schizophrenia. Current guidance from the National Institute of Clinical Excellence recognises the important contribution of CBT in the overall management of schizophrenia. It is important to recognize that the successful use of CBT strategies depends upon the development of a positive therapeutic relationship between the therapist and patient. Thus, NICE guidance recommends that individuals should be offered CBT on a one-to-one basis and over an extended period of 16 weeks in the first instance.

The main aims of this type of intervention are to:-

- Establish links between the patient's thoughts, feelings or actions with respect to the current or past symptoms.
- Re-evaluate the patient's perceptions, beliefs or reasoning in relation to the target symptoms.

As part of this work, AG developed in June 2005 a 'Good and Bad Points for killing CJ' plan. We understand that she adopted this approach so that MH would rehearse and appreciate the consequences of killing CJ and, in fact, his conclusion was that '*The sensible message is 'don't kill him', there is enough badness around anyway*'

Commentary: Notwithstanding this conclusion, we consider that this exercise served to demonstrate how disordered MH's thinking was and the seriousness of his threats to others. We are clear that at the time that this work was undertaken by AG, she knew that CJ was a real individual and we are concerned that she took no steps to establish whether MH continued to have contact with CJ. In the context of this limited information known to AG, we consider that this was not an appropriate approach in response to a threat to kill a named person. Such an approach should only have been considered and implemented on the basis of comprehensive consideration and agreement by all members of the multi-disciplinary team working with MH. We found no evidence that joint decision making did occur and criticism is due of AG for this failure.

In her written statement to us, AG stated:- '*The good v bad review was one action among a number of actions to help challenge MHs thoughts about killing CJ and I believe that it was an effective intervention at the time, partly contributing to the reduction in MH's thoughts about killing CJ in the year that followed.*

I decided to work with MH at thinking through the reasons for and against killing CJ because he was continuing to talk about the benefits of pursuing this course of action, in spite of his mother, his care co-ordinator, his Consultant and staff at Hazelmead telling him that it would be an unwise thing to do. I hoped that in encouraging him himself to the reasons against killing CJ that he would be able to come to a more balanced view and make a balanced decision. This proved to be the case; with some prompting he was able to think of the bad things that would result from killing CJ and drew his own conclusion that the sensible message was "don't kill him" as there was enough badness around anyway. We rehearsed this reasoning and his conclusions a month later and it appeared to still be in place. If I have any regrets in having done this exercise, it is that I did not rehearse it with MH on subsequent occasions, although the reason I did not do this was because it appeared to have faded as an issue.'

Commentary: The development of the 'good versus bad' points for killing CJ formed part of the psychological work undertaken by AG with MH and was appropriately based on a CBT model. However, there was a major failure to ensure that the wider team of professionals working with MH was fully aware of this piece of work and the importance it should have played in the management of the risk MH posed towards CJ.

AG was aware in her work with MH that CJ was a real individual known to MH. As part of her work she supported MH to report the alleged abuse to the police. Additionally MH had reported to her during the course of her work with him that he had actually met CJ in the street and had spoken to him for about 5 minutes.

There was no record that AG took action to identify CJ and to ensure his safety. Nor did she alert other staff to the fact of CJ's existence and the risks posed to him by MH. This was fundamental missing information that should have led to a very different formulation of the risk that MH posed to CJ and to a very different course of action by AWPT.

Recommendation 40: When a member of staff is made aware of threats to others (s)he should ensure that all members of the clinical team working with the individual are aware of the threat and escalate any concerns to his or her line manager and urgent, appropriate management action should be taken, including involvement of other statutory agencies and carers/families.

In her evidence to us AG stated 'There were bits and pieces that he was piecing together and not always clear cut around CJ. Sometimes (TV) would be the person that he saw as being responsible for what had happened and sometimes not. It is quite hard to get an idea from MH about his friendship with CJ, his mum, I gather, would say that they had been quite good mates at one point and spent quite a lot of time together and M had talked about going camping with CJ and having good fun. He was also I think not quite approving of some of CJ's behaviour at that time.....My contact with him in that latter period was not as good. He was not engaging as well and...it was quite difficult to get hold of him and see him. He was much more all over the place in terms of his conversation. It was hard to explore any idea in the particular. He would just go off in other directions.....I understood that to

be down to his increased use of drugs and alcohol at that time, that his thinking was much less grounded and I did tie that up. Also his mental health had deteriorated, in my mind, significantly at that time.....He was very unwell. His mood was much more variable and his thinking was totally chaotic and bizarre. His engagement was poor, his self care was poor and I think that he was significantly unwell. My involvement in the process was often through talking I think SG, feeding back what MH and I had been talking about and things from that. The more formalised meetings would often not be the formal CPA reviews,....a CPA review can end up being fairly intimidating, if you have a young lad who is struggling with illness anyway, so probably less through those meetings which I tended not to go to...the formal meetings would be my attendance at the East CMHT meeting on about a monthly basis’.

Commentary: It is surprising that, given her involvement with and knowledge of MH, AG did not generally attend that ICPA review meetings, where she could have shared crucial information.

In respect of these meetings, she advised ‘it was our shared feeling that the care package was not working. It was trying to involve the service managers in various discussions. We had a systems problem going on rather than one of medical care, so to try to involve the manager of the crisis team and the community services manager.’

Commentary: However, the majority of other witnesses questioned by us were apparently unaware that CJ was a real individual known to MH. Most witnesses had little, if any, understanding of the work undertaken by AG. This was important information that should have been integrated into MH’s care and treatment.

Recommendation 41: The Trust should instigate an urgent review of the process of communication between psychologists undertaking psychological interventions and the wider multidisciplinary team, to ensure full availability and understanding of all clinical information and adherence to Trust Records Management Policy and to guidance from the British Psychological Society.

AG’s Involvement in the Integrated Care Programme Approach

MH’s care and treatment were managed with the ICPA system. AG did not have direct involvement in the ICPA process. Communication was largely informal and there were no written reports of the psychological approach, interventions or on-going issues provided for the ICPA reviews. Appropriate communication would have informed the wider multi-disciplinary team of the psychological interventions.

A major component of the ICPA is the regular review of risk and development of an appropriate risk management strategy. AG did not have direct input into this and a further opportunity for multi-disciplinary consideration of the risk MH presented to others based on the disclosures he made within psychological sessions was therefore missed.

Initially AG advised us that she was generally unable to attend due to other commitments. AG subsequently advised us that she could not be involved in ICPA meetings in MH's case because meetings always tended to be called at short notice.

Recommendation 42: The Trust should review practice and policy regarding the process of multi-disciplinary assessment and communication of risk, and formulation of risk management plans within the ICPA Procedure. In cases of significant risk, all professionals should take the advice of other colleagues in the development and sharing of risk management plans.

Professional Supervision

The Early Intervention Service in Swindon had been set up in 2003 and whilst AG had extensive experience as a clinical psychologist within the NHS she recognised that she was at a relatively early stage of working with this patient group. At the time AG was involved with MH's care, she was able to access monthly group supervision in that individuals were able to discuss cases of concern within the group. AG is a senior clinician who provides regular supervision for others but case based supervision for her from a colleague with more experience in this new area of clinical practice for AG was not available. We considered that this was an oversight when the Early Intervention Service was set up. (Note: supervision arrangements for staff are dealt with more fully in Chapter 9 of this report)

Recommendation 43: The Trust should undertake an audit of the supervision arrangements in place for senior clinicians and take steps to ensure that appropriate provision is available and accessed.

Windswept Rehabilitation Unit

Dependent upon assessment as to suitability, Windswept generally accepts patients who are recovering from their mental illness and are no longer acutely unwell, with the aim of moving them into independent living. Generally patients remain at Windswept for periods of 3 months and up to 2 years.

MH was first assessed for Windswept on 21 June 2006 but was not accepted as it was considered that he was currently too unwell to participate in a rehabilitation programme.

A further assessment was carried out on 25 July 2006 (MH had refused to go for assessment on 24 July) and he was again considered to be unsuitable as his condition was judged to have deteriorated.

Whilst there are no notes pertaining to an assessment, it appears that MH was again assessed for Windswept on 6 September 2006 whilst he was an in-patient on Applewood Ward. He had been admitted under Section 2 of the Mental Health Act on 31 July 2006 and became an informal patient on 25 August 2006.

On 15 September 2006, MH was transferred from Applewood to Windswept for a period of trial leave over that weekend. At the end of the weekend, MH could not be transferred back to Applewood Ward because his bed had been allocated to

someone else. MH was considered to be displaying psychotic symptoms, he was abusive, sexually inappropriate and generally bizarre in his behaviour and speech.

Commentary: MH was on a period of trial leave and his bed at Applewood should have been held for him until it was determined that it was no longer needed for his return.

A summary was prepared by a staff nurse member of Windswept staff on 31 October 2006:-

'15.09.06 – MH was transferred from Applewood to Windswept for a period of trial leave over that weekend. On Applewood, he had been compliant with medical treatment but was drinking alcohol and displaying verbal aggression, sexually inappropriate behaviour and generally bizarre behaviour and speech.

Over the weekend, MH slept on the unit each night and was compliant with medication. However, he made abusive comments to other residents and made sexually inappropriate remarks to female staff. He appeared thought-disordered and continually pushed boundaries of acceptable behaviour. He left the unit each day, to drink alcohol and visit his mother and places such as MIND and Hazelmead - both organisations contacted Windswept to inform of his anti-social behaviour there which had resulted in him being banned from visiting.

At the end of this weekend, Applewood did not accept MH back and the Crisis Team were unable to facilitate transfer to a hospital bed. MH then began staying overnight at the flat belonging to Applewood patient (G/F). He would stay in irregular contact with Windswept, returning for medication and food but refusing to stay overnight or to engage in the rehabilitation process. He continued to visit his mother who informed staff his mental state was deteriorating, that he was turning up at her home demanding money and tobacco.

28.09.06 – MH's CMHT was updated on developments (his Care Co-ordinator was on leave). CMHT Manager agreed MH needed readmission to hospital. CMHT staff were unable to locate MH in the community.

29.09.06 – MH was assessed at Windswept by Dr V who thought his mental state had improved, despite staff reports indicating otherwise. He received his depot medication and after discussion with the Crisis Team, MH was allowed to return to (GF's) flat.

2.10 06 – MH stayed overnight at Windswept because (G/F) was 'sleeping with someone else'. However, he then returned to stay with her.

6.10.06 – the Crisis Team collected MH's treatment chart to deliver his medication at (G/F's) flat. They noted he and (G/F) were drinking heavily and smoking cannabis.

13.10.06 – a Professionals Meeting was held. Action plan: Emergency accommodation to be found for MH; Crisis Team to continue to provide community support; MH to be discharged from Windswept on 18.10.06.

19.10.06 – (G/F)PD re-admitted to Applewood. MH attended there and was asked to leave; he was intoxicated and allegedly carrying a knife. He later arrived at Windswept, still intoxicated and expressing delusional ideas of a grandiose nature. He admitted feeling stressed re (G/F). He denied carrying a knife but implied he would kill any other man who “went out with” (G/F). He then left the unit.

21 10 06 – MH visited Windswept; presented as restless, thought-disordered and unhappy. Consented to personal search for weapons/drugs – none found.

23.10 06 – MH’s mother called Windswept in a distressed state, reporting he is “deteriorating rapidly”, saying he claims to have knives and is threatening to kill himself, (G/F) and any other man (G/F) goes out with. He continues to be verbally abusive to her and has assaulted his 8 year old brother. When informed that the Crisis Team finds him behaving appropriately when they visit, she states he can present a ‘calm front’ for a short period of time. MH then arrived at Windswept, agitated, restless, delusional and talking of wanting to kill himself.

24.10 06 – MH visited Windswept and joined the other residents for a meal. He denied feeling unwell or having strange thoughts, only admitted to feeling sad and getting angry with his mother.

29.10 06 – MH visited Windswept requesting to stay overnight. There is apparently no electricity or food at (G/F) flat. Crisis Team was informed, however they came to collect MH and his belongings and took him back to (G/F’s) flat(!) Telephone call later received from MH’s mother who reports he complained of being “homeless and penniless”.

Commentary: Windswept staff made regular attempts to have MH transferred back to Applewood but this appears to have been impossible due to bed availability. He was a patient at Windswept for a period of 6 weeks although he spent much time away and overnight with (G/F). MH was discharged from Windswept on 1 November 2006.

Windswept staff also reported difficulties with the decision making process by the Crisis Team. It was felt that despite opinions of staff at Windswept being expressed, patients’ needs would still be subject to further assessment by the Crisis Team who were not expert in the Windswept environment. At that time it was not unusual for Windswept to be used as an overflow to the acute ward at times of bed pressures, but this practice has now changed so that Windswept is used more appropriately.

In our view, the summary produced by the Windswept Staff Nurse was appropriate and of a high standard and it was of considerable assistance to us.

The Vulnerable Adults Unit

‘The Policy and procedure for safeguarding vulnerable adults in Swindon and Wiltshire’ is dated September 2006 and is stated to replace the ‘Policy and

Procedures for the Protection of Vulnerable Adults from Abuse in Swindon and Wiltshire October 2001'.

In the Introduction to this document, which comprises 166 pages, it is stated *'The White Paper 'Modernising Social Services' signalled the Government's intention to provide better protection for individuals needing care and support. This is being taken up through the Care Standards Act 2000. The Government is also committed to providing greater protection to victims and witnesses and is actively implementing the measures proposed in 'Speaking Up for Justice', the report on the treatment of vulnerable or intimidated witnesses in the criminal justice system'.*

First Referral on 20 October 2004

At the first session with the Early Intervention Resource Team on 13 October 2004, MH disclosed to AG two allegations (1) relating to circumstances when he was 9 years old when he alleged that CJ sexually assaulted a 6 year old boy (*initial*) and (2) when MH was 16 years old that CJ and/or (TV) did something sexual to him. AG agreed that she would try to arrange for MH to meet someone from the police in respect of the first alleged incident when he was 9 years old, although the notes made by AG refer (incorrectly) as being when he, MH, was 6 years old.

The Multi-Agency Vulnerable Adult Protection Referral Form - Report of Allegation is dated 20 October 2004 but is unsigned. It indicates that there is another mental health service user with the same name, that MH is currently under the care of Crisis Team and is also being seen by AG (Psychologist). The form shows the Vulnerable Adult Service User Group to be Mental Illness and that AG is detailed as being the alerter. Details of the allegation state that MH describes when he was 9 years old having witnessed sexual abuse on a 6 year old boy. AG's records do not show that a referral was made on 20 October. The report form headed Multi Agency Vulnerable Adult Protection Referral Form was contained in the clinical records. Details of the Alleged Perpetrator were shown as CJ but with no further detail of surname, address or any other relevant information.

On 27 October 2004, the Crisis Team notes (*author unidentified*) state that he/she had attended an Early Strategy meeting with AG and Child Protection Officer. (*Note: issues relating to record keeping in AWPT are dealt with in Chapter 9 of this report*)

On 28 October 2004, AG recorded in her notes that she told MH about the meeting with the Child Protection Officer (the previous day). On that occasion, in addition to expressing his willingness to agree to a video interview, MH told AG he alleged an assault by CJ at a time when CJ and (TV) were there.

On 10 November 2004, the Crisis Team recorded that MH and the unidentified author attend the police station to give an interview (*Chapter 9 section on record keeping refers*) *'re abuse issue between two acquaintances in childhood'*.

On 18 November, 2004 AG recorded *'MH was concerned about whether the police should talk to CJ. Said he'd seen CJ for 5 minutes but hadn't talked to him.'*

On 2 December 2004, AG fed back to MH about enquiries made about the alleged assault on (*the boy*) On that occasion, MH asked whether the police could see (TV) to find out what he knew about (the rape). There is nothing in AG's notes to suggest that she pursued this matter.

On 10 December 2004, AG fed back to MH that (police) were unable to take the case any further because (the boy) was adamant that nothing had happened.

Commentary: We were concerned that AG did not pursue identification of CJ. This referral identified MH as a vulnerable adult. Given that MH was making threats to “gouge the eyes out” of his abuser, he was also making threats to kill CJ and (TV) and the reason he had been required to leave his mother’s house was because of her concerns for her younger son being the subject of untoward behaviour, it is of concern that:-

- 1. No attempt was made to investigate the second and more recent allegation of sexual assault.**
- 2. No efforts were made to identify (TV) (whom we established as probably being part of his delusional system).**
- 3. CJ was neither identified nor warned by AWPT of MH’s intentions towards him.**

Recommendation 44: Where any employee of the Trust becomes aware of an actual, or potential, serious risk to a third party, then (s)he must escalate this to his/her line manager and the Trust must assign a specific individual to alert the appropriate authorities and, where necessary, establish the identity (or otherwise) of the subject of threats. (S)he must also record this in the records to ensure that other staff are duly advised. Where the subject of threats is found to be a real person, then the Trust should seek immediate advice of the relevant agencies so that the individual is aware of the threat and that appropriate protective measures are put in place. The current care plan must be reviewed and modified accordingly.

Second Referral

The second VAU Referral Form is dated 08/02/05 and is completed by SG and sets out the details of the allegation *‘MH is/has experienced an episode of psychosis during which time abuse allegations were made. MH reports he both witnessed and experienced the abuse. I believe this has been investigated however no evidence found etc. MH is now talking about “killing” the person who the alleged assaults about. Some of his beliefs around this appear delusional as he believes if he was to kill him he would be “crowned”.*

Third Referral

Although there is no official form of Referral to the Vulnerable Adults Team in the records, on 2/8/05 SG records having been advised (by her team leader RG) to contact Vulnerable Adults team. This was as a consequence of having received a telephone call from JM that MH had exchanged his TV for a knife which he was keeping in his room at Hazelmead. SG recorded that she spoke to (*name 1*) of the Vulnerable Adult Team who advised her to discuss the situation with Dr PS and see

MH and find out if there was any intent to use the knife and for what purpose MH had the knife. SG informed (*name 1*) of the Vulnerable Adult Unit of MH's thoughts about killing CJ by 'slitting' his throat. She endeavoured to discuss the matter with (*name 1*) on 3, 4 and 9 August 2005 but could get no answer on the telephone. We had no evidence that this contact had been recorded by the VAU.

Fourth Referral 17 July 2006

A referral form, accompanied by fax (completed by the police and sent from the VAU (dated 17 July 2006) was sent to SG and stated '*Concerns raised by mother. Requesting further support*'.

The User group section on the form is shown as "*Mental Illness*". In the Disposal section, no boxes are ticked. There is a corresponding note in SG's record.

Fifth Referral on 9 January 2007

This form was faxed to SG by the police and shows the Vulnerable Adult Service User Group for MH as Mental Health Act and Mental Illness. The details of the allegation are set out as '*Officers were called to attend the H/A of JH (In fact, JM) Mother to MH, he had attended his mothers H/A and had started to call and shout at his mum through the front door, he also started to kick the front door, no damage was caused to the property and no offences were disclosed by mum, she did want to confer with officers re MH's attendance due to the fact that he has not been taking his medication for schizophrenia since Christmas 06.*

This is having an effect on his behaviour and is likely to be the reason why he acted the way he had tonight.

Mum was concerned for MH and wanted the police to contact the Crisis Team as when she had called them herself that evening, they refused to attend and see MH.

Is it possible for a referral to be made to Mental Health Services re getting an assessment carried out on MH why he has stopped taking his meds and also getting him re-started on his meds'.

The form, which comprises 2 pages, indicated the Vulnerable Adult Service User Group as Mental Health Act/Mental illness and on page 2 after the details of allegation set out above under 'Check Made on Vulnerable Adult' also shows under 'Check made on Vulnerable Adult' as '*PNC – No -VAU 'Yes' – result 'Could not trace or confirm' Optimus – No*'

Under Disposal '*Concerns substantiated but the adult is not judged to be at the risk of significant harm*'.

Commentary: We did not have access to all records of the VAU but it would seem that apart from the initial referral in October 2004 only the first allegation was investigated. It is a matter of some concern that it was not considered appropriate to identify CJ and that allegations concerning the possession of knives coupled with threats to kill were not subject to full investigation,

forensic referral or referral to MAPPA and that reliance was placed on Mental Health Services to remedy the situation.

The current VAU policy suggests a 24 hour referral service yet, according to SG, not only did she get no response to her attempts to have further discussion with the VAU regarding the confiscation of a knife in the possession of MH, but there was no answerphone facility when she called by telephone. We noted from the minutes of the RCA meeting held with members of the CMHT on 17 July 2007 that it was said regarding the VAU, *'It is difficult to get hold of them.'*

Q. Do you think they are familiar enough with the process. Good liaison – why did it not happen on this occasion.

A. (Name 2) was on her own at the time, no manager or staff and she also had a fair bit of sickness. Lack of resources. Since then they have increased the number of staff even though it is only part-time.'

Recommendation 45: The Trust should initiate an urgent meeting with Wiltshire Police to address any concerns about, or failings in, the VAU response to reported dangerous behaviours.

Vulnerable Adults Database

We were provided with a copy of Vulnerable Adult Database Records held by the police for MH covering the dates 26 July 2006, 23 October 2006 and 6 March 2006. The database entry for 27 July 2006 shows *'Caller has tried calling the Crisis Team but can get no reply. MH sat on step, his taxi turned up whilst we were there. He has been told not to return.'*

An entry on 29/10/06 relates to an incident which occurred on 23/10/06 and reads as follows *'This file relates to an incident which occurred on 23/10/06. It relates to a male with mental health issues who is alleged to have assaulted his 8 year old brother. There are no witnesses to the incident and no cctv. There are no injuries or marks as a result of alleged assault and the complainant is the mother of the pair. She has requested that we get involved as the eldest son is also alleged to have made threats against his father and his girlfriend who is also a mental health patient Mother states that his condition is worsening and that he is abusive towards everyone but that he does not back up his words with actions. She states that she does not want her eldest son arrested or her youngest son video interviewed but wants us to ensure that some pressure is put on the mental health facilities in the town to ensure that they give her son the help that he needs to deal with his condition.'*

I have attempted to speak with Sandalwood but they state that the only person who can help him is his psychiatric nurse who is currently on leave. They have advised me to call back when he returns in week commencing 30/10/06.

Please note and return for further enquiries unless you feel this may be more suitable to be dealt with by a local officer who may be better able to speak with the family to bring about a lasting solution.'

Commentary: Although SG was still MH's Care Co-ordinator, MH was under the Crisis Team for home treatment on a daily basis. The absence of the Care Co-ordinator is not an acceptable reason for failure to respond to concerns raised, particularly those raised by statutory agencies.

Following this initial report, there is a number of entries on the database. Of particular note is one on 30/10/06, which includes the comment '*.....it is my understanding that charges cannot be brought against offender with mental health issues.*'

Commentary: There appeared to be a misunderstanding by the officer involved in this respect.

Recommendation 46: The police should ensure appropriate training for all staff in respect of criminal liability of those with mental health issues.

On 5/12/06 the police database record includes '*I have spoken with mother of the I/P and the offender. She states that her son has since been hospitalised to be treated for his condition and that he seems calmer on his release. She is not happy with the service that the mental health care trust are giving her son and is in the process of making a formal complaint against them. She is happy with the fact that her son has not been arrested as she feels that this could have set him back in his treatment. She is concerned about her son and has stated that should he commit any other assaults she will expect us to deal with him in a more robust fashion as he will have brought it on himself.*'

On 5/12/06 the database reads '*If the elder son is predisposed to violence and it is reported, he should be arrested and brought to the station. A doctor can have him Sectioned.....*'

Other entries post date the homicide. We were not provided with any database or other records referring any other referrals.

The Forensic Service

The Forensic Service in Swindon appears to have been valued but apparently viewed within the new Executive Team as somewhat of an anachronism in that it was separate from the otherwise Trust wide service and was a community service. We were advised that it was originally established as a commissioned court assessment liaison scheme and developed into a community service, interfacing with the prison service; the secure hospital service, police service; and probation service. This was described to us as being a local arrangement supported by local finances and not part of the Trust's "*strategic type strategy*".

In addition, the service was partly linked to 'low secure beds' in Rosewood, a unit in the Sandalwood Court complex. The introduction of Strategic Business Units in the Trust lead to the incorporation of the Swindon Forensic Service into the Trust wide service. This, however, took place in September 2008 and post dated MH's contact with the Trust prior to the homicide on 4 March 2007, at which time the Swindon Forensic Service remained a source of specialist advice and expertise to mental

health services in the Swindon area. We heard evidence from KHo, then manager of the service and now Modern Matron in the Trust, that he had been concerned about the disbandment of the service and that he had completed a very comprehensive analysis of the risks of that approach but that disbandment went ahead regardless. KHo was unable to produce a copy of that risk analysis because all non clinical records for the Forensic Service had been destroyed (see below). In terms of MH himself, the Trust's representative advised us in an email that:- *'He (MH) was never referred to Swindon Forensic Service for case management or a risk assessment and never had his case presented to the team. There was a couple of informal telephone calls to staff members. No file was created.'*

This accords in part with evidence from members of the Crisis Team. One person believed that there were 'several conversations' where KHo was involved about whether MH should be assessed under the Forensic Services, stressing certainty that these conversations had taken place.

In terms of the alleged telephone calls, KHo was able to comment on one only, which he believed to have been made by KO, then a Trainee Social Worker attached to the Crisis Team. KHo could not say categorically that she was the person who made a call to the Forensic service to express concerns and to ask advice about MH but was fairly certain that it was she. He was also fairly certain that the call was made in November or December 2006. Unfortunately, we were not able to interview KO, who gave her reasons why she was unable to provide a statement to the Investigation or to attend a hearing. We were unable to hear from a witness, who may have been able to provide crucial information about MH's mental health and the Crisis Team response thereto in the critical period from late 2006 up until the time of the homicide.

In respect of the Forensic Service, KHo said that *'One thing about Swindon Forensic Service, we prided ourselves in not setting barriers to support and help and assessment from our service and we have set up different ways that people could access the service. One was phone any team member and we will advise you accordingly.'*

He also advised that the view of the Forensic Service was that the person seeking informal advice and information from the service (as opposed to a formal paper referral) would record the contact on the patient's records.

He advised us of the process whereby any concerns would be formalised by a member of staff seeking specialist advice from the service. In respect of this particular referral, KHo stated *'I definitely remember it (the telephone conversation) because it was an exceptionally important conversation and I was very concerned at the time ... and I honestly expected my recommendations to be followed through and that is why I did not go to the other stages of doing A, B, C, D, which we would normally have done. That was part of the telephone conversation, he had these beliefs about his friend (CJ) ...*

I do believe that it was a member of the Crisis Team... I thought it was KO. I was informed that they were concerned about the potential risk that MH may pose to his friend CJ. The nature of the risk was that MH said that he needed to kill his friend

and this threat had been expressed on numerous occasions to several community staff. I do recall they were based on delusional beliefs, however, cannot recall the nature of these beliefs. I was further informed that MH was a heavy substance user, primarily cannabis, and had a history of poor compliance with services and medication.

I advised the caller that the primary risk to CJ needs to be managed, his substance misuse needs to be addressed/restricted and his psychosis needs to be aggressively treated, and recommended admission into hospital and a Mental Health Act assessment should MH refuse admission. I was informed that MH had been recently admitted to Green Lane Hospital under Section 2 (of the Mental Health Act) and was discharged from section and hospital after 2 weeks and I strongly advised a referral be made to SFS (Swindon Forensic Services) emphasising that this should not delay immediate assertive action being taken.

.. there was this feeling from that person's (the caller from the Crisis Team) point of view that (Mental Health Act assessment and admission) may not necessarily be an option because it had been tried a couple of weeks previously..... But that was the bit where I made the strong recommendation that this does not matter, you need to do this type of thing, regardless of what has happened previously, and that was the message and that is why I felt quite strongly about that. I did make that recommendation.'

In respect of the fact that this conversation was not recorded in SFS notes, KHo said 'I am usually pretty good at record taking and I am surprised that I did not. I think the thing was I expected action to be taken.....we record information because we have to, because we should record information, but as a professional defensive measure we record information.....I honestly believed that they were going to act on my recommendations and that is why I did not give it a second thought. I did not think there was anything contentious within the conversation. I honestly believe that my recommendations would have been followed up.....Any conversation taking place about a patient's care, risk or risk management strategy that was not on the SFS caseload' was deemed to be informal.

KHo commented '.....part of the nature of the telephone conversation was the person who rang me was quite frustrated that these risk issues had been persistent It had been an ongoing situation for a substantive period of time and that is what triggered the phone call... The level of risk was as I understood it very high.

..... We were happy to receive a referral, that was not a problem or an issue, but we never ever received a referral. I expected this chap to be admitted to hospital and that was my strong recommendation.....

We make it very clear, a telephone conversation does not constitute a referral.....we had one side of A4 for the person to put details in and then all we asked for was the risk, we asked for the core assessment and we asked for any other reports like Tribunal reports etc. That is all we asked for so it is a very simplistic way of referral and we would accept a paper referral.'

