Report of the

Independent Investigation

Into the care and treatment of Mr SN

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 SN.

Our completed Report was submitted to the Authority in May 2010.

At the request of the Authority, and after further discussion, the Report was subsequently amended so that all names are anonymised. The process was completed in August 2010.

HEATHER MORGAN	**Dr MARTIN DONOVAN**	**RICHARD LINGHAM**
Tribunal Judge	**Consultant Forensic**	**Panel Member**
Chairman	**Psychiatrist**	

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Chapter One

Introduction

1.1 On 17 October 2008, at Bristol Crown Court, Mr SN was convicted of the murder of Mr Philip Hendy, whom he had fatally stabbed on 29 April 2007. Mr SN received a life sentence with a minimum term of 16 years.

1.2 Mr SN had been in receipt of mental health services, latterly provided by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), since 1990. An internal review was conducted by Dr CV, Ms CM and Mr RE with Dr GL as the independent expert panel member. Their Root Cause Analysis report was dated 4 September 2007. The Investigation Panel was greatly assisted by this report and its detailed chronology.

1.3 In these circumstances, Health Circular HSG(94)27 and subsequent guidance require that an Independent Investigation be carried out into a patient's care and treatment in order to learn lessons for the future. There was some delay in setting up the Investigation caused in part by awaiting the outcome of Mr SN's trial. The panel was appointed in February 2009 and was to commence its work in July 2009, once Mr SN's consent to release of his records had been obtained.

1.4 Terms of Reference for the Investigation are included at Appendix i. Statements were obtained from witnesses (see Appendix ii). They and the agencies concerned provided the documents listed at Appendix iii. The panel received papers that had not been available to the internal review, such as the trial transcript and expert reports from 2008, the full Offender Assessment System document and probation reports and records, and also had the benefit of interviewing Mr SN. Oral evidence was taken over twelve days between October 2009 and 16 January 2010. Where the draft report made any express or implied criticism of a witness an opportunity to provide a written response was given. Without exception witnesses were courteous, helpful, and co-operative. We extend our thanks to all who participated.

1.5 The panel is satisfied that at the time of the murder, Mr SN was suffering from a paranoid psychosis generated by heavy and prolonged use of amphetamine. Although he had been in contact with mental health services on several occasions in the months and days before the homicide, the full extent of his use of amphetamine and its resulting bizarre behaviour was not known by those who examined and assessed him. Mr SN had consistently denied and minimised his use of drugs.

1.6 We do not consider that responsibility for the homicide can be attributed to the failings of any individual, but we do make a number of findings and recommendations aimed at improving clinical practice and case management. We express particular concern about record keeping, the lack of diagnostic formulation, risk assessment, and the sharing of information between agencies.

We make strong recommendations about the care of the bereaved families of victims, and we propose a review of the Independent Investigation process to reduce delay and duplication.

Chapter Two

Mr Philip Hendy and his family

2.1 On the morning of Sunday 29 April 2007, Mr Philip Hendy went for a jog. At about 8.15 am he called at the local newsagent to pay his paper bill. As he left the shop en route to his beloved allotment to pick some beans for Sunday lunch, he was followed out by Mr SN, whom he did not know at all, who then stabbed him twice, once in the neck, severing the carotid artery, and once near his hips. Mr Philip Hendy died on 8 May 2007, at the age of 75, as the result of the injuries he sustained.

2.2 The Hendy family have lived in Bristol for over 300 years. Mr Philip Hendy was born in 1931 in the Greenbank area of the city, where he remained throughout his life. He was married and had three sons, J, P and S and three grandchildren whom he *'absolutely adored'*.

2.3 In his written and oral evidence to the Investigation, Mr JH described his father as '*a very law-abiding, peaceful man, a very funny man, a very practical man….well-liked… decent, honest, self-sufficient……He often stated his aim was to live longer than his mother, who died at the age of 95……He was an honest and decent man who just went to pay his paper bill one Sunday morning and never came back. He did not deserve to die'.*

2.4 For most of his professional life Mr Philip Hendy was a salesman but, apart from his family, his greatest interest was his allotment. He was site representative for the allotments committee and after he died, his friends there instituted the Philip Hendy Cup for the keeper of the best allotment.

2.5 Our deepest sympathy goes to the bereaved family of Mr Philip Hendy. The pain of their loss is all the greater because of the nature and circumstances of the homicide.

2.6 The Investigation received a lengthy and detailed written submission from Mr JH. The first witnesses to give oral evidence to the panel were Messrs. JH, PH and SH. The panel was in no doubt of the strength of their feelings, and we wish to pay tribute to all three brothers for their dignity and restraint in what must have been a difficult and distressing process. We are grateful to them for the clarity of their evidence, and for highlighting some key issues in the events leading to the death of Mr Hendy, in the immediate response of the Avon and Wiltshire Mental Health NHS Partnership Trust, and about the inquiry process in general. We have responded to their principal concerns in the body of the report.

Chapter Three

Mr SN

Recorded Personal History

3.1 Mr SN was born in Fishponds, Bristol on 13 September 1965. He has two brothers both of whom are married with children, and from whom he is now estranged. His father, who ran both a pub and a car business, was a heavy drinker and there is evidence that he was consistently violent to his sons and, on occasions, to his wife.

3.2 Mr SN attended Begbrook School where he first experienced difficulties in concentrating which endured throughout his full time education. He was identified as having special needs with regard to reading, writing and arithmetic. He did not learn to read until he was aged 12. At the age of 11 he went to Filton High School. He left school without any qualifications.

3.3 After leaving school, Mr SN worked initially at his father's garage and thereafter he had a number of casual jobs before running a pub for a short period in the late 1990s. It seems that he has been unemployed since 1998.

3.4 He appears to have had two significant relationships. The first started when he was aged 20 and lasted for about three years. The second began in 1992 when he was aged 27 and lasted on and off for 7-8 years. His partner already had five children, and they had three children together, a boy and two girls now aged approximately 16, 14 and 10, who now live with their mother in Wiltshire. Mr SN has continued to have contact with his children. Both of his long term relationships were turbulent and they were characterised by excessive consumption of alcohol by both parties. Reports refer to physical fights with his first partner and to incidents of violence and aggression perpetrated by Mr SN towards his second partner.

3.5 By the time he began secondary school Mr SN was described as exhibiting behavioural problems manifested in regular fights and increasing truancy. He was temporarily excluded at the age of 15, apparently for physically threatening a teacher, but the Police National Computer Record shows no formal cautions or findings of guilt as a juvenile.

Record of Offending

3.6 The first of Mr SN's 20 convictions prior to the homicide was in 1985, at the age of 19, for theft from a vehicle, for which he was fined. The record includes motoring matters, burglary, deception, and drugs offences. There are a number of violent offences; assaulting a constable in 1987 reportedly in the course of being arrested for taking and driving away a motor vehicle, for which he received a community service order; actual bodily harm against his then girl friend in 1991; racially aggravated threatening behaviour, possession of an offensive weapon,

and assaulting a constable - all directed at a black police officer in 2002; and harassment and battery of his mother in 2003. He served several custodial sentences, the longest being 15 months. His compliance with court orders was seen as poor with instances of driving while disqualified, breach of a probation order and failing to surrender to bail.

Psychiatric History

3.6 Mr SN was first referred to community psychiatric services in December 1990 following the death of his father, the start of the prolonged, though intermittent, engagement with Community Mental Health Teams which is described and analysed at length in this report. He was at various times diagnosed as suffering from depression, anxiety, personality disorder and paranoid schizophrenia. His records also refer to a long history of using alcohol to excess and of using illicit drugs.

3.7 At the time of the homicide, Mr SN was single, unemployed, and living with his mother in her home. In the preceding few months his behaviour had become increasingly erratic and aggressive, almost certainly as a result of his escalating consumption of amphetamines. As a result of concerns expressed by and on behalf of his mother, a psychiatric assessment was conducted on 27 April 2007 during a home visit. Mr SN denied using amphetamines and in the absence of symptoms of mental disorder he was deemed not to meet the criteria for detention under the Mental Health Act 1983. His next outpatient appointment was with Dr RN on 3 May 2007, and a carer's assessment to support his mother was pending.

The Homicide

3.8 On 29 April 2007, Mr SN left his mother's home armed with a kitchen knife with a 4½ inch blade. The Court received evidence that he was acutely intoxicated and psychotic as the result of ingesting a substantial quantity of amphetamines. After fatally stabbing Mr Philip Hendy in an unprovoked attack outside the local newsagent's shop, he assaulted Mr HT, an 85 year old man in the street by punching him twice.

3.9 On 13 October 2008, the jury at Bristol Crown Court rejected Mr SN's submission of manslaughter on the grounds of diminished responsibility, and he was convicted of the murder of Mr Philip Hendy. He received a life sentence with a minimum term of 16 years.

Chapter Four

Clinical Chronology with Commentary

Introduction

4.1. In this chapter the Investigation panel identifies the key events contained in the Trust's clinical records from 1990 to May 2007 and offers an initial commentary on significant factors relating to Mr SN's treatment and care during that period. The events contained in the records from May 2007 to October 2008 are added in order to complete the clinical picture.

4.2. The clinical records as received by the panel numbered 534 pages which were not compiled sequentially, but mostly grouped in relation to his contact with particular consultants or, in later years, community mental health teams. There appear to have been at least two volumes of notes by 2007, each containing several separated clusters of clinical notes and correspondence. Throughout the records there were substantial collections of blank sheets and Trust forms.

4.3. In setting out this chapter, the panel has chosen to quote verbatim from notes, related forms and correspondence rather than to paraphrase them, in the belief that in many instances the texts speak for themselves. In most instances the panel's commentary relates to facts and issues having a bearing on the Investigations findings, which appear in the next chapter.

Initial referral and first period of care 1990-1993

4.4. In mid-1990 Mr SN was initially treated by his GP for depression following his father's death, but with limited response so that on 20 December 1990 he was referred to Dr MN, consultant psychiatrist. He did not attend appointments until February 1991 when *'slightly unusual grief reaction'* was noted. Referred to a Community Psychiatric Nurse (CPN) for grief counselling, Mr SN did not attend two appointments and contact lapsed after one further outpatient appointment in February 1991.

4.5. In June 1991 he was charged with Actual Bodily Harm and Affray and seen by Dr MN at his solicitor's request. The Court report stated, *' more obviously depressed than before…low mood, suicidal feelings and increased irritability'*. He did not attend follow-up appointments, but when seen in October 1991 had improved and was discharged.

Comment
This was a routine, non-acute referral for specialist assessment and support, followed by a request on his behalf by Mr SN's solicitor for a report relating to impending criminal proceedings.

These first contacts with mental health services identify (1) low level mental disorder (2) frequent non-attendance at appointments (3) contacts associated with court action.

4.6. Mr SN was next seen in March 1992 by Dr MN at his mother's request having been charged with burglary. He did not attend until a request from the Probation Service, when he saw Dr MN in May, July, August and September 1992 with *'typical depressive symptoms'*. He failed to attend two consultant appointments in October and December 1992 and to see a CPN and contact then lapsed.

4.7 In July 1993 he self-referred to the CMHT '*in a bad way*' and requesting hospital admission. He was advised to ask his GP for referral, but no action on his part is recorded in mental health or GP notes.

Comment
Concerns were expressed by his family, Probation and himself, but Mr SN failed to keep appointments with the psychiatrist and CPN after September 1992 and did not pursue his own request for help in July 1993.

Apart from monthly prescriptions for Amitriptyline (antidepressant) in the GP's notes, there are no other records relating to mental disorder in primary health or mental health services' notes until March 1996.

During those 2 years and 9 months there were court appearances for possessing drugs in September/October 1993, handling stolen goods x 3 in October 1993, deception in January 1994, traffic offences x 8 in March 1995, none of which appears to have attracted requests for mental health reports by the Courts.

Second period of care March 1996 – February 1999

4.8. In March 1996, having been referred by his GP *'feeling depressed and tense'*, Mr SN was seen in May and July 1996 by consultant psychiatrist Dr SO'C and referred for psychotherapy but after an initial assessment he did not attend there or two further appointments with Dr SO'C and was discharged in October 1996. Her report to the Court in November 1996, when Mr SN was charged with 5 offences of handling stolen goods, possession of drugs and driving offences, said *'he has suffered from low mood at times over the past few years, but does not however present as seriously depressed.'* The Court made a Probation Order for 2 years. During 1997 there were no recorded contacts with mental health services but the GP's notes refer to continuing monthly prescriptions for Amitryptiline.

4.9 In February 1998 his GP noted worsening depression and paranoid feelings and referred again to Dr SO'C, who saw Mr SN in April, June and Sept 1998 and prescribed anti-depressants and low dose antipsychotics, noting *'tablets have helped a lot'*. Her subsequent Court Report in November 1998, following his breach of the Probation Order described *'a man with an emotionally unstable personality. There is some evidence of a paranoid personality and mood instability, none of which amounts to serious mental illness. He is fully responsible for his own actions. He is already getting appropriate low level psychiatric support'.*

4.10 In February 1999 he again did not attend outpatients and was discharged. In March 1999 he was convicted of drugs offences and given a 6 months suspended prison sentence.

Comment
Mr SN frequently failed to attend outpatient and associated specialist appointments. Similarly his poor compliance with Probation appointments resulted in his being returned to Court for breaching the terms of his Probation Order.

After three years' intermittent contact and having examined him twice for Court Reports, Dr SO'C clearly saw him as only mildly mentally disordered.

In the eight years 1990-1998, Mr SN received regular medication from his GP for his depressive condition. His diagnosis and mental state were re-examined at 2-yearly intervals by psychiatrists after referrals by his GP and/or in response to requests for Court Reports. He was consistently seen as suffering from a mild depression, more latterly associated with paranoid personality traits and mood instability.

This pattern of treatment in co-operation between primary health and specialist mental health doctors would be typical for a patient with his clinical presentation and personal circumstances.

Mr SN's contacts with mental health services were repeatedly broken by his failures to attend appointments and to respond to follow-up arrangements.

Third period of care April 2000 - July 2002

4.11 During this period Mr SN ended his relationship with his partner to live independently from her and their 3 children.

4.12 Re-referred by his GP in April 2000, he did not attend an appointment offered in July, but saw consultant psychiatrist Dr SB on 5 October 2000, who noted *'depression getting worse….ex has stopped him seeing them.. increase Paroxetine* (antidepressant*) to see if he feels better..'*

4.13 On 27 November 2000 Mr SN was charged with racially threatening abuse. He saw Dr SB on 16 January 2001,who noted '*feels very low'* and adjusted his medication. He did not attend in March but on 5 June 2001 self-presented at hospital, when the duty medical officer noted *'…totally lost, confused, can't work things out….. Thinks people are following him/talking about him/trying to get him into trouble'.*

4.14 Dr SB then saw him on 7 June 2001 when he noted *'under pressure, depressed, drinking, 2 court cases'*. In his letter to the GP he concluded *' I feel he does have a mild depressive illness with some paranoid ideation' and 'if his drinking continues, to consider taking himself to Drug and Alcohol Services…'*

4.15 The Probation Officer's Pre-Sentence Report of 27 June 2001, which was copied into the medical notes, included that Mr SN '*denies being racist, however he tended to minimise the seriousness of his behaviour. The earlier consumption of alcohol mixed with anti-depressant medication clearly would have had some impact on his emotional state. However, it is my view that he should be held fully responsible for his own actions. He describes his behaviour as stupid, but did not seem to understand the effects of his actions upon the victims. He displayed little victim awareness……….From previous Probation reports it appears that his attendance on Probation and Community Service has been erratic and irregular. The Breach Report stated that he was referred to the group work programme and attended an initial session but was assessed as being unsuitable to complete the work due to his learning difficulties and mental health issues………..He states that he has no motivation to work with the Probation Service and he feels unable to respond to any Probation intervention. From the list of previous convictions, my understanding is that he is currently subject to a six-month imprisonment sentence suspended for two years. Considering that this offence was committed in November 2000, the Court may wish to consider what action to take regarding his suspended prison sentence today…It is my assessment from our interview that he is not motivated to address his offending behaviour. He has stated explicitly that he does not want to be made subject to Probation supervision ...In any event unless his attitude changes radically he will not be suitable for Probation. I am therefore not in a position to offer the Court a suitable community penalty which would protect the public from harm and reduce the risk of further offending. It is my view that this case should be committed to the Crown Court for sentence.'*

4.16 In connection with these offences, Mr SN was offered an appointment in July 2001 to see consultant psychiatrist Dr GU of the Inner City CMHT for a court report, but he did not attend and was discharged in August 2001.

4.17 On 4 October 2001, having not attended court, he was seen at outpatients by Dr GU, who noted; *'jumped bail… reported paranoid ideas, drink nil, drugs nil-previous amphetamine, not for 6/12...Delusions "I think people are following me" low grade intensity, good insight, stelazine helps this… Imp. PD,* (personality disorder), *dysthymia, alcohol probs. Low grade paranoia ? cause, oversedated with Trifluoperazine, switch to amisulpride, review in 4 m'*.

4.18 On 5 October 2001 having been arrested after a fracas at home, Mr SN was seen by Dr GU and an Approved Social Worker in custody. He stated he was depressed, asked for hospital admission but was told; '*this not available he should allow new medicine time to work .'* Dr GU assessed him as fit to be interviewed by the Police.

Comment
The Probation Officer's and psychiatrist's records show many similarities, in terms of poor co-operation and attendance, persistent disengagement and limited insight. By Autumn 2001 Mr SN would have been aware that imprisonment was increasingly likely and this may have prompted his attempts to secure a psychiatric label and obtain hospital admission.

Dr GU had identified amphetamine abuse within the past year and alcohol problems.

4.19 In March 2002, Mr SN did not attend outpatients, but was seen in May 2002 by Dr AF, a Staff Grade psychiatrist; *' Frustrated by his history of interaction with the services. Since he has been on amisulpiride he has felt much better – describes it as like seeing things very muzzily before and now can see crystal clear for miles and miles. Can concentrate on watching TV, can read, no longer worries so much about what other people might do to him (beforehand would worry that people might sneak up behind him and harm/kill him). Feels his life has been transformed by the amisulpiride and wishes it had happened before. Angry that the change in medication took so long. Asking for a diagnosis and thinks it would help him a lot to know. I said I did not think it was straightforward schizophrenia………Feels his life is gradually coming together but would like things to be better still. Plan; continue amilsulpiride 200 mg bd and ref to neuropsychology for help with diagnosis. Move to consultant clinic (his request).'*

4.20 On 30 May 2002, Mr SN did not attend an appointment with consultant psychiatrist Dr DA of the Inner City CMHT. He attended an initial neuropsychology appointment in July 2002 but not the follow-up in August, or his next outpatient appointment on 27 August 2002.

Comment
After a lapse in attendance, Mr SN appeared motivated to obtain further psychiatric help but did not attend the specialist appointments as arranged.

Although in contact with consultant psychiatrists who were members of the Inner City CMHT, Mr SN continued to be seen in medical outpatient clinics rather than assessed by the whole team. The resulting clinical assessments did not fall under the Care Programme Approach policy and procedure adopted by the Trust in the previous year and risk assessments were not specifically recorded even though he was known to be involved in offences against the person.

Dr AF's reference to schizophrenia in her discussion with Mr SN seems to have been the first time it was mentioned in his clinical notes. **There was no mention of drug abuse and Mr SN denied drinking alcohol.**

Offending, Imprisonment and fourth referral April 2003

4.21 On 7 September 2002, after repeated adjournments, Mr SN was remanded in custody charged with assaulting a policeman, possession of an offensive weapon and public order offences. On 8 October 2002 he was imprisoned for 40 weeks and released from HMP Dartmoor on 23 December 2002

4.22 On 28 April 2003, he was re-referred by his GP with –'*ongoing anxiety and depression',* but events were overtaken by his next remand to prison until 4 June 2003, charged with harassment. He could not therefore attend an outpatient appointment on 2 June 2003 with Dr RN, consultant psychiatrist, who had joined

the Inner City team. She then replied to GP:- *' On reviewing the notes, he still suffered from abnormally low mood associated with suicidal feelings since 1998 with a bereavement in l989…..a court report in l998 noted...an emotionally unstable personality and mood instability none of which amounted to a serious mental illness…. There has been a tendency to default from follow up appointments and I note that in Sept 2002 he had failed to attend two appointments ……I shall write to asking if he wants a further appointment, but if I do not hear I will not take any further actions unless requested'*.

4.23 Mr SN called at the CMHT office on 11 June 2003 but was not prepared to wait. A team member then phoned him and recorded; '*verbally abusive and incoherent… may have been intoxicated… Case to be discussed 12.6.2003, staff to exercise caution if SN presents at reception… should be seen by two staff.*'

Comment

Dr RN was unaware that Mr SN had not attended the appointment with her on 2 June 2003 because he was on remand in prison. Her note to the GP was based on information from 1998 rather than on the more recent notes by Dr SB and Dr GU in 2001 and Dr AF in 2002.

4.24 Charged with harassment on 9 June 2003 and assault by beating on 17 June 2003, Mr SN was again remanded in custody on 15 September 2003 and seen by Dr JT, locum consultant psychiatrist, on 7 October 2003. Her report to the Court, stated *'…speech was normal in form and content and there was no evidence of any difficulties in concentration during the interview. There was no evidence of formal thought disorder or any abnormal beliefs. He told me that he used to hear voices in the past and to believe that somebody would kill him, but it usually happened when he was drinking or taking amphetamines. He also reported having "fits" (while in custody) which was not recorded in his notes.*

Subjectively and objectively he did not appear to be clinically depressed and he confirmed that. I was not able to elicit any psychotic symptoms from him and did not consider him to be clinically depressed when I examined him. However, Mr SN was very keen to have a "label" of mental illness, asking me to confirm that he has mental illness. He refused to accept that he has serious alcohol problems, saying "everybody is drinking in this country" and does not want to get any help regarding his alcohol and amphetamine intake…………

Mr SN has reported paranoid symptoms and auditory hallucinations and he has received treatment on the basis that these may have been psychotic. However, doctors appear to have been unaware that he was also abusing Amphetamines at the time.