Commentary: We believe KHo demonstrated a very clear and detailed recollection of the content of the telephone conversation with the person he believed to be KO and we have no reason to doubt his word that this conversation did take place but was not recorded by him. His account of the information shared with him, accords with the history of MH and the advice he gave to the caller was deemed to be appropriate. However, given that the caller was, to the best of KHo's recollection, an untrained member of staff and given the very real concerns that the information raised for KHo, we believe that it would have been prudent for him to have recorded the conversation and to have followed the matter up with the manager of the Crisis Team, so as to ensure that the advice he had given was acted upon. Crisis Team records provided to us did not contain any record of this conversation.

We subsequently heard from KHo that there was a local agreement that where a caller to the Forensic Service was a person, who had direct responsibility for or involvement in the care of the service user, then it was the responsibility of that person to record the conversations/discussions. We heard also from him that KO had extensive experience in mental health and was shortly to qualify; and that, had he believed that he was talking to a junior, untrained member of staff, he would have acted differently. He also advised us that the conversation with the person he believed to be KO did not constitute a referral, either formal or informal.

Commentary: Notwithstanding the local agreement; the probable experience of KO; or the status of the conversation, we consider that the magnitude of the situation, which was described to KHo, was such that he should, ideally, have made a written record and, anyway, escalated the matter to a senior member of the Crisis Team.

Notwithstanding, we accept KHo's view that he would have expected a record of the discussion to have been made by the person making the informal referral and that his advice would have been followed. Although KHo advised, on that basis, that he did not make a record of the call, he also told us that all the non-clinical documentation relating to Swindon Forensic Services had been destroyed by a secretary in the decommissioning process. His evidence of this destruction of records accords with evidence from the Trust's Chief Executive although we were not provided with an explanation as to why non-clinical evidence, which would have had at least some measure of indirect bearing on clinical aspects of the service, was not retained.

AS, a senior nurse in the Crisis Team, was asked about the reported referral to the Swindon Forensic Service and her only comments were that she could not remember and could not recall that. PC, Manager of the Crisis Service at the time of the reported referral, agreed that referral to the Forensic Service would have been entirely appropriate in the context of MH's possession of knives. PC did not say anything about whether or not an informal referral had been made. There is nothing in the Crisis Team notes to indicate either that KO made the informal referral described by KHo or, if so, that she subsequently discussed this with PC or AS but evidence from KHo and two members of the Crisis Team indicates that someone from the Crisis Team did so and that it was probably KO. Of those two people, JE was unequivocal in the view that *'I believe there were several attempts to refer MH*

to Forensic I know there were several conversations where KHo was involved about whether he should be assessed under Forensics and whether he should be MAPPA'd. I was aware that there was a conversation with KHo then, definitively.... I am certain, yes, I am certain that there were conversations with KHo..... I think it may have been someone senior. I think it may have been DB or PC. It may have been AB or AS..... It would be someone senior within the team.'

Commentary: This is a matter of significant concern us, as we believed the veracity of the evidence provided by KHo; his description was vivid and comprehensive and his concern evident. From within the Crisis Team it was reported to us that there had been interaction with the Forensics Team and it surprised us that PC seemed unaware of this and that AS could not even recall it. In addition, whilst we believe that the full set of missing Crisis Team notes eventually came into our possession, we cannot be sure of this. As late as March 2011, we were provided with a record of a meeting in July 2007 in which (XX) appears to have advised that Crisis Team notes were missing in January 2007. It would seem odd that, given the seriousness of the issues, that KO is reported as having discussed with KHo and the fact that, albeit still in training, she would have been very aware of the professional obligations on her in respect of record keeping, she failed to make a record. Notwithstanding, as a trainee, KO should have been provided with an appropriate level of supervision, in all aspects of her work, including keeping records.

We considered the possibilities that:-

(a) She did make such a record and that it was part of missing Crisis Team records that have not been discovered.

(b) She reported the matter verbally to PC, AB or AS and that it was decided that no action was necessary and either no record was made or, again, any record was part of missing Crisis Team records that have not been discovered.

We were not able to reach a clear conclusion in respect of KO's reported actions. However, we believe that the caller's (believed to be KO) and KHo's very real concerns indicated a key point at which appropriate action could have averted the homicide.

Recommendation 47: Clear records must be made of every relevant conversation or piece of information provided/received, however informal, in respect of a patient in care of the Trust, including third party information. These should be incorporated in the patient's clinical records.

Recommendation 48: The Trust should determine and enforce agreed processes for the retention of all records, clinical and non-clinical, on decommissioning of a service, combined with inclusion of relevant information in the single RIO (*electronic system*) patient record so that ongoing (and new episodes) of care and risk management are informed by past patient history.

Sandalwood Court Psychiatric Unit, Swindon

MH was admitted to Applewood Ward, Sandalwood Court, Swindon, under the provisions of Section 2 of the Mental Health Act 1983 following a Mental Health Act assessment organised by JD on 31 July 2006.

During the course of his detention, MH was seen by Dr V (SHO) who made notes in the medical records on 2 occasions - 2 August 2006 and 29 September 2006.

We wished to obtain a statement from Dr V and to call her to give evidence but were unable to do so because, we were informed, she had left the Trust and her whereabouts were unknown.

On 2 August 2006, a comprehensive note in the clinical notes made by Dr V includes a differential diagnosis as '*Paranoid schizophrenia. Multiple substance dependency.*' With an immediate management plan '*To continue medication as per chart Bloods to be sent (taken and in the fridge)*'.

Commentary: Whilst a differential diagnosis was made by Dr V, this is not a formal diagnosis, which should be established by a senior clinician through an extended process of assessment. Although MH had been in receipt of mental health services since September 2004 (almost 2 years earlier), this is the first occasion upon which any formulation of a diagnosis had been recorded, although a note was made in February 2006 in Great Western Hospital notes that MH was "diagnosed as schizophrenic". We were unable to establish the source of this early information. It is acceptable for a junior doctor to indicate a differential diagnosis, which is an initial working diagnosis. It is a matter of significant concern that no formal diagnosis was formulated and recorded by either Dr MS or Dr PS. The first formal diagnosis was made after the homicide.

The range and complexity of symptoms presented by MH were sufficient as early as November 2004, for it to be appropriate to formulate a working diagnosis of schizophrenia. Reference to the NICE guidelines at this, or any later stage, stage would have indicated the following requirements for appropriate care and treatment:

- Reach a diagnosis
- Develop a psychological formulation
- Identify strengths and needs
- Develop a risk assessment and management plan.

In addition, the guidance recommends that:-

- Where co-morbid conditions such as substance misuse are identified specific assessments and care plans are developed with regard to this.
- When a diagnosis has been made, it should be fully explained and discussed with the patient and if appropriate with their family.

MH's care and treatment fell significantly short of that recommended within the NICE guidelines, specifically

- At no time was a clear and formal diagnostic formulation made and recorded.

- **AG's psychological 'tentative' formulation was not explicitly shared with MH and his carers or with the other clinicians involved in MH's treatment.**
- **MH's strengths and needs were not explicitly assessed and recorded**
- **No specific care plan was developed to manage co-morbid substance misuse.**
- **In the absence of a diagnosis there was no discussion with MH and his family.**

Recommendation 49: The Trust should ensure that a formal diagnosis is made at the earliest opportunity.

Dr V again saw MH on 29 September 2006 as duty doctor. At this point MH had been discharged from Windswept and was seen by a duty doctor rather than by his 'own' junior doctor who had responsibility for reviewing him at Windswept. The reason for the consultation is noted as *'had been refusing his oral medication and didn't want to take his depot.'*

After making a detailed record of her observations and conducting a mental state examination, Dr V noted a plan *'To continue on Risperdal consta and oral Risperidone Crisis Team will review him over the weekend For team to review situation on Monday.'*

A summary document provided by Windswept staff on 29 September 2006 stated *'MH was assessed at Windswept by Dr V who thought his mental state had improved, despite staff reports indicating otherwise. He received his depot medication and after discussion with the Crisis Team, MH was allowed to return to (G/F's) flat.'*

PALS (Patient Advice and Liaison Service)

The Patient Advice and Liaison Service became involved at the request of JM, MH's mother. Initial contact was made on 6 November 2006. This was followed up by ABi, PALS officer for mental health in Swindon, on 8 November 2006 and on 9 November 2006 she wrote to JM a comprehensive letter as follows:- *'Thank you for accepting my call yesterday and for explaining the distressing situation, your son and all your family are attempting to cope with.'*

You explained that MH is currently very unwell and behaving in a very dis-inhibited, violent and frightening manner towards you, your daughter and your young son who is only 8 years old. He has attacked your son twice during the last week, followed your daughter menacingly and is threatening to kill other people as well as himself.

MH is only 19 years of age and until he became ill he was a quiet, loveable son who had never been in any trouble with the police. It is likely that his illness was triggered by cannabis and is made worse by alcohol.

When mental health services became involved, a combination of supported housing at Hazelmead, medication and family work all helped you to believe that there was light at the end of the tunnel and that MH would be able to rebuild his life.

It was a great shock when MH took an overdose of his medication and nearly died. It remains your fear that he may act again to kill himself – he has described how he might do this by throwing himself under a train. You are aware that when MH overdosed, he started using illegal drugs again which makes him even more unwell and very difficult to manage.

Three months ago MH was admitted to Applewood under section. His discharge plan involved a period of rehabilitation in Windswept but when he went there for a trial week-end his behaviour became unacceptable – described to you as bizarre, thought dis-ordered, sexually dis-inhibited, non compliant and abusive. At the end of this week-end, he was refused by Windswept and neither would Applewood accept him back. The Crisis Service were unable to facilitate a transfer to a hospital bed and he is now technically homeless but living at a girlfriend's flat while she is in Sandalwood Court herself.

You are aware that MH himself has tried to gain access to both Hazelmead and Windswept but that when he has been collected by the Crisis Service he has been returned to the flat.

As his mother, you want to do all you can to help him but he has become very frightening and threatening to your other children. On top of this, there appears to be conflict of opinion amongst the professionals involved in MH's care and treatment about where and how he should be treated.

You feel that resolving this conflict is critical to both MH's safety and that of the rest of your family. You were extremely disappointed last week when a round table review was not attended by the Crisis Service and you are left feeling frustrated that the more ill he has become, the less help that there appears to be available.

It is your fear that he will be accommodated inappropriately in bed and breakfast and continue to deteriorate – a tragedy waiting to happen to someone still only 19 years old.

You have contacted PALS in the hope that I can help facilitate a resolution of this situation by requesting the professional(s) come together as quickly as possible to jointly plan the way forward. And as MH's main carer it would be my concern that you too need support and information on how to manage these circumstances.'

PALS Communication with the Crisis Team and the CMHT

On 10 November JM gave written consent to PALS to 'Contact managers of mental health services to alert them to the need to work together to support MH and his mother, JM as his main carer.'

On 14 November 2006, a copy of the letter to JM dated 9 November was e-mailed to SG (Care Co-ordinator) and copied to PC (Manager of the Crisis Team) and RG (Team leader Manager, East CMHT).

On 7 December 2006 ABi attended a meeting at the invitation of SG (JM being unable to attend). Also in attendance were PC and AG. ABi wrote to JM on 8 December informing her of the outcome and matters discussed. (This letter was copied to SG and PC)

Matters referred to in the letter and the responding actions under headings 1 – 6 by Trust staff were:

'1. MH's Housing needs are being considered with a referral to YY Street, run by Stonham Housing Association. SG will follow this through'. SG's noted on 8/12/06 that referral had been made to YY Street. AG's notes confirm.

'2.(a) The Crisis Service currently undertaking a twice daily drop off of medication. This will be reduce(d) to once daily with a dosette box and will be monitored to ensure MH remains compliant'. SG's note stated 'Crisis Team will visit x2 a day to deliver medication. Current medication Risperdal Consta 50mg 2/52, Risperidone 2mg (?od) Depakote 500mg bd.' (SG made no reference to dosette box).

AG noted:- 'Crisis Team - they are currently delivering his medication once a day but feel they are doing nothing else particularly with MH. They will continue this for two weeks'.....'Currently on Depocote (Depakote) and Risperdal (Respidal) - to be reviewed at end of January.'

'2 (b) The Outreach and Recovery Team are being approached to take over the issuing of medication, as it is much more their role than the Crisis Service'.

SG notes:- 'PC to D/W (discuss with) AD the ongoing referral to the Outreach Team.' There was no corresponding note in Crisis Team records. *AG notes:- 'we all agreed that this was the level of support MH needed though their capacity is limited – PC will call AD and speak to her.'*

There is no record that he did so.

'3. In turn, the Crisis Service want to restore your confidence in their service so that you feel able to contact them for advice, if and when you are struggling at home with MH. It was agreed that what you can expect in terms of help and support from the Crisis Service will now be written into MH's Care Plan. This means that the person answering the telephone should be familiar and knowledgeable about MH and offer an appropriate response. In these circumstances the Crisis Service will speak to both you and to MH if he will come to the telephone.'

SG noted:- 'For JM's confidence to be restored in the Crisis Team so that she will contact them when needed'. There is no corresponding entry in Crisis Team records to indicate what, if anything, was done or what, if any, contact was made with JM.

'4.(a).AG to attend MIND and negotiate with staff for MH to be able to re-use this service. It was also suggested that New Dimensions may be able to offer MH some occupational interest and activities and SG will be making a referral to them. DM (of New Dimensions) who MH knows, will be approached to offer support to MH in attending these community based services to gain the benefit of social contact and occupation' SG noted 'AG to take him back to MIND' AG's note confirms:- 'MIND -

AG will pursue MH having access to MIND again.' The only reference in her notes thereafter is on 14/12/06:- *'We talked about going back to MIND - MH said he realised he needed to be quiet, not run about, not stupid (sic), be sensible. He thought he could do this.'*

In her evidence to us, KA of MIND recalled speaking with AG in December 2006 and recalled that it was agreed that MH could return although he was still hearing voices but they were not as intrusive. We found no corresponding record in AG's notes.

'4.(b) Suggested New Dimensions.

SG notes having made referral to New Dimensions on 8/12/06. *'MH's recent mental health history was discussed and it was agreed that the aim is to restore MH's health to where he was when he was at Hazelmead, although it was acknowledged that his overdose came as a complete shock for everyone. Confidence was expressed that MH's psychotic symptoms can be reduced again if he receives on-going structured help and support. It was also suggested that whilst his cannabis and alcohol use may contribute to his difficulties, it may not be the most substantive factor. What might be explored is, if there are any difficulties underlying his mental illness. Because he has expressed in the past some 'social' difficulties and he appears to benefit from a structured environment (Hazelmead) with a familiar routine, AG may speak to you about screening MH for an autistic spectrum disorder. People with such a disorder have social and communication difficulties that can lead to frustration and behaviour that is unacceptable to others. AG will explain more clearly.'*

AG noted: *'Aspergers - AG will arrange to do questionnaire with mum.'* This was done on 20 December 2006

5. *'I think these are the major points that I was able to take away from the meeting. Both SG and AG are very sympathetic to you in your circumstances and SG will remind you about the support service offered by (name), of Swindon Carers. I know (name) – he is a lovely man who will come out to you if you need someone to talk to. They also want to do their best for MH as a young man still with his life ahead of him.'*

Commentary: ABi did not meet MH on any occasion and her involvement was due only to JM's request for assistance. After the homicide she followed up with supportive correspondence to JM. We consider that ABi's response to JM and the support offered were entirely appropriate.

There is some disparity between the content of the agreed actions as set out in ABi's letter and subsequent action taken by Trust staff, although this is not substantial. Notwithstanding, the absence of any notes or actions recorded by the Crisis Team is of concern, particularly given that PC was present at the meeting.

Green Lane Hospital, Devizes

MH was admitted to Green Lane Hospital, Devizes as an informal patient on 22 November 2006. The need for a Mental Health Act assessment had been proposed on 1 November 2006 but did not take place until 17 November 2006, at which MH

was found not to be detainable. Another assessment was arranged to take place on 22 November 2006 at which MH agreed to admission as an informal patient.

MH's allocated consultant at Green Lane Hospital was Dr DS, a consultant in general psychiatry. In summarising his role and responsibilities, Dr DS informed us *'MH was admitted to Green Lane Hospital on 22nd November 2006 on an informal basis. I was allocated Consultant Responsibilities for MH's admission. As he came from Swindon which is outside the hospital's catchment area, we have a rota for Consultant Responsibilities. It so happened that I was the next on the list to take care of such a patient.'*

'My role was to supervise the care of MH during his admission, to make sure his medication was appropriate for his needs and that a Discharge Plan was put in place.'

MH was seen at Green Lane Hospital by a junior doctor on 24 and 27 November and on the second occasion the doctor recorded *'Need to discuss case with Dr PS and create POC (pathway of care)'*.

We could find no evidence of any direct contact between the psychiatrist at Green Lane Hospital with MH's Crisis Team Consultant, Dr MS, or with Dr PS, CMHT Consultant.

In the hospital medical records, Dr DS noted *'MH appears calm and friendly. He was willing to see me without question. He denies any auditory hallucinations, thought insertion, withdrawal or broadcast. He denies that he feels he is being threatened or wishes to harm others or himself. He wishes to go back to Swindon? Has accommodation) He is not concerned if he lives with his g. friend.'*

*Plan. I have had contact with SG (care cor (sic)
: I have contacted the Swindon CAHTT (Crisis Team) and they will phone back.
: MH is fit to return to Swindon. He is voluntary and thus can go on his his request.
I have no reason to stop him.'*

MH was discharged from Green Lane Hospital on 30 November 2006. In the continuous written record at Green Lane Hospital, there are 4 separate entries for that day:

'30/11/06 Dr S reviewed MH. He feels he doesn't need to be here and staff are to liaise with crisis team. His mother contacted ward and she is aware of this.'

30/1106 Contacted Swindon CAHTT (Crisis Team). They will liaise with ward this afternoon and are aware that MH does not wish to be in GLH and wants to return to Swindon. MH has been appropriate on the ward. Pleasant in manner.'

30/1106 T/C (telephone call) received from PC from CAHTT (Crisis Team) in Swindon to say they will support MH in community. PC agrees MH can be discharged. MH is currently off the ward at present so does not know the decision. Copies of medical notes and drug chart faxed to CAHTT in Swindon.'

30/1106 Returned to ward and informed of plan. MH was keen for d/c/ taxi has taken MH to girlfriends address. Given Ha's for 2 days and discharged as planned.'

Commentary: Dr DS's involvement was very limited. The episode of admission was managed in isolation from the longitudinal history and management of MH's care. MH's mental state and presentation settled quickly within the environment of the inpatient ward and a decision to discharge him was therefore not unreasonable, given that MH was an informal patient and that Dr DS did not have his full history, including recorded risks. However, the opportunity to consider any appropriate longer term management strategies was missed as MH was not cared for by his usual clinical team. We could find no corresponding entries in the Crisis Team records relating to any discharge or care planning consequent upon MH's return to the community.

The lack of consultant to consultant direct discussion and liaison is a clear deficit in the process of transfer of MH's care between the various teams who held responsibility for his care and treatment throughout the period of his contact with mental health services.

We conclude that this episode of care was not integrated into MH's overall care plan in accordance with the guidelines for ICPA.

Recommendation 50: The Trust should ensure that a clear process is established to ensure the integration of information and decision making for patients, where circumstances dictate that in-patient admission is not provided within the patient's usual care team.

Service Provided after the Homicide

We consider it appropriate to include the following excerpts from the evidence of Drs C and SB of the AWPT Forensic Service to give a clear picture of MH's mental state and presentation immediately after the homicide and his response to treatment in a medium secure hospital.

Following the homicide, MH was remanded to prison and he was seen there by Dr C, Consultant Forensic Psychiatrist with AWPT. Dr C saw MH on a number of occasions, including for the purpose of writing a report at the request of solicitors acting for MH. MH was transferred from prison to a Medium Secure Unit and Dr C was MH's Responsible Medical Officer (RMO) for a period of about a year until RMO responsibility was passed to a colleague in the same hospital.

We had sight of the report provided by Dr C to MH's solicitors and although this and Dr C's evidence to us related to matters immediately after the homicide, he was able to assist us with aspects of MH's diagnosis, presentation and treatment including the effects of prescribed medication.

In his evidence to us, Dr C stated '*.....When I first saw him, whatever about his past history, he was floridly psychotic. He has got very straightforward schizophrenia; he has been one of the most profoundly psychotic men I've treated. Very badly damaged by his disorder, I'm afraid.*

'.....It was becoming increasingly clear that there was no point in persisting with conventional anti-psychotics.....because he simply wasn't improving at the rate I would expect with conventional anti psychotics.....There had been some improvement but not much and we tried a range of conventional anti psychotics, as had the community, and we were rapidly arriving at the conclusion, once he'd got through the trial process, that we ought to treat him as a man who clearly was suffering, a young man actually who was suffering with treatment-resistant schizophrenia.'

In accordance with NICE guidelines, treatment was commenced with Clozapine to which MH made a good response although at the time that we received evidence from Dr SB (Later RMO) he was described as having made *'some improvement*.

Dr SB is a Staff Grade Forensic Psychiatrist who was acting as Responsible Clinician (or RMO) for MH during an extended period of consultant leave. She had been involved continuously in MH's care since his admission to the Medium Secure Unit on 27 March 2007. This was initially under the consultant care of Dr C, and briefly under the consultant care of Dr CB and Dr NC.

Although all of Dr SB's evidence relates to MH's treatment after the homicide, it is appropriate to include her evidence to provide some detail of MH's illness and presentation. Dr SB said *'MH has a diagnosis of paranoid schizophrenia. Over the time that he has spent (at the Medium Secure Unit) it has become increasingly apparent that MH's schizophrenic illness is treatment resistant, in other words, that high doses of a variety of antipsychotic medications have not fully resolved his psychotic symptoms, and he continues to suffer psychotic symptoms at the (then) present time.*

There has been a significant improvement in MH's presentation since his admission. Currently, and for at least the past twelve to eighteen months MH's mental state has remained relatively stable. He denies hearing voices but continues to believe that others can hear his thoughts at times. MH has described experiences which appear to be episodes of acute paranoid anxiety associated with feelings of panic and a need to retire to his room. These episodes appear strongly related to anxiety, but undoubtedly have a psychotic influence. It is clear that the amount to which MH is distressed by these incidents has reduced with time, and he repeatedly states that he feels more able to manage them. He continues to be very disabled by these episodes and they restrict his willingness to either take leave outside the hospital grounds or to take on new experiences and challenges.

MH has developed considerable insight into the more severe symptoms of his illness and is aware that this played a significant part of his index offence. However he continues to express mildly disorganised thinking at times particularly around the influences causing him to carry out the homicide of CJ.'

On his mental state at the time of his admission from prison Dr SB stated *'It was evident almost straightaway that he was thought disordered and it was a progression....it was within a couple of sentences it was obvious that he was not thinking in a clear logical way, but the longer you spoke to him the more disordered it got and the less sense it made.'*

In respect of MH's current explanation for the homicide Dr SB stated *'He clearly regrets what he did and is extremely remorseful. He understands the implications of it. Now he is of the view that he did not need to do that.....although he has got some insight into his illness and symptomsI think that in his own mind he is not completely convinced that Osama did not speak to him and that CJ did not commit these acts when he was a young boy. I think that for MH it is still one of those areas where he is really quite confused. He understand what he did was wrong, that he did not need to do it, but he deeply regrets it....what drove it is nothing like the intensity that it was at the time that he committed the act....I think that he lacks the real insight into that still.'*

On diagnosis Dr SB stated *'For the most part he remains much the same...he is better than on admission in that there is some stability to his mental state. He is nowhere near as thought disordered.....if you talk to him for 20-25 minutes there is some evidence that he is still quite disordered.....I think that he still guards and harbours quite a few vague delusional ideas.....they are quite unconstructed in his mind. They are vague odd ideas, but I think that they are delusional.....as a feature of his illness we have noticed a mood disorder part of it as a major feature.'*

Commentary: Drs C and SB were very clear in their view of the severity of MH's mental illness. Other than the fact of the homicide, we understand that they had no more information than Drs PS and MS.

Chapter 8

Non-statutory bodies and organisations

MIND (Swindon and District MIND)

Swindon MIND provides a range of services as follows:-

- What's on (Activity and Learning opportunities).
- Advocacy (Support for people to have their views heard).
- Solutions (Group 1 to 1 sessions).
- Information (Leaflets, articles etc on Mental Health Issues).
- Crisis House (Respite accommodation to aid recovery).

From our examination of the clinical (NHS) notes, we became aware that not only had MH been referred to and attended MIND but also that he had been banned on two occasions because of his behaviour. We invited KA, the Manager of Swindon MIND, to give evidence. She provided us with a written statement and her oral evidence was supplemented by copies of correspondence upon which she had engaged due to her concerns regarding the provision of mental health services in the Swindon area.

MH was referred in February 2005 to MIND What's On programme. This project offers leisure and learning opportunities for people with mental health problems. There are basic ground rules and in exceptional circumstances, if someone is unwilling to comply with the rules, then they are excluded from the service.

KA provided us with a copy of the Mind Activities Referral Form signed by both MH and a MIND worker. The form is dated 28 February 2005 and under Comments states '*Previous cannabis use. Psychosis. Voice hearer – stress related. Has never been hospitalised through mental illness.*'

The form is annotated '*Attended TWIGS but did not enjoy the work*'.

In her accompanying letter, KA says '*The referral form for MH did not raise any major issues as there was no information about offences or history of aggression or violence. We were also not told subsequently about anything serious until we banned him from our services and AG told me that he had command hallucinations that were worrying.*'

MH was judged to have broken MIND's rules repeatedly, ignoring warnings about his behaviour, and in June 2005 he was banned for a month.

In October 2006, MH was again excluded as his behaviour was unacceptable and he was considered to be too ill to attend '*agitated, acting inappropriately and disinhibited*'. His exclusion was until such time as his appropriate worker (AG of AWPT) considered that he was well enough to return.

In December 2006, AG contacted KA and it was agreed that MH could return to MIND although he was still hearing voices. However, it was stated that MH's behaviour would be monitored closely.

In January 2007, it was reported by a worker with MIND to KA that MH had attended the MIND Drop-in, that his mood was high, and that he (MH) had said that he not had his medication for weeks. It was the intention of MIND to assess MH carefully on his next visit but he did not return between then and the homicide in March.

KA's evidence to us was that, on their accepting MH to MIND, the information given to them was that MH had immature behaviour and was depressed. She advised that there was nothing significant at all in the risk assessments for MH provided by AWPT. MIND was unaware of the reason that MH came to mental health services and had absolutely no knowledge of any threats to kill or that MH carried knives.

Recommendation 51: Where the Trust is aware of serious threats or risk to others, it should ensure an appropriate exchange of information with other agencies engaged in the care and /or treatment of the patient.

Other Concerns expressed by MIND.

On 13 June 2006, KA wrote to the Chief Executive of AWPT, raising concerns about the provision of services in Swindon, and raising issues about the reduction in acute beds (2 wards closed), management, freeze on training and staff morale.

On 5 July 2006, LMc wrote a comprehensive reply explaining that she was new in post and was in the process of restructuring across the Trust.

On 16 June 2008, KA wrote to the South West Strategic Health Authority expressing major concerns and referring to a disruption of services over a period of 2 years while management changes had been implemented. The letter is a comprehensive document and in summary states '*AWP is a centrally run organisation covering too large a geographical area without the expertise or processes to run good local services*'.

KA also made reference to plans by AWPT to achieve Foundation Trust status.

On 6 April 2009, KA wrote a 3 page letter to the Member of Parliament for North Swindon setting out her concerns and in the final paragraph of her letter says '*I hope that by involving local MPs AWP staff will finally acknowledge how serious the situation is in Swindon and have a recovery plan that shows how they intend to improve the quality of their services. If not, I do not think they should be given any more chances otherwise AWP may be the next NHS Trust to hit the headlines*'.

Commentary: We were impressed by the strength and genuineness of the concerns expressed by KA both at her hearing with us and in her correspondence with AWPT, the South West Strategic Health Authority and the Member of Parliament for North Swindon. It is our view that KA is to be commended for her desire, and her actions, to highlight concerns about the service, with the intention of effecting improvement therein.

Culvery Court

When MH first came to the attention of psychiatric services, he was living at Culvery Court. Information obtained from the Internet indicates that Culvery Court is run by Threshold Housing Link, a registered charity which has been running accommodation projects for the homeless since 1972. It aims to provide safe and comfortable short stay accommodation. In respect of medication, their brochure states *'All medicines should be handed in to staff, who will secure it for you. Staff will monitor your medication to ensure that it is being taken as prescribed and not being misused.'*

Commentary: The plan formulated by DB stated *'Commence home treatment - Daily visits - 10 mg Olzapine Velotabs, - Administered by the Crisis Team.'* The subsequent non formalised delegation of responsibility for the administration of medication by the Crisis Team on 10 October 2004 to Culvery Court contravened both this plan and the instructions of a consultant psychiatrist.