According to Mr SN's medical notes regarding the assessments of five consultant psychiatrists since 1996, there was no evidence that he suffers from mental illness, but clearly has personality difficulties and alcohol and drugs problems.

Both these substances of abuse can lead to the symptoms which Mr SN has reported. Since he has been in prison his mental state has improved and in fact has not had access to alcohol or Amphetamines……

In my opinion Mr SN is not suffering from mental illness but his problems can be attributed to his personality difficulties and heavy alcohol and amphetamine abuse.'

Comment
Contacts continued to be delimited by Mr SN's lack of co-operation and poor acknowledgement and/or concealment of abuse factors but were also increasingly disrupted by remand/prison episodes. The persistent level of his offending and his poor compliance with non-custodial measures had now resulted in his imprisonment.

Between October 2001 and October 2003 Mr SN had only occasional contact with the CMHT, but he was psychiatrically assessed on three occasions as a result of his offending. In each case, the psychiatrists could identify no active symptoms but related his presentation to personality factors and substance abuse.

Dr JT's examination and report of 7 October 2003 were the only recorded clinical contact with Mr SN that year. Her report reviewed his clinical history since 1996 and provided a comprehensive assessment of his current mental health, establishing its relationship to his abuse of alcohol and drugs, in particular with reference to amphetamines. Her conclusions also made some clear distinctions between his mental state and his offending behaviour.

4.25 On 20 October 2003, Mr SN was sentenced to 16 weeks for harassment and battery but, due to time spent on remand, he was released on 12 November 2003, when his GP wrote to Dr DA at his request, but events were overtaken by a further remand in custody.

4.26 On 17 November 2003 an injunction was granted by the County Court excluding Mr SN from his flat on grounds of his racial intimidation and anti-social behaviour as a tenant. His residence then moved to his mother's home address.

4.27 Mr SN's GP again referred him to Dr DA on 31 March 2004, enclosing a copy of his letter of November 2003, and adding *'This man has since been taken into prison for a few months and was discharged as being diagnosed with epilepsy. He did appear a little better after his discharge, probably due to reduction in alcohol intake. However he still complains bitterly about his weight and from his mother I understand he takes amphetamine intermittently. He is unfortunately in trouble with the police again for various criminal offences…From his mother's point of view he appears to be suffering quite severe paranoid psychosis type symptoms and due to the fact that he has been evicted from his housing he is now living with her and causing considerable distress. He still seems to be going on rampages and getting into a lot of trouble, causing disturbance and often getting arrested'*.

Comment
It is unclear why the GP wrote to Dr DA rather that Dr RN, but this was at Mr SN's own request. However, It seems clear that contact with both his GP

and consultant psychiatrists had been somewhat disrupted by repeated periods of remand and imprisonment.

By 2003, Mr SN had been seen by a number of psychiatrists except, as it happened, Dr RN, the consultant psychiatrist attached to the CMHT covering his home area. At this stage most of their reports were copied to her and to the GP.

4.28 In April 2004, responding to a letter from South West Law relating to impending eviction proceedings against Mr SN, Dr RN replied '*I have not actually met this patient personally and can only refer to his psychiatric notes. There is a detailed report prepared by Dr JT, Locum Consultant Psychiatrist in October 2003, which would be most useful in this context, and is enclosed……As I have not met him and he has not been in touch with our service since July 2002, having failed to attend a number of appointments, it is difficult to assess his current mental health problems…..I am sorry I cannot answer these questions more helpfully. He was sent an appointment to come and see me on 2 June 2003, but did not attend. He had turned up at our community mental health centre on 11 June 2003, but this was not for a scheduled appointment. He appeared to be intoxicated and was verbally abusive. The social worker involved in this episode left a message with probation, and the GP was informed. We have had no further contacts about him until this request for a report'.*

4.29 Again at the court's request, an Adult Care Assessment was conducted by Bristol Social Services and a copy was sent to the CMHT. Under the heading Health and Mental Well-being, it noted the response of the Team Manager Inner City Mental Health Team on 25 February 2004 '*Mr SN is not known to our service. He failed to show up at two o/p appointments with in Sept 2002. Dr RN wrote to his GP on 5.6.2003 stating that he does not have a serious mental illness. Dr RN felt he may be better served by seeking help for his drinking'.*

4.30 The Adult Care Assessment also reported *'The Approved Social Worker Service received a request via the Emergency Duty Team on 27 April 2004 from Mrs VN (mother) requesting a Mental Health Act Assessment. Clarification of the ASW/Crisis Team's response to Mrs N's request was sought on 30 April 2004 by the Adult Care Team. The response of the Team Leader, is that after 'due consideration' it has been decided that a Mental Health Act Assessment is not required.'*

4.31 From the interview with Mr SN and his mother, the Social Worker noted*…'he has insight into the fact that he loses touch with reality….an example...at times believes he is a millionaire then suddenly realises he is not… the feeling of depression that accompany this realisation can be overwhelming and result in him lying in bed for weeks at a time….Mr SN has stated that he believes there are people living under his mother's house. His mother returned home this morning to find him digging at the living room floor….I checked this out with Mr SN, who was firm in his belief…. He hears people in his home and well as hearing voices saying sentences…. Mrs VN says that her son constantly talks to others within home… Mr SN stressed that the people he talks to do exist. He has*

difficulty in orientating to the present because of his fears and preoccupation with people who he states are a threat to him.
However I found him to be articulate during the assessment and able to express his feelings and emotions clearly. He stated he feels depressed the majority of the time and has no energy or enthusiasm for life… for the majority of the time he wishes to be left alone and would like to block out the world. .. Although he wishes to retreat into himself, at times he needs to leave his bedroom and on these occasions he goes to public houses and binges on alcohol….
Mrs VN stated that her son takes speed regularly although not daily and that with the prescribed level of medications he takes, the mixture of speed, alcohol and medication has a very negative effect on his state of mind and subsequent behaviour. Mr SN categorically denies that he currently takes speed.
He firmly believes that he has schizophrenia and says he has long accepted that this condition cannot be cured but can be managed and in his view this should be with more medication….
Mrs VN states that she cannot continue to house and care for her son after the court hearing on 6.5.2004 because of the stress his behaviour places on her….(She) is desperate for her son to receive a thorough mental health assessment in the hope that a diagnosis of his mental health condition can be made and appropriate treatment given'.

Comment
Dr RN was aware of Dr JT's assessment of Mr SN, although neither she nor another member of the CMHT had been able to assess him in person for almost two years due to his non-attendance and sequence of absences in prison. It is unclear whether she and the CMHT were aware of the further corroborating information contained in the Social Services' assessment.

Social Services' care assessment described Mr SN's disturbed behaviour in terms similar to the GP's at a time when he was experiencing exceptional stress and disruption of his personal circumstances. The delusions and associated behaviour described were of a kind not previously reported.

There is no reference in the clinical notes to Mrs VN's request to the Approved Social Worker Service for a Mental Health Act Assessment on 27 April 2004.

Referral (fifth) to another CMHT April 2004, Imprisonment June- September 2004

4.32 In April 2004 the GP's notes indicate increasing actvitiy to obtain a psychiatric assessment for Mr SN and by 29 April 2004 record '*telephone encounter. for assessment urgently by Dr SBZ'*, who was the consultant psychiatrist member of the Bristol East Primary Care Liaison Team .

4.33 On 7 May 2004 a home visit was made by Dr SBZ and CPN Ms JP, when Mr SN and his mother were seen. The only record of that visit was contained in Dr SBZ's subsequent letter to the GP. ' *….we were told that Mr SN had moderated*

his alcohol intake but even then once fortnightly he can drink anything from 7-14 bottles of alcopop in a single sitting. He admitted that he had been abusing up to a gram of amphetamines on a daily basis but he is insistent that he stopped abusing amphetamines about a week ago.
His mother started becoming very concerned about his behaviour because he started becoming increasingly paranoid and he was convinced that people are out to harm him and as such he was afraid to leave the house on foot and would only feel safe if he was out and about driving in his car because then these people could not get to him. In addition he was hearing voices and these voices were located both inside his head as well as in external space. He started becoming convinced that he could hear people talking beneath the floor boards of his mother's house and he became so apprehensive that he tried to take his mother's floor up. Thankfully she returned home just in time and prevented him from doing so. He was also convinced that the television has been giving messages to him and continues to refer to him. Mr SN is inclined from time to time to drift off in a world of his own when he feels that he is talking to presidents etc.
He claimed that from time to time he can feel low in mood but this is fairly understandable given his abuse of amphetamines and alcohol. He has had thoughts of wanting to harm himself but during the course of the interview he denied any active suicidal intent. His mother did say that when he is well he is the nicest chap to have around but when he becomes unwell then he can become very argumentative and verbally aggressive. She did not feel that she was fearful or apprehensive about him or that she may come to some harm from him.
As you are aware Mr SN has had numerous assessments by various psychiatrists who could not find any evidence of a fundamental disorder and have attributed all his difficulties to a culmination of substance mis-use and abnormal personality. I did feel, however, on balance that he was showing evidence of a psychotic shift and I felt this had primarily been brought about by his abuse of substances. In the past SN has responded to a combination of Carbamazepine 800 mg daily in divided doses and Olanzapine 10 mg nocte. However probably because of the massive amounts of substances that he has been abusing until recently it is possible that the medication could not contain him and hence the elaboration of psychotic symptoms to which I have already referred.'

4.34 Dr SBZ arranged to see Mr SN again in May, outcome unclear, but he was in prison at Cardiff, Bristol and Liverpool from early June until 26 August 2004 for motoring offences. He was discussed at the Team's clinical meeting on 11 June 2004 when it was noted that Ms JP, the CPN, '*had a different view from Dr SBZ…he feels psychotic illness'*.

Comment
Mr SN's condition in March/April 2004 was clearly causing increasing concern to his GP and Social Services, who also reported the concerns of his mother with whom he was now living as a result of the eviction. The GP's discussions with local CMHTs culminated in an urgent referral to Dr SBZ.

It appears that Dr SBZ had taken on responsibility for Mr SN's care in response to the GP's urgent request. The assessment at home of his mental

state confirmed the behaviours described in the GP's referral to Dr DA in March and by Social Services in April 2004.

Dr SBZ identified a change in Mr SN's presentation, which he described as a 'psychotic shift', although it later appeared that the Ms JP, CPN, was uncertain about this. In addition, the extent of Mr SN's substance abuse, which had been identified by Dr JT in October 2003 was confirmed.

This was Mr SN's only recorded contact with mental health services in the year 2004.

Return to Inner City CMHT and Imprisonment November 2004 – September 2005

4.35 On 8 July 2004, Dr RN wrote to the GP '*Thank you for asking us to see Mr SN in view of your concerns about him. He was sent an appointment to be seen in outpatients but I then discovered he had already been in touch with Dr SBZ. If he needs to be taken on by the Inner City Team, I shall be happy to become involved again.'*

4.36 In fact by then Mr SN was in prison, but on his release on 2 September 2004 he rang for and was offered appointments with Dr SBZ that month and again in January 2005. This was in parallel with a follow-up appointment offered by Dr RN in December 2004. However, he was again in prison on remand from November 2004, charged with possession of controlled drugs, half a kilo of cannabis, with intent to supply, and with driving offences. He was convicted in February 2005 and remained in prison until September 2005.

Comment
Despite the continuing attempts by the two teams to see him, the already intermittent contacts with Mr SN resulting from his persistent failures to attend appointments with psychiatrists and associated services were increasingly disrupted by further, longer spells on remand and in prison.

There appears to have been some confusion on the part of the psychiatrists as to which CMHT or other local team was responsible for his treatment and care. As a result he was at one time offered overlapping appointments when neither consultant was aware that he was in fact in prison.

At this time it is unclear where his medical records were located and whether the most recent reports and notes were shared and/or consolidated in one file. This was potentially hazardous at a time of apparent changes both in Mr SN's psychiatric presentation and in his personal circumstances.

His ongoing treatment between October 2000 and his removal to prison in November 2004 had involved separate psychiatric assessments by a sequence of six different consultant psychiatrists. His recurrent disengagements when in the community and increasing absences in prison may have contributed to the fact that a full CPA assessment was never

undertaken, so that his assessment, review and treatment were largely reactive and episodic.

Nevertheless, between them the psychiatric reports add up to a fairly comprehensive picture of his psychiatric symptomatology, drug abuse, record of offending and personal circumstances. The reports provided by Probation in 2001 and Social Services in 2004 amplified the record of his personal circumstances, his responses to penal measures and the views of his mother as his nearest relative regarding his behaviour at home. These reports did not, however, include a formal risk assessment, although their descriptions of his behaviour acknowledged elements of risk.

Dr JT's finding in October 2003 regarding substance abuse involving amphetamines, which was confirmed in May 2004 by Dr SBZ's clinical assessment was also contemporaneously corroborated by the statements of Mr SN's mother contained in the Social Care Assessment.

No up to date history was completed, which could have identified the changes over time in his thoughts and behaviour and the emergent association with amphetamine abuse.

Mr SN had no direct contact with community mental health services after his assessment by Dr SBZ in May 2004 until October 2005, following his discharge from prison.

Referrals from Prison 2005

4.37 On 11 February 2005 the Trust's mental health in-reach team at HMP Bristol requested the Inner City CMHT urgently to follow-up Mr SN - ' *Next in Court 16.2. Known to Dr SBZ, diagnosis schizophrenia, paranoid features, 15 years on Olanzapine 20 mg, Seroxat 50 mg. Current relapse, potential release date 17.2.2005. Lives with mum…. Needs urgent follow-up, has CPN based at Blackberry Hill.'* The request listed associated risk factors as *'substance abuse, violence and aggression.*'

4.38 In the event Mr SN was sentenced on 17 February 2005 for 15 months, for possession of cannabis with intent to supply. He served his sentence at HMP Guys Marsh, and was released on 15 September 2005. A fax message to the Inner City CMHT from the prison's Registered Mental Nurse on 12 September 2005 noted '*Appears to have coped relatively well with imprisonment, states the regime here helps him cope better. No active psychosis at present, also some weight loss has been achieved over the last few months….History of paranoid schizophrenia 12-15 years, depression/bereavement issues also, seen by myself with no serious relapses during his stay… compliant with medication… I anticipate a comprehensive assessment of his mental health and any potential problems will be essential at this time, plus if possible a support package for himself and his mother (carer)…'*

Comment
The categorical assertions from both prisons that Mr SN's mental illness was schizophrenia do not appear to have been based on medical examination, but to have originated from his own account of his health history and current medications.

However, the CMHT does not appear to have clarified this matter with HMP Bristol at the start of his sentence, or to have discussed the reasons for that diagnosis with HMP Guy's Marsh at the time of his discharge.

Any medical support for the diagnosis during his stay in prison would have influenced his subsequent assessment, treatment, care and clinical supervision.

In contrast to the referral note from HMP Bristol, the letter from HMP Guys Marsh included no reference to risks.

Formal CPA Assessment and Care, October 2005-April 2007

4.39 The Trust's CPA core assessment form was completed after a home visit on 4 October 2005 by Dr LH (specialist registrar) and Mr SE (CPN), when Mr SN and his mother were seen. Mr SN described his personal history and contacts with psychiatrists, most recently with Dr SBZ in 2004.

4.40 Dr LH and Mr SE noted that his mother reported; *'he suffers with schizophrenia, has a split personality…. over the years he had become enraged at times and whilst he has never hit someone he had broken the windows, mirrors and other items in the house.*' She also described the incident when *'in a psychotic state Mr SN tried to remove the wooden floor in her front room believing that there were bodies under the floor'*.
He '*agreed with what his mother said about him, although….feeling that she was making things sound worse that the reality. He does not feel any longer that there is something under the floorboards'.*
He told Dr LH that he '*took amphetamines 10 years ago otherwise he does not take any illicit drugs.'*.
Under Mental State Examination, Dr LH noted: '*Currently and due to his medication there did not appear to be any symptoms that would indicate mental health problems…. When not on medication he describes himself as being very disturbed and emotional… It was not very clear about the extent of the hallucinations that he experiences. He hears voices when alone or when in bed. He hears voices of children and men saying things like "when are you ready to sleep". He seems to suggest that sometimes the voices he heard are from within his head and sometimes from outside. He talked about getting messages from the TV and radio, he feels that at times Tony Blair and others talk about him, and that what they say somehow relates to his life. Sometimes he sees a message on TV and feels that it is about him and for him……He gets paranoid about people generally. He feels that if he went out that people will get him. He did not (possibly could not) expand on this. He avoids going out due to his feelings of paranoia.'*

In terms of his own needs it was noted that Mr SN '*Feels that he needs help. He wants to stay stable. He wants to continue taking his medication. He wants help with finding a flat. He does not want to re-offend. He feels that he is a good driver…………*'
The Carer's View was reported : '*His mother cannot look after him any longer and wants him to live in his own flat. She however worries about him and feels that he will not be able to take care of his needs by himself. She feels that he is like a child and that he needs an accommodation where someone can take care of his needs.'*
Within the tick box section or the assessment form, Dr LH and Mr SE indicated that a carers' assessment was required, but that Mr SN did not meet the service entry criteria and that the risks of not providing a service were low.
Next Steps were recorded: '*Discuss assessment at clinical meeting', 'outpatient appointment with Dr RN'*. A footnote added '*Get old notes, see Dr RN in o/p, meet him and mum separately'*

A copy of the assessment was sent to Mr SN's GP.

4.41 A full set of the Trust's ICPA Risk Assessment and Management Plan forms appears on file immediately preceding the above assessment. The only section completed is a tick-box relating to new referrals. Dated 26 September 2005, it identifies substance abuse and driving while disqualified as known risks, but all other categories as not known.

4.42 In November 2005 Mr SN was assessed by 2nd Step for housing support and after viewing some properties, in February 2006 signed a tenancy agreement, which he later did not take up.

Comment
Although the Trust had introduced its CPA policy and procedure in 2001, this was the first comprehensive initial assessment under that policy and procedure. The home interview by Dr LH and Mr SE with Mr SN and his mother on 4 October 2005 was the first prolonged contact by any member of the CMHT since May 2002, due to his non-attendance and periods in prison.

In the absence of previous clinical records, the assessment was based primarily on information gained from Mr SN and his mother that day. Although the most significant areas were explored, the information recorded is only partially consistent with existing knowledge of Mr SN. It recorded his mother's use of the term schizophrenic and recorded at face value his assertions about not using illicit drugs.

Dr LH conducted a mental state examination, which described in some detail the nature of Mr SN's hallucinatory experiences and paranoid feelings, but no conclusion was recorded regarding their significance.

The ICPA Risk Assessment form identified drugs and driving as the only known risks. Other risks were unknown and the rest of the assessment forms were blank. The CPA assessment form completed by Dr LH and Mr SE

did not include a section on risks other than 'Risks of not providing a service' which was recorded as 'low'.

The latter was contrary to what Dr JT and Dr SBZ in 2004 had recorded in the previous two years but Dr LH's footnote on the assessment form makes it clear that their notes had not been seen before the home visit.

In view of the fact that the CPA core assessment was incomplete, and would remain so until Mr SN had been seen by Dr RN and the old notes had been obtained, it was premature to have recorded that the service entry criteria were not met. However it appears that on the basis of that assessment, he was regarded as not fulfilling the access criteria for a full CPA and therefore was not allocated a CMHT worker. The remaining decision was whether he should be added to Dr RN's list of outpatients, which would at that time have amounted to standard level care under the Trust's CPA policy.

4.43 Mr SN was offered an outpatient appointment with Dr RN for 22 December 2005, but he did not attend. In her letter to the GP dated 12 January 2006, Dr RN stated '*In view of his history we need to keep in contact with him. On reviewing his notes he is unlikely to attend a follow-up review. A routine home visit with another member of the team will be arranged*.'

4.44 He was seen at outpatients on 23 February 2006 when Dr RN noted,*'He feels well, medication OK Olanzapine 20 mg… was ill last time he tried to come off end of last year… coped by sleeping in bedroom until a bit better and started taking Olanz again only came off a couple of days….. Got convicted for driving without licence and using hash, 20 m sentence, 10 m came out in Sept 2005, no Probation officer. Living with mum, get on OK. Used to have own flat 2 years ago, would like to have his own place, 2nd step going to help him*.'

4.45 Her letter to the GP confirmed the above; '*He was currently well. He has felt well on medication and been stable for 3-4 years now. He said he became ill last time he came off (end of last year) but only stopped for 2 days. He still relies on his mother but would like his own place.'*

Comment
This standard half hour outpatient appointment, was Mr SN's first attendance at an appointment with Dr RN and was her first direct contact with him. It was her first opportunity to assess him clinically since he had been re-referred by his GP to the Inner City CMHT on 23 April 2003.

Her assessment of his mental state and her clinical impressions regarding his diagnosis are not recorded, neither is there any reference to risks.

Dr RN's conclusion that he had been stable for 3-4 years does not accord with Dr JT's clinical findings in October 2003 of which she was aware (see 4.28). It is not clear if she had seen Dr SBZ's letter of May 2004 or the associated information contained in the Social Care Assessment.

Her note appears to be based primarily on what Mr SN himself had reported to her and at the CPA assessment by Dr LH and Mr SE in October 2005. It did not complete that CPA assessment as requested by Dr LH or expected by the Trust's operational policy.