Hazelmead House

In November 2004, MH was referred to and accepted for accommodation at Hazelmead House, which caters for people with severe and enduring mental health issues. As was the case with MH, most people are referred through mental health teams. In its brochure, Hazelmead House is described as a short term service, which can accommodate people for up to 2 years. Up to 14 people can be housed there. It is run by Jephson Housing Association and is staffed 24 hours a day. MH took up residence on 8 November 2004. In its literature, Hazelmead states *'The Aims of the service are*

- *To Promote the potential of each individual.*
- *To Empower each resident to achieve maximum independence, and to move on into appropriate accommodation.*
- *To Support each resident to exercise their rights and choices, in decisions relating to their lives'*

Staff of Hazelmead were experienced in mental health matters; and the managers were appropriately qualified.

MH was a licensee of Jephson Housing Association and resident at Hazelmead House between 8 November 2004 and 18 June 2006. Conditions of his licence required that he agreed to adhere to a set of House Rules for all residents. One of the House Rules is that no alcohol is allowed on the premises. Between 17 February 2005 and 17 June 2006, Hazelmead records show 9 recorded incidents of MH having alcohol on the premises, and 3 incidents of his being abusive to staff and other residents. MH was also served with 5 warnings, as set out in the statement by LC (Supported Housing Officer with Jephson South & West), dated 16 November 2009 as follows,

'09/04/05 Written warning for breach of licence agreement for causing damage to the property.'

18/07/05 28 days Notice of Termination of Excluded Licence for visitor nuisance, verbal abuse of staff, and violence (aggressive behaviour towards other residents). (This notice was successfully appealed after MH promised to modify his behaviour)
21/12/05 Written warning for breach of licence for nuisance by self and visitors (drunk and incapable) and visitors at the project after 10 pm

07/04/06 Notice of verbal warning for breach of house rules and/or licence agreement regarding alcohol on the premises.

18/05/06 28 day Notice to Quit for not accepting the support service, and consuming alcohol on the premises. MH did not appeal this notice, and alternative accommodation was found through his Care Co-ordinator.'

Monitoring of Mental Health

Initially in his engagement with the mental health services, MH talked about his beliefs that he had been abused when he was younger but later went through a period of months of not mentioning it until after an overdose of medication in February 2006 when he again talked about the alleged abuse and that he was going to stab the person involved. This information was relayed back to SG (MH's Care Co-ordinator) and AG (the Early Intervention Team Psychologist seeing MH) by his Hazelmead Key Worker, SH. There is no evidence to show that any of these staff identified that CJ was a real person with whom MH had contact.

In the Hazelmead statement of its aims current at the time, there is no mention of the monitoring of medication. Initially SG had monitored MH whilst he filled his 'dosette' box of medication.

According to SG's notes, she received a telephone call on 31 August 2005 from SC (joint temporary manager of Hazelmead with DS and a person of 20 years experience at the project) informing her of discussions that MH should take responsibility for his medication with which SG was in agreement. SG then discussed this with AG and continued to supply MH with prescriptions for a 28 day supply of medication. MH overdosed on a significant amount of Olanzapine tablets in February 2006 and was admitted to Great Western General Hospital in Swindon.

Note: Following the overdose, empty Olanzapine boxes were found on the floor of MH's room at Hazelmead.

The first incident concerning a knife is said to have occurred on 2 August 2005. Records indicate that the knife was taken from MH and placed in the safe at Hazelmead House. Given that the knife, which was used to kill CJ, was described in records as an oriental knife, we sought information as to the whereabouts of the knife which was taken by staff at Hazelmead House. Records at Hazelmead apparently do not show what happened to the knife and their records for the period 3 August 2005 to 31 August 2005 were missing.

Commentary: in July 2011, we were advised that the notes in question had been shredded by a former manager, contrary to Hazelmead's policy of record

retention. Hazelmead apologised to us for the late discovery of this information.

SG alerted staff at Hazelmead as to the existence of the knife, following a telephone call to her from MH's mother on 2 August 2005. Hazelmead records in evidence from LC in a correspondence report that the knife was a lock knife (the sort that fishermen use) and was operated by pressing a button on the handle. The blade was two to three inches long. In her notes, SG records that MH had obtained the knife to peel potatoes and she described the knife as a small oriental knife which was to be kept in the safe at Hazelmead. Hazelmead staff report that the knife is no longer in the safe but stated it would not have been handed back to MH and is likely to have been handed to the police for disposal.

Commentary: The absence of records is a matter of some concern. Further, the issue of supervising and monitoring medication does not appear in the brochure as part of the service provided by Hazelmead as it does in the Culverly Court Brochure.

In retrospect, the agreement that MH should assume responsibility for his medication with effect from 31 August 2005 could be deemed to be an inappropriate decision. However, we accept that risk is inherent in such a decision. Our concern, therefore, is that no risk assessment was undertaken and recorded.

Recommendation 52: Where medication is self-managed by a patient living in supported accommodation, the records of that organisation relating to AWPT prescribed medication should be maintained so as to ensure conformity to NHS standards of record keeping.

Recommendation 53: Any Service Level Agreement between AWPT and other providers of care and/or support, should include the obligation to keep and maintain records to NHS standards.

Recommendation 54: All organisations providing services for people, who are patients of AWPT, should have clear policies on medication and these policies should be approved by AWPT.

Note: Jephson has advised us that, since the homicide, it has introduced (or is in process of introduction of) the following changes:-

- I. Development of a *Disposal of Weapons Procedure* to ensure that a record is made of any weapons found and handed to the Police.
- II. Addition to the client's induction checklist to indicate who to call in event of an emergency.
- III. Replacement of the written Office Log with an electronic system .

Chapter 9

Organisational issues

Organisational Change and Impact

LMc, the current Chief Executive of AWP, set out for us her perceptions on the state of the organisation when she took up post in April 2006. This included a range of matters of considerable significance, which required immediate attention, and LMc and the Board were faced with a very substantial challenge. She advised us that, at that time, there was a major ongoing programme, which included a significant capital development programme (the Avon Transformation Programme) for the modernisation of estate; a smaller capital programme mainly in and around Swindon; and a major redesign programme of mental health services in Wiltshire. She described the impact thereof as she found it, '*.. the Trust and the Trust Board had been working for I would remember three or four years at this major programme and a huge amount of attention had been focused on modernising its estate and modernising the services and modernising the buildings that the services were provided out of. I felt that because they had been so focused on that, they had maybe lost ground in relation to the expectations of a Trust like ours in the round in terms of governance, in terms of national performance standards, in relation to managing the budget, so kind of managing it in the round I felt the focus had been put on to a very, very important piece of the Trust's work at the expense of some of these other issues.*'

In addition to the above major areas of activity, she advised that the Trust had not 'balanced its books' since 2001, thereby incurring an increasing debt; that level 1 of the NHS Litigation Authority Clinical Negligence Scheme for Trusts (NHSLA CNST) which is determined against a set of very clear standards, had been withdrawn; that a Health and Safety Executive prosecution was a possibility; that the Trust was not compliant with *Standards for Better Health for the NHS*; and that the then current structuring of the Trust mitigated against coherence in standards for, and integration of, clinical governance; and expectations of common clinical standards and responses to users of the Trust's services.

The Trust was not compliant with ICPA (the longstanding Integrated Care Programme Approach, a key foundation stone to ensure that patients receive the right level of care and that the health and safety of patients and others are at the forefront of activity). The Trust did not have a Patient Advisory Liaison Service (PALS), despite this being a statutory requirement; and was not meeting national targets for responses to patient complaints. It was necessary for LMc urgently to put into place the systems, structure and processes, which would allow 'grip' of the organisation and delivery of the responsibilities of the Trust and the Executive Team.

Commentary: It is evident that LMc inherited a very difficult situation, requiring an extensive change agenda, which would take considerable time to deliver in full and which could not have been fully completed by the time of the homicide in March 2007. Major change had to be effected on a number of fronts concurrently as each of the factors involved was of equal importance. The situation was subsequently compounded by the Department of Health decision that all English NHS Trusts, which had not achieved, or commenced the process of achieving, Foundation Trust status, were to be included in the next round of the process of assessing the 'state of readiness' for later application for Foundation Trust (FT) status. For the Trust, the process was to commence in September 2006 and there had apparently been no consideration at national level as to whether there were competing service and service user issues in the Trust. We were convinced of LMc's commitment to the improvement of services and to effecting positive change, whilst managing the state of readiness assessment. Notwithstanding that some staff at the time of investigation hearings indicated that they remained sceptical of, and distanced from, the change process, we recognised that the positive impact of changes is becoming partially evident in the current service, although concerns remain at operational level. There is a sense at that level that the change process had been protracted and remained incomplete at 2010. We would endorse this view on the basis of evidence provided to us.

Structural Change in AWPT

In May 2006, the Trust commenced a process of structural change for the organisation. Prior this, services had been provided on a geographical basis, with each area providing the same range of services, with the exception of the Swindon Forensic Service. There were eight separate geographical 'localities' and three specialist Units. The new structural model adopted by the Trust was that of the 'Business Unit' whereby services were managed across the Trust through Trust wide Strategic Business Units (SBUs). The five SBUs were Drugs and Alcohol Services; Older People Services; Secure and Prison Services; Adult Services; and CAMHS (Child and Adolescent Mental Health Services.) Some months after adoption of the SBU model, appointments to the posts of SBU Service Directors and SBU Clinical Directors were confirmed, with SBUs going live on 20 November 2006.

Commentary: We heard substantial evidence from witnesses in 2009 and 2010 about the time taken to implement these changes and the detrimental effect on operational services and the staff providing those services. This issue is dealt later in this chapter.

Timescale and Impact on Services

We were advised that *'there was a new structure of operational management.... (Strategic Business Units)..... In Swindon, there were very real concerns that there was a strong corporate approach for AWP, which was losing sight of local need and there was a feeling amongst staff that the management team were in Chippenham at Jenner House and the feedback we were hearing was that it was management by e-mail and comments like that..... AWP have redressed that now so it gives them*

a much stronger ability to stay in touch with what their staff in Swindon are saying, what their service users are saying and what the public in general are saying about their services and I think they had lost that for a bit with the reorganisation and the reshuffling of AWP as a whole organisation..... There was, I do now know what, some issues around recruitment to substantive posts and acting people in those posts in the interim. I think that caused some sort of issues around leadership.....staff were at a very low point, service user confidence was at a very low point.

Also about the Trust's current culture at January 2010, almost three years after CJ's death *'No, I could not say that they are there yet with the culture. They are certainly going in the right direction, but from the point that they started from I think it will take them some while and, in fact, LMc's view was that it would take her two years to turn the culture round.'*

Commentary: LMc took up post almost 4 years prior to our hearing this evidence (January 2010).

In terms of communication *'I would not be confident that the communication is as effective as it should be right now ...'*

In terms of the results of a patient survey undertaken in 2009 *'When I first read all the typed up feedback from service users, I have to say I felt sick because it was not service users asking for a gold standard – all singing, dancing service – they were asking for a basic one... i.e. someone to answer the telephone when you 'phone up; staff sticking to appointment times that had been agreed with service users, or phoning to reorganise if they were not able to, 'phoning to let them know they would be late.'*

We heard from individual current and past staff of AWPT that *'....it took a year and a half to have a management structure' and 'I guess that the frustration at that time was that there was no overarching responsibility for any of the teams, so all the teams were working basically in their own way, to their own criteria, there was no overarching management at all, so nobody was resolving any dilemmas or any conflict between teams.'*

Commentary: It would seem from this description that, at least initially, the change to SBUs prolonged the operational difficulties which they had been introduced to correct.

'The reorganisation should have taken 6 months – that's what they said it would but it is still going on now. Clinical Governance had just got embedded, then there was the 2006 reorganisation and then we had to start all over again..... I understand that they are continuing to reorganise to strengthen processes across the patch but that things are still not embedded. There is also the big impact of intended Foundation Trust status.

If they (staff) are confused, then it is explicable. The consequences are firstly that there is no place where staff are able to reflect quietly on their practice; they do not

know who is in charge or how to reflect their own practice; and secondly, there is the pressure of work, especially the pressure to get things done right.

.. all structures seemed to solidify and stand until the new system came in and it is still (at March 2010) only just coming in ...there are big improvements at one level but you cannot leave a workforce vacillating with no leadership and expecting it to continue.

Once there was the decision that localities would stop, everyone from top down was looking at jobs and whatever. If you do not look after people who are delivering, they do not look after people who need it delivered ...';

Commentary: Our view, based on the evidence we heard, was that clinical staff felt isolated, unsupported, outside the change process and unable to influence the direction of change. Also, that they were working in a situation without clear management support and accountabilities.

'The process is still continuing (at November 2009) We still wait for a major reorganisation of community teams within Swindon. We are still in the process of redesigning services in a Trust that is now we hope fit for Foundation status, which we are aiming to get in 2010'

And in response to a question as to whether leadership was there but focused on organisational change rather than leading the organisation ' I think that is absolutely the point – we had breakfast meetings at MIND of all the organisations .. and we heard it in those meetings. And the commissioners heard it..... I think the management of change has been at fault, the way that they manage that change. And I think a Strategic Business Unit could work if they felt secure and people do not appear to be secure. Certainly, patients are not at the centre. They are on paper but they are not..... staff were at a very low point, service user confidence was at a very low point.....I feel that the modernisation that has happened is I think actually putting pressures on the system, which is not always in the best interests of the patients.'

Involvement of Staff in the Change Process

Evidence from staff at operational level was generally to the effect that they did not understand, or did not accept, the reason for the structural change and that they did not feel engaged in the process. Comments from staff included *'I would say that the focus was more on financial management than clinical management. In order to drive that through, I think there were conflicts, not around clinicians, who felt disempowered, and at the same time I think, after having brought things to the notice of management at whatever level, I think they felt disenchanting that nothing was happening and ultimately there came a stage where people were afraid to express these views.....I think there have been concerns expressed about clinical involvement and management for a very long time and to some extent I think it is delivery of care, how things should be managed, but there is also an issue around patient focus and quality compared to financial management The other thing is that staffs have felt really unsupported. Their work has not been acknowledged,*

difficulties are not acknowledged at times and support has been lacking. People have been doing a very good piece of work but at times feeling quite demoralised.

Team management excellent, above that one got the impression that they were finding it difficult and did not know what to do. In fact, one of the managers used to tell me he was only a messenger.... above that there was another culture of this must be done by this date and at times I think people..... were expected to produce a report within 24 hours, that you should look at your caseload and produce this within the next 48 hours, which I think put people under stress.'

In terms of the management culture then prevailing, 'All I can say is that that sense of caring does not exist.'

Commentary: The lengthy process of implementing change and the consequent impact on operational services were highlighted in the earlier internal investigations into the care and treatment of MH and we were concerned to hear that the fundamental underpinning involvement of staff in the process for safe and effective patient care was being reported as still not having been addressed nearly three years later.

We are aware of the obligation to consult with staff on the process of change and also to follow employment law and NHS specific processes when organisational change puts staff potentially at risk of redundancy and were aware that both obligations may delay the implementation of new structures. In this case, there were very clear views from staff at operational level that the processes followed were unduly protracted; that there was inadequate consultation with staff working at clinical level; and that the change process left them feeling isolated, unsupported and unclear as to where their lines of managerial and clinical accountability lay when key posts were becoming, or being left, vacant as the 'top down' approach to implementation of the new structure progressed.

It is not for us to comment on the SBU model per se apart from concerns about the geographical spread of AWPT and its impact on the feasibility of managing all services on this basis. However, it is appropriate to comment on evidence from some staff, which indicated that the continuing process of necessary change was damaging, divisive and reported to be still not fully complete as late as 2010, 4 years after the change process commenced and 3 years after CJ's death.

These issues are addressed in more detail later in this chapter but this period of organisational and managerial instability, combined with consequent uncertainty at the level of service delivery, occurred at a critical time in respect of the care and treatment afforded to MH by the Trust. The change process covered the latter part of the period in which MH was receiving care and treatment from AWPT and when his mental health was deteriorating and we consider that some of the failings in his care were a probable consequence of the concomitant organisational disruption arising from structural change. The assessment of the Trust's state of readiness for Foundation Trust

preparation commenced in the autumn of 2006, coincident with deterioration in MH's mental health.

LMc provided us with copies of papers, which she had presented to the Trust Board in April, May, June, August, September, October and December 2006; and January 2007, together with an Operations Report presented to the Board in September 2007 by MS, then Chief Operating Officer for the Trust. In each of LMc's Board papers, the primary subject was the challenge of sustainability and this was addressed under the following headings (albeit that some of the exact headings differed in different papers). Also, there were other items included in individual papers, such as the NHS Confederation Conference, but these were not recurring themes:-

- Financial sustainability – achieving and sustaining financial balance. (4/06; 5/06; 6/06; 8/06; 9/06; 10/06; 12/06; 1/07 Board meetings)
- Governance – achieving and sustaining integrated governance structures, systems and processes necessary both for the present and for Foundation Trust status and beyond. (4/06; 5/06; 6/06; 1/07 Board meetings)
- Organisational shape/sustainability – achieving the benefits of scale and the range of high level skills in the delivery of consistently high quality services. (4/06; 5/06; 6/06; 8/06; 9/06; 10/06; 12/06; 1/07 Board meetings)
- Director portfolios – ensuring the close alignment of the director portfolios with the achievement of Trust wide organisational objectives. (4/06; 5/06; 6/06 Board meetings)
- Technological – making maximum use strategically and operationally of technological solutions given the size and scale of the Trust. (4/06; 5/06; 6/06; 8/06; 9/06; 10/06 Board meetings)
- Estate – making maximum and cost effective use of all the Trust's physical assets. (4/06; 5/06; 6/06; 8/06; 9/06; 10/06; 12/06 Board meetings)
- Environmental – developing as far as is practicable cost effective 'green' solutions to a number of business challenges given our shape and scale as an organisation (4/06; 5/06; 6/06; 8/06 Board meetings)
- Workforce – ensuring that we have the processes in place to appropriately support our existing workforce and constantly address appropriate skill mix issues across the whole Trust. (4/06; 5/06 Board meetings)
- Service users and carers. (4/06; 5/06; 6/06; 8/06 Board meetings)
- Sustainable partnerships. (6/06; 8/06; 9/06; 10/06; 12/06; 1/07 Board meetings)
- Next steps in Foundation Trust status. (6/06; 8/06; 9/06; 10/06; 12/06; 1/07 Board meetings)
- Meetings with staff. (6/06 Board meetings)
- Service sustainability. (8/06; 1/07 Board meetings)
- Service news – 10/06; 12/06; 1/07 Board meetings)
- Sustaining high performance – 1/07 Board meetings)

Commentary: We recognise that NHS strategic and service activities are subject to national direction but were concerned that a Board facing the range of issues set out by LMc was being required to consider such issues as the 'green agenda' and Foundation Trust application when there were major concerns about the context in which services were being delivered to patients. Equally, we were concerned that there was minimal reference to, and

apparently no strategy for, the effective engagement of staff at all levels at a time when financial recovery inevitably impacted on those activities (particularly communication, managerial continuity and training), which support safe and effective clinical activity.

We felt that there was a parallel here with LMc's own comment about the major modernisation and development programme in place at time of her appointment '....*managing it in the round I felt the focus had been put on to a very, very important piece of the Trust's work at the expense of some of these other issues.*'

In respect of staff training, we noted the contrast between LMc's oral evidence at a hearing with us that 'You *do not cut back on training. It does not save you anything in the short term, let alone the long run. It is not part of our strategy.*' And her paper to the December 2006 meeting of the Trust Board, in which she stated 'All training which is not statutory or mandatory has ceased and will not be reinstated during this financial year' (1/4/06 – 31/3/07) This was a situation inherited by LMcM as the budget had already been set prior to her appointment as Chief Executive and allowed for statutory and mandatory training only. She advised us that increased resources were allocated to the training budget as soon as possible. Notwithstanding, we heard evidence in January 2010 that staff were unable to access mandatory Risk Assessment training '.....*we are asking on a regular basis .. all we are doing is sending an e-mail so that we have evidence (for professional Codes of Conduct responsibilities) if asked it is very difficult for the manager as well*'

The Trust informed us that from 2007 to the present day, it has had a full programme of statutory and mandatory training. There is never full uptake of training opportunities and therefore always spare capacity. In the 2010 national NHS staff survey in relation to the question on the 'percentage of staff receiving job-relevant training, learning or development in the last 12 months' the Trust scored 81% putting it in the top 20% of mental health/learning disability Trusts. This score was consistent with the 2009 results. The Trust had a good response rate to the survey at 58% response.

Commentary: Our view is that a primary force for safe and effective services for patients is the staff themselves, particularly those working at operational/clinical level. Effective financial recovery involves a holistic approach, which addresses every aspect of an organisation's operations and the long term agenda, as well as the immediate (albeit 'crushing' in AWPT) need to 'balance the books' and conform to national requirements. (There is further comment on this in paragraphs below relating to Risk Assessment training, clinical supervision and clinical caseloads)

External Pressures on AWPT

LMc set out her view that the degree of specificity required by the National Service Framework for Mental Health had actually mitigated against fluidity in the care pathway for a service user, resulting in '... *a much more clunky set of systems and*

processes and handovers than we might have had, had we not been having to adhere to fidelity criteria which was rigorously enforced in relation to National Service Framework targets of what teams needed to do, who needed to be in them, what was expected of a team, the training that they needed to have in order to meet those expectations.'

She intimated to us her hope for 'Much more relaxation in terms of the next mental health strategy from the next government when we can get back to much more flexibility of clinical judgement within the standards that are being accepted as opposed to the process of one team's responsibilities vis a vis another and all the skills that have got to be in that and if you do not tick all the boxes....'

Commentary: On the basis of our own interface with the service in the process of this Investigation, we have some understanding of, and sympathy with, the frustrations experienced by NHS managers in the context of a largely prescribed approach to care. Board and other papers provided to us were complex and difficult to comprehend. We felt that the size, standardisation and complexity of those Board documents which were provided to us would allow for very little effective consideration and debate of the issues in question, potentially leading to a situation where the Board level recorded evidence of service provision was not aligned to practice at the operational level.

Approach to Organisational Change and Sustainability

The Strategic Business Unit restructuring was based on a top down approach and we were made aware of substantial changes at senior management level. Staff reported that a number of people holding key posts left the organisation, although this may have reflected internal moves rather than people leaving employment within the Trust. Some staff felt that the change process did not take due account of history, relationships and the differing needs of the different areas of this diverse and geographically dispersed organisation.

One witness advised us 'I think it was the transition between we had the localities and I think we had something like ten localities within the Trust ... There was not proper direction, there was not proper communication from the central Trust. I felt Swindon was left very isolated, very unsupported and we were left to get on with things.....'

Also 'And then we have had the transition into the SBUs, Strategic Business Units and that has brought issues within itself and I think one of the issues is that you have numerous directorates, who are giving numerous directives and they are not always integrated. That is one issue. I think another issue is that directives, what may suit Bristol South many not necessarily suit Swindon'

Also '...we had a fantastic carers' initiative in Swindon many years ago and then when the SBUs came in you lost it because there was big brother telling you what to do as regards the carers..... Sometimes the Trust is too slow and ... If decisions have to be made it is very slow as well and sometimes you need to get on with things.'

In December 2009, another member of staff said in evidence, *'I think in moving determinedly away from locality management we lost a certain amount of clinical engagement in those localities and people said it is all being done up at HQ and indeed that is what was happening but that was determined and sensible for the Trust to do that, but I think there is a loss of some of the local engagement so the issue now is to get reconnections but within a much more streamlined structure that makes the clinical governance and whole issue of quality of care something that the teams live and breathe week to week, month to month...'*

Another witness advised *'The locality system had been abandoned..... within a locality, we had partnerships with all the major stakeholders, we had monthly meetings with all of them.....I think the dissolution of the systems that were in place like an Acute Care Forum, monthly meeting with the police, regular weekly management meetings with the Community team meetings with charitable organisations ... all of that just went at a stroke.'*

Evidence from clinical staff suggested that Executive focus on patient care took second place to the financial recovery and change programme, rather than being a driving feature of an integrated, 'whole system' approach to recovery. When asked about what was conveyed to us as a perceived break in the relationships between the executive function and the clinical function, LMc told us *'That is not how I recognised it when I came. I do not think there was one there in the first place. I do not say there was a strong relationship. I will not say any relationship. There was no evidence to me of any strong relationship between the locality senior managers and the Executive Team and the Board.'*

We were advised that during the recovery process, appointments to clinical vacancies were rigorously reviewed and in some cases cancelled or delayed adding to the high caseloads and pressures reported by clinical staff. LMc's paper to the December 2006 Board meeting stated *'The weekly recruitment scrutiny panel continues to meet to consider whether, when a post becomes vacant anywhere in the Trust, it should be released for immediate recruitment to, held for a specified period or held for the rest of the financial year. Potential clinical risk to service users is the most important consideration for the panel in reaching its decision about whether and when posts should be released.'*

This is not reflected in the views of clinical staff who considered it to be a vacancy freeze, which did impact negatively on services to patients as clinical posts were not released for recruitment.

We were told that in the Assertive Outreach team (AOT) *'We had a period back in 2006 when all posts were frozen, we did not (recruit) any staff, two care co-ordinators had left and we had no consultant cover..... It was a very difficult place and time we were going through. It was about financial stability and the Trust getting back on track and all posts were frozen for a period of time and there were no replacements for a period of time.... We had two unqualified posts uncovered.'*

We were told that there was a later recruitment programme.

Commentary: It appears that vacant posts, some of them in frontline clinical services, were concurrent with new appointments at Executive and senior manager level. If the information given to us was correct, then there is an issue around the later recruitment drive. Our view is that either those posts were essential for safe and effective clinical services, in which case they should have been released for recruitment; or they were not and should not have been reinstated. We heard from CMHT and Crisis Team staff involved in MH's care that their view was that the team best able to address his needs would have been the Assertive Outreach Team. This team had decided that they should not accept any new patients onto their caseload as this would compromise the care of existing patients. This was just one of the teams where medical and nursing staff numbers were reportedly depleted.

Organisational Culture

Many staff seen by us expressed their view that the Executive Team, the Trust Board and senior managers were, and have continued to be, distanced from the operational service and did not involve staff and clinicians effectively in the change process, leaving them disengaged, disempowered and with a strong sense of not being listened to and of arrogance by both individual managers and the organisation. The sense of exclusion was not related to the Trust alone and evidence from MIND and NHS Swindon indicated that they felt isolated from the change process. The structural change involved significant job changes and, in accordance with usual NHS practice, the process was 'top down' with top level structures being implemented first, followed sequentially by changes further down the organisation. This resulted in staff feeling left 'in limbo' as existing organisational structures and lines of accountability and leadership were fractured or disappeared. We heard that some clinical staff were unsure for a protracted period as to the chains of command and where services fitted in the new organisational structure.

We heard that significant managerial vacancies and/or temporary 'acting up arrangements' during the change process led to a sense of what is best described as 'organisational stasis' for many staff at operational level and the number of changes at senior level, both managerial and clinical, was notable. The Trust subsequently advised us that staff may have mistaken internal job moves and retirement for more 'generic' leaving. Whilst we recognised that this was an opportunity for the Trust to implement new and key appointments, we were concerned at the impact of the change process.

It was within this relatively chaotic period of change that staff were managing the care of MH.

We heard evidence from CA about AWPT's unwillingness to provide information either on time or to request and her view was that the Trust had still '*a bit of a culture in there about openness and transparency and sharing.*'

Commentary: We would endorse this view as consistent with some of our own engagement with the Trust.

A wide range of witnesses expressed their views that the Trust did not listen to staff and in the case of MH, to carers, or listen in terms of learning from past experience. In some cases, staff were willing to acknowledge this and in others the response appeared unconcerned. We were told *'If JM (MH's mother) feels that she was not listened to that is regrettable. It is central to the delivery of our care that we should take on board the views of relatives, families and carers.'*

In contrast *'I would say that looking back on it now, we certainly failed with JM in terms of what she needed as a carer and a vulnerable person.'*

Commentary: It seems that the messages from JM, both direct and indirectly through SG, had been unequivocally clear throughout but appear to have been generally recognised only after the homicide had occurred. Furthermore some members of the Crisis Team had been dismissive of information and views provided by JM about MH and dismissive of her own needs.

In the clinical context of MH's care, it was clear that some individuals were not listening to colleagues or to MH himself about the degree of risk he posed. With the exception of primary notes kept by AG, Psychologist in the Early Intervention Service, staff had access to the same records as we did but many did not 'hear' the risk:- knives, threats to kill, threats of self harm, harm to others, cruelty to animals and failure to comply with medication. Even within the Crisis Team, the threat to kill two of its members was not communicated.