4.46 On 3 March 2006 Dr RN completed a medical statement relating to Mr SN's application for Disabled Living Allowance in which she wrote; '*Diagnosis schizophrenia onset 1992, numerous relapses until 3-4 years ago, has been in remission. Does not have epilepsy. Has not any alcohol or drug problems for 10 years or more…. Is currently well and insightful. Has been no problem for over 12 months in terms of any concern. Has a history of feeling suicidal some 4 years or more ago but no attempts. No history of violence to others. He is aware of common dangers. He has been stable for 12 months but has an illness which can relapse….In the past he became self-neglectful when living on his own. He has phases when he feels too low to wash, change clothes etc and may go up to 3 weeks without caring for himself, his mother providing the food, does the shopping and manages his finances, otherwise he would suffer form self neglect….His prognosis is favourable in terms of the acute symptoms, but he has residual problems with concentration, hygiene and has a lot of sleepiness from his medication. This is less favourable.*'

Comment
This form represented related correspondence rather than a part of the main clinical record. However, it contains several significant assertions, which appear to represent Dr RN's understanding of Mr SN's current condition and recent history:-

i. that he was then, and had been for the past 13 years, suffering from schizophrenia. This was the first time that diagnosis had been given by any of the Trust's consultant psychiatrists and differed from the diagnoses recorded from 1991 to 2004.

ii. that he had not any drug problems for 10 years or more. This assertion was completely at variance from the clinical records up to 2004.

iii. that he had no history of violence to others. The Trust's records include references to his convictions for assault, affray, offensive weapons, threatening behaviour, harassment and battery up to 2004.

4.47 Mr SN did not attend his next appointment with Dr RN on 11 May 2006. She informed his GP and sent another appointment which he attended on 27 July 2006. Her notes for that date record '*Stopped seeing Probation Officer in Feb 2006. No other professional involved. Still with mother, gets on OK, she is 69 years in good health. Mostly in house, takes dog for a walk.. watches TV, can conc OK. Did hear a few voices a few weeks ago, people's names, just a couple of minutes. Came out of prison 10 months. In for driving w/o licence, selling hashish, doesn't use cannabis. Says "went off his head" when not on medicine – in a fantasy land. Never actually attempted sui… when ill gets depressed sleeps in bed a lot. When unwell does things eg dig up floor, lots of voices, thinks police after him. This is the best I've had. Became ill 28-30, been ill constantly since,*

never been admitted, I've learned to cope. Olanz 15 mg - massive appetite, cut it down to 7.5 6/12 ago, been Ok since then, Stick at 7.5 mg, don't sleep so much. "I've nowhere to live"- needs more help. CPA 3/12.'

4.48 Following this appointment Dr RN sent a letter to Mr SN, which was headed 'Standard ICPA Care Plan-Outpatient'. This was copied to his GP. It set out under a series of headings the substance of her records above, adding; *'We agreed you may need extra support if you become paranoid or hear voices again. In the past you have heard lots of voices and believed the police are after you. You can also become very depressed and sleep all day. In which case you should contact me or the duty desk at Brookland Hall… or your GP,. This care plan will be reviewed at your next appointment with Dr RN, CPA with mother'.*
'We have discussed whether there are any risks to yourself or to others as a result of your mental problems, and we have agreed how best these will be coped with. I hope you agree that the risk plan is helpful and here are the contact details if you circumstances change and you need further professional assistance please either contact me on the above number or contact your GP. In the past although you have used drugs and got into situations which you later regret, you have never been violent and never attempted to kill yourself. At present you are well and we can see no risk of self-harm'.

4.49 Mr SN attended his next outpatient appointment on 23 November 2006, when he was seen by Dr RN accompanied by Mr TG, a senior CPN who was involved in caseload monitoring. . She noted *'Hears voices, ask questions, I voice male doesn't know whose, no idea, must be from my own mind.. Doesn't tell him to do things, like one- sided conversation, no disgusting comments "just ignore". Olanz 15 mg incr, himself in July. Ok on higher dose (when laid on bed and it is quiet, hears voices).S/E only weight. Sleeps 16 hours a day feels OK. Takes dog for a walk. Goes for a walk. 10 bottles of beer a week. Driving whilst disqualified and TWOC – charged October needs Report. Saw the car 'Was a bit fed up' tempted, wanted to go and see friends. First time he drove for 3 years. Would have been due to get his licence back soon but now will have to wait again. He regrets this. More social contact (I think he attends day centre already but if not we will refer)'.*

4.50 Dr RN's subsequent letter of 6 December 2006, written in the format prescribed by the Trust's ICPA procedure, was addressed to Mr SN and copied to his GP. It reiterated much of the above and added '*We agreed that you may need extra support if the voices get worse, if you get depressed particularly if you feel suicidal or if you stop caring for yourself. In the past you have become severely neglected when living on your own but now your mother provides food, does the shopping etc.'* The next appointment was set for 22 March 2007.

4.51 0n 21 December 2006 Mr SN attended a mental health review with his GP who noted, *'Came for script – on same doses for a while. Ran out of Paroxetine. Saw Dr RN 3 weeks ago – tells me all fine and no change. Seen by consultant 4x/yr – no letter recently. Appropriate in behaviour and conversation.'*

Comment

Although not set out in her notes as such, Dr RN had given consideration to Mr SN's mental state at interview and she also had attendant risks in mind. She was heavily reliant on him as the only informant and her earlier intention to include his mother had not been acted on.

From July 2006 Dr RN's records followed the Trust's standard ICPA format, so that together with Dr LH and Mr SE's assessment of October 2005, the Trust procedure was now being more fully applied. Mr SN's contact as an outpatient was solely with Dr RN but he now received a written note of her conclusions and intentions.

Although Dr RN now knew that he was again due to appear in Court she had not been contacted by the Probation Service for a report.

At this time Mr SN was also seeing his GP who was observing his health on a number of fronts – his weight, his general health and his mental health.

4.52 In January 2007 Mr SN was convicted of the motoring offences committed in September 2006 and conditionally discharged.

4.53 On 25 January 2007 he saw his GP regarding his weight, when it was noted '*working hard to lose weight positive and happy today. Likes to be seen on a monthly basis at the moment due to mental health issues –OK.'*

4.54 On 2 March 2007 Mr SN again saw his GP, who noted *'weight symptom-losing-surprised as been on holiday and ate chocolate etc. Pleased. Missed three doses of Olanzapine and got in a real state. Has re-started, no intention of stopping again. Chat re tiredness with Olanzapine – benefits outweigh side effects'.*

Carers' contacts with CMHT March-April 2007

4.55 On 8 March 2007 the notes of the CMHT's meeting recorded *' Long history of schizophrenia. Lives with mum. Drives without a licence. Frantic phone call received from mum, who is afraid of him. Is okay when he sees R (*Dr RN*) but will not let R see mum. Advice/plan To listen to mother when she calls. JD* (a CPN) *to see him.'*

4.56 On 23 March 2007 Mr SN did not attend the appointment which had been set in Dr RN's last CPA letter.

4.57 On 13 April 2007 Mr SN's GP noted '*Patients condition deteriorating. More agitated. Hearing more voices .Withdrawn this week. Certainly more tense. Good insight and appropriate in communication and decisions today. Refusing CPN involvement and promises to return if worsens. Asking for increase in Olanzapine which seems sensible. Advised to be seen I week – tells me he will make an appointment if needs it.*'

At the same interview the GP noted *' Erectile dysfunction a problem for years………Asking for Viagra free. Needs bloods again. See again and reconsider when mental health improving.*'

4.58 On 17 April 2007 Dr RN wrote to his GP, to report his non-attendance on 23 March 2007, adding, *'His mother was quite concerned about him recently but did not want him to know she had contacted us. I did offer to phone her back but she was concerned he would pick I up the phone. I shall write to him offering another appointment on 3.5.07 at 3.30 pm. In the meantime please let me know if you have any concerns about him.'*

4.59 On the same day Dr RN wrote to Mr SN's mother, *'It is sometime since anyone from our service has made contact with you. I would be happy to offer you an appointment to come and see me to discuss any concerns you may have about your son. If it is difficult to come to Brooklands Hall I would be happy to make a telephone appointment for you to phone me, or another appointment to suit you.'*

Comment
In the first three months of 2007, although Mr SN had again missed his outpatient appointment, he saw his GP on three occasions, at the last of which, on 13 April 2007, a deterioration in his mental health was noted, but not such as to initiate an immediate referral to Dr RN.

It appears that during March 2007, decision-making regarding Mr SN's care became increasingly shared within the CMHT, although Dr RN remained his designated care coordinator under Standard ICPA. The extent to which any changes to roles and responsibilities were defined is unclear, but it seems that team members and managers were becoming more familiar with Mr SN's situation as reported by his mother and his GP.

There is no note in the clinical records of the call from Mr SN's mother referred to in the CMHT meeting notes of 8 March 2007, when Dr RN reported her increasing concerns regarding her son's behaviour. The multi-disciplinary team was alerted to the situation at home, but there is no subsequent record of a follow-up contact by Mr JD (CPN) which had been agreed.

It seems that communications between Dr RN and the GP may have crossed on 24 April 2007 when the home visit was being arranged.

CMHT's response and urgent home visit at family's request 24 April 2007

4.60 On Tuesday 24 April 2007 a call was received by Mr SE at the CMHT office from Mrs GN, sister-in-law to Mr SN, who was '*very concerned about his behaviour since this weekend – he has become paranoid – he is bullying and threatening towards mother – current treatment not working – won't allow mother to phone out or receive calls – has been physically aggressive towards mother in the past. G is asking for help.'*

4.61 Mr SE noted his discussion with Ms MH, Manager, Dr PS and Dr RN *' initially home visit this pm by two people – if Mr SN does not accept any help then refer to ASW Team'*. He later noted '*phoned Mrs GN to inform her that we will visit this pm – also spoke with S's mum – she informed me that…it is the speed that is causing him to become more ill. She does not want us to tell S that it was her who asked for help.'*

4.62 Dr PS, Staff Grade Psychiatrist, and Mr JW, Care Assistant, visited Mr SN at his mother's home that afternoon. On their return Dr PS noted '*concerns expressed by mother regarding S – that he is using drugs, has become paranoid and threatening……S claimed that he was not sure whether his children were actually his as he suspected the children's mother of infidelity but he is not concerned about it. As regards his own mother he felt if she 'left me alone' I will be fine.' Later on Mrs VN also agreed with him and said that S was never physically aggressive towards her. S denied all hallucinatory experiences and any other delusion apart from the infidelity one.*
Mrs VN also said that he starts getting ill after he takes the 'speed'. She drives him to get his speed because he cannot. She also worried about 'maintaining the peace'. She also felt that the services were not doing enough for her. But she is ambivalent about what she wants with her son – whether she wants him to stay or leave – stays provides company – leaves easier for her to be in contact with her family. She wanted him sectioned – I explained the MHA and told her that if she is ever concerned about her physical safety she should call the Police.
Right now there is little evidence that S is going to harm her physically – as he has never done that nor has ever threatened her. He also appears not to have any thoughts of self-harm. Explained to Mrs VN about the consequences of S taking drugs and her helping him acquire it. S denies using drugs.
Plan (1) Dr RN to see Mrs VN (2) Carer's assessment to be done (3) S to be sent an appointment. If he does not attend I will see him again ?next week.'

4.63 On Thursday 26 April 2007 the notes of the CMHT record: *'Have received several telephone calls from S's mother. He is becoming more unwell. Pressures his mother into taking him to buy drugs (speed). Does not physically attack her but throws things. Mother desperate for help with S. J and P visited yesterday (25/04). Discussed his drug taking with him. Advice/Plan – S to see Dr RN and Dr PS. To do a carer's assessment at Brookland Hall – M to decide who will do it. To write risk assessment.'*

4.64 On Friday 27 April 2007, Dr PS confirmed this in a letter to the GP in the following terms:- *'I saw SN at his home with JW community Care Work on behalf of Dr N.*
His mother had raised some concerns about Mr SN not taking his medication, having a relapse and using drugs. She also felt that he was expressing paranoid ideas.