Witnesses provided many examples of where staff believed that they had not been listened to. These included:-

- Non-implementation of agreed action and policy for the Mental Health Liaison Service based in Great Western Hospital, following representations by staff.
- No response to a letter from the Assertive Outreach Team (passed on to a senior manager at SBU level) setting out concerns about the lack of medical staff cover. The Trust advised that the senior manager at SBU level did not refer the letter to the Recruitment Scrutiny Panel for consideration.
- No change of plan following provision of a reported comprehensive risk assessment in respect of the proposal to decommission the Swindon Forensic Service, nor in respect of a secondary proposal to allow an 18 month decommissioning period so that knowledge and skills could be transferred to the community teams. (In the event, the decommissioning was reported as being speedily implemented and we were advised that in the process all non clinical records were destroyed.) (*This issue is considered in more detail in Chapter 7*)
- Failure to take action on reports of an inappropriate approach and management style by a senior manager.
- A Risk Management Plan about one service area, development of which involved other teams and Consultant Medical staff, which was believed not to have been presented to the Board.
- Evidence that:- *'On a daily basis, my manager was saying that this job is not manageable, it is not doable, it is dangerous, it is risky but it is not just risky to patients it is risky to our staff and that cannot be allowed to continue..... I think it has possibly even got worse now (2010) but the boxes have been ticked and it looks wonderful, all singing, all dancing a wonderful service....'*

- Evidence that:- *The team members look after themselves but managers live in a separate, you know, or that is how I feel' (January 2010)*
- No meaningful engagement of clinicians in the process of management, leading to action by consultants in Bristol, developing a proposal for them to leave the Trust. (with subsequent mediation arranged by the Strategic Health Authority)
- Evidence that:-*'I think the problem has been lack of meaningful involvement, lack of meaningful consultation..... Yes, you could say we were asked for an opinion but usually I think it was a fait accompli, that you were asked an opinion after something had been decided..... Basically, it was decided that this is what is going to happen and this is what we are going to do... there was a sense that you could not speak against management'*
- Evidence that:- *'There was a sense that clinicians were deliberately not being involved.'*
- Two staff at Executive Level referred to the failure to learn from previous Investigations and Inquiries, one asserting that *'Nobody ever learns from the lessons... the issues are the importance of record keeping – importance to staff – and the quality of interactions with patients.'*
- There was evidence of a lack of appreciation at senior management level of the seriousness of some of the issues involved. One senior manager described long-standing, extensive and divisive relationships between two of the teams engaged in MH's care as *'the rub'* and another as *'frayed conversations.'* Others told us of *'heated conversations'* and that *'tensions were at a hatred level'*.
- With the exception of LMc, Chief Executive, and Dr SO'C, previous Medical Director, we did not hear any evidence that, at senior level, there was real acknowledgment or appreciation of the enormity of the homicide in terms of its tragedy and the impact on the families and the staff, who had been closely involved in MH's care.

Commentary: We noted the information provided by the Primary Care Trust to the effect that in a user survey *'.... all the way through the feedback we got from service users and carers, from the initial angst and frustration at no point has the service user ever had criticisms of an individual worker. They have praised them.'*

Threatening Management Style

We were presented with a range of evidence to support what staff perceived to be a threatening culture within the Trust. One very senior manager in particular was singled out as demonstrating this approach.

One manager described having submitted a report about genuine service concerns and *'since then have found myself in a sort of trouble.'*

Other staff comments included *'a critical atmosphere characterised by 'You've got to' approach.'*

'I have been at meetings where it has been said and voiced to several people around that people need their jobs, don't they, so there is a threat or backhanded threat. I

have heard that on more than one occasion, they need their jobs; they need to be able to work. Those are the threats in the background unfortunately. (Names of two senior managers) have been at those meetings, and said those types of things.'

'Overall it is a toxic environment, where people keep their heads down and get on with their own work.....The management style of the Trust underpinned all these issuesthese are human beings, who were stretched and not managed and supported. There was a culture where people felt the need to be seen to be doing things. Dissent and disagreement were not encouraged or seen in a positive light..... if you are resistant to management, you become a marked person.... That is a powerful message and part of the dominant culture. People will fear to use Whistle Blowing... the Trust needs a management culture where people can say what they like. Staff are not listened to.....It was the speed of the organisation, the critical culture, the 'Your job is on the line' approach.'

'.....a huge amount of organisational change and a critical atmosphere characterised by 'You've got to' approach. This all put managers under a lot of pressure.'

'There are a lot of people who do and even today there are a lot of people, who would use bad language'.

Recommendation 55: The Trust should review its Dignity at Work policy to ensure that it supports appropriate management styles and that staff can raise genuine concerns without fear of retaliation.

Commentary: We consider that this reported management style is inappropriate and not conducive to best clinical practice. There are also the potential issues that services were being driven by the management agenda, as opposed to patients being at the heart of all Trust activities; and that important clinical activities may have been taking second place to managerial demands.

Adherence to Appropriate and Good Practice

Wider concerns about clinical record keeping in the Trust in general are addressed in a separate section in this chapter. However, in the process of the Investigation, we heard evidence of poor practice and potentially malpractice. We were told *'Well unfortunately I have seen this happen on more than one occasion. When there are some serious questions to be answered, a lot of things are swept under the carpet in my opinion. I have seen it happen before..... I have seen the whole lot go missing..... staff before this happened got concerned that care plans that they had written and filed away had been torn outThere was another case where the notes disappeared....."I think the (Police) were deflected (from seeing the Crisis Team).'*

We were told by a member of the Trust's Executive Team *'I think every inquiry that has ever sat on any aspect of mental health care discovers problems with the notes and I would be amazed if this inquiry did not. Am I satisfied with that? Certainly not.'*

And in respect of any system for audit and checking of notes to see whether they are adequate for the purpose *'There is a system -- trust wide organisation of the way we handle our medical records ... a policy was developed and may well have been around this time in 2003/04, for getting a unified approach to the record, getting a single health and social care record in place for a state that covered the whole Trust and then getting organised systems as to how we physically hold the records and move the records around. It is imperfect and in many parts of the organisation really does not work very well. That is simply because we remain in a manual hard copy record that has to move around between functional teams often at great speed ... and the tracking of notes is exceptionally difficult'*.

Commentary: It is clear from this evidence that the Trust, including at least one Executive, was aware of problems with records management but the case of MH appears to indicate that nothing had been done to address this, albeit that it is a feature identified by most homicide Inquiries and Investigations. And thereby that, by omission, senior managers in the Trust were culpable in this matter in not enforcing and monitoring its own policy in respect of records management. We noted that the Police did not interview members of the Crisis Team, given their involvement with MH in late 2006 and early 2007 and the fact that there was major disagreement between the Crisis Team and the CMHT in respect of the proposal to hand MH's care back to the latter in early 2007.

We heard from DB, the first manager of the Crisis Team, that as Team Manager he had responsibility for quality assured records and notes, which are legal documents, and that he was surprised that there was no record of his own reported visits to MH.

Commentary: Our view was that DB's lack of record keeping on occasions did not accord with Trust policy requirements, his professional obligations or his responsibility for acting in an exemplary way for other members of the Crisis Team; and that he also failed in his responsibilities for ensuring that records were properly completed by the Crisis Team.

Staff Engagement

LMc advised that the Trust put in place a number of processes for improved staff engagement, including her as Chief Executive meeting staff across the Trust in the four weeks before she formally took up post and afterwards spending *'a long time talking and engaging with clinical teams'*, team briefing system (including video team briefing); staff magazine, staff Award Ceremony, and development programmes for clinical staff and middle managers. But staff perceptions on the inadequacy of staff involvement in the change process, were highlighted by a much later article which appeared in the *Health Service Journal* in 2009 (two and a half years after the homicide and when we were still hearing continuing concerns from clinical staff about the change process).

PC described the set up of the Crisis Team as *'Well, basically a team had been put into place. There was some consultation but not really a huge amount of consultation. That left the CMHT extremely angry.... The tensions were very*

serious.....at a hatred level.' He also confirmed that these tensions detracted from the effectiveness of care.

Commentary: Staff involvement cannot be judged solely by the processes put in place to facilitate it but rather than by the efficacy of those processes as demonstrated by the perceptions of the staff themselves. In a situation of major change, uncertainty and the loss of many senior staff, the effective involvement of staff is a challenging issue and we believed from evidence presented to us that, in AWPT in at least 2006 and 2007, gaps in the managerial structure exacerbated the sense of clinical staff being 'adrift' and uninvolved.

The Integrated Care Programme Approach (ICPA)

We drew on the advice and assistance of an independent expert, JMo, in respect of the documentation associated with Care plans for MH.

The term '*Care Programme Approach*' has been used since 1990 to describe the framework that supports and co-ordinates effective mental health care for people with severe mental health problems in secondary mental health services. AWPT provided us with a copy of a document entitled '*Integrated Care Plan Approach (ICPA) and the Assessment and Management of Risk Policy, Procedures and Guidance.*' This policy is stated to have been reviewed in November 2006, comprises 49 pages and in the introduction states that '*This policy replaces previous Trust policies, Framework for the Integrated Care Programme Approach, Non-attendance and Failure of Patients to Keep Home Visit Arrangements and Policy and Tools on Assessment and Management of Risk for AWP.*' This policy was stated to have been ratified by the Integrated Governance Committee in March 2007.

MH came into psychiatric services in September 2004, but the first documented Enhanced Level Care Plan is dated 3 March 2005 although the ICPA meeting is shown as taking place on 1 March 2005.

There was an initial core assessment carried out by the Crisis Team on 17 September 2004, the reason for referral being noted as '*Bizarre behaviour - ? Early onset of psychosis. Expressing suicidal & homicidal ideas.*' There is also reference to wanting to *seriously harm his alleged abuser, was of low mood and if he is unable to confront his alleged abuser then he will jump in front of a train to end his life. He believed that a DJ on the TV is pointing at ?him? and has some strange and unexplainable delusions relating to 'Rusk'. MH also believes taking medication will show the 'scar' on his face (no visible scar) and is therefore very suspicious of taking medication.*

The Mental State Examination record includes '*MH being guarded and suspicious with poor eye contact. Mood - quite low, very frightened and confused. Believes a scar appears on his face when he takes medication. Obsessed about abuse at 9 years + 16 years 'Rusk' unclear at present. Delusions - Possible delusions re above. Believes DJ on T.V. is pointing at him. Paranoid about people on street + in hostel. Insight – Some*'

On 1 March 2005, Dr PS saw MH for the first time. At the end of his notes of that consultation, he states *'Plan (1) continue medication (2) support/monitoring Hazelmead staff (3) support/monitoring SG (4) review as required.'* In her record on that date SG recorded *'CPA review with Dr PS, view letter. Action (1) to complete full core assessment.'*

An undated core assessment document appears in the records. The content of this document appears to accord with the action required following the ICPA review by Dr PS and SG. The core assessment is 24 pages in length and contains a comprehensive history including reference to MH using cannabis and alcohol, to alleged abuse and *'Obsessional thoughts - Centred around this is MH believing he has to now kill CJ and if he succeeds in this he will be 'crowned' (street cred) and gain respect and be feared by everyone in Swindon. Any plans to act upon this have been denied as MH fears prosecution. He also believes that (DJ) on a video is pointing at MH on his video, this indicates that (DJ) has also witnessed and suffered sexual abuse. Believes he's caused a friend of his to get schizophrenia by staring at him.'*

The Care Plan appears to have been formulated from the core assessment and is a document of 9 pages. It is signed by both MH and SG and is dated 31/3/05.

The form indicated that a copy had been given to MH but the entry to indicate that a copy had been given to his carer was not completed. It also shows under the heading Assessment completed *'To be completed'* on 15 April 2005 SG noted *'CPA copy given to MH and his mum.'* SG advised us that the Carer Assessment process was not so driven at that time but that she was involved in a lot of Family Work sessions with JM and had frequent contact with her although the formal paperwork was not completed.

There is no record of a carer's assessment being carried out but the form shows that the Care Plan will be reviewed on or before *'Date Sept. 05 -Time -TBC(2) (to be confirmed) - Place The Mall'* (the work base of the CMHT). There are no notes or documentation to support any review of MH's care plan in September 2005.

On 31 January 2006, apparently some 4 months after the written review date, the Care Plan was reviewed. MH, SG and Hazelmead staff were present when a Keywork Session took place. The review consists of 2 pages with page 3 missing. However it was signed by MH and SG and shows that copies were given to Dr PS, AG and Hazelmead, and to the service user (MH). Carer's needs were shown not to have changed and that MH's needs should not be reassessed. Within the records, we could find no reference to a carer's assessment having been carried out. It was agreed that a review of the care plan should take place on or before July 2006 with the care team. JM confirmed that no carer's assessment or plan had been produced for her.

On 25 July 2006, an enhanced level care plan was signed by LD (Crisis Team) as Care Co-ordinator although SG was still, in fact, the Care Co-ordinator. SG was not recorded as being present at the review. The document is incomplete as to attendees and whether they received copies. The form gives details of MH's medication but gives no details of his care plan and the *'Summary of risk factors'*

section is blank. There is no information as to the date when the care plan would be reviewed, but the form shows that MH's current medication was prescribed by Dr MS.

JMo, expert witness, examined the documentation relating to MH's care planning and commented that *'Compared to other documentation the review of 25.07.06 appears to have been filled in rather hastily with quite a lot of information missing and as far as (I) could see there are still no involvement of MH or his mother in the care planning process. The care plan is also signed by a member of the Crisis Team rather than SG'* (MH's appointed Care Co-ordinator).

The next Enhanced Level Care Plan, of which there are 2 copies, shows the date of the ICPA meeting as 26 July 2006. Document (1) eICPA 8 is handwritten with page 7 missing. This document is unsigned and the date of the ICPA meeting is blank. However Document (2) eICPA 12 Enhanced Care Plan (printed April 2006) is typed and consists of 4 pages. This document is unsigned but it shows that SG and the Crisis Team were invited, present and given copies of the plan.

A further entry by SG on the same date in her record states, *'Attended the Crisis Team base. Risk assessment and plan formulated.'*

JMo commented that *'.....this care plan again (does) not set a review date on the final page nor was it signed by the service user or Care Coordinator and therefore it is very difficult to see how this particular care plan is a valid document as again there is no evidence that the views or presence of Mrs JM or MH were at the meeting and without a review date being set and a signature being offered I do not see how this could be accepted as a valid document in relation to the review of MH's care and treatment within the Trust.'*

On 14 November 2006 another Enhanced Level Care Plan was formulated and comprised 7 pages. This form also includes updates on 22/11/06 and 30/11/06 within the body of the plan which is signed CS as Care Co-ordinator and dated 14/11/06.

Commentary: From examination of the Crisis Team Clinical Records, it appears that CS was a student nurse in training with the mental health service and not Care Co-ordinator (nor qualified to be) as SG rightly remained MH's Care Co-ordinator throughout the whole period of his engagement up until the homicide.

The form shows that the Crisis Team was invited and present as was Dr MS (Consultant with the Crisis Team). SG, Care Co-ordinator, was not invited nor was the Team at Windswept, where MH was then living. SG, Windswept and Dr MS were not given copies of the plan nor was MH's GP.

In the summary of risk factors it is set out *'If you do not continue with your current plan i.e. taking medication and agreeing to home visits you are likely to suffer from a relapse in your mental state - psychosis. Risk of not engaging with mental health teams. Risk of severe lack of self care. Risk of becoming aggressive - MH has stated that he is angry with certain people. Withdrawal from social networks i.e. (G/F) his girlfriend. MH has also been known to carry a knife.'*

Risks associated with excess alcohol and cannabis are also noted. When signing the form on 14/11/06 CS stated '*not appropriate to ask him (MH) to sign due to MH's lack of insight and fears of him not engaging.*'

There is no record to indicate that copies were given to either MH or his carer.

Page 3 of the document has columns for completion as to the service user's Needs, How these will be met, Person Responsible and Start date and how often. Under the heading '*Your needs*', the entry reads '*update 22-11-06 - review of mental state. Deterioration in psychotic symptoms, medication does not appear to be holding him*'.

Under the section '*How these will be met*' is stated '*MHA Assessment. Informal admission to Green Lane hospital Imber Ward.*'

The section headed, '*Person responsible*', reads, '*Crisis - LDS Green Lane Hospital - with liaison with Swindon crisis team.*'

The section, headed '*Start date and how often*', reads '*22-11-06. Update 30-11-06.*'

Under section, '*Your Needs*', is stated '*monitor mental state*', and under '*How will these be met*' is stated '*..discharge from Green Lane. Twice daily visits from crisis team. Medication administered x2 daily + fortnightly depot. Medication review with Dr MS – weekly.*'

The person responsible is identified as '*Crisis Team Dr. S*'. And under '*Start date and how often*' '*....30-11-06 x2 daily. (Medical review) Weekly.*'

The Crisis Team were to visit twice daily from 30 November 2006 and Dr MS was to review medication weekly. SG's records do not show that she participated on any of the three dates referred to. On 14 November 2006, she spoke to PC, who informed her that the Crisis Team were looking for an out of area bed as (G/F) had been admitted to Applewood and it would be inappropriate for them to be in the ward together. On 22 November 2006, she liaised with the Crisis Team and her note reads '*Liaised with Crisis Team, MH has agreed to an informal admission to Green Lane Hospital, he will go in today. T/C (telephone call) to Green Lane spoke with SC (Staff nurse) gave her some background information and my contact details if needed + current medication of Risperdal consta 50mg 2/52 Risperidone 2mg of Depacote 500mg BD.*'

On 1 December 2006, SG discovered from JM that MH had been discharged from Green Lane Hospital. On 27 November 2006 Dr N (SHO to Dr Stevens) noted '*need to discuss case with Dr PS and create POC (Pathway of Care)*'.

Commentary: SG should have been involved in the discharge. Had there been good reason why this was not possible, she should have been notified by the Crisis Team.

On 30 November 2006, Dr DS noted the Plan 'Have *had contact with SG (Care Co-ordinator)*' (Note:- there is no corresponding note in SG's records but SG advised us that she could not recall this contact having been made) "*I have contacted the Swindon CAHTT (Crisis Team) and they will phone back. MH fit to return to Swindon. He is voluntary and thus can go on his request. I have no reason to stop him.*'

In the continuous written record from Green Lane Hospital for 30 November 2006 there are 4 entries as follows:-

- 1.*Dr DS reviewed MH. He feels he doesn't need to be here and staff are to liaise with Crisis Team. His mother contacted ward and she is aware of this.*
- 2.*Contacted Swindon CAHTT. (Crisis Team) They will liaise with ward this afternoon and are aware that MH does not wish to be in GLH and wants to return to Swindon. MH has been appropriate on the ward. Pleasant in manner.*
- 3.*T/C received from PC from CAHTT in Swindon to say they will support MH in the community. PC agrees MH can be discharged. MH is currently off the ward at present so does not know the decision. Copies of medical notes and drug chart faxed to CAHTT in Swindon.*
- 4.*Returned to ward and informed of plan. MH was keen for d/c. Taxi has taken MH to girlfriend's address. Given Ha's for 2 days and discharged as planned.'*

Helpfully JMo referred us to NHS Guidance, '*Refocusing The Care Programme Approach*', which places a focus on ensuring effective co-ordination of care, effective and safe assessments and development of care plans.

Commentary: The ICPA policy of which we had sight was ratified at or about the time that this homicide was committed. We did not see the pre-existing policy but it is clear from the documentation provided to us that the comprehensive guidance now in force was not complied with during the time that MH was in receipt of care.

In her evidence to us, LMc (in reference to ICPA at the time she joined AWPT) '*We were not compliant with ICPA, our compliance ratios were low, 35 per cent, and ICPA expectations had been around for nearly 10 years by that time.....we had not been balancing our books, we did not have a Patient Advisory Liaison Service, despite that being a statutory requirement, and many of the statutory building blocks of people, of processes and systems were not there.....around 38 per cent of people who should have had an integrated care plan had one, which makes 72 per cent who should have had the care plan did not... I had a number of discussions and seminars with a number of clinicians around the organisation, including some very senior cliniciansand they thought the process was really cumbersome and did not add a great deal to the sum of clinical management and that it was a not terribly important complying with it.*

Note: We recognise that MH was the subject of an Enhanced Level Care Plan but it will be observed under the heading Mental Health Act assessments in Chapter 5 of this report that there are serious issues surrounding the ICPA documentation and the validity thereof, including doubt as to whether some of the Plans were valid documents on the basis of, inter alia, the absence of consultation with the Care Co-ordinator, MH and JM, his carer.

Risk Assessment

Risk Assessment Training

We heard compelling evidence to the effect that some members of the Crisis Team had not received Risk Assessment training, despite making requests to the manager of the team at the time. There appeared also to be some confusion as to whether Risk Assessment training should be offered to members of the Crisis Team, who were not registered with a professional body. We were told by a Support Worker, who works in both the CMHT and the Crisis Team that, in terms of the training in 2010, *'I know there was one a couple of weeks ago and that was for assessments and Dr PS had told us that we can all go to it, because actually he would feel that it is good for us all to learn things, but our manager said I was unqualified so I did not get it I was looking forward to going actually because it is about gathering facts and all these things you should be aware of and how to pick it up.'*

Commentary: This was some 3 years after MH killed CJ, an event which appeared, from evidence given, to have been a complete shock to some of those who had been involved in his care, despite the fact that there was evidence, all of which was known to the service, albeit that communication failures meant that different risks were known to different people and not brought together until after CJ's death. If the information provided to us was correct, then this appears to be evidence of a failure to learn from that death. Non registered members of staff engage with patients, some of whom may be able to mask their symptoms in the way that MH did, and those staff also have contact with carers and family members, who are a key source of information about the patient's behaviour and any deterioration. We are of the view that they should have Risk Assessment training and regular up-date training should be provided.

Recommendation 56: Risk Assessment training should be provided to all staff of the Trust, who have engagement with patients, whether or not they are providing clinical care. For clinical staff, training should be provided at the level commensurate with the clinical responsibilities of the role.

There was other evidence from registered staff to the effect that they had not had Risk Assessment training or that past training had not been updated in accordance with Trust policy. We were advised by a registered nurse in the Crisis Team *'Although there was Risk Assessment and other things, we never had any training... we have requested it. I clearly remember one of the team members going up to the manager and saying, 'Can we have training?' When asked if it had then been provided: 'No, not me.....definitely not. To be honest, when MH stabbed somebody, it was a complete shock to me because if I had known that he had carried a knife.... I never knew about it, never.... I was totally unaware of the risk.'*

In respect of the situation at time of giving evidence in 2010 (3 years after the homicide) *'No, I have not had it (Risk Assessment training) yet...Definitely nowadays we are asking him (line manager) on a regular basis ... all we are doing is sending an e-mail so that we have got evidence that we have asked. It is very difficult for the manager as well.....we have requested it.'*

AS, one of the Senior Nurse Practitioners in the Crisis Team told us in respect of how much Risk Assessment training she had received 'Once I think if I remember it was probably a two day AWP generalised Risk training..... to be honest, I have not done an update for a long time.' She added that the absence of a Risk Assessment training update probably did not conform with the Trust Policy.

She was, however, and despite the leadership responsibilities inherent in her role, unable to remember how frequently Risk Assessment training should be provided other than that people should be offered updates. She advised us, in answer to a question, that she would not be comfortable if she knew that Band 6 and Band 5 staff had not had the training, apparently unaware that this was the situation for some such staff and aware that she herself had not had up to date training.

Commentary: We consider that Risk Assessment training falls within the definition of mandatory training and particularly so for the Crisis Team in the context of its remit. MH's recorded history held by the Trust indicated a pattern of potential serious risk to himself, CJ, his mother, his step brother, (G/F), (G/F's) boyfriend and members of the Crisis Team itself. Risk Assessment training should have been provided for every member of the team and clear evidence was given that it was not, compounded by the fact that known risks were not communicated to them, particularly MH's explicit statement that he intended to kill members of the Crisis Team.

We were concerned also that registered staff were apparently not concerned about the probability that they were in breach of their own professional Code of Conduct as well as Trust policy. In addition, it would appear that the Trust was either failing to monitor and enforce its mandatory training requirements or took no action in respect of the failure to ensure that annual update Risk Assessment training was delivered. Both LMC and the RCA panel knew that staff were failing to attend Risk Assessment training which had been organised but did not present any evidence as to why that was happening or why the Trust had not taken steps to address the situation. The later section in this chapter on clinical caseloads may explain why some staff did not attend required training but highlights also the clinical burden carried by some staff in the exacerbating context of not having up to date training in Risk Assessment. Our understanding is that update Risk Assessment training should be provided on an annual basis. (Note: the Trust's current situation in relation to training is set out earlier in this chapter)

Principles of Risk Assessment

The well recognised general principles that underpin risk assessment are

- Accurate risk prediction is never possible at an individual level.
- The use of structured risk assessment when systematically applied by a clinical team within a tiered approach to risk assessment can enhance clinical judgement. This will contribute to effective and safe service delivery.
- Risk assessment is a vital element in the process of clinical assessment.
- Risk assessment forms a major component of the ICPA process.

- Risk assessment informs risk management and there should be a direct follow-through from assessment to management.
- Risk management requires an organisational strategy as well as competent efforts by individual practitioners.
- The contribution of substance misuse to risk must be recognised, co-morbid substance misuse problems must be adequately treated, and improved prevention and treatment options made available.
- Risk management needs explicitly to involve collaborative work between the mental health service with both patients and their carers.

Guidance on the clinical assessment of risk is well established and the essential elements are set out within the Royal College of Psychiatry guidance for risk published in 1996, that *'A formulation should be made based on the history and mental state. The formulation should, so far as possible, specify factors likely to increase the risk of dangerous behaviour and those likely to decrease it. The formulation should aim to answer the following questions.*

- *How serious is the risk?*
- *Is the risk specific or general?*
- *How immediate is the risk?*
- *How volatile is the risk?*
- *What specific treatment, and which management plan, can best reduce the risk?'*

General principles...

- '1. A clinician, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to ensuring that risk is reduced and managed effectively.*
- 2. The management plan should change the balance between risk and safety, following the principle of negotiating safety.*
- 3. When seeing a patient who presents a risk of dangerous behaviour, the clinician should aim to make the patient feel safer and less distressed as a result of the interview.'*

The management plan

A management plan must be based on an accurate and thorough assessment and follow the principle of negotiating safety. This entails paying close attention to the interaction between the patient and the clinician, aimed at reducing the risk of dangerous behaviour and making the patient feel as safe as possible.

Transfer of clinical responsibilities

If responsibility for implementation of a management plan is passed on to another clinician or service it must be handed over effectively and accepted explicitly. Information passed on under such circumstances must be comprehensive, and include all information known to the informant likely to be relevant to the assessment and management plan, i.e. covering the points above as a minimum. Direct discussion will probably need to supplement correspondence. More than one discussion may be needed to ensure adequate handover'

Responsibility for Risk Assessment and Management

The Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk, Council Report CR 53, provides clear guidance regarding the responsibility for clinical risk assessment and management. It considers responsibility at the level of the individual clinician, the clinical team, the organisation

Guidance specifically for the individual Psychiatrist is that (s)he is expected:-

- To respond as rapidly as possible to concerns about patients thought to present an increased risk.
- To make a systematic assessment of risk.
- To consult as widely as is possible and appropriate in making the assessment and considering a management plan.
- To make a decision on what to do as a result of that assessment. If the assessment shows a significant risk, a decision to take no action will be exceptional; it must be made explicitly and the reasons recorded.
- To make a management plan based on the assessment.
- To record details of the assessment and of the management plan.
- To share the management plan as appropriate with all those who will be legitimately concerned with its implementation.
- To make appropriate arrangements for monitoring of the management plan and subsequent review.

Commentary: Our view is that the above guidance refers not only to the individual responsibilities of the Consultant Psychiatrist but also to his/her responsibility in clinical leadership to ensure that the practice of other clinicians within the multidisciplinary team accords to this guidance.

In the care of MH, it is evident that members of nursing staff played the lead role in risk assessment and the formulation of risk management plans. Questioning of individual members of nursing staff during interviews led to a very variable response in relation to whether the nursing staff and non-registered staff felt that they had sufficient, or any, level of training to undertake this responsibility.

The responsibilities of clinical teams

- To have an agreed protocol for responding to patients showing significant risk. The protocol should identify the appropriate senior clinicians to be contacted when assessment or re-assessment is necessary. The senior clinicians identified must be readily available to staff and to the other agencies involved.
- To have agreed protocols for follow-up and review of patients.
- To establish and maintain links with other agencies involved in the care and management of patients who present a significant risk.

Commentary: Although some non-nursing professionals were consulted as part of the collation of risk information, it is not evident that they were part of the process of development of a risk formulation or risk management plan.

The responsibilities of service managers

- To recognise that effective assessment and management of people presenting increased risk of harm should be of the highest priority for allocation of resources.
- To recognise that risk assessment and clinical risk management are time consuming and expensive and to make appropriate resources available.
- To provide a safe environment and adequate facilities for the assessment and management of clinical risks.
- To develop with senior clinical staff a risk management strategy, appropriate to local circumstances, including policies and procedures for:-
 - (a) clinical risk assessment and management;
 - (b) induction training for new staff and continuing training for established staff;
 - (c) serious incident review;
 - (d) clinical audit.
- To ensure that senior staff are always available to take responsibility for decisions about risk assessment and management.
- To assess training needs and ensure that clinicians have access to training appropriate to their needs.
- To encourage and support the development of links with other agencies involved in the care and management of patients who present a significant risk.

Commentary: There does not appear to have been a clear risk assessment and management procedure in place that all the staff were aware of and working within. There are different sets of documentation in use and some of the documents are not of the same quality as other pro formas.

In the case of MH, the occurrence of significant clinical events did not prompt a process of reconsideration of the risk management plan. Risk assessment should be a dynamic and on-going process central to the safe and effective management of complex patients.

It a matter of grave concern that many witnesses questioned were unaware of known major risk behaviours particularly in relation to the carrying of knives and threat to members of the Crisis Team. In retrospect, this assumes greater significance given that MH acted on his threats to CJ.

Recommendation 57: An urgent review of risk assessment and management processes and procedure should be undertaken and an action plan developed stating actions for individual clinicians, Clinical Teams and Service Managers.

Risk Assessment for MH

There are a number of sets of risk assessment documentation within the case files for MH.

Confidential Risk Screen 3 February 2005

At this time MH was under the care of the CMHT and the risk screen was completed by SG as his Care Co-ordinator. The risk screening tool is in a check list format differentiating between past history of specific risk and current history of specific risk.

The tool is comprehensive and covers an appropriate range of types of risk factor. It is evident from the form that information was sought from a number of different sources to complete the form. There is a summary presented of the level of each category of risk. In the final section of the document a specific plan is elaborated to manage each category of risk that has been identified as moderate in level.

'MH currently denies any suicidal ideation, however he has disclosed that he thought about jumping in front of a train. Plan: 1. CPN to monitor mental health 2. MH to be honest and open about his feelings in a safe environment 3. Continue with Early Interventions work 4. Support from housing staff (C and S) 5. Continue with current medication 6. Assess risk factors at each visit

Risks to other –Due to alleged sexual abuse, MH has made threats to kill CJ who the allegations are against. Plan: 1. Referral to vulnerable adults 2. Allow MH to discuss his thoughts regarding this within a safe environment. 3. Inform other professional involved.'

Commentary: The documentation provided by the Trust meets with the recommendations for a risk assessment screening tool and facilitates the development of a summary of risk and development of an appropriate risk management plan. MH had been receiving care from mental health services for 5 months before a risk assessment and plans were formulated. This is of concern given the frequency and severity of the risks and the behaviours he was demonstrating, which are documented during this period. Our view is that the clinical team should have considered the need to establish whether CJ existed and have followed the obvious option of asking MH or members of his family about this. (This issue is further addressed later in this Chapter)

Risk Assessment and Management Plan, July 2006.

The format of this documentation has altered from that of 2005 but contains the essential components to record both historical and current risk factors covering a variety of risk areas. Guidelines are provided to assist in the process of formulating a risk management plan. This was completed and presented within the documentation.

'Management plan

Daily visits by the Crisis Team

Weekly visits by CPN

Weekly visits by AG

Weekly visits by Early Interventions worker, (Name).

Dr MS to review on 26/07/06

Re-assessment at Windswept on 25/07/06

Professionals meeting on 28/07/10

Administration of depot every 2/52

Continue attempts to engage MH in therapeutic activities'

Commentary: At this point MH was under the care of the Crisis Team. It is a matter of concern that a number of highly significant clinical events had occurred since the previous risk assessment summary and formulation but these had not prompted an earlier urgent review and re-formulation of MH's current risks and the development of further risk management plans.

Events of note include:-

Continued expressions of wanting to 'kill CJ'.

Eviction from Hazelmead due to behaviour July 2005 (drunk and threatening towards others – throwing bottles and assaulting residents).

Reports concerning a knife in August 2005 leading to the knife being confiscated.

Overdose of Olanzapine February 2006.

Deterioration in mental health March/April 2006.

Intermittent compliance with medication.

Continued excess alcohol intake.

Arrest for breach of the peace May 2006.

Substantial concerns expressed by Mother.

The completion of the document and the risk management plan formulated were undertaken to a reasonable standard and reflected the known risk factors.

Confidential Risk Screen August 2006.

The format of this document is different again. It consists of a risk assessment tool to collect historic and current risk information but is not apparently linked to a risk management plan. The signature of the professional completing this record was not decipherable. Also not included on the form is any indication of the sources of information that have been consulted in order to complete the form.

The completion of this document is inconsistent with the information that was known and available in the records concerning MH. Of particular concern is the completion of the following sections:-

Suicide and self harm - no detail of this is given

Risk to others - no entry is given for 'past' and 'current' is recorded as 'N'

Additional risk factors - no entry is given for 'past', history of any risk factors including alcohol abuse, other substance misuse, and symptoms e.g. command hallucinations, paranoid delusions, limited insight and unable to communicate

Commentary: The purpose of this documentation is unclear. Major pieces of historical risk information are omitted from the risk assessment and there is no corresponding risk management plan available within the files. Both the structure of this document and its completion fall short of the standards that should be reasonably expected. The identity of the professional completing this document should have been clear.

Clinical Supervision (for non-medical staff)

LMc said in her evidence to us that '*We have team supervision rates, we have SBU supervision rates and appraisal rates and we have directorate rates and we have exception reporting into monthly performance.*'

We understood this to reflect the situation current at 2010. Our concern, however, was to establish the situation for the period of MH's care and treatment. The Trust had in place a policy for clinical supervision at the time. This document, entitled '*Policy and Procedure for Clinical Supervision*', is dated January 2005 with a review date of January 2008. It is 33 pages in length and contains a number of academic references, which we consider serve to confuse at times. There is no '*How to*' flow

chart but the process is fairly clearly set out, although the interweaving of good practice and academic references does not make it easy to determine exactly how the Trust expects the process to be followed. The policy defines Clinical Supervision as *'....regular, protected time for facilitated, in-depth reflection on clinical practice. It aims to enable the Supervisee to achieve, sustain, and creatively develop a high quality of practice.....'*

It further states *'With increasing demands on services, an effective Clinical Supervision Policy and Procedure is fundamental in ensuring that the best interests of the service user and carer come first and that staff are developed and supported to meet this goal.'*

Commentary: Our view is that it is the effective implementation of Clinical Supervision, which will meet this goal, rather than the mere existence of the Policy. We heard considerable evidence to the effect that staff were not receiving *"formal and regular Clinical Supervision"*, as required by the Policy, which recommended as an absolute minimum *".....no less than one hour of Clinical Supervision per month"* and that *"It is essential that Line Managers ensure that staff are released for Clinical Supervision"*.

However, evidence included that a Senior Nurse Practitioner in the Crisis Team was benefiting from monthly supervision from a colleague in a different clinical profession but PC said that supervision *'was not part of the (Crisis) Team ethos.... there was a clinical handover meeting twice a day and I think the view was that that was a kind of form of supervision ... in terms of individual supervision and looking at maybe the way people were working, certainly not I was not supervised.'*

Commentary: At a second hearing with us, when PC was questioned as to why he had apparently not escalated concerns, which he confirmed put him in breach of his professional registration Code of Conduct, he stated that the issues of concern *"would be in my supervision notes. I am really confident in my supervision notes"* (those with his current line manager, JMc).

SG said that (XX) was initially assigned as her supervisor, then went sick (for almost a year) and another supervisor was allocated. (XX) then came back. She told us *'but it could be hard because unfortunately we were and still are under extreme pressures and sometimes even then it is essential for working practice. It is sometimes difficult but it would be postponed and put off for a couple of weeks and things like that.'*

She felt, however, that she had effective supervision because *'it was also from Dr PS and other team members. They were a good support network, not only with MH but also for my ongoing case load at the time as well.'*

It was reported by other witnesses that Dr PS was very supportive in clinical supervision terms but we consider this to be a demonstration of his commitment to members of the team rather than planned and executed in accordance with Trust policy. Dr PS said of SG *'What she used to do (in the period when MH was in the care of the Crisis Team) if she had seen MH or had heard from his mother, she*

would usually bring it to the team meetings and it was basically brought for supervision and support.'

Commentary: This, however, was peer discussion and support and not supervision in accordance with the Trust's stated policy. We were aware that SG was a relatively recently qualified Registered Mental Nurse and that her own evidence was that she had been given no specific training prior to taking up the role of Care Co-ordinator. Taking account of these factors, combined with her concerns about the difficulties in MH's case, regular and effective supervision on a one to one basis should have been provided for her in accordance with the Trust's stated policy.

CM in the Mental Health Liaison Service reported that she saw her line manager on a regular basis; RK of the Crisis Team said that she had regular supervision with a more senior colleague (but that she had had only one appraisal in 6 years although this is a required annual process in the NHS); and DQ in the CMHT described her supervision as '*..... informal, we often had informal supervision really.*'

A trained member of staff in the Crisis Team stated that she had had one appraisal in 6 years and believed that the next would be in further 6 years.

In December 2009, JMcD said '*.. through my working as a manager there I have found very little evidence of proper supervision and appraisal systems in place.*' She also confirmed that it would be unlikely that supervision notes for (XX) could be found. Following a request from us, enquiries within the Trust indicated doubt as to whether supervision was in place for (XX) and we were informed '*.....the conclusion I draw from this is that there was not supervision in place for (XX) and JMcD concurs with this conclusion, however obviously the panel will need to reach its own conclusion.*'

AG described how '*There was a specialist supervision group ... there would be between three and five of us usually and we would make an agenda of things to talk about, clients to discussOther than that, there would be informal discussions with my colleague at that point*'. She confirmed that that there was not a system for more systematic supervision for her which she attributed to the seniority of her post in Psychology. She said also that '*I had individual clinical supervision. Not as a regular thing. I sought it out.*'

Commentary: On the face of it, AG's experience was not entirely inconsistent with policy which has a section setting out the Methods of Delivery of Clinical Supervision as:-

'One to One Supervision – with a Supervisor from own discipline.

One to One Supervision - with a Supervisor from a different discipline.

One to One Peer Supervision – with a person of a similar clinical competence and expertise.

Group Peer Supervision – with peers from the same discipline. This may be facilitated by an external Supervisor or by the group itself.

Group Supervision – with people from within a multi-disciplinary team. This may be facilitated by an external Supervisor or by the group itself'

LMc did refer to group supervision as being used for staff such as ‘facilities staff’ or where someone is so part time that one-to-one supervision cannot apply. This clearly was not applicable to AG.

The remainder of the policy, including pro forma documents to support the Clinical Supervision process, refers exclusively to the ‘Supervisor and the Supervisee’ so the above is assumed by us to be part of an academic reference, describing possible levels of supervision, rather than agreed Trust practice. Notwithstanding, the flexibility it conferred presumably legitimised the process as applying to AG. Also, we were not provided with any evidence of monitoring and enforcement of the Trust Policy requirements, which would have identified inconsistency in individual staff experiences of supervision and appraisal. The policy also states that there should be an individual, written contract (pro forma provided within the policy document) between each Supervisor and Supervisee. This was not mentioned by anyone and we were concerned that this was apparently another aspect of the policy which was not adhered to in practice.

Recommendation 58: Where academic references and good practice are included in any Staff Policy, these should be clearly separated from the actual process and guidance for delivery of required actions.

Recommendation 59: The Trust should put in place, and monitor rigorously, effective policies on clinical supervision and annual appraisal. The Trust should ensure that staff with new responsibilities are allocated a supervisor with the appropriate skills, commitment and experience.

Recommendation 60: The Trust should ensure that the pro forma supervision contract is completed for all staff undergoing individual supervision.

Clinical Caseloads

We were advised that CMHT staff had individually assigned patients making up their clinical caseloads; that the Crisis Team and the Assertive Outreach Team worked on a generic basis and that the Forensic Service had a ‘capped’ caseload

We heard substantial evidence that case loads were unacceptably high in many cases.

RG of the CMHT, ‘If you spoke to any members of either of my teams, they would probably be doing two/two and a half hours per day over and above what they should be doing.... That was really to try to keep up with what was expected.’

He advised in respect of the advent of the Crisis Team and the consequent reduction in CMHT resources, ‘Over half of them (staff) were taken away.... If somebody left they would not be replaced or there would be moneys taken out of the budget ... so it was under half the staff that we were left with but not with a particularly reduced workload. In fact, in many areas working alongside the Crisis Team it increased our workload ...we just did not have the resources to cover a lot of the eventualities.....’

A lot of my staff had more than 50 each (on their caseload) (XX) had one of the largest caseloads than I can ever remember ... we are talking way over 70 at some point.'

SG agreed that her caseload was over 40, which was above the NMC guidelines and that the local Trust policy was *"...it should be between 25 – 30. However, she stated, 'That has not been the case since I qualified.'*

Commentary: SG qualified in 2003 and was appointed as a Care Co-ordinator in the same year, for which role she was given no training. Despite her relative inexperience, she was carrying a caseload, which exceeded the requirements set down by both the Trust and the Nursing and Midwifery Council.

Recommendation 61: The Trust should ensure that all staff have the necessary training and competence to undertake new/additional roles.

MS said in respect of the caseload carried by SG, *'I think there comes a time when it does not matter the frequency of input the number is too high and numbers like 25/30 is a reasonable guide. That is where management of the team, the team manager and clinical supervision of the care co-ordinator by her clinical supervisor in this case becomes very important in order to guide and help decisions as to whether or not the workload of that individual is manageable in terms of health and safety and clinical quality.....'* Where anyone is a care co-ordinator in a team, I would expect their team manager and clinical supervisor to be reviewing with them the size of the caseload and any clinical issues that came up from that caseload.'

Commentary: We do not dispute this advice but also did not see that there was any mechanism within the Trust for such situations to be addressed. SG's evidence indicated that she did not receive regular supervision; her CMHT manager did not have the authority to remove cases from caseloads; and it appears that no action was being taken by more senior managers. It would appear that immediate managers of clinical teams were held accountable for a matter over which they had no authority or control.

Recommendation 62: The Trust should implement systems to ensure that caseloads remain within recommended boundaries.

Dr AT stated that, *'.. what I have discovered in the last year or so is that consultants, depending on your point of view, have either been left behind or set outside some of the team structures which has left them carrying, and certainly feeling very responsible for carrying large, and to my mind, unmanageable caseloads of follow up in the community.....It has become apparent to me that in many areas the doctors are not at that end of the care pathway but rather at the other end doing supervision and follow up with huge caseloads that come to out-patients once or twice.'*

In December 2009, a member of the RCA panel told us *'it is true that we have had until quite recently a disconnect between clinical governance systems and the managerial systems.'*

A member of the Crisis Team said *'From what I gather from the team members who were there at the beginning, a lot of them were very, very exhausted from very long hours. There were no proper breaks. Suddenly they were working 24/7 so I think they did not realise how overworked they would be... I do not think there was really much time to actually sit down and say we need to take a different approach, do it differently.'*

In respect of the CMHT, we were told by a member of the RCA panel that *'One of the big things with the Swindon community teams was the size of the caseload, which was unsafe for them to effectively manage. People had very large caseloads.....'*

Before SBUs each locality, as they were then, did operate quite differently, so practices were varied. For example, in some parts of the Trust team an individual's whole time equivalent caseload might be around 25 maximum. In Swindon it was a lot, lot higher than that..... It was part of the rationale for restructuring into SBUs to try to bring things into line ...but it is a massive piece of work and it is still ongoing now.'

CA of the PCT, who took up post in 2008, advised us that *'One of the things we monitored very closely through that and got feedback from staff was around their workload and a number of actions were very specifically around reviewing caseloads and training programmes, rostering, cover for sick leave, not allowing sick leave and absences to go uncovered and AWP have put in during that period quite an intensive review and recruitment programme.....We did an evaluation of the activity for the Crisis Team and they had a huge number of phone calls, a massive amount of workload was phone calls from individuals who did not need the expertise of a secondary Crisis Team but they did need some support, a listening service ... (which) appears to have significantly reduced the workload of the Crisis Team.'*

JE of the Crisis Team indicated that the Team was breaching the European Working Time Directive in its early days.

In evidence, CA stated *'As far as managerial is concerned, I think that the thing that I would have to say is that there were some local managers that were criticised by service managers and other provider managers. I think that for me, I felt very strongly that the responsibility was higher than that, because I felt there were managers in place that were being expected to deliver impossible jobs, because of the spread across BANES (Bath and North East Somerset) and they were stretched between two areas with an awful lot of the day spent on the M4 and they were always in the wrong place.'*

Commentary: Contextually, it is important to recognise that the major structural change from a Locality approach to cross Trust Strategic Business Units impacted also on managerial staff.

Trust Policies and Procedures

The Trust provided us with a range of policies and procedures on request and those that were extant at the time of MH's engagement with the service (many post dated that period) were useful in informing comparisons of practice with stated policy. In

terms of the policies themselves, we found them generally to be very lengthy (as an example, the Medicines Management Policy, initially provided to us, exceeds 100 pages and cannot be deemed to provide a practical working guide for busy clinicians); in some cases, extremely complex and, in others, lacking clarity and ease of reference by busy clinical staff. We recognise that policies and procedures must conform to the standards required by the NHS Litigation Authority Clinical Negligence Scheme for Trusts but were concerned that those that we reviewed often failed to provide an immediate and readily understood practicable guide to staff working at operational level.

Recommendation 63: Trust Policies and procedures should be translated into short clear reference documents, ideally with a flowchart in each case, to allow staff readily to access guidance which clarifies the appropriate actions in response to operational and clinical events.

Apart from this issue of practicability, we were concerned that some key policies were not in fact applied in practice and there was no obvious process at the time to assure the effective implementation of policies.

Evidence from records provided and from managers and staff interviewed by us was to the effect that, contrary to written Trust policies, application was patchy in those teams involved with the care and treatment of MH. Not all staff were having annual appraisals (one employee stated clearly that she had had one appraisal in 6 years); clinical supervision was not applied in accordance with stated Policy and Procedure for Clinical Supervision and was reported to be postponed due to pressure of work; training in Risk Management was not provided to all staff, despite requests for this; the process of delivering and monitoring medication for MH was not in accordance with the Medicines Management Policy; the ICPA policy was not properly applied in respect of either MH or his mother as main carer; the Caseload and Capacity Management policy was not applied consistently leading to some imbalance in caseloads, some of them far exceeding recommended safe levels, AG did not on a timely basis produce summaries of her notes of Psychology interactions with MH for inclusion in the main file of notes – again contrary to requirements locally, nationally and also those of her own professional registering body; the overall state of the notes for MH (dealt with more fully in paragraphs below) indicated a failure to adhere to both national and local policy for record keeping. Whilst caseloads were recognised to be inappropriately high in some cases, local managers had limited power to reduce these and senior managers did not intervene.

Commentary: In practice, we concluded that the Executive level decision to review recruitment to clinical posts exacerbated the issues felt at operational level, including the application of Trust policy.

We were advised that new policies were issued by e-mail, an apparently ‘HQ-centric’ approach, as staff in headquarters and in office functions are likely to have access to a dedicated computer. Clinicians working at operational level may not have the same access and there need to be other means of alerting staff to new or changed policies. Appraisal and supervision provide opportunities for managers to assure themselves that policies are known, understood and implemented but there were clearly gaps in both the processes in AWPT at the time of MH’s care and treatment.

One registered nurse in the Crisis Team stated *'All we do is get an e-mail that the new policy is up and running, so it is all on the Internet, I think. Timewise, as I said to you earlier, we are unable to get time to read the policies or anything and we do not get allocated time to do it. It is very difficult to be honest.'*

An unqualified member of staff said that when a new policy comes out *'It should be put in a file and then we should all have access to the file. You are notified now that there is a new policy come out''.*

Another stated *'My only criticism of the policies is that a lot of people are not given that time actually to read though. We have all got them but, obviously, with the increase of the electronic system, most people are still trying to keep their heads above the water with the paperwork and the extra paperwork which has been generated by this system, that reading policies comes pretty low down their priorities.....they have always made policies so that people switch off. I quite enjoy reading policies but I am quite alone in what I am saying there.'*

In her evidence to the panel, LMc stated in respect of policies *'Things that are needing to be immediately available to people, we encourage people to carry hard copies actually on the team or on the ward.'*

Our concern, however, was not the availability of key policies per se but either their functionality or the factors which prevented their application; or, in some cases, an unmonitored and unchecked approach by staff.

We were advised by RK that, within the Crisis Team, the analysis and explanation of new policies to members of the team were undertaken by her and that she was not a registered nurse.

This witness also advised that, in respect of a new policy *'That is the individual's responsibility to read that policy. We do have hard copies. Policy updates are sent to people and it is their responsibility on receiving it to read it..... I am being given them from management (confirmed as being Manager of the Crisis Team or the secretary) to pass them on but no one is checking up on me.'*

Commentary: We had no concerns about the competence of the individual to do so, in general terms. She presented as very competent and capable and she believed that the team recognised her interest and ability in this important activity. We were, however, clear that this was inappropriate and a significant management failing.

Where policies relate to clinical practice, it is important that the explanation of them and training in their use are undertaken by a senior clinician, who can ground any training and understanding within clinical practice. The responsibility would be expected to lie with the two Crisis Team Senior Nurse Practitioners, rather than an unregistered member of staff. We were concerned that the manager of the Crisis Team and those members of the Team, who were registered with the Nursing and Midwifery Council, had apparently not identified this as risky and inappropriate practice.

Recommendation 64: Within the Crisis Team, the training in, and active promulgation of, new policies (and including the training and induction of new staff in respect of existing policies) should be undertaken by either of the Senior Nurse Practitioners with the manager of the service held accountable for ensuring that a process is in place for assurance that all staff understand and practise Trust policies.

Recommendation 65: Appraisal and clinical supervision should be provided in accordance with stated Trust policies

In terms of Risk Training (which is considered in its own right earlier in this chapter), we were told by PC that there was a register of those members of the Crisis Team, who had attended Risk Training 6 months previously. He said in evidence to us that *'most staff except those on annual leave attended'* and later confirmed that everybody should have had up to date specific risk training that *'works on the shop floor'*.

PC agreed to provide a copy of this register to us but failed to do so. Contrary to PC's evidence, Senior Nurse Practitioner AB later advised us (in January 2010) that she had not had any Risk Assessment Training recently (*'three to four years at least'*). In addition, we heard compelling evidence to the effect that some members of the Crisis Team had not received Risk Assessment training, despite making requests to the manager of the team at the time.

Another member of the Crisis Team advised that she had not had Risk Assessment training in the five years she had spent in the team. In respect of training, she advised *'Unfortunately, the budget on training had been very, very tight so actually there has not been the opportunity that there was. When I ... went into the Crisis Team, the opportunities did not seem to exist as they had done previously.'*

She also advised that she had not had formal induction training, just 'on the job' training. This was mirrored in the evidence of another member of the team, who described just going out with other members of staff to learn how things were done in the team

Commentary: Risk Assessment training should have been provided and updated for every member of the Crisis Team and clear evidence was given that it was not, compounded by the fact that known risks were not communicated to them, particularly MH's explicit statement that he intended to kill members of the Crisis Team.

Whilst sympathising with clinical staff at the situation in which they found themselves, we were concerned firstly that neither PC nor AB escalated this issue to higher levels. Both should have been aware not only of Trust policy but also of the importance of Risk Management in preventing harm. Both were also contractually bound by the Codes of Conduct of their respective individual registering bodies, which address the broader issues of patient and client safety. Secondly, we were concerned that PC's statement about recent training for the Crisis Team was not backed up by records as promised by him

and that it was contradicted by evidence from other members of the Crisis Team.

Records provided to us evidenced failure by members of the teams engaged in the care and treatment of MH to comply with a range of policies and, thereby, failure by successive managers up to and including those at Executive level of the service who hold ultimate responsibility to ensure that policies are adhered to.

Recommendation 66: In respect of the effective application and monitoring of Trust policies, there should be clear managerial accountability at all levels from Board down, combined with systematic (but appropriately targeted) action to address failures at any level.

Tensions between the Teams and Communication Issues

In the *'Initial Management Investigation'* report under the heading *'Joint working between the CMHT, Crisis Team and Early Intervention Service'* it is stated *'A number of workers involved in this case have identified difficulties of joint working across the three teams most closely involved in MH's care.....These difficulties may have hampered effective communication of the intensity of MH's feelings about CJ, and the risks associated with this..... It appears the extent of MH's thoughts re CJ were not handed over to (XX) when he took on care co-ordination from SG.'*

In the *'Root Cause Analysis Report'* under the heading *'Communication'* it is stated *'The reporting and recording of difficult and potentially dangerous behaviours was inconsistent.....This meant that valuable information that could have informed risk assessments was not available.....Referrals to the Vulnerable Adult Team....referrals were never apparently picked up or pursued..... When MH's care co-ordinator went on planned but sudden sick leave the information the CPN had who took over care was limited.....'*

Commentary: We consider that (XX) was provided with the information he needed. This is supported by a witness saying to us that he was surprised that (XX) could not find MH as the information was in the notes.

Under the heading *'Team Interface Issues'* it states *'There were tensions between the CMHT and the Crisis Team.....The conflict between the Crisis Team and the Community Mental Health Team was of long standing and was not only in relation to the specific issues that MH presented. Managers were aware of this conflict but at this time there was no successful resolution of the conflict.'*

In the course of the Investigation, we interviewed some, but not all, members of the CMHT and the Crisis Team. Eventually we were able to gain access to the minutes of two meetings held by members of the Root Cause Analysis Team with members of the CMHT and the Crisis Team (later we were provided with notes of meetings with individual staff, which pre-dated the other two sets of notes). Opinions expressed varied as to the extent of tensions between the Teams as demonstrated

in the following extracts from witness hearing transcripts and written witness statements.

In his statement for the investigation DB as Crisis Team Manager (and then latterly Acute Services Manager) said *'I had a very amicable working relationship with CMHT managers and all other Community Teams. It is not unusual in my opinion for tensions to arise between crisis and community teams on occasions due to the nature of our work, however, in my view, there were no significant issues and patient care was not affected.'*

In his oral evidence to us, DB said *'Well, the Crisis Team was not the most well received service amongst all professionals I would have to say. It was treated or received with some suspicion, some caution and indeed some resistance in many quarters.....I think it is right to say that the crisis team were unpopular.....I had one particular issue with - or a consultant had a particular issue with me.....It was almost like in the beginning him and I were arch enemies and he actually - I was very unpopular with him but certainly within a year I believe his respect or his view on me completely changed 180 degrees to the opposite and indeed when I left I believe he had the greatest respect for me.....I was very driven.....Although I was driven, focused, assertive, I also like to believe I was fair, even handed, and would listen, and learn by my mistakes too and put my hands up when I make mistakes.....I do accept from time to time that there were occasions - there were occasions when differences of opinion and the way that the crisis team worked in trying to assert the model came into, if you like, contention with one another. There were sometimes frayed conversations, heated conversations at times.....the crisis team worked incredibly long hours....and sometimes tempers got frayed.....I do not believe that it (the system) had any compromise in patient care. I believe that the Crisis Team enhanced the care to the patient.'*

In his evidence PC advised *'It would be fair to say that the (Crisis) team was set up at the beginning to keep people out of hospital.....there was a lot of pressure to keep people out of hospital. Risks would have been taken to achieve thatthere were a lot of frustrations inter team....so between teams about how the functions had been introduced.....there was some consultation but not really a huge amount of consultation.....Dr PS in particular found the loss of his beds very difficult. There was a lot of anger within the CMHT about this team coming in, essentially deskilling CMHT to a degree...essentially we had a team come along and say you are no longer good enough to make decisions about whether someone needs to come into hospital or to make those kind of more risky decision making processes. That left the CMHT extremely angry. I think at one point I anecdotally heard about signatures that were going round the CMHT signing names down for the manager to be dismissed because of this tragedy that was happening in this Crisis Team. Some of that was about change and about people not wanting that change.... so clearly there was a tension immediately between the teams.'*

In answer to a question as to whether the tensions were in fact quite serious. PC replied *'Yes, they were, very serious'*. In his individual interview with the RCA panel, on 9 July 2007, it was recorded that:- *'Tension was tremendous, on a hatred level.'*

When asked whether these tensions detracted from the effectiveness of care, PC replied *"Without a doubt....Without a doubt, yes"*.