Initially at the home visit, we first spoke to Mrs VN, who said that she was worried about S as he was expressing bizarre ideas about his children not being his and saying that he was Jesus Christ etc. On further questioning, she did say that this usually happens when he takes speed. She also informed us that as S does not drive she goes with him to get drugs. When we challenged her about this she

said that she was afraid of S, he would get angry and break things in the house if she didn't. I did ask her whether she was worried about her own physical safety and she denied this. She said that S has never been violent towards her and has never threatened her. He has always threatened to break things and she did not seem too concerned about her own physical safety. I did also try to explain to her that even driving S down to get drugs could be illegal and if she ever feels threatened by him she can always call the Police. She agreed with this, but did not seem satisfied.

Mrs VN said that she wanted S sectioned and taken away to the hospital. We then did assess S, who denied taking speed. He did however say that he was concerned about his children not being his and suspected his wife of infidelity when they were together. He didn't seem too bothered by it and appears that he wants his children and his mother to leave him alone.

S seems to be someone who completely lacks motivation and would like to just lie down on his bed and get up only to eat or take drugs. We tried to elicit hallucinatory experiences and first rank symptoms, but I could not elicit any of them. We also tried to talk to him about going out and doing other activities, but he did not seem to be interested at all. Hence the conclusion is that although S could possibly get violent and paranoid, this is largely due to his drug intake. Otherwise he is someone who would probably just lie down on his bed and do nothing. There is little we can do about this and we tried to make his mother understand this. I also could not elicit any thoughts of self-harm or harm to others. Hence there would be little justification of the use of the Mental Health Act.

Later I discussed him in the team meeting at Brookland Hall and plan from that is:-

1. *S would continue taking his medication as it is*
2. *A carer's assessment would be organised by us and a letter to that effect would be sent to Mrs VN. This assessment we will try to see what her concerns are and whether she wants S to stay at her home or not. She at present is ambivalent about this. We would also reinforce at this meeting that if there is any threats etc., she can always contact the police.*
3. *We will offer S an appointment to see Dr RN and myself. If S does not attend this appointment, I will go with Mr JW again to see him at a later date.'*

Comment

It was unusual for Mr SN's family members to have made direct contact with the CMHT and for that reason the team responded immediately following Mrs GN's call.

Dr PS and Mr JW had no previous experience of Mr SN, but they were given some details by Dr RN and Mr SE, who had direct knowledge of him and Dr PS had a brief time to acquaint himself with the clinical notes before the home visit.

At the visit, Mrs VN spoke freely of her son's use of speed (amphetamine) and it is evident from his notes that Dr PS observed this factor in his presentation. Mrs VN was also reassuring about the physical risks her son represented to her.

She clearly wished Mr SN to be sectioned that day, but Dr PS as a doctor approved under S12 Mental Health Act decided there were insufficient grounds to initiate a formal assessment.

Mr SN exhibited little in the way of the disordered thoughts and behaviour which had initiated the visit or were previously recorded at times when he was low in mood and/or intoxicated. No hallucinations or other first rank symptoms were elicited.

Mounting family concerns had resulted in a quick reaction by CMHT but the home assessment by Dr PS and Mr JW, as their first contact with him, relied almost entirely on presenting evidence rather than historical knowledge.

If Dr PS had received fuller briefing and examined the clinical notes in depth on 24 April 2007, there was little on record to alert him and Mr JW to the emergent acutely disturbed and highly dangerous behaviour which Mr SN displayed five days later.

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Attendant events not known to CMHT

4.65 On 30 September 2006, Mr SN had been charged with offences relating to his mother's car and remanded in custody to HMP Bristol. He was released from there on bail on 6 October 2006 awaiting trial.

4.66 On 31 October 2006 his Probation Officer 's Pre-Sentence Report to the Court read: ' *For some time prior to the date of the offence… he had refrained from taking his anti-psychotic medication. As a result he claims that in his mind he believed that the car outside (which belongs to his mother) was in fact his. Mr SN says that on the spur of the moment he decided to take a drive and meet with a friend in a local pub. As he pulled into the pub car park he was observed by Police Officers who knew Mr SN to be a disqualified driver. They immediately challenged Mr SN who admitted he was driving illegally. Mr SN stated that as soon as he was approached by the Officers his sense of reality immediately returned. Mrs VN was duly contacted and confirmed that she had not given her son permission to drive the car.*
Mr SN has been subject to community penalties in the past which he has subsequently breached. However he was released on licence after serving his last custodial term and was supervised by the National Probation Service (NPS) up until February of this year when his licence expired. Feedback from his supervising officer was very positive, she tells me that Mr SN had attended all his appointments and engaged well in the individual targeted interventions she undertook with him.

Mr SN disclosed that he began experiencing mental health problems in his mid-twenties which were initially diagnosed as depression. However as his symptoms worsened it was eventually identified that his problems were more severe. Mr SN states that he is a paranoid schizophrenic, I have been unable to verify whether

he has been diagnosed as such but have ascertained from the Mental Health Team based at Brookland Hall that Mr SN is a patient of Dr RN (Consultant Psychiatrist) and he is indeed prescribed anti-psychotic medication via her and his GP. Previous reports indicate that Mr SN has a personality disorder and problems increase when he fails to take his medication. Mr SN describes hearing several different voices when his mental health worsens. He says they don't encourage him to carry out instructions but engage him in an internal dialogue. Mr SN described being delusional when he is not taking his medication for any length of time and he imagines himself for example to be the Prime Minister or a leading figure in one of the armed forces.

Mr SN stated that he had experimented with Amphetamines in his mid-twenties coinciding with the onset of his mental health problems, which are likely to have exacerbated the situation. He categorically denies any illegal drug misuse now and insists his previous convictions for possession were all the result of being persuaded to sell Cannabis on behalf of others. Mr SN has made attempts to reduce his alcohol consumption and says he drinks occasionally on a social basis only. It is of note however that previous reports indicate some of his violent offences have been linked to alcohol. It remains a concern that he continues to drink despite this being contrary to medical advice, having the potential to negatively affect his mental health thus increasing his risk of reoffending and causing harm to others.

I have used two nationally approved risk assessment tools in order to assess Mr SN. One focuses on static factors such as age and previous offending history, the second combines static factors with dynamic factors such as lifestyle, thinking and behaviour and emotional well-being. Both tools assess Mr SN as being of high risk of reconviction. It is in my professional opinion that these are accurate at the present time. Mr SN's historical pattern of behaviour and his inability to self-monitor his medication appropriately for any significant length of time is indicative of consistently faulty actions and thought processes. Mr SN's ongoing mental health problems are thus significantly linked to the risk he continues to pose in terms of re-offending. Without the benefit of more intensive interventions via local mental health services this risk is unlikely to be reduced.

I have used both assessment tools to assess the risk of harm posed by Mr SN. These indicate that at present Mr SN poses a medium risk of harm to the public, a medium risk of harm to a known adult (namely his mother) and a medium risk to staff. Whilst Mr SN continues to drive illegally he poses an obvious risk of harm to other road users/pedestrians. His mother has been the victim of Mr SN's offending, not only in terms of the theft of her property but also when she has been subject to harassment and abuse from him in the past. In addition Police Officers and other perceived 'authority figures' are assessed as being at risk of harm from Mr SN in light of his previous convictions. His mental health issues and possible ongoing alcohol misuse would see to be the primary contributing factors linked to the risk of serious harm Mr SN poses. As stated above, without rigorous and I would suggest more frequent input from mental health professionals this risk is not likely to decrease.
The Court has indicated that it is considering a medium level community punishment with the purpose being to punish, reform and rehabilitate. However in

light of Mr SN's individual circumstances, my assessment of him indicates that he may not be suitable for any community penalty managed by the NPS. I have also discounted the option of a Curfew Order which has the potential to place Mrs VN at increased risk of harm should her son become agitated at the restrictions on his liberty. I would also suggest that a custodial term is unlikely to address the specific needs of Mr SN or serve the purposes of the Court.

I would therefore respectfully recommend that the Court either adjourns for a further period and asks that a psychiatric assessment is carried out (with the aim of ascertaining whether or not Mr SN is able to comply with the strict requirements of a Community Order), or alternatively, given Mr SN's mental health problems the Court might in this particular case wish to consider the imposition of a fine and/or a Conditional Discharge.'

Comment
In the event the Court did not request a psychiatric report and Mr SN was conditionally discharged on 29 January 2007.

Because no psychiatric report had been requested by the Court, the Probation Officer was not able to verify Mr SN's current psychiatric status beyond confirming that he was a patient of the CMHT.

Her report, as a confidential Court document, was not copied to the CMHT. If it had been, Dr RN would have known that Mr SN had not taken his prescribed medication for a period and that he was categorically denying substance abuse.

It must be noted that in October 2006, six months before the index offence, the Probation Services' standard assessment tools placed Mr SN as high on risks of re-offending but only medium on risks of harm to the public, his mother and staff. However, those assessments identified that the risks were significantly related to his mental health.

It is unclear why the Court exercised its discretion not to call for a psychiatric report in the light of such a clear recommendation from the Probation Officer.

4.67 On Saturday 28 April 2007 two Police Community Support Officers, one male, one female, were on cycle patrol near to where Mr SN resided with his mother. Their records noted; '*Our attention was drawn to a male stood still in the centre of the road in front of us. The male, who I now know to be Mr SN, asked us if we were police. We informed the male we were police community support officers and asked him if there was a problem. Mr SN then said 'There's some strange things afoot round here.' We then asked him what he meant and he told us his daughter was missing. PCSO H asked how long she'd been missing for, to which Mr SN replied 'Three years…that is if she is the original one as she's been cloned many times before.'*
Mr SN then went on to tell us that his mother had a shallow *grave underneath her car, which he pointed out as being a vehicle parked in Carlyle Road, and he asked us if we'd go with him to look at it.*

At this point a female, who I believe to have been Mr SN's mother, came out from a house and into the road.
She shouted over to him 'What are you saying now?' And then proceeded to shout to (us) 'Take no notice! I expect he's been telling you all sorts!'.....His mother then told him to get back inside the house, and beckoned a small white dog towards her, which had been sat underneath a car close to where (we) were sat on our cycles. Mr SN, his mother and the dog then went inside a house on Carlyle Road.
My perception of the male was that initially at the start of the conversation I could not tell whether or not he was being serious or having a joke with us, as he remained very serious and stern faced. He came across as a very strange, odd man, who looked rather angry as his eyes were fixed to one point throughout the entire conversation. Because of this and his apparent demeanour, I thought we had better seemingly take his words seriously and see the conversation through to a suitable conclusion. I did not want to upset him by dismissing it, due to it being an apparent fabrication or someone with an over active imagination'.

Comment
By this account Mr SN was openly expressing disturbed ideas in a public place near his home the day before the homicide. The PCSOs noted what he had said but took no further action once his mother appeared to take control by telling Mr SN to go indoors. Mr SN's words and actions as reported did not contain threats or cause alarm to the PCSOs and by their account he went quietly indoors at his mother's bidding.