Regarding MH and his threats to kill, PC stated *'I never knew that and I had not obviously read, and that was part of my mistake.....but I never knew that he had made threats to kill others....I became aware of that (number of times aggressive/threats to kill) round the time of the incident. I think that probably the team to a degree was in a bit of chaos really.....The sort of unofficial ethos of the team was that there was a high level of bravado, a high level of sort of the team being maybe better than other teams, in terms of managing risks, it was slightly chaotic in terms of any formulation, being very clear what that formulation meant in terms of care plan, so there was a sort of ad hoc super hero kind of feel to it What we were lacking in was that clear formulation, a clear idea of what we were doing and why we were doing it.'*

Related Views from Team Members

It was clear from other evidence we had that there was constant clash between the CMHT and the Crisis Team and there was seen to be arrogance in the approach of the Crisis Team. However, we heard also some members of that team were of the view that there were no abnormal tensions between the teams.

Evidence from members of the CMHT indicated that there were tensions because, for example, communication with the Crisis Team was not good; the Crisis Team was seen as elitist; the Crisis Team had been imposed without consultation; the Crisis Team gate keeping function was not well received; the CMHT was not listened to and their professional assessment was not valued; and the relationship with the Crisis Team was difficult and challenging.

In respect of tensions between the teams, evidence from various witnesses was that:-

'There were observable tensions between the Crisis Team and the CMHT. These were not particular to MH's care but were a ... systemic problem within the service'

'..... I think it is also fair to say that the manager that originally set up the Crisis Team had a fairly aggressive approach to management and other staff, which probably did not help other members of the team to develop a more (collaborative) way of working with the other teams'

'He (Crisis Team manager) was brought in to shake the tree and shake the tree he did'

'The Crisis Team was overstretched but their necessary and important focus on providing sufficient crisis help to keep people out of hospital engendered a negative attitude at times. An important target for the team was to reduce hospital admissions; they were very successful at this, reducing the number of inpatient beds in Swindon by half. However a consequence of this was that it engendered a negative attitude towards requests for admissions'

'CMHTs were....struggling to adapt to the changes that the advent of the Crisis Team had brought in. They had previously had control over admissions, but this had been handed over to a different team, necessitating them to justify the reasons for an admission to a team who they saw as having less knowledge of the patient. A number of specific difficulties resulted - CMHT felt that Crisis Team did not recognise their knowledge of particular patients, their histories and symptoms....incidents when members of Crisis Team had been dismissive of experienced CMHT staff in phone conversations; Crisis Team would make their own assessment of a service user's mental health based on their contact with them, and would not always take into account information from community staff or from family and carers.'

'The CMHT felt that it was inappropriate that Crisis Team assessments were at times carried out by unqualified staff.....Crisis Team at times verbalised that the CMHT did not put effective plans in place for managing patients.'

'The Crisis Team struggled with patients with challenging behaviour problems and with dual diagnosis of mental health and alcohol or drug problems or personality disorders.'

'The CMHT struggled with the fact that admissions were controlled by the Crisis Team, and there were lots of occasions when the CMHT felt strongly that an admission should be facilitated but the Crisis Team did not.'

'Because they were so busy, Crisis Team visits to service users were often very brief.'

'These tensions did impact on the management of MH's care during 2006 – 2007.'

'Although principles of early intervention would argue for treatment in the least restrictive setting, MH was not responding to home treatment and the period prior to his admission saw a deterioration in his mental health, and increasingly chaotic life style and a significant increase of alcohol intake. It is possible that an earlier admission (July 2006) to the acute inpatient ward, followed by a period in the rehabilitation unit, may have achieved a more favourable outcome.'

One member of the early Assertive Outreach Team indicated that 'Previously I know there had been difficulties and I thought it was much easier now because of the meetings that go on. I know there have been difficulties, I will not deny that. I know there have been difficulties with information on clients going between community health team and the crisis team. As I said, I cannot comment on that, because we never had that difficulty, because, as I said before, we do not use the crisis team that often.'

In answer to a question about the Assertive Outreach Team's awareness that on 17 November 2006 he (MH) made a threat to kill two members of the crisis team 'No. We should have been more aware of the risk. We should have been more aware'.

Views of the Mental Health Liaison Nurse at Great Western (General) Hospital Swindon indicated in respect of the Crisis Team 'It can be quite ad hoc as to who is on duty as to what kind of service you might see.....One day you can have a really

good experience with the Crisis Team and you think that has worked really well and then another day your call might not get returned or you have been chasing round the country looking for information on a patient when it turns out it is on their desk in front of them. It is really patchy.'

In respect of admission 'it is a two tier system. If you are coming in over the weekend you probably do not get as good a service as you get if you are there during the week and there is a designated liaison there spare.'

Commentary: The RCA panel identified that managers were aware of the conflict between the CMHT and the Crisis Team but that there was no successful resolution of the conflict. It also highlighted that, as the AORT did not take on MH, the other community team (CMHT) had to try and undertake a task for which it was not well suited to delivering. This increased the potential for conflict.

Views of Responsible Director and Consultant

MS, Trust Director for Wiltshire, including Swindon, advised '.....from my experience.....if you have spoken tohowever many involved in Swindon ...there would be strong and different perspectives of clinical decision, on team operating etc. but clearly the question is whether that impacts on the clinical quality of care.....I knew that there was a rub and I do not think that rub was unusual from any services I know and it depends on clinical quality, equally which I cannot comment on.....I think there were some personalities involved who were strong leaders in different way, clinically and in different parts of the service.....if I thought that there were those sorts of tensions that made it difficult for people to come together, that would mean they would need to come together in a supportive, and safe and exploring environment because that is not helpful.'

Dr MS, Crisis Team Consultant advised that 'There were some difficulties surrounding communication with the Community Mental Health Team...when patients are referred to us for the first time, the CMHT knows them quite well and it is very vital that we communicate with them and learn about the patient rather than just reading the notes.....to liaise with the care coordinator and the consultant in my opinion is the best way to learn about the patientthe main feedback was from SG, she gave me good feedback. There was one letter I could find....after that suddenly the notes disappear, but I had no knowledge of that.....I repeatedly emphasised 'please get the notes when the patient is referred to the Crisis Team because that is the only way you learn about patients, so I did not have the notes.'

In respect of advice to Dr MS that AG wrote copious notes, she responded 'I did not read those. I mean you could say it was my fault'. In response to the question 'If you had wanted to get background information how easy would it have been', she replied 'Very difficult. "It was a newly formed team. As there was no consultant before I went there, the team was pretty autonomous.....they were quite dominant people there. Prime driver is to reduce bed numbers close beds....close the ward.'

In response to the question about her knowledge of MH's threats to kill CJ, she replied 'Nil, absolutely nothing. Because nobody mentioned it in the team. If that

would have been the case, threats, specific, you are talking about forensic assessment, you are talking about informing the police, a MAPPA meeting, the whole package of treatment changes. It was not ever mentioned to me.'

In answer to a question about her knowledge of the risks posed towards MH's brother, that MH was carrying a knife and had threatened people and had threatened members of the Crisis Team, Dr MS said *'I was not aware of it, no, not at all.....when I was preparing the report (for the Investigation) it was then only that I discovered in one of the risk assessments that he had a knife and it was taken away by a member of the crisis team. A specific threat to a member of the crisis team I did not read anywhere'*

Responding to the question about possible changes in her formulation if she had known that MH was in contact with CJ during late 2006, *'And threat to this individual? Number 1. I would have called for a very urgent forensic opinion, 2. I would have informed the police and call for a meeting. Those are very basic things. And then we would take it quite seriously. One thing I would like to say is that when I joined the team all the members of the team used to go and tell the clinical questions to the manager, and it was very alien, all these things to me, why do they not come to me, I am the clinician. But that changed but it was still there when PC was there. You can see that, informed PC, what about the clinician.....But this was the culture, this was very much the culture, and they used to go in his room, the whole mob, and give the clinical rundown, but I had to undo that and it does take time, it does take a long time.....Communication if it is not done can become serious. You can see that this is the outcome of it.'*

In answer to a question whether she knew that there had been allegations that MH had held a knife to (G/F's) throat, Dr MS said *'No'* and in response to the question as to her awareness that MH was carrying a knife with the intention of harming someone else with whom (G/F) was involved, she also said *'No'*.

The RCA panel was told that there were strong feelings that Crisis Team members were criticised by the CMHT and that they were *'treated on the dumping by the cmht....'*

Commentary: The above sampling indicates that the perspectives of the various teams and the communication of information vary from the RCA team finding it impossible to have both teams in the same room at the same time, to the markedly lesser description of it being part of the 'rub'. Taking the evidence as a whole, it was clear to us that there were serious tensions between the CMHT and the Crisis Team, of which senior members and senior managers, including at Executive level, were aware, and that little, if anything, was done to resolve the issues, which, it was acknowledged by some senior members of the teams, resulted in a compromise of patient care, particularly as it related to MH. It was also clear to us that within the Crisis Team, serious incidents relating to threats, weapons and particular threats to specific persons inside and outside the team were not communicated to other team members. *(This is dealt with in Chapter 7.)*

Records and Records Management

The NHS Code of Practice '*Records, Management: NHS code of practice*' was published 5 April 2006 and replaced 3 HSC Guidance documents. The guidelines contained in the Code of Practice are stated to apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held.

Commentary: We consider that this includes diaries maintained by clinical staff, as these contain, as a minimum, details of contact with patients. It is clear from the Code of Practice that under the Public Records Act all NHS employees are responsible for any records that they create or use in the course of their duties. Thus, any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

In respect of Information Quality Assurance, The Code states:- *'It is important that all NHS organisations train staff appropriately and provide regular update training. In the context of records management and information quality, organisations need to ensure that their staff are fully trained in record creation, use and maintenance, including having an understanding of:*

- *What they are recording and how it should be recorded;*
- *Why they are recording it;*
- *How to validate information with the patient or carers or against other records - to ensure that staff are recording the correct data;*
- *How to identify and correct errors - so that staff know how to correct errors and how to report errors if they find them;*
- *The use of information - so staff understand what the records are used for (and therefore why timeliness, accuracy and completeness of recording are so important);*
- *And how to update information and add in information from other sources'.*

The AWPT Records Management Policy 'Initial draft for comment' is dated 31 December 2003. On 14 January 2004, the policy was amended and approved by the IM&T Steering Group. This policy was in force until it was updated after review for compliance against changed standards on 21 February 2008 and this draft was approved by the Board of Directors on 26 March 2008 and was published on 31 March 2008. In its introduction, the Policy states:- *'The Department of Health's publication "Records Management: the NHS Code of Practice" baselines the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice'*

Commentary: We consider that the final policy did not provide staff with practical guidance.

Paragraph 6 of the policy sets out the Trust's intention to implement appropriate records management systems and practices to ensure compliance with national standards with appropriate staff training provision.

Clinical Notes

We identified a number of key issues relating to the content and extent of records maintained by individuals responsible for MH's treatment and care in the months preceding the homicide.

The Management of MH's Records

LH acknowledged in respect of the fact that it had not been noted at any time prior to or immediately after the homicide that notes of another patient were included in MH's file, advising that *'It is obviously really unfortunate'... that is very concerning 'I think that in terms of the old guidance that used to be around when an incident has happened, seize the notes and lock them up.... is not terribly practical in that people need to access the notes to prepare the initial management report, to inform information sharing generally, and so the notes were used to do that initial work that was necessary.'*

MS advised us that *'On Tuesday (6 March) I went straight to Swindon with an immediate attention on several things, one of them being in terms of notes and I remember going to Sandalwood Court and being very clear we take a copy of the notes now so that we are very clear that nothing is taken out, nothing is added without anyone else knowing that, and that to me was an absolute standard thing..... I took them back to Headquarters'*

Commentary: This does not appear to accord with the evidence of GR, Service Improvement Manager who stated *'On 8 March 2007 at 12:20 hrs I handed to LP, an investigator with Wiltshire Police, copies of the Health and Social Care Records of MH – Copy No. 2. I handed this file to LP at Sandalwood Court, Highworth Road, Swindon. I undertake to keep the original file of MH safe within Sandalwood Court and produce them if required.'* The Trust's policy extant at the time (*Serious Adverse Incident Policy and Procedure 2006*) states the required action within a timescale of 24 hours to be to *'Secure all relevant medical, nursing and other records for future reference. Prepare one full copy and return originals to area if required for ongoing treatment.'* Following the homicide, MH was in the care of the criminal justice system and his notes were not needed in a clinical environment for ongoing treatment. In MH's case, the notes were not secured within 24 hours and remained in a clinical unit. This was of concern given that key records went missing at a time and in a manner, which neither we nor the Trust were able to establish.

MH's notes, including wrongly filed notes of another patient, were provided by the Trust to us, to police and possibly to others, which we consider to be a breach of the other patient's fundamental right to confidentiality. In addition, such an error could result in the wrong care decisions being made, for either patient involved, and potentially fatal outcomes. The issue of the breach of the other patient's fundamental right to confidentiality was not mentioned by LH. We were clear that the requirement to seize and secure the patient records after a homicide had not changed as implied.

Recommendation 67: The Trust should implement a system for the regular review of patients' notes to ensure that they (a) are comprehensive and (b) do not contain records relating to other patients.

Commentary: We considered the possibility that there was a failure to secure the notes as required and that this may have been the point that key notes from the Crisis Team records went missing. Although the Trust provides services 24 hours a day every day of the year, with an aligned management 'on call' rota, evidence indicates that the notes were not secured until at least two days after the homicide. We were unable to determine whether those notes were complete at that time or whether they then lacked Crisis Team notes for the end of 2006 and beginning of 2007.

Recommendation 68: The Trust should develop a system, based on best practice, to secure notes immediately following a serious incident, so as to ensure the integrity of copied information provided to those undertaking later investigations.

LH also stated in evidence, *'I have never heard of that requirement that you have to keep an NHS diary. I have never heard of that.'*

Commentary: Other staff were aware of this longstanding requirement contextualised by the fact that clinicians' diaries contain patient related information.

LH also told us that *'I think that we have a really strong executive management team in place. I think that the Trust is ambitious and is reaching for the stars really. It is really wanting to make changes and improvements and modernise and go for it.'*

In the CMHT, Dr PS stated that there were *'No notes available'* at an out-patient appointment with MH on 30 January 2007. Dr PS' record of that appointment included *'doesn't want to be referred to DAT'* (Drugs and Alcohol Team) and *'I can do it on my own.'* There was no note by Dr PS about SG's concerns on 11 - 19 January about speaking with PC with regard to admission for treatment. .

There are no notes of any consultations or actions taken by RG. This was left to junior members of staff. There are no notes of his advised telephone call to PC in January in respect of effecting admission to hospital for MH.

The only notes made by (XX) relate to January/February 2007 when he says did not have information about MH or the full file. The only reference to (XX) in the NHS notes is on 16 May 2006 when SG says on return from leave that (XX) had been out to see MH. In her statement to the police it is recorded that when she was on leave in 2006, (XX) had gone out to see MH who had refused his injection. Also there is a note in the file that SG is on leave but nothing to indicate who covered for her during that absence. (XX) was her supervisor and yet there are no notes made by any member of staff during any period when SG was absent.

SG's notes were generally comprehensive and contemporaneous although there was one late entry on 18 December 2006, 'Referral made to YY Street and to New Dimensions.'

The notes on her handover to (XX) when she went on planned absence in January 2007 are not comprehensive. However, she told us that she provided (XX) with the folder she had compiled on MH as the Crisis Team was holding the full records at the time. She included in her first entry about MH on handover from the Crisis Team in December 2004 that '*Information not available*'.

Although this is not recorded in the clinical notes, SG stated in her written statement to us that '*There is no formal procedure/form for arrangements to cover sickness or annual leave. It is done on an informal basis between workers. I introduced MH to (XX) at the Mall on 30 January 2007 following a review with Dr. PS and gave (XX) all the information/notes for MH including contact details. At the time in question MH's threats to harm others was not a risk (possibly low/moderate) and there were more concerns over his own safety*'. In her evidence to us SG stated (in relation to the hand over in January 2007) "*.....at that time we did not have M's medical notes. I had been keeping his notes, as I said, in a separate folder with all the relevant information that I had been keeping with contact details for him even though his mobile sometimes – it is very difficult to get hold of him, his mother, her address, G/F's) address as well. So that information was given*'.

In the Early Intervention Service, all notes were made by consultant psychologist, AG, who in her evidence to the investigation admitted that her notes were typed up some time (even weeks) after her meetings with MH. Her handwritten notes were not available. Even the typed notes were at times perfunctory and in some cases the date is noted but without any detail of the content of her meeting with MH. Typed copies of AG's notes relating to her Family Sessions and contact with MH are contained in the clinical records.

As a Clinical Psychologist, AG is subject to the British Psychological Society's Guidance on Record Keeping. We found that her practice did not always accord with this guidance in 5 aspects, viz :-

- Use paper provided by the organisation, (e.g. Clinical Notes sheets and CPA paperwork)
- Always write in black ink
-keep the original intact (do not erase)
- Write your name, sign, date and time the entries
- Always write up notes on the same day or the day after

Commentary: Some of these failures by AG led to the lack of formalised sharing of critical information with members of the wider professional team.

In the Crisis Team there was no consistent pattern of record keeping. Some notes were of the quality required but others lacked detail and did not conform to the NHS Code of Practice. For example, in respect of recording the personnel attending MH and the content of the record. Illustrative entries were:- '*We attended*' without disclosure of who the team members were; and '*bizarre behaviour*' without description of what the bizarre behaviour was.

Some signatures and initials could not be deciphered so as to identify the person making the record, even by fellow members of the Crisis Team. It was accepted by the RCA panel in their own report that the notes were perfunctory. And the current Medical Director of the Trust (at the time of the Investigation) stated that he had never known of an Investigation/Inquiry where notes had not been subject to criticism.

Commentary: We were concerned that this situation was known to senior management, including Executive level, but that no action was taken to ensure quality and audit of records or their conformity to national and Trust requirements.

Note: The issue of record keeping in respect of medication and drug charts is dealt with in Chapter 4.

Missing Notes

During the course of examination of the clinical records, we became aware of the absence of Crisis Team records for part of December 2006 and January 2007, a critical time for MH whose family and Care Co-ordinator (SG) were raising concerns. The absence of these records was not included in the initial internal investigation or the Root Cause Analysis and it became clear to us through questioning that this had been overlooked by the RCA team although the records related to a crucial period of MH's involvement with mental health services. The absence of these records was drawn to the attention of PC and he was requested to, and agreed to, provide a list of the names of the Crisis Team who were visiting MH at the time and to provide a schedule derived from their diaries so that we could reconstruct the records to allow further investigation with the team members at that time. PC did not comply with this request. In September 2010, LMCM wrote to us explaining that this was because of the amount of work involved and that advice had, therefore, been sought. On the basis of that advice, she wrote to us proposing that we consider asking her to arrange to provide us with copies of the relevant sections of staff diaries. By that date, the need for this information was obviated as we had received (*as set out in the following sentence*) photocopies of Crisis Team notes from two sources and were thereby able to address outstanding issues. Subsequent to our seeing PC, it was reported to us by members of the CMHT when giving evidence in January 2009 that some notes by the Crisis Team made during December 2006 and January 2007 were found in the CMHT offices and upon discovery had been passed to PC. We received an e-mail from GT (*Acting team leader in CMHT*) that the notes had been handed to PC personally by her, she believed in December 2009. We recalled PC to give evidence on this issue and gave him an opportunity to return to his office to conduct a search for these notes but he failed to communicate with us further. It was a matter of significant concern to us that these notes should have been available to assist other members of the Crisis Team who were called to give evidence after December 2009 and some of whom relied on the absence of records as a reason to be unable to assist the Investigation to any great degree. Fortunately the member of staff into whose possession these notes came had made a photocopy of them and was able to provide a copy to us.

Some staff relied on the absence of records as the reason why they could not remember what part if any they took in MH's treatment. Notably AB, who was identified by both SG and DW as the person who took away envelopes of medication not taken by MH. PC failed to assist the Investigation with regard to identification of persons attending MH. He failed to follow up on provision of notes which had come to light and which we were advised by four other members of staff had been handed to him in December 2009, thus preventing team members from refreshing their memories of events in preparing for hearings with us.

Some members of the Crisis Team produced diaries of their own volition and were able to assist the investigation in endeavouring the reconstruction of events during period December 2006 and January 2007 (before some of the missing records were found). Others, when asked, could not produce all or some of their diaries, and did not know of their whereabouts. AB, who confirmed that her role involved managerial responsibilities, was aware of the requirement to retain diaries but did not know the specified timescale. Other staff did know this requirement and referred to it without any question from us.

There were numerous decisions in MH's case, either reported or confirmed, which were taken by senior members of the team. Many of these decisions were not recorded, nor were the reasons therefore. In the initial period when MH was seen by Dr Ra, the latter's notes clearly record the need to hand over to the CMHT but there is no similar entry by Dr MS in respect of the Crisis Team hand back to the CMHT in January 2007. An entry by RK (Crisis Team Support worker) states that she would report back to PC SG's concerns expressed about the inappropriateness of the handback given the lack of resources in the CMHT, MH's presentation and his mother's concerns. She informed us that she did report back to him and yet there is no written record by PC of this conversation or of any decision to proceed with the handback or the reasons for that decision or of subsequent conversations between PC and RG. The Minutes of the RCA team meeting with the Crisis Team members on 25 July 2007 (PC being shown to be in attendance at the meeting) disclose that 'PC spoke to his manager about the case and the advice was to hand it back.' No entry was made in the notes by PC of this critical decision.

We were told that decisions were taken by the team as a whole at their 'whiteboard meetings' (Where information was temporarily recorded but not otherwise copied or retained) on handover of shifts.

Minutes of the Clinical Risk and Incident Review Group dated 16 March 2007 disclose under the heading '*Access to single health and social care record - Need to push for electronic records*' and '*Need for a patient information sheet to be put at the front of the patient's record.*'

Commentary: We concluded that there were serious shortcomings in the record making methods employed by the Crisis Team which did not accord with the NHS Code of Practice on record keeping, which is a mandatory and legal requirement for all NHS bodies. Also, that senior managers and Executive Directors of the Trust were aware of the fact that poor record keeping was a constant theme in other such Investigations but took no action to assure adherence to national and local standards.

Note: Since the Homicide, the Trust has been concerned to improve records management and took the decision to begin implementing the new RIO clinical records system in 2008 with implementation beginning in 2009.

Commentary: We heard also from more than one witness about the absence of records of a referral of MH to Swindon Forensic Service.

Recommendation 69: The Trust should ensure that diaries of clinical staff are secured at all times and retained for 6 years after the year end, since any entry about a patient (including time, date and location of an appointment) is deemed to form part of the clinical record.

Recommendation 70: The Trust should ensure full compliance with the NHS Record Keeping Code of Practice.

Carer records

The NHS notes (for MH) provided to us include a section entitled '**CARER INFORMATION**'. This heading is followed by a note, '**THE INFORMATION IN THIS SECTION MUST NOT BE DISCLOSED WITHOUT WRITTEN CONSENT OF THE CARER.**' The section contains information provided by four members of MH's family.

Commentary: We had no evidence to the effect that the written consent of these four people to the disclosure of these records had been obtained by AWPT.

Swindon Forensic Service

There were no records relating to any referral of, or consultation about, MH with SFS. However, we were assisted by the then manager who clearly recalled having a conversation with a member of staff (Crisis Team) to whom he had given firm advice on the facts as presented to him for advice, that the matter should be addressed by hospital admission. No official file or SFS record was raised. There is no record in the Crisis Team of such a consultation or recognition of the advice given and we were unable to pursue the matter with the person by whom contact was alleged to have been made. (*This episode is considered in further detail in Chapter 7 of this report*).

Chapter 10

Strategic Change

The Homicide Action Plan

During the course of our Investigation, we acquired a copy of a *'Review of the Incidence, Distribution and Characteristics of Homicides in Avon and Wiltshire Mental Health Partnership NHS Trust: Benchmarked against the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. April 2001 to September 2007.'* The document is dated January 2008 and the reason for the existence of this document is set out in the first paragraph of the Executive Summary as follows:- *'Homicides committed by people with mental illness are a rare and shocking event. The occurrence of 4 homicides alleged to have been committed by service users in contact with AWPT Teams within a 6 month period in 2007 has caused great concern. This Review was requested by the SHA to benchmark the incidence of homicides in AWPT against national rates, and to compare the characteristics of the cases with information from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI).'*

Avon and Wiltshire Partnership NHS Trust was established on 1 April 2001. Between 1 April 2001 and September 2007, 8 homicides had occurred. In the above report, it was stated that *'Examining the incidence of homicides committed, and alleged to have been committed, by AWPT service users since the Trust was established within current boundaries reveals that the AWPT rate is three quarters of the national average, even when the 4 cases occurring in 2007 are included. However, the occurrence of 4 alleged homicides in a 6 month period is highly unusual, and is more than twice the (national) average rate for the period. However, this may not indicate any underlying change in incidence, and it should be noted that due to natural variation there will be annual variations above and below the range of the average rate'*

Paragraph 2 of the Summary states *'The NCI judges that homicides committed by people with a mental illness are less preventable than suicides. In their most recent report, 'Avoidable Deaths' (Appleby et al, 2006), they conclude that overall 13% of homicides committed by people in contact with mental health services were preventable.'*

In the final paragraph of the summary it states *'The characteristics of the 8 AWPT cases were broadly similar to the national sample reported in 'Avoidable Deaths'. The Discussion reviews some conclusions to draw from the series of cases when compared to the national data and highlights 4 issues: use of the Enhanced ICPA in Schizophrenia, recent violence, Early Psychosis and risk, and dual diagnosis. The Trust has generated a combined Action Plan based on the Internal Investigations of the four 2007 cases, and it is recommended that these points are considered as part of the Action Plan''.*

The Discussion section at 6.1 – 6.8 of the summary states

'Short term changes in the incidence of very rare events, however serious, need to be treated with caution. An analysis of the incidence of homicides committed, and alleged to have been committed, by AWPT service users since the Trust was established within current boundaries reveals that the AWPT rate is three quarters the national average, even when the four cases occurring in 2007 are included.

None of the 8 AWPT cases fell in the "most preventable" categories identified by the NCI. Applying their finding that 13% of community homicides were potentially preventable (Appleby et al, 2006) means that on average one of the 8 homicides which have occurred in AWPT since 2001 could have been prevented.

However the occurrence of 4 cases within 6 months in AWPT has been a traumatic experience for the clinical staff involved, and for the service. The Trust has undertaken 4 separate Internal Investigations using Root Cause Analysis, but generated a single Action Plan based on the findings of the Investigations. The root causes and findings of these Investigations broadly match the issues highlighted by Avoidable Deaths'.

A detailed comparison of the characteristics of the AWPT cases to the national sample also found that these were in the main part similar. However 4 points of interest emerged; the use of Enhanced ICPA in Schizophrenia, recent violence, early psychosis, and dual diagnosis.

Only one of the 4 AWPT patients diagnosed to be suffering from Schizophrenia was subject to Enhanced ICPA, in comparison to 66% of cases nationally. 'Avoidable Deaths' identifies use of the Enhanced ICPA as one of the key ways to aim to reduce the risk of both suicide and homicide. Since the MN Inquiry (Downham et al, 2006) the Trust has undertaken a major programme of work on ICPA, however the use of ICPA specifically for service users with the diagnosis of Schizophrenia has not been reviewed, and this should be considered as part of the Trust Action Plan.

AWPT cases were reported to have a higher level of violent and threatening behaviour in the previous 12 months, when compared to the national sample. The Trust is undertaking a review of Risk Assessment and Management as part of the national Review of the ICPA and of Risk Management in mental health services. This finding needs to be included both as a learning point for clinicians and for consideration in Risk Assessment protocols.

In 3 of the cases of individuals with a diagnosis of Schizophrenia the disorder was of recent onset, and met the criteria for an Early Intervention in Psychosis service (Department of Health 2001). 2 of these homicides occurred before the Trust had EI teams in place, and one perpetrator was receiving input from an EI team. This confirms the very high risks associated with the early stages of psychotic disorders, which have been described as the 'critical period' of psychosis (Birchwood, Todd and Jackson, 1988). The Trust is now implementing the national Early Intervention in Psychosis strategy, and it is essential that all EI teams have the capacity to meet the 8 national Fidelity Criteria set by NIHM/CSIP.

Lastly, the AWPT cases reflect the national findings of the increased risks associated with dual diagnosis of severe mental illness combined with drug and alcohol misuse

or dependence. The Trust has recently developed a Dual-Diagnosis Strategy, and the effective implementation of this needs to be given the utmost priority'.

Commentary: We noted that in May 2002 the Department of Health issued guidance entitled **Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide**. The guidance stated that 'The development of comprehensive services for this group is a priority'. We were concerned that at January 2008, the Trust had only recently developed its Dual Diagnosis Strategy and had yet to implement it. This was following the homicide by MH, a patient who should have been referred to such a service.

Recommendation 71: The Trust should ensure that an effective Dual Diagnosis Strategy is in place and is being applied effectively for all relevant service users.

The Plan's Recommendations

The Homicide Action Plan and the concluding summary are dated 18 August 2009. Together, they consist of 32 pages.

The plan lists recommendations, agreed action, work completed and actions outstanding under the headings:-

- Clinical care.
- Multi- agency information sharing.
- Formulation.
- Risk Assessment
- Training.
- Service Capacity and Competencies.
- Information Sharing.
- Specialist Drug & Alcohol Service.
- Dual Disorder Strategy & Training.
- Early Interventions Services.
- Managing of Absence of Staff.
- Managing Conflict between Teams.
- Relationships between members of Staff.
- Family Approaches to Care.
- Mental Health Liaison Service.
- Safeguarding.

The concluding summary includes actions completed, actions outstanding and, where appropriate, the date for completion.

Commentary: We noted that most of the headings reflect those of our own findings of the situation as it pertained in the period 2004 to 2007, and that some necessary actions remained outstanding over two years later.

The Swindon Rapid Improvement Programme

The work for the Swindon Rapid Improvement Programme commenced in April 2009 and was instigated by LMCM, in response to concerns from Commissioners, service users and other stakeholders, including MIND, about adult community services (not in-patient services)

We believe that the initial plan was produced in April 2009 but had sight of Version 7, which had been adapted to update on progress to inform a report being submitted to the Joint Commissioning Board in July 2009. We were told that the Joint Commissioning Board includes Swindon Borough councillors and Executive Directors from NHS Swindon.

Excerpts from the programme plan include 'Concerns have been raised by GP's, service users, carers, Health & Overview Scrutiny Committee and third sector providers at various forums over the past few weeks about some aspects of the Swindon Community Mental Health Services provided by AWP for Adults of Working Age.....'

These concerns have been collated, 'themed' and presented in an 'action plan' format by CA, MH Commissioning Manager for Swindon PCT&LA to AWP on 29 April 2009.....

Whilst it is recognised and accepted that some of the service improvements/developments will take some time to be realised, we all want and need to see tangible improvement by early July 09.

It is important to acknowledge that whilst the emphasis of this feedback had been on the things that need to be put right I have also heard about the good things in Swindon. Many people have also said that they recognise and value the good work being provided by AWP staff in Swindon.'

There are 16 headings to the plan, with associated targets, as follows:-

- Community Mental Health Teams (11 targets)
- Crisis Resolution & Home Treatment Team (6 targets)
- Information about AWP services & Information about all Mental Health services/support services (4 targets)
- Involvement, Engagement & Consultation (3 targets)
- Care planning & Care Co-ordination (5 targets)
- Staff approach, support and training (4 targets)
- Links between AWP Services/Teams (3 targets)
- Links between AWP Services and Great Western Hospital (1 target)
- Medical Staffing & Medicines Management (3 targets)
- Link between AWP and GP's (3 targets)
- Links with Service Users/Service user Group, Carers and Carers Groups (2 targets)
- Links between AWP and other Mental health Service Providers (2 targets)
- Facilities/buildings (1 target)
- Process to review progress of this action plan (2 targets)

- Relationship and Communication Management (1 target)
- Developments with Carers (3 targets)

Commentary: These 54 targets in total reflect examination of fundamental expectations relevant to any health care organisation. We do not consider it necessary to go into the detail of the targets identified but given the relevant infancy of the Plan, the statistical information available from a recent survey conducted by SUNS (*Service Users Network Swindon*) was encouraging, albeit that it represented contributions from a fairly small sample. Notwithstanding these results, there was reference in evidence to us that the sampling was a *'box ticking exercise'*

Whilst we welcomed the fact that processes have been put in place to address what appear to be longstanding issues, we noted that these postdate the homicide. We would again draw attention to the letter of 6 August 2008, written by the then Medical Director, which highlighted key themes which pertained at the time of MH's engagement with the service and continued to be an issue at the time the letter was written. The Homicide Action Plan of 2009 indicates that the same set of issues pertained at July 2009 over 2 years after CJ's death.

Chapter 11

Was this homicide avoidable?

Introduction

This chapter deals with what we consider to have been a range of missed opportunities in the care and treatment of MH, and failures by individuals and in systems, which we consider impacted upon his care and treatment. We considered causal and influencing factors in concluding that this homicide was avoidable and the following pages set out our reasons for this view.

A 'causal factor' is one which describes an act or omission, which in our view had a direct bearing on the failure to manage MH effectively and that this failure contributed to the death of CJ. An 'influencing factor' denotes a process or system which failed to operate successfully (as opposed to individual failure to comply with an effective system), whereby we consider that it made a direct contribution to the breakdown of MH's mental health and/or the failure to manage it effectively.

The following sets out the factors upon which - some of them individually and others through accumulation - we base our conclusion, on the balance of probabilities, that CJ's death was avoidable.

Synopses and conclusions

Identification of CJ as a real person, known to MH and living in the same area of Swindon; and of (TV) as a fictional character would have focused attention on potential for violent events and led to appropriate warnings being given and actions taken, including different decisions on care and treatment. There was a failure to involve the Forensic Services formally when it was known that MH was exhibiting threats to kill from the outset. There were many references to knives and a demonstration of how he would kill CJ; he held a knife to his girlfriend's throat; he threatened to do harm her new boyfriend. His threats to CJ and (TV) were ongoing from 2004 until mid 2006. All threats should have been taken seriously and investigated, including instigation of the MAPPA process at an early stage. Knowledge of knives, threats to kill, threats and aggressive behaviour were features of MH's presentation throughout. In addition, there were records of cruelty to cats (including attempting to strangle them). Each of the key teams and some other agencies engaged with MH held some or all of this knowledge. Proper use of the required single and comprehensive set of notes for MH and instigation of the MAPPA process would have ensured that all such important information was shared and services were alerted to the need to investigate further the risk of violence.

CONCLUSION: On the balance of probabilities, this homicide would have been averted by the identification of CJ and the involvement of appropriate services and agencies

Notes did not follow the patient (*and indeed were incomplete*). Notes were not available on the transfer of care in December 2004 or on the transfer of care in January 2007. At these stages, clinical care decisions were therefore unavoidably made in the absence of Crisis Team records. This is of particular significance in January and February 2007 as Crisis Team records (from April 2006) up to that point demonstrate evidence of deterioration in MH's mental state, recent and substantial non compliance with medication and non engagement with the Crisis Team service.

CONCLUSION: some care decisions were made in the absence of MH's full history and thereby not informed by key facts and known risks.

Care Plan updates were not systematically carried out and formalised. Formal documentation relating to Care Plans was not always completed, although ICPA reviews were embedded in CMHT clinical notes. Other Care Plans were – actually or apparently - inappropriately completed by staff other than the Care Co-ordinator. In November 2006, a Care Plan was completed and signed by a Student Nurse, this at a time of recorded deterioration in MH's mental state and without involvement of the assigned Care Co-ordinator. This particular Care Plan was invalid and also completed without the Care Co-ordinator's longitudinal knowledge of MH's history. It was completed without the knowledge and contribution of the assigned Care Co-ordinator and the Crisis Team would, therefore, have been operating to an inadequate, partially informed and invalid care plan. This document was the last putative Care Plan developed. The Care Plan was updated on two occasions, by staff other than SG. In fact, good practice would indicate that a new Care Plan is completed at each review date or in response to a significant change in circumstances. There was no formulation of a new Care Plan on MH's discharge from Green Lane Hospital on 30 November 2006. .

CONCLUSION: Appropriate and up to date Care Plans were not properly formulated for MH, to reflect changed care and treatment needs following significant episodes in his illness. We conclude that MH was therefore, at times, not afforded the care that his current circumstances required and that he was provided with inadequate care.

Only one formal Risk Assessment was carried out and this was in July 2006, almost two years after MH's first referral to the mental health services. Other risk screens and core assessments were undertaken but they were of variable quality, information therein was incomplete and these documents did not constitute formal Risk Assessments. Recorded events of violent behaviour and threats after July 2006 should have led to further Risk Assessments and changes to the care and treatment provided to MH. This one formal Risk Assessment (completed on 26 July 2006) was a joint assessment by the CMHT and the Crisis Team. However, this did not reflect fully the complete history of recorded risk, not only to CJ but also to others. Further Risk Assessments should have been undertaken, following a number of later events, including the threat to kill two members of the Crisis Team.

CONCLUSION: The lack of a complete chronology of risk was indicative of the fact that potential risk to others, including CJ and staff themselves, was not addressed in a systematic way. We conclude that, even at this relatively late stage and in a situation of marked deterioration in MH's mental state, steps

could, and should, have been taken to minimise the risk of significant harm by MH to others.

MH was a known user of cannabis from the outset and of alcohol sometime later. No attempts were made seriously to engage MH with this problem, through the intervention of the Dual Diagnosis approach. We noted that, at January 2008, AWPT had yet to implement its newly developed Dual Diagnosis Strategy, despite Department of Health Guidance in 2002 that the development of comprehensive services for Dual Diagnosis patients was a priority.

CONCLUSION: there was failure to take account of MH's significant use of drugs and alcohol in determining his care and treatment, despite recognition of the impact of drugs and alcohol in mental health conditions. There was no formal Dual Diagnosis policy to advise and guide staff in this matter.

There were numerous occasions of non compliance with medication recorded in MH's notes, including one in early 2006, which related to his hoarding of medication then taken as a substantial and serious overdose, resulting in hospital admission. This, as well as the requirements of the Trust's Medicines Management Policy, should have informed the Crisis Team's practice from April 2006, including close monitoring of his compliance. Delivery of medication by posting through the letterbox for a patient deemed to require the specialist home treatment from a Crisis Team is considered to be not only ineffective home treatment but also an inappropriate and dangerous practice. This is particularly so when the medication is delivered to the address of another known service user. MH's compliance with medication was not monitored effectively by the Crisis Team thereby allowing a significant build up of untaken medication, discovered in January 2007. The decision by (XX) to post a prescription to MH in February 2007 was also poor practice both generally and particularly in the context of MH's known non compliance. From early February onwards, MH did not receive all medication prescribed for him, compounding his failure to take some 20 doses sometime in the period from December 2006 to 3 January 2007.

CONCLUSION: This key aspect of care for MH was not carried out fully. Of critical importance is that in late 2006, when his mother was reporting a serious deterioration in his mental state, a view shared by his Care Coordinator, MH was allowed to miss significant amounts of medication, which was deemed to be appropriate to his condition. This was well documented in the notes and should have informed (XX) in his contact with MH from late January up until the homicide. Despite this, (XX) failed to make contact with MH for a period of approximately three weeks although information of MH's current address was on file. In this period, MH was not provided with continuous prescribed medication. He had received a test dose of new medication on 30 January 2007; the first therapeutic dose was administered on 22 February 2007, when (XX) saw him face to face; and a further injection was due on 8 March 2007. The homicide occurred on 4 March 2007. The prescription for ongoing Depakote (*mood stabiliser*) had been posted to MH by (XX) and there is no record of whether MH received this prescription; obtained the prescribed medication; or took the medication. We found that there was significant recorded evidence of non adherence to the

Medicines Management Policy, throughout MH's involvement with the mental health service which, latterly, allowed failure to ensure that MH took the prescribed medication during 2006 and 2007; and we conclude that this was a major factor in the continuing deterioration of his mental state and a causal factor. We were concerned that poor Medicines Management practice spanned some two and a half years without being exposed by audit or managerial review of medicines management practice.

During the course of MH's involvement with mental health services there were four Mental Health Act assessments. In November 2006 there were two assessments both of which were delayed. The first on 17th November occurred 16 days after a Mental Health Act assessment had been called for and despite a number of enquiries by the Care Co-ordinator during the month, no reason for the delay was recorded by the Crisis Team and no satisfactory explanation was provided to us. Although MH was considered not to be detainable on that date and a management plan was agreed with him, including his agreement to comply with medication (the ASW had clearly recorded that he had a history of non compliance with medication). There was also information in the notes from JM, MH's mother, that MH could 'hold it together' (*that is, mislead clinical professionals as to his presentation*). We concluded that a delay of 16 days to organise a Mental Health Act assessment was unacceptable and had it taken place on 1st November as proposed and taken account of the report by Windswept as to MH's mental state and the opinions of SG recorded in their respective notes then in-patient admission would have been a probable outcome. The second assessment on 22nd November 2006 and records indicate that the delay in this case was due to lack of availability of a Section 12 doctor and the fact that a bed at Green Lane Hospital had been lost but would become available the next day. The assessing doctors did not find MH to be detainable but he agreed to informal admission to Green Lane Hospital. In January 2007, the CMHT was proposing that MH be hospitalised for his mental state to be stabilised and a change of medication considered as they believed that it was not possible for them to provide the care he needed in the community. The Crisis Team did not take account of the CMHT views and did not arrange a Mental Health Act assessment but proceeded to discharge MH to the care of the CMHT. Whilst Dr PS indicated that he believed hospital admission for MH would be beneficial and, in his own words, 'the best course of action' at this stage, he did not exercise his authority to call for a Mental Health Act assessment. Nor did Dr MS. The process for appeal against the Crisis Team decision to hand back MH's care to the CMHT in 2007 did not work in practice and there was no apparent right of appeal against decisions by the Crisis Team not to arrange a Mental Health Act assessment.

MH could well have been detained under the Mental Health Act in November 2006, if the Mental Health Act assessment had occurred when requested, this being at a time of his very fragile mental state as reported by clinical staff of Windswept and evidenced in the Crisis Team notes; and if due account had been taken by the Crisis Team and the assessing doctors of all the available relevant information and the views of MH's mother and Care Co-ordinator. We conclude that a further Mental Health Act assessment in January 2007, fully informed by the range of concerns being expressed and by the knowledge that MH had not taken a significant amount (reported variously as 20 or 28 doses) of

prescribed medication in the preceding weeks, would have resulted in admission, a formal diagnosis and revised care and treatment for MH.

There was no formal 'one to one' consultation between the Crisis Team, and CMHT aligned Consultants (*Drs MS and PS respectively*) but both indicated that there was some informal discussion. Such discussion should have been formally recorded in the notes and was not. In addition, there was a lack of communication by AG of key information to other clinicians, including consultants. Whilst AG advised that she did communicate key information to other clinicians, this was often verbally or by telephone and was not always supported by a record in her own notes.

CONCLUSION: These deficits in communication constituted a major missed opportunity to share information about risk and about MH's deteriorating mental state and, thereby, to ensure a concerted multi-team approach to his diagnosis, care and treatment and to the management of risk to a number of people.

Dr MS did not review MH after 13th November 2006, when she had noted in records, "review by me in 2 days" albeit that MH had been admitted to Green Lane Hospital informally. She did not appear to have been consulted about MH's discharge from Green Lane Hospital. There is no evidence that Dr MS followed up on the consultant aspects of the associated care plan to review MH weekly. The next Consultant review was by Dr PS on 30 January 2007. Sometime between 30 November 2006, when MH was discharged from Green Lane Hospital and 3 January 2007, some 20 doses of medication had accumulated because Crisis Team, on occasions which were recorded in the records, delivered medication as opposed to administering it to MH in accordance with the terms of the care plan.

CONCLUSION: Between mid November 2006 and the end of January 2007, MH was not seen by either of the Consultants with some longitudinal knowledge of his history despite clear evidence of MH's deteriorating mental state and non compliance with medication.

Throughout MH's contact with the mental health services, there was a number of events and situations where a formal diagnosis should have been considered or made, which would have resulted in a more robust care plan, formal involvement of the Forensic Service and changes in treatment and medication.

CONCLUSION: these were major missed opportunities.

Unfilled vacancies in the Assertive Outreach Team led to their feeling of being unable to take on new cases safely and thereby a refusal to do so. Vacancies in that team were formally notified to a senior manager in AWPT who did not refer it to the Trust's Recruitment Scrutiny Panel and the posts remained unfilled.

CONCLUSION: In January 2007 MH's care was not transferred to the AORT, the service most appropriate to his needs at the time.

The general lack of liaison between all teams and the poorly integrated approach to care derived from a lack of inter team cohesion and, in some cases, clear animosity.

Teams appeared to work largely in isolation, although some individual members of staff sought to work jointly with colleagues in other teams. There was little evidence of any overarching senior manager supervision, control or support which would have ensured that individual and team accountabilities were delivered; that staff were working effectively and cohesively; and that known problems of conflict and resourcing difficulties were addressed to ensure the safety and appropriate care for patients. Crisis Team and CMHT cooperative working to ensure an integrated pathway of care for MH, was not effective because the Crisis Team was largely working in isolation of the Care Co-ordinator and some other professionals and not taking into account the broader picture of MH's presentation needs and how the best care and treatment could be delivered and by which team.

CONCLUSION: Had the teams been working collaboratively, they would have had a better understanding and recognition of the nature and degree of MH's severe and enduring mental illness. They could then have worked together to provide an appropriate and effective integrated package of care so that MH would have received the treatment and support required. The Root Cause Analysis process after the homicide, itself identified that there was longstanding conflict between the Crisis Team and the CMHT and that managers were aware of the conflict between the teams but that there had been no successful resolution of that conflict.

Records were not kept fully in accordance with NHS guidelines and requirements of professional Codes of Conduct. They should have been legible; contained all relevant information; shown the name of the person(s) making the record/in attendance; shown the time spent with the service user; and been signed and authenticated with the initials of other(s) present. Likewise, Crisis Team diaries should have been retained in accordance with standard good practice as they contained (*at least*) reference to visits to patients. Incorrect filing of notes made it difficult to follow the trail of events and the inclusion of notes for another patient provided misleading information. There were examples of scant attention to detail particularly by the Crisis Team and failure to make records by a range of staff, including managers and consultant psychiatrists. With the exception of SG, there were examples of lack of cross referencing between the separate records of each team. Registered clinical staff are subject to record keeping standards set out by their registering bodies. However, day to day records management processes should be set out in the Trust's own policy to ensure that staff adhere to required practice. The policy extant throughout MH's engagement with the service did not, in itself, provide staff with sufficient and immediate clear guidance as to Trust requirements and there was no apparent process of monitoring and quality control.

CONCLUSION: This not only prevented the protection of MH, clinical staff and AWPT but also led to a situation where key information was not available – or readily available – to staff dealing with MH, to inform their care decisions. In addition, the threat to CJ was never effectively investigated, thereby preventing action being taken to avoid consequent harm to him.

The decision was made by the Crisis Team to return MH to G/F's empty flat on 29 October 2006, despite clear evidence from Windswept and his mother about his

fragile and deteriorating mental state. JM's regularly reported concerns about MH's deteriorating state were largely not given credence by members of the Crisis Team

CONCLUSION: This was an unsafe decision.

There was no evidence of a formal carer's assessment being carried out for JM, although she was able to maintain contact with SG and AG, who were aware of her concerns, which were noted in the CMHT records. JM herself confirmed that no formal carer's assessment had been undertaken. This is a failure in respect of a key component of the ICPA process.

CONCLUSION: This was a breach of Trust policy.

Mental State Examinations by some members of the Crisis Team were often perfunctory or not recorded at all. Where crucial information was recorded, which would have informed necessary changes in the care and treatment provided to MH and care provision and alerted colleagues to changes in MH's mental state, this information was not effectively conveyed to the wider care team. There was no evidence that particular risks, such as MH's threat to kill members of the Crisis Team, ongoing threats by him to kill or harm others and the increasingly fragile state of his accommodation arrangements were conveyed to others involved in the direct care and treatment of MH. The AORT, which was visiting at the address shared by G/F and MH, was not alerted to the risks posed by MH. These were not escalated to a higher management level or, if they were, then appropriate action was not taken to minimise those risks.

CONCLUSION: the paucity of many Mental State Examinations and failure to identify, share and address risk were significant failures, which we consider to be a causal factor.

The delay between July and December 2006 in pursuing assessment of MH for autism was in itself a missed opportunity in that an earlier exclusion of that diagnosis could have led to a review and formalisation of a diagnosis of schizophrenia and changes to the medication for MH. In practice neither did this occur in December 2006, when the autism diagnosis had been excluded.

CONCLUSION: this was an important missed opportunity.

There was a lack of recognition by teams other than the CMHT of the role of MH's Care Co-ordinator and appreciation of her crucial need to be involved and aware of all key decisions, actions and information. In addition, her views on MH's mental state and care needs were not always sought or, when expressed, taken into account

CONCLUSION: Despite her best efforts, SG was rendered unable to fulfil her essential role of Care Co-ordinator to required standards. A key example was when her serious concerns about the CMHT's ability to provide the level of care, which she believed he needed, did not affect the decision of the Crisis Team to proceed with MH's discharge to the CMHT in January 2007. Other staff in the CMHT felt that MH required admission to hospital. Such admission

would have provided the opportunity for a proper review and assessment of MH's mental state and treatment needs, which would include his response to medication and any changes deemed necessary, as a result of his being in a controlled situation. We conclude that, had SG's views and the supporting views of other clinicians been taken into account, MH would have been treated in hospital and we conclude that CJ's death could thereby have been avoided.

After MH's overdose in February 2006, no formal psychiatric assessment was undertaken, either when he was an in-patient in Great Western General Hospital or post discharge, although the need for this was recorded in the medical notes. There was no active consultant psychiatrist involvement at this stage, except for discussions between the Care Co-ordinator and a consultant covering for the aligned CMHT consultant. No one followed through on this omission.

CONCLUSION: The failure to undertake a formal psychiatric assessment was a clear breach of Trust policy, albeit that the policy did not address explicitly the particular set of circumstances of MH's admission. A psychiatric assessment would have provided the opportunity to determine MH's underlying motives for the overdose and the potential for further risk to himself and others.

The ethos of the Crisis Team was to provide home treatment as an alternative to hospital admission, where appropriate. This managed process, between 2004 and 2006, had the effect of reducing bed usage to the point where two in-patient wards were closed. As a consequence, pressure on the remaining beds was high, which we were told necessitated an increase in seeking beds outside Swindon. One effect of this was, as in MH's case, that where two service users were in a relationship and in need of in-patient admission; and, as also in MH's case, there were concerns about relationships with other in-patients, this could not be accommodated in Swindon due to there being only one in-patient Unit. .

CONCLUSION: As a consequence, in November 2006, MH was not treated by the team, which knew him well and had available a full history. His assigned consultant at Green Lane Hospital was unaware of the longitudinal picture of MH's illness and therefore was not able to take this into account in relation to his in-patient treatment and subsequent discharge.

On 3 January 2007, SG visited MH at G/F's flat where DW of the Assertive Outreach team was present, visiting G/F. SG recorded that DW told her that MH had not been taking his oral medication and that she felt that he was still very unwell (psychotic). SG recorded that two members of the Crisis Team then attended to administer MH's depot. Crisis Team records for 3 January 2007 show that they became aware on that morning that MH had not taken any of his medication 'for the last couple of weeks' and we conclude that this information was not of their own observation but became evident when SG handed them some 20 envelopes of medication (as stated in her evidence to the police). This was the first recorded face to face Crisis Team contact with MH since 24 December 2006, prior to which there is a series of recorded occasions when they were not able to administer MH's medication or they posted it through G/F's letter box. On 6th January, the Care Co-ordinator was requested to

contact the Crisis Team and did so, voicing her concerns about the intention of the Crisis Team to hand MH's care back to the CMHT. Her concerns were recorded as being about compliance with medication, poor engagement and symptomatology. On 9 January, the Care Co-ordinator received a fax from the Vulnerable Adults Unit advising that MH's mother had reported to the police that he had not taken his medication since Christmas 2006, that his mother had contacted the Crisis Team and that they had refused to attend. Notwithstanding, the handover was effected on 11 January 2007 despite the Care Co-ordinator expressing her concerns at MH's presentation on that day to the Crisis Team member, who was a support worker rather than a registered nurse, and who promised to report back to the manager of the Crisis Team. There was no note of this by the manager in the Crisis Team records. The handover still went ahead. Sometime in November 2006, an unqualified member of the Crisis Team had alerted the Forensic Service to her very real concerns about MH. We heard from KHO of the Forensic Service that his advice was that hospital admission should be sought as a matter of urgency but this conversation was not recorded. We were unable to see this Crisis Team key witness.

CONCLUSION: we conclude that the Crisis Team's failure to home treat MH effectively prompted a peremptory decision without recorded reasons to hand back MH's care, without acknowledging the consequences of such a decision but in the full knowledge that whatever care MH required was not going to be available to him. This deficit in service provision was because the Assertive Outreach Team had refused to take on new patients due to unfilled staff vacancies; the Care Co-ordinator was clear that the CMHT did not have the resources to provide the care needed, care which had been formulated and recorded by Dr MS, Consultant aligned to the Crisis Team, and updated on discharge from Green Lane Hospital; and because the Early Intervention Team had lost contact with MH. Dr MS was not involved in the decision to hand back care and should have been. Given the repetition and strength of the Care Co-ordinator's views and the concerns conveyed to the Forensic Service, there should have been a multi-team case conference, involving senior managers and consultant psychiatrists, to resolve the dilemma of how MH's ongoing care should be managed. If this could not then be resolved at clinical level, the matter should have been escalated to a higher level than the managers and consultants of the Crisis Team and the CMHT before the hand back was approved. This was a major missed opportunity and a causal factor.

Failure by Drs PS and MS to adhere fully to ICPA Policy and NICE guidelines meant that no defined diagnosis for MH was formulated and recorded (*other than Dr V's differential diagnosis of paranoid schizophrenia plus multiple substance dependence in August 2006, which was subsequently carried forward in records by two other junior doctors at Green Lane Hospital*) until after the homicide when he was formally diagnosed as having paranoid schizophrenia and as being '*floridly psychotic*' and a '*most thought disordered man*'. Neither Dr PS nor Dr MS, who individually had Consultant responsibilities at different times for MH, recorded any diagnosis. The general overall approach, with the exception of SG, seems to have been one of taking at face value MH's explanations of his actions, given in order to minimise concerns about his behaviour, rather than acknowledging and exploring serious issues being highlighted. There appears to have been no process within AWPT to

assure adherence to the critical need for early formulation of a firm diagnosis by a consultant psychiatrist.

CONCLUSION: Taking account of NICE guidelines, we concluded that the complexity of symptoms presented by MH was sufficient at the end of 2004 to formulate a working diagnosis of schizophrenia and that this responsibility lay with a consultant psychiatrist. Dr PS first saw MH in March 2005 and Dr MS first saw him in May 2006. Neither formalised and recorded a diagnosis at those times or at any time thereafter. At those points in time, MH's care and treatment fell significantly short of NICE guidelines, specifically in that a clear diagnostic formulation was not then (*or ever*) made and recorded. Although a psychological formulation was developed, this was not explicitly shared with the other clinicians involved in MH's care. This omission on behalf of the Early Intervention Service is a particular concern in respect of its influence on later decisions of the three consultant psychiatrists, Drs PS, MS and DS. In any event, a psychological formulation cannot replace a formal medical diagnosis. MH's needs were not explicitly assessed and recorded through a diagnostic formulation and no specific care plan was developed to manage co-morbid substance misuse. One consequence of the failure by any consultant psychiatrist to formalise a working diagnosis of schizophrenia for MH meant that the consideration that his illness fell into the categorisation of 'treatment resistant' was not undertaken. This was a major missed opportunity.

We heard compelling evidence to the effect that all four of the teams involved in MH's care were not sufficiently staffed to provide the level and standard of care needed. This was due to three main factors: the fact that the Crisis Team was partly funded by resources transferred from the CMHT (which was thereby depleted), and in any event was reported by witnesses not to have sufficient staff to provide the required 24 hour, 7 days a week service; the Early Intervention Service was embryonic and staffing was not increased until after the homicide; and a senior manager did not refer AORT staffing vacancies to the Trust's Recruitment Scrutiny Panel, which led to gaps in that team. In addition, at least Crisis Team and CMHT members individually were working in excess of contracted hours. In the CMHT, caseloads substantially exceeded the level recommended in the Nursing and Midwifery Council guidelines, resulting in all staff working excess, unpaid hours, risking unsafe practice. We heard evidence from staff to the effect that training, supervision and appraisal were not systematically delivered.

CONCLUSION: We concluded that the focus at senior management and Board level in AWPT was on strategic issues, admittedly major and pressing and a legitimate aspect of the Executive function, but to the detriment of focus on operational services, which are the *raison d'être* of the organisation and also a legitimate responsibility at Board level. We conclude that this undoubtedly impacted upon the support and processes necessary to assure competence and actions of clinical staff to plan, provide and deliver the appropriate levels and standards of care. We conclude that this was exacerbated by the disillusionment amongst many clinical staff in the context of reorganisation; separation of strategy from clinical services (albeit the decision to establish Strategic Business Units was made to help ensure that there was not a separation of strategy from clinical services); a sense at operational level of

isolation and lack of managerial support; and actual or perceived gaps in the management structure. Key activities to support staff, such as supervision, appraisal and mandatory training, were not comprehensively delivered during the period of MH's engagement with the mental health services.