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The events of Sunday 29 April 2007

4.68 Mr SN fatally assaulted Mr Philip Hendy at around 8.30 am that day, and committed a further assault on Mr HT a few minutes later. Eye-witness accounts described Mr SN's behaviour as odd and when challenged regarding the assaults he said only '*It's personal. Mind your own business'*....Shortly after, when apprehended by the Police who asked where he had come from, he replied *'I've been to the shops but they were all shut'.*

4.69 Following his arrest and removal to the Police Station, he was examined at 10.20 am by Dr MH, the duty Forensic Medical Practitioner (FMP) who noted '*History of paranoid schizophrenia and depression. Controlled with medications. Stopped taking his medications 2 days. Symptoms of paranoia and delusions. Given diazepam 10 mg at 1100 hrs. Review later at 1600 and constant obs – unfit to be interviewed at the present time.'*

4.70 Some time later a blood sample was taken for drug and alcohol analysis by the duty doctor, noting '*Very agitated, constant obs please'.* The results of significance were; '*Amphetamine 0.82 micrograms, Olanzapine 0.24 micrograms, Diazepam – low conc.'*

4.71 Dr MH saw him again at 1632 noting '*Nothing changed since this morning – talking to himself + delusions + paranoia. Hearing voices sometime – history of*

paranoid schizophrenia and depression. I left a message to EDT at 1652 – full mental health assessment under MHA. Constant obs'.

Comment
These initial notes show that Mr SN was able to relate a history of paranoid schizophrenia and depression and to describe auditory hallucinations. This, together with his degree of disturbance and agitation, which required close observation, led to a formal assessment under the Mental Health Act some 10 hours after his arrest in the street.

First formal Mental Health Act Assessment 29 April 2007

4.72 That evening, Mr SN was assessed under the Mental Health Act by Dr H, Dr S and Mr MacP (Approved Social Worker). Mr MacP's notes stated:-*'Mr SN presented as extremely psychotic and recounted a whole series of incidents relating to his three children. He believes one of them was murdered, then cloned, another kidnapped in the USA until he phoned President Bush who had him returned while the third D aged 13 has been forced to have a sex change although he doesn't know who is responsible for it. He believes his brothers have been sexually abusing his two daughters and that they have broken his mother's ankles in order to pressurise her to persuade him not to go after them. He also believes his mother has been sexually abusing one of his daughters.*
Mr SN denied having attacked anybody this morning although he admitted to a shouting match with someone who criticised him for not controlling his dog……….he appeared to be totally oblivious to the charges he was facing and denied any illicit drug abuse.
I then talked to his mother who told me that he had been addicted to amphetamines for the last 4 months, had not slept for the last 3 nights due to his constant usage. She was deeply concerned about his mental state and confirmed that he had been in her bedroom earlier in the morning, looking under her bed covers for one of her daughters. She feels that she could easily have been the one that he attacked rather than the strangers in the street, such is her fear of his present condition.
After long consideration and consultation with the CID Custody Sergeant, we decided not to detain Mr SN tonight but that he should be re-assessed tomorrow. The reason for this is (1) HIT were unable to provide us with any previous history as the system was down (2) the possibility of his presentation being profoundly affected by amphetamines/withdrawal (3) it would not have been possible for find a secure enough bed for him tonight in view of the seriousness of the charge (4) we felt that ideally RMO and Forensic Services at Fromeside should have input into the decision making process. Finally (5) Mr SN was not in a distressed/agitated state that warranted an immediate need to transfer him to hospital care especially as his medication was being given to him whilst in custody.'

Comment
Although Mr SN exhibited some florid symptoms to the Mental Health Act assessment team, they determined that his condition and the associated risks were not such as to demand immediate transfer to mental hospital.

Furthermore, his history, the extent of his amphetamine abuse and the need for an expert forensic psychiatric opinion were also needed before a valid decision could be reached. In the meantime he was seen as safely cared for in police custody overnight.

Second formal Mental Health Act Assessment, 30 April 2007

4.73 Mr SN was seen at 1030 am on Monday 30 April 2007 by Dr SB (Consultant Psychiatrist) and Ms LL (Approved Social Worker). Dr SB noted:- '*Mr SN recognised myself as a consultant who he had seen 8 years previously when I was working in the inner city. He claimed that he was ill and wished to go to hospital. Mr SN then enlarged on this explaining that he felt things were happening in his house which were frightening him, he complained about a severe smell which was extremely unpleasant and that certain people were interfering with his house and his Mother. He said that he was mentally unwell, if he could not go to hospital he would go to Prison. He did not explain why.*
Mr SN was not prepared to enlarge early in the interview on any of the difficulties he was experiencing at home saying they were private matters. He did however eventually enlarge upon the fact that he felt there were people interfering with his privacy with a series of tunnels and flaps in his house. Mr SN said that he had been feeling unwell for several months. He recognised that he was in the Police cells because of a serious incident that had happened and he did not deny his involvement, however he had no memory of being involved in any such event.
On mental state examination it appeared that Mr SN was suffering from a paranoid psychosis, although some of his answers were avoidant, especially with regards to the serious incident that had occurred to the elderly gentleman, his memory before and after the event was good. He did not appear confused about other aspects of the history. He knew that he had seen Dr RN in outpatients and also recently been assessed by Dr PS and Mr SE, his CPN.
SN denied the use of any amphetamines early in the interview but towards the end admitted that he may have taken it within the last two weeks.
On mental state examination Mr SN suffered from a paranoid psychosis with quite a well systematised delusional set of beliefs concerning a series of flaps and tunnels and people getting into his house and interfering with his Mother. He also had separate worries and concerns that his children are being sexually abused and were not being looked after by his estranged wife. He is also concerned about her past infidelity which did not appear to be relevant to any of the reasons of why he was in Police custody. He denied hearing any auditory hallucinations whilst he was awake and he said that his mood was normal and he did not feel with happy or sad.
Mr SN did not appear to be confused, he was orientated in time and space, had a reasonable memory for past and recent events but did not appear to remember anything that occurred on the morning of Sunday 29 April with regards to a gentlemen outside a Newsagents. He remembered walking the dog prior to the incident and remembers being arrested afterwards.
I made a provisional diagnosis of paranoid psychosis of uncertain cause. During the interview Mr SN was co-operative largely throughout apart from one incidence asking the attending Police Officer why he was smiling (which he was not).

Ms LL and myself after discussion with senior colleagues in the Trust were able to give advice to the Custody Sergeant that Mr SN did not require urgent psychiatric treatment, he had taken his tablets that morning which were a simple and straightforward anti depressant and anti-psychotic which he was supposed to have been taking for some time. These tablets could be taken in either a custody setting or in a treatment health setting. Mr SN was also fit to be interviewed with an appropriate adult in view of the fact that he could converse logically and describe this experience in a co-operative and reasonable way.'

4.74 Ms LL noted:- '*Mr SN was interviewed in the cells…. He made good eye contact and responded to questions appropriately. He was not aggressive but would not answer personal questions. Mr SN was not able to recall the stabbing or the assault. He did recall going to the shop and finding it closed. He next found himself being handcuffed by a police officer. Mr SN reported a conspiracy involving high society. He believed that the terrible smell in his house was coming from his mother having sex with different men. Mr SN referred to being abused since birth and that his children had also been abused. He was prompted by questions and reported hearing voices but could not remember what the voices had said,. He stated he has schizophrenia. Mr SN showed no emotional connection to the crime he committed.*
Following discussions with Custody Sgt and CID, Dr SB and I confirmed that Mr SN was not in immediate need of hospital admission and treatment. We confirmed that he was fit for interview, that he could answer questions, he was receptive and expressive, he was not disorientated with time, place or persons.
Due to the seriousness of the offence Mr SN will be charged this afternoon. He will appear at the magistrates court tomorrow morning and then taken to Horfield Prison. He will be transferred to Fromeside under s48 for full assessment and treatment.'

4.75 Mr SN was remanded to HMP Bristol on 1 May 2007 and transferred to HMP Long Lartin on 11 May 2007.

Comment
During three separate examinations on Sunday 29 April 2007 and Monday 30 April 2007, Mr SN was seen by four doctors and two social workers who had no previous knowledge of him and latterly by a consultant psychiatrist who had known him 6 years earlier. At each stage their conclusions did not result in a decision that he should be detained under the Mental Health Act. On the basis of what they observed at first hand and had gleaned from the records, none of those who saw him dissented from that decision. Two days after the index offence Mr SN became a prisoner on remand.

First forensic psychiatric admission and assessment 10 May 2007 – 11 April 2008

4.76 On 10 May 2007 Mr SN was examined at HMP Bristol by Dr AT, Consultant Forensic Psychiatrist from Fromeside Secure Unit, Bristol, as a result of which he was transferred there from prison on 21.5.2007 for assessment under Section 48 of the Mental Health Act 1983. He remained in Dr AT's care until July

2007 when he was transferred to the care of Dr PC until his return to prison custody on 11April 2008.

4.77 In his report to the Crown Court dated 15 May 2008, Dr AT stated '*I formed the view that he needed to be admitted to hospital in order to thoroughly appraise his case prior to any court proceedings on the basis that he appeared to have had a fifteen year history of relapsing paranoid psychosis but that it was unclear whether or not this related directly to misuse of amphetamines or not. I also noted rather dependent and perhaps avoidant traits in his personality characteristics which were not a marked feature of his life before the death of his father which I noted was approximately coincident with the onset of his later mental health problems around fifteen years earlier.*

He was then transferred to Fromeside, remained on the admission assessment ward throughout and was reasonably consistent in his presentation throughout that time. He has consistently reported odd feelings as if others were talking about him and consistently reported bad feelings which appeared to be his expression of apprehension. He would generally hold himself apart from others, often retiring to his room despite feeling that others were looking at him whilst there. He also consistently reported 'fits' which were never witnessed by observant staff and no suggestion of any associated phenomena which might suggest a tendency to epilepsy. He was, not surprisingly, anxious and apprehensive about the situation he found himself in

As a planned manoeuvre much of his admission was under observation without antipsychotic medication and throughout that extended period of approximately eight months there was no good evidence from the observations of trained staff that he had developed a psychotic illness despite his repeated report of odd symptoms. His mood was consistently reported as low but this was not felt to be indicative of a true clinical depressive illness in the absence of other features.

Investigations included abnormal EEGs (brain wave traces) however, expert opinion in interpreting these suggested there was no indication of any liability to seizures and, although there was evidence of change in brain function, these changes could be attributable to already known substance misuse.
In the absence of any continuing need for hospitalisation and with investigations complete, Mr SN was returned to continue his remand in custody………….'

4.78 In his report to the Crown Court completed on 13 December 2007, under the heading Diagnosis, Dr PC stated: '*Mr SN has in the past been diagnosed with episodes of depression. These were clinical diagnoses made in outpatients, sometime perhaps without using the full rigour required of the current diagnostic manuals, but nevertheless likely to be valid.*

What appears far less clear is whether or not he suffers from an innate predisposition to true clinical depressive episodes, recurrent in course, or whether in fact his bouts of low mood are more related to disordered personality and the use of drugs which are associated in themselves with the genesis of low mood (alcohol and amphetamines).