The Trust stressed to us that assurance processes were in place at Board level but our conclusion was that there was evidence that many key requirements were not, in fact, being delivered effectively or in accordance with Trust policy and procedure. These included record keeping, both legal and administrative good practice; mandatory training; adherence to recommended safe caseload levels; working hours; supervision; adherence to policy; and audit. Our view is that the fact and accumulated impact of these failings would have become known to the Board if their assurance processes had, in fact, been effective.

CONCLUSION: We conclude, on the balance of probabilities, that effectively managed assurance processes would have exposed early at least some of the factors which impacted negatively on the care and treatment of MH, allowing corrective actions, which in his case, would have changed the course of events.

CONCLUSION: The Trust itself failed to maintain an environment where all clinical staff felt able to exercise appropriate judgment, based on their skills, training and experience. At Executive Level, there was a lack of appreciation of, and appropriate response to, the reality of the pressures caused by organisational changes. We conclude that the essential qualities of competent leadership necessary to support and ensure the highest levels of clinical service were not universally evident at senior management level.

OVERALL CONCLUSION: We conclude that an accumulation of poor practice, failures in systems and a lack of comprehensive overarching managerial direction and control were causal factors in respect of the death of CJ.

Chapter 12

Recommendations

Chapter 1

Recommendation 1: The person completing the initial service management review must sign and date the report and set out his/her full job title. (S)he must also list the names and job titles of those contributing to the review.

Recommendation 2: The Trust should ensure that its Medicines Management Policy is understood by all staff involved in its application and strictly adhered to, with particular reference to the administration and delivery of medication to a patient in his/her own home or other place of residence.

Recommendation 3: All discussions and decisions concerning a patient, and other information of relevance to his/her care, must be recorded in accordance with Trust procedure and national guidance.

Recommendation 4: An RCA panel investigating an incident of this gravity should be supported by a person, who understands the issues and is able to take comprehensive and attributed verbatim notes for greater understanding when referred to much later in the overall Investigation process.

Chapter 4

Recommendation 5: The Trust should ensure that all staff adhere to the principles set out by NICE for the treatment with anti-psychotic medicine. The Trust should ensure that all staff are provided with appropriate training to ensure their understanding of these responsibilities and to develop competence to discharge these responsibilities.

Recommendation 6: The Trust should ensure that staff complete drug charts in accordance with its own stated policy and report any errors or omissions without delay.

Recommendation 7: The Trust should ensure that all members of the Crisis Team adhere to their remit and professional responsibilities in respect of the administration of medication and monitoring of compliance and that failure by a patient to comply is formally escalated, including an appropriate report to the Responsible Clinician, so that any necessary actions can be determined and implemented.

Recommendation 8: The Trust should ensure that staff are aware of the process and need for partnership working with carers and adhere fully thereto.

Recommendation 9: Comprehensive Mental State Examination should be undertaken on a regular basis, particularly in respect of commencement of treatment with an anti-psychotic drug.

Recommendation 10: The Trust should ensure that clinical staff are aware of and implement relevant NICE guidelines.

Recommendation 11: All entries in clinical notes must include in capitals the name and title of the person making the entry and the name(s) of any others involved in/present at the matter being recorded.

Recommendation 12: There must be a psychosocial assessment prior to, or as soon as possible after, discharge of a patient who is admitted to hospital following a self-harm episode.

Recommendation 13: Formal assessment of capacity to consent to treatment, including medication, should be undertaken and recorded on the patient's first contact with the service. Thereafter, new assessments should be undertaken where there are changes to the treatment regime. In addition, where there is evidence of, or concern about, actual or potential non-compliance, the issue of capacity to consent should be reviewed as part of the process of managing compliance.

Recommendation 14: The Trust should ensure that, whatever system it operates for the recording and collation of patient notes, the complete record is readily available to those seeing the patient, particularly on transfer of care between teams, including in-patient admission, and Mental Health Act assessments.

Recommendation 15: Whatever system of clinical records is in use, all available information should be passed to the lead clinician where an admission or discharge takes place.

Recommendation 16: The Trust should ensure that clinical supervision, and monitoring by Team leaders, include regular review of all current cases to ensure that concerns and/or deteriorating mental state are responded to speedily and appropriately and then monitored continuously. The Trust should develop a system which includes some form of visual marker for notes files, which highlights for staff concerns about changes in presentation and actual/potential risks, including compliance with care plans.

Recommendation 17: Where a patient's care moves between different care teams, consultant medical staff should have a formal, recorded process of handover of responsibility to ensure that all relevant clinical information is shared. This process of transfer of clinical responsibility should be managed within the framework of the Care Programme Approach. However, reliance on this process does not necessarily entirely discharge the individual professional responsibility for each consultant to ensure that they are adequately informed regarding the key clinical issues relating to each patient for whom they have RMO responsibility.

Chapter 5

Recommendation 18: All handwritten notes made at the time of a Mental Health Act assessment should be retained and filed in accordance with NHS policy.

Recommendation 19: Application for assessment for admission under Mental Health Act Sections should be conducted without delay and should not be conditional upon the availability of a bed.

Chapter 6

Recommendation 20: The Trust should put in place a mechanism for early support for, and communication with, the families of the perpetrator and victim of a homicide (or families affected by any other incident of similar impact) albeit that this might be through the services of another NHS organisation or non NHS organisation.

Chapter 7

Recommendation (Repeat of recommendation 17): Where a patient's care moves between different care teams, consultant medical staff should have a formal, recorded process of handover of responsibility to ensure that all relevant clinical information is shared. This process of transfer of clinical responsibility should be managed within the framework of the Care Programme Approach. However, reliance on this process does not necessarily entirely discharge the individual professional responsibility for each consultant to ensure that they are adequately informed regarding the key clinical issues relating to each patient for whom they have RMO responsibility. See also Chapter 4.

Recommendation 21: Where a member of the clinical team is unable to undertake the prescribed administration of medication in a timely manner, (s)he should refer this immediately to the RMO to agree what action is to be taken.

Recommendation 22: Where there is a transfer of care between teams (or between members of the same team), this should be done within the framework of a Care Programme Approach and include a written record indicating the written documentation available; the information transferred, including known risks and other historical information which would indicate the potential for risk; and immediate action to address risk. This document should be signed by all parties to the discussion in respect of the action to be taken, including the need to review the care plan.

Recommendation 23: Crisis Team staff should be trained in the recognition of Dual Diagnosis and its impact on existing mental health problems and the requirement to alert other agencies as appropriate.

Recommendation 24: The Trust must ensure that Care Plans are completed and signed off by the Care Co-ordinator and, where possible, the patient countersigns the entries.

Recommendation 25: Employee files should contain a copy of all prime documentation, which forms part of the contract of employment

Recommendation 26: All discussions concerning a patient must be recorded in notes in accordance with AWPT policy.

Recommendation 27: Key decisions relating to patients, including discharge, must involve discussion with the consultant(s) involved.

Recommendation 28: The Trust should review all Operational Policies on a regular basis to ensure that they are up to date and fit for purpose.

Recommendation 29: The Trust should promulgate and facilitate the escalation by staff of genuine concerns and respond appropriately.

Recommendation 30: The Trust should ensure that Team leaders understand and fully apply their responsibilities as managers and, where appropriate, as senior clinicians and are able to demonstrate competence, integrity and leadership.

Recommendation 31: The Trust Board should establish a process whereby it is appraised of and responds to the concerns of operational staff.

Recommendation 32: When a consultant is appointed as clinical lead of a new service, (s)he should be afforded the appropriate support and training in order to fulfil the required responsibilities. Furthermore, the Trust should ensure that there is an appropriate process in place to ensure the contribution of consultant medical staff in the development and implementation of the new clinical service.

Recommendation 33: The Trust should put in place a clear process for sharing relevant information about actual or potential risk and for ensuring that appropriate training and protective measures are put in place, and that this process is monitored in practice.

Recommendation 34: The Trust should review its procedures in practice to ensure adherence to Trust policy in respect delivery of medications to patients' homes (or other residence). Where it is discovered that medication delivered in this way has been retrieved by, or handed to, Trust staff because it has not been taken, there should be a formal system for reporting the facts to senior staff and recording them in the Crisis Team notes and determining appropriate action in accordance with Trust policy.

Recommendation 35: The Trust should establish a process whereby clinical and operational deficits are addressed at senior level so that more junior staff are not faced with making decisions outside their sphere of authority and ability.

Recommendation: (Repeat of recommendation 12): There must be a psychosocial assessment prior to, or as soon as possible after, discharge of a patient who is admitted to hospital following a self-harm episode.

Recommendation 36: The Trust should undertake an audit of episodes of self harm and compliance with the objectives set down in Trust Policy for the General Hospital management of Self Harm; and the associated actions of clinical staff whom the policy covers.

Recommendation 37: The Trust should review the policy and amend it to include more specific guidance in relation to the completion of the SAD PERSONS risk screening tool when patients are admitted to Accident and Emergency and for medical reasons it is not possible to complete the tool whilst the patient is under the care of the Accident and Emergency Department. This is to ensure that an appropriate risk assessment and psychiatric assessment is undertaken as soon as practicable.

Recommendation 38: The Trust should review the process of 'joint' management of patients by the Crisis Team (Including Mental Health Liaison Service) and CMHTs to ensure that there is clarity regarding the responsibility and accountability for ensuring that an adequate assessment is completed for all patients following an episode of self-harm.

Recommendation 39: The Trust should implement the agreement for the training of junior medical staff in respect of patients presenting with self-harm.

Recommendation 40: When a member of staff is made aware of threats to others (s)he should ensure that all members of the clinical team working with the individual are aware of the threat and escalate any concerns to his or her line manager and urgent, appropriate management action should be taken, including involvement of other statutory agencies and carers/families.

Recommendation 41: The Trust should instigate an urgent review of the process of communication between psychologists undertaking psychological interventions and the wider multi-disciplinary team, to ensure full availability and understanding of all clinical information and adherence to Trust Records Management Policy and to guidance from the British Psychological Society.

Recommendation 42: The Trust should review practice and policy regarding the process of multidisciplinary assessment and communication of risk, and formulation of risk management plans within the ICPA Procedure. In cases of significant risk, all professionals should take the advice of other colleagues in the development and sharing of risk management plans.

Recommendation 43: The Trust should undertake an audit of the supervision arrangements in place for senior clinicians and take steps to ensure that appropriate provision is available and accessed.

Recommendation 44: Where any employee of the Trust becomes aware of an actual, or potential, serious risk to a third party, then (s)he must escalate this to his/her line manager and the Trust must assign a specific individual to alert the appropriate authorities and, where necessary, establish the identity (or otherwise) of the subject of threats. (S)he must also record this in the records

to ensure that other staff are duly advised. Where the subject of threats is found to be a real person, then the Trust should seek immediate advice of the relevant agencies so that the individual is aware of the threat and that appropriate protective measures are put in place. The current care plan must be reviewed and modified accordingly.

Recommendation 45: The Trust should initiate an urgent meeting with Wiltshire Police to address any concerns about, or failings in, the VAU response to reported dangerous behaviours.

Recommendation 46: The police should ensure appropriate training for all staff in respect of criminal liability of those with mental health issues.

Recommendation 47: Clear records must be made of every relevant conversation or piece of information provided/received, however informal, in respect of a patient in care of the Trust, including third party information. These should be incorporated in the patient's clinical records.

Recommendation 48: The Trust should determine and enforce agreed processes for the retention of all records, clinical and non-clinical, on decommissioning of a service, combined with inclusion of relevant information in the single RIO (*electronic system*) patient record so that ongoing (and new episodes) of care and risk management are informed by past patient history.

Recommendation 49: The Trust should ensure that a formal diagnosis is made at the earliest opportunity.

Recommendation 50: The Trust should ensure that a clear process is established to ensure the integration of information and decision making for patients, where circumstances dictate that in-patient admission is not provided within the patient's usual care team.

Chapter 8

Recommendation 51: Where the Trust is aware of serious threats or risk to others, it should ensure an appropriate exchange of information with other agencies engaged in the care and /or treatment of the patient.

Recommendation 52: Where medication is self-managed by a patient living in supported accommodation, the records of that organisation relating to AWPT prescribed medication should be maintained so as to ensure conformity to NHS standards of record keeping.

Recommendation 53: Any Service Level Agreement between AWPT and other providers of care and/or support, should include the obligation to keep and maintain records to NHS standards.

Recommendation 54: All organisations providing services for people, who are patients of AWPT, should have clear policies on medication and these policies should be approved by AWPT.

Chapter 9

Recommendation 55: The Trust should review its Dignity at Work policy to ensure that it supports appropriate management styles and that staff can raise genuine concerns without fear of retaliation.

Recommendation 56: Risk Assessment training should be provided to all staff of the Trust, who have engagement with patients, whether or not they are providing clinical care. For clinical staff, training should be provided at the level commensurate with the clinical responsibilities of the role.

Recommendation 57: An urgent review of risk assessment and management processes and procedure should be undertaken and an action plan developed stating actions for individual clinicians, Clinical Teams and Service Managers.

Recommendation 58: Where academic references and good practice are included in any Staff Policy, these should be clearly separated from the actual process and guidance for delivery of required actions.**Recommendation 59:** The Trust should put in place, and monitor rigorously, effective policies on clinical supervision and annual appraisal. The Trust should ensure that staff with new responsibilities are allocated a supervisor with the appropriate skills, commitment and experience.

Recommendation 60: The Trust should ensure that the pro forma supervision contract is completed for all staff undergoing individual supervision.

Recommendation 61: The Trust should ensure that all staff have the necessary training and competence to undertake new/additional roles.

Recommendation 62: The Trust should implement systems to ensure that caseloads remain within recommended boundaries.

Recommendation 63: Trust Policies and procedures should be translated into short clear reference documents, ideally with a flowchart in each case, to allow staff readily to access guidance which clarifies the appropriate actions in response to operational and clinical events.

Recommendation 64: Within the Crisis Team, the training in, and active promulgation of, new policies (and including the training and induction of new staff in respect of existing policies) should be undertaken by either of the Senior Nurse Practitioners with the manager of the service held accountable for ensuring that a process is in place for assurance that all staff understand and practise Trust policies.

Recommendation 65: Appraisal and clinical supervision should be provided in accordance with stated Trust policies

Recommendation 66: In respect of the effective application and monitoring of Trust policies, there should be clear managerial accountability at all levels from Board down, combined with systematic (but appropriately targeted) action to address failures at any level.

Recommendation 67: The Trust should implement a system for the regular review of patients' notes to ensure that they (a) are comprehensive and (b) do not contain records relating to other patients.

Recommendation 68: The Trust should develop a system, based on best practice, to secure notes immediately following a serious incident, so as to ensure the integrity of copied information provided to those undertaking later investigations.

Recommendation 69: The Trust should ensure that diaries of clinical staff are secured at all times and retained for 6 years after the year end, since any entry about a patient (including time, date and location of an appointment) is deemed to form part of the clinical record.

Recommendation 70: The Trust should ensure full compliance with the NHS Record Keeping Code of Practice.

Chapter 10

Recommendation 71: The Trust should ensure that an effective Dual Diagnosis Strategy is in place and is being applied effectively for all relevant service users.

Appendix 1

Terms of Reference

TERMS OF REFERENCE

1. In the light of the findings of the Internal Investigation conducted by Avon and Wiltshire Mental Health Partnership NHS Trust under the heading 'Root Cause Analysis Report' to examine the strengths and weaknesses of the provision and management of the treatment and care provided to MH by and on behalf of the NHS Trust.
2. To inform the victims, perpetrator, carers and families about the investigative process, how they will be enabled to contribute to it and how they will be kept informed of the Investigation's progress.
3. To review the extent of progress in the implementation of the recommendations and action plans of the Root Cause Analysis Report and assess whether they will be as effective as possible in minimising the likelihood of a similar event recurring.
4. To examine the extent to which the care and treatment provided to MH corresponded with statutory obligations, in particular the Mental Health Act 1983, and also with relevant Department of Health guidance as laid out in HSG(94)27/LASSL(94)4 and the Care Programme Approach (HC(90)23/LASSL(90)11).
5. To examine the quality and scope of his healthcare treatment and the assessment and management of risk as informed by the following:-
 - i. The appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary care programme approach, and the assessment of risk in terms of harm to himself or others.
 - ii. The standard of record keeping and communication between all interested parties.
 - iii. The quality of the interface between the mental health services, other agencies and family members, including the extent to which the concerns raised by carers and relatives of MH were taken into account in the management of his care and treatment.

- iv. The extent to which his care corresponded with local AWP policies; recommendations from previous homicide inquiries; and dual diagnosis practice guidelines.
 - v. The standards and practice of caseload management within the CMHT.
6. To identify any deficiencies in the areas covered by 4) and (5) above.
7. To build on the work of the Internal Investigation. In particular to:-
- i. Review the facts of the events preceding the homicide of Mr Carl James by MH on 4th March 2007 in the form of
 - a. a chronology starting from MH's first involvement with NHS mental health services; and
 - b. a commentary as appropriate on the assessment, treatment and care provided to him by and on behalf of the NHS Trust and in association with the other agencies involved in his care and/or as a result of any previous criminal activity.
 - ii. Review all other factors, including the exercise of professional judgement surrounding previous assessments, treatment and care of MH and to comment on the suitability and monitoring of his care plan and treatment.
 - iii. Identify whether the policies, procedures and practices implemented by the hospital and Community Mental Health Teams and others on behalf of the NHS Trust were properly carried out in respect of that treatment and care, including arrangements for the assessment and management of risk.
 - iv. Determine whether those procedures and practices were managed and monitored adequately.
 - v. To comment on any other relevant factors raised in the internal and independent investigations, including issues for other local agencies such as social, housing and voluntary services working in partnership with the NHS Trust.
8. To prepare a report based on the findings and to make recommendations to the South West Strategic Health Authority. The report should define any matter where changes to local policies or central government guidance could be useful. It should also identify and any issue needing to be highlighted to NHS Trusts responsible for commissioning mental health services, or to other NHS and partner organisations responsible for providing mental health services in England and Wales.
9. To publish a report and review the implementation of any recommendations.
10. To comment on the commissioning and timings of the Investigation in relation to national guidance.

Appendix 2

Procedure adopted by the Independent Investigation

1. Following a review of the report of the internal investigation, and an examination of all relevant case records, operational policies and procedures, the Investigation will consider which individuals should be invited to give evidence.
2. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:
 - (a) of the terms of reference and the procedure adopted by the Investigation, and
 - (b) the areas and matters to be covered with them, and

inviting them to provide written statements and outline the issues which they are invited to deal with, and explaining that after receiving their statement the Investigation will decide whether they should also be invited to attend the Investigation to give oral evidence

 - (c) that when they give oral evidence they may raise any matter they wish, and which they feel might be relevant to the Investigation, and
 - (d) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Investigation witness, and
 - (e) that it is the witness who will be asked questions and who will be expected to answer, and
 - (f) that at the conclusion of the Investigation panel's questions, the person accompanying the witness (in f) may question the witness in respect of any matter contained in the witness' written and oral evidence in order to assist the Investigation or to ensure that the witness is fairly heard
 - (g) that their evidence will be recorded and a verbatim transcript sent to them afterwards for them to sign.
3. Any points of potential criticism will be put to a witness of fact, either verbally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

4. Representations will be invited from professional bodies and other interested parties as to present arrangements for service users in similar circumstances and also to any recommendations they may have for the future.
5. Those professional bodies or interested parties may be asked to give oral evidence about their view and recommendations.
6. Anyone else who feels they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.
7. All sittings of the Investigation will be held in private.
8. The Investigation's findings and any recommendations will be made public.
9. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final Report.
10. Findings of fact will be made on the basis of the evidence received by the Investigation. Comments which appear within the narrative of the Investigation Report and any recommendations will be based on those findings.
11. At the conclusion of the Investigation and following publication of the official Report, all statements and other records of proceedings will be held by NHS Southwest as custodian under seal.

Appendix 3

Witnesses to the Investigation

Note: (W) denotes written evidence only

Family members

MH family

MH
SH Sister of MH.
JM Mother of MH.

CJ family

BB Sister of HJ (CJ's mother).
AJ Brother of CJ.
HJ Mother of CJ.
KJ Father of CJ.
MJ Wife of AJ.
EP CJ's partner at time of the homicide.

Employees of AWPT

(Showing designation(s) at time of MH's care)

ABi PALS Officer for Mental Health in Swindon.
DB First Manager of Swindon Crisis Team.
AB Senior Nurse Practitioner, Swindon Crisis Team.
Dr SB Staff Grade Psychiatrist, Medium Secure Unit.
Dr PC Consultant Forensic Psychiatrist, Medium Secure Unit.
PC Second Manager of Swindon Crisis Team.
AC Support Worker with Swindon AORT.
AD Manager, Swindon AORT.
SD (W) CPN with Swindon Crisis Team.
JE AMHW, Swindon Crisis Team.
GE AMHW, Swindon Crisis Team.
AG Psychologist, Swindon Early Intervention Team.
RG Team Leader, Swindon East and South CMHTs.
SG CPN, Swindon East CMHT, Care Co-ordinator for MH.
KHo Manager, Swindon Forensic Service.
KHu CPN, Swindon Crisis Team.
LH Head of Risk and Compliance.
JKd Support Worker, Swindon Crisis Team.
JKg RMN and Unit Manager of Windswept.
RK Support Worker with Swindon Crisis Team.
JMy (W) PA to then Medical Director.
LMc Chief Executive for AWPT from April 2006.
CM Specialist Practitioner, Mental Health Liaison Service.
DQ Support Worker, East Swindon CMHT.
Dr Rm Consultant Psychiatrist aligned to South Swindon CMHT
Dr MS Consultant Psychiatrist aligned to Swindon Crisis Team.

AS	Senior Nurse Practitioner, Swindon Crisis Team.
MS	Senior management roles, including Director and acting Chief Executive.
Dr DS	Consultant Psychiatrist, Green Lane Hospital.
Dr PS	Consultant Psychiatrist aligned to Swindon East CMHT
GT (W)	Team Leader Swindon East CMHT (<i>at time of giving evidence</i>)
Dr AT	Consultant Forensic Psychiatrist.
Dr AW (W)	SHO Sandalwood Court.

Staff seconded to AWPT

JD	AMHP attached to Swindon Crisis Team.
HQ	AMHP attached to Swindon Crisis Team.

Representatives of other statutory organisations

CA	Commissioner, NHS Swindon (formerly Swindon Primary Care Trust)
SB	Detective Superintendent, Wiltshire Police

Root Cause Analysis team members

JMc	Area Manager, BANES and Swindon.
Dr S O'C	Consultant Psychiatrist and then AWPT Medical Director
MR	Consultant Nurse/Senior Lecturer.

Representatives of non statutory organisations

KA	Swindon MIND.
LC (W)	Jephson Housing Association.
DS (W)	Jephson Housing Association.

Other witness

AE	Former AWPT manager
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Expert witness

JMo	Independent Social Worker.
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Witnesses the panel was unable to see

SB	CPN (Team unknown)
(XX)	Senior CPN, South and East CMHTs.
Dr N	SHO, Green Lane Hospital.
KO	Trainee Social Worker attached to Swindon Crisis Team.
Dr Ra	Locum Consultant Psychiatrist Swindon Crisis Team.
CS	Student Nurse attached to Swindon Crisis Team..
Dr V	SHO Sandalwood Court.
DW	CPN, Swindon AORT.

Appendix 4

Glossary of terms

Affect	Observable behaviour of an individual which represents the outward expression of a subjectively experienced emotion.
Agency staff	People working for the Trust through an employment agency.
AMHP	Approved Mental Health Professional.
AWPT	Avon and Wiltshire Mental Health Partnership NHS Trust.
CMHT	Community Mental Health Team.
CNST	Clinical Negligence Scheme for (NHS) Trusts.
CPN	Community Psychiatric Nurse.
Depot	Injection of prescribed slow release medication.
Dosette box	Medication box.
DNA	Did not attend.
Differential diagnosis (D/D)	Range of diagnosis(es) under consideration (ie not formalised by a consultant psychiatrist).
Dual Diagnosis	Patient has drug and/or alcohol problems as well as a mental illness .
D/W	Discussed with.
EIT	Early Intervention Team.
GP	General Practitioner.
HAP	Homicide Action Plan
ICD	International Classification of Diseases
HV	Home visit.
ICPA	Integrated Care Programme Approach
Locum	Person employed to cover a short term absence, usually through an employment agency
MAPPA	Multi Agency Public Protection Arrangements.
MHA	Mental Health Act (1983)
Marisys	Electronic patient records system.
MSE	Mental State Examination.
MSG	Message.
NPSA	National Patient Safety Agency.
NSF	National Service Framework.
MIND	Charity concerned with mental health.
NICE	National Institute for Clinical Excellence.
NMC	Nursing and Midwifery Council.
P/C	Phone call
PCT	Primary Care Trust.
PNC	Police National Computer System.
Quicklet	Tablet form of medication.
RC	Responsible Clinician.
RCA	Root Cause Analysis.
RIO	Electronic patient records system replacing Marisys.
RGN	Registered General Nurse.

RMN	Registered Mental Nurse.
RMO	Responsible Medical Officer (<i>latterly Responsible Clinician</i>)
SAD	'SAD Persons score' (used to assess likelihood of self harm)
SBU	Strategic Business Unit – AWPT name for units of service management.
SFS	Swindon Forensic Service.
SHA	Strategic Health Authority.
SHO	Senior House Officer.
Skunk	Form of cannabis.
SRIP	Swindon Rapid Improvement Plan.
S/W	Spoke with.
T/C	Telephone call.
T/T/A	To take away (usually medication).
VAU	Vulnerable Adults Unit .
Velotabs	Tablet form of medication.

Appendix 5

List of Documents and policies provided by Avon and Wiltshire Mental Health Partnership NHS Trust at the request of the Investigation panel and other documents considered by the panel

1. Trust policies

- Policy and procedure for Clinical Supervision (2005)
- Information documents for service users and carers (March 2009)
- Records Management policy (31 March 2008)
- Policy for the reporting, management and investigation of adverse incidents (including Serious Untoward Incidents) (Also known as the Incident Policy) (20 February 2009)
- Serious adverse incident policy and procedure (24 February 2006)
- Staff Supervision policy (25 March 2005)
- Appraisal policy (1 August 2005)
- Trust policy to safeguard adults (26 November 2008)
- Identifying carers and carer networks (Undated but to review 31 1 2010)
- Meeting the needs of carers and their key rights (Undated but to review 31 1 2010)
- Carer information on care pathways (Generic and SBU) (Undated but to review 31 1 2010)
- Children as Carers (Undated but to review 31 1 2010)
- Managing disputes and escalation (Undated but to review 31 1 2010)
- Expert practitioner and expert panels (Undated but to review 31 1 2010)
- Dual diagnosis (Undated but to review 31 1 2010)
- Assessment, risk assessment, assessment tools (core and comprehensive) and recording (Undated but to review 31 1 2010)
- Public protection and safeguarding (Children, adults, MAPPA and MARAC) (Undated but to review 31 1 2010)
- Therapeutic engagement of service users, carers and families (Undated but to review 31 1 2010)

- Diagnosis and formulation (Undated but to review 31 1 2010)
- Caseload and capacity management (Undated but to review 31 1 2010)
- Policy to manage care pathways and risk (Including the Care Programme Approach, and practice directives and guidance for managing care pathways and risk) (17 December 2008)
- Policy to safeguard adults (26 November 2008)
- Integrated Care Programme Approach (ICPA) and the assessment and management of risk. Policy, procedures and guidance (March 2007)
- Dual diagnosis strategy – co-existing mental health and alcohol and drug use problems (22 October 2008)

2. Other Trust documents

- Untoward Incident Report form completed by Avon and Wiltshire Mental Health Partnership NHS Trust immediately after the homicide.
- Report of Avon and Wiltshire Mental Health Partnership NHS Trust Root Cause Analysis after the homicide.
- Homicide Action Plan developed by Avon and Wiltshire Mental Health Partnership NHS Trust (18 August 2009)
- A review of the incidence, distribution and characteristics of homicides in Avon and Wiltshire Mental Health Partnership NHS Trust: Benchmarked against the National Confidential Inquiry into suicide and homicide by people with Mental Illness. April – September 2007 (January 2008)
- NHS Avon and Western Wiltshire Mental Health Services Approved Social Work Report on Integrated ASW Service responses to referrals in Bristol during 2008 (February 2009)

3. Other non Trust documents

- *Redefining Justice. Addressing the individual needs of users and carers* (Published March 2009)