My own opinion is that the latter is the more likely explanation but the high likelihood is that he will, in consequence, be prone to episodes of true depression in the future.

There is no real evidence that he is currently suffering with an episode of clinical depression, though he undoubtedly complains of low mood. Objectively we are not at all clear that what we see is indeed indicative of clinical depression. Rather he appears to be presenting with quite understandable anxiety and possibly dysthymia (chronic low mood, though not of the degree required to establish a clinical diagnosis of depression).

Historically Mr SN has attracted a wide variety of diagnoses, and in particular the question of whether his experiences were suggestive of a psychosis or not has been raised. In particular, Dr SBZ thought so in 2004.

More recently it is not at all clear that clinicians looking after him were satisfied that the most appropriate diagnosis for him continued to be that of a schizophrenic illness. In order to be clear about this it has always been necessary that he remain off alcohol and other psychotropic (street drug) drugs and at the same time offer him a trial off antipsychotic medication. This is what we have done in Fromeside while he has been here.
We are clear that there has been no re-emergence, as might have been expected under the stressful circumstances, of symptoms suggestive of his suffering with a psychosis which might amount to a schizophrenic disorder.

In particular it is worth noting that he achieved elevated and moderately elevated scores across a wide range of scales on the Structured Interview of Reported Symptoms. The combination of scores seen was characteristic of individuals who are feigning a mental disorder and is rarely seen in people reporting truthfully.

It is my opinion, and that of my team, that Mr SN is not now suffering with a psychosis or with a schizophrenic illness.'

Second forensic psychiatric admission and assessment
July - September 2008

4.79 When, on 30 June 2008, Mr SN appeared at Bristol Crown Court, he alleged that he had surreptitiously been taking neuroleptic medication during his admission to Fromeside Clinic at a time when it was believed he was free of such medication. The Court therefore decided that proceedings should be adjourned for him to be re-admitted to Fromeside Clinic for a further period of assessment free of medication.

When proceedings resumed on 13 October 2008 Dr AT's subsequent addendum medical report stated: '*Once again, despite his attempts to impress upon me that he is experiencing a range of psychotic phenomena at the current time, I do not regard him as suffering from a mental illness within the meaning of the Mental Health Act 1983………….I regard his mental state as having been considerably disordered at the material time and conclude that he was suffering from an acute*

paranoid psychosis at that time. There is no basis to change my earlier opinion that the most likely cause for his mental illness at that time was his continuing high dose use of amphetamines.
Having said that I remain of the opinion that amphetamines induced mental illness in his case which persisted for some time after he had not used the medication before those features gradually resolved.
As noted earlier I do not regard his condition therefore as simply being a result of intoxication from illicit substance misuse and therefore that the illness was induced by the 'injury' of repeated amphetamine misuse.

That, together with the fact that the various acts committed by Mr SN which resulted in the death of the victim, were directly related to his abnormal mental experiences.

Taking all this together I am of the considered opinion that he was suffering from an abnormality of mind at the material time.
Once again it is clearly a matter for the jury to consider whether or not such an abnormality of mind could be said to have substantially impaired his responsibility but, if pressed on the point, I would conclude that it did amount to substantial impairment.'

4.80 In his addendum psychiatric report dated 9 October 2008 Dr PC gave his opinion: '*My view remains that it is likely that he was suffering with a psychosis at the material time and that this influenced his actions. That psychosis was likely precipitated by his amphetamine use but in my view it is important to draw a distinction between intoxication and a free standing illness, albeit generated by drugs.*

In the event of his not being found guilty of a crime the sentence for which is fixed by law I remain of the opinion that there is nothing about his presentation which suggests he ought to be detained under the Mental Health Act and consequently so disposed of.'

4.81 The Prosecution had obtained an opinion from Dr AA a Consultant Forensic Psychiatrist, working in Hertfordshire whose report to the Court dated 30 September 2008 concluded: '*My recent re-assessment of Mr SN does not cause me to depart from the opinion expressed in my previous report that he does not suffer from a functional psychotic illness such as schizophrenia. I remain of the view that whilst his mental state at the material time could be properly described as an abnormality of mind, I do not believe that this abnormality of mind arose from a condition of arrested or retarded development of mind, or any inherent cause, or was induced by disease or injury. I remain of the view that the abnormality of his mind was produced by the voluntarily ingestion by himself of psycho-active illicit substances. I do not therefore believe that Mr SN has a defence of diminished responsibility available to him within the meaning of Section 2(1) of the Homicide Act 1957.'*

4.82 On 16 October 2008 Mr SN was found guilty of the murder of Mr Philip Hendy and on 17 October 2008 he was sentenced to life imprisonment and returned to HMP Long Lartin.

Chapter Five

Findings : The Treatment & Care of Mr SN

Mental Disorder
Introduction

5.1 Mr SN was treated for depression by his GP in mid-1990 following the death of his father in September 1989. The response to this treatment was limited, and in December 1990 he was referred to Dr MN, a consultant psychiatrist, whom he saw for the first time in February 1991. This was the beginning of Mr SN's involvement with mental health services in the community. His last contact with them before the homicide was on 24 April 2007 when he was assessed by Dr PS and Mr JW.

5.2 In the intervening years he was seen by at least nine consultant psychiatrists in the community, and occasionally by community psychiatric nurses and social workers. His engagement was intermittent, with many missed appointments, and interrupted by periods in prison, where he was treated by prison mental health services. His compliance with medication was inconsistent, and on occasions he negated its effectiveness by the effects of alcohol and/or illicit drugs. Mr SN offended consistently during these years, and a number of his referrals were in the context of criminal proceedings.

5.3 From a careful analysis of the records, the panel concludes that it would be mistaken to view Mr SN as a long-term patient in continuous contact with local mental health services. He was seen in 1991 and 1992 for outpatient consultations. Then for 3.75 years from September 1992 to May 1996 he had no contact apart from his call to the CMHT in July 1993. He was next seen in May 1996, then not until April and September 1998, but did not attend in 1999. He was referred again in April 2000 but did not attend until October 2000. Seen next in January and June 2001, he then did not attend until examined in custody in October 2001. He was next seen in May and August 2002, then imprisoned and not seen until again examined in custody in October 2003. He attended once in May 2004 and was then largely in prison until September 2005.

5.4 For the purpose of summarising and analysing diagnosis and treatment before the homicide, his involvement with community mental health services can usefully be divided into three parts; 1991-mid 2004, September 2005-November 2006; November 2006-April 2007. After his arrest, Mr SN was assessed by forensic psychiatric services. Throughout this period, he consulted his GP frequently about various physical ailments in addition to his mental state generally.

1991 to mid 2004

5.5 Between 1991 and the middle of 2004, there is a pattern of referrals resulting in treatment aptly described by Dr SO'C in November 1998 as *'appropriate low level psychiatric support'*. The symptoms noted consistently are

personality disorder, low mood –'*dysthymia in the setting of personality disorder*' in the opinion of Dr GU in October 2001, and some persecutory ideation for which excessive intake of alcohol was offered as a possible cause, both by Dr GU and by Dr SB. His presentation in that time was described by Dr SB in his oral evidence as 'a *miserable young man who was low in mood, feeling he had come up against the buffers, was in trouble with the law, and was binge drinking…..I did not see him as someone who had unipolar depression…He seemed to be somebody who had far more life-long problems with relationships….This was not somebody who was coming across as somebody who had a serious mental illness*'. At no time in these years was any serious illness diagnosed, and most particularly there is no suggestion that Mr SN suffered from schizophrenia.

In her report of October 2003, Dr JT summarised the position succinctly. *'He was assessed by Dr SO'C in 1998, by Dr GU in 2001, by Dr AF in 2002, and Dr AL and Dr RN in 2003, who all stated in their reports that Mr SN does not suffer from mental illness'.* She was of the same view and attributed his problems to personality difficulties and heavy use of alcohol and amphetamine. In this period he was prescribed both anti-depressants and anti-psychotic medication. In May 2004, when Mr SN was seen by Dr SBZ and Ms JP, CPN, he was said to be increasingly paranoid. Dr SBZ noted the past assessments by various psychiatrists who had not found any fundamental disorder and who had attributed all his difficulties to a culmination of substance abuse and abnormal personality. On this occasion he felt that on balance Mr SN was showing evidence of a *'psychotic shift…brought on by his abuse of substances'.* Dr SBZ increased the dose of Olanzepine and intended to see Mr SN again at home the following week. The notes suggest that the CPN took a different view about the existence of a psychotic illness. In his oral evidence, Dr SBZ told the panel that by '*psychotic shift'* he meant that whatever the previous diagnoses, he had seen in Mr SN's presentation clear signs of psychosis, but that he was not thereby making any comment as to the origin or cause of the psychosis, simply that he was more psychotic than had been described before. In the opinion of Dr SBZ, the psychosis could be managed, and he felt that any risk was containable. He emphasised that he was not suggesting on the basis of the consultation in May 2004 that Mr SN was suffering from schizophrenia, and that if others had concluded, with the benefit of much more evidence, that there was drug induced psychosis, he had no reason to dispute that diagnosis. There is no record of Dr SBZ having seen Mr SN the following week, and his later attempts to secure a follow-up appointment were frustrated by Mr SN's subsequent sojourns in prison.

5.6 On 4 June 2004, Mr SN was sentenced to 60 days imprisonment from which he was released on 26 August 2004. In November 2004 he was arrested again and remanded in custody, until, on 16 February 2005, he was sentenced to 15 months, from which he was released on 15 September 2005. It is in prison medical reports that the diagnosis of paranoid schizophrenia first appears. In a discharge letter to Mr SN's GP of 7 September 2004 from the Prison Community Mental Health Team of Mersey Care NHS Trust, Mr PH (mental health practitioner) informs Mr SN's GP that *'SN stated that he has a diagnosis of paranoid schizophrenia, which I was unable to confirm'.* In February 2005 the referral note from the Inreach team at HMP Bristol under reasons for referral wrote '*diagnosis schizophrenia, paranoid features-15 years'*. In the referral to the

Bristol Inner City Mental Health Team dated 12 September 2005 on Mr SN's release from HMP Guys Marsh, Ms SO (CPN) describes *'history of paranoid schizophrenia 12-15 years, depression/bereavement issues also'*. The panel has not been able to establish the basis of the diagnosis on these occasions while Mr SN was in prison, but the note from Liverpool suggests that it was likely to have been self-attributed.

September 2005-November 2006

5.7 From September 2005 onwards it seems that these references to schizophrenia heavily influenced the diagnosis and care of Mr SN. In response to the referral from Guys Marsh, he was assessed by Dr LH and Mr SE on 4 October 2005. They did not have the previous extensive notes and treated it as a new referral. In addition to the diagnosis contained in the fax from prison, they were mindful of the report from Mr SN's mother, who spoke to them at some length. Dr LH told the panel in oral evidence that *'the evidence of my and Mr E's assessment of our history and examination of him [Mr SN] would not have been conclusive that he had a diagnosis of schizophrenia'.* Mr SE confirmed in his evidence to the panel that Mr SN was neither paranoid nor hallucinating, but that he and Dr LH felt that he probably did suffer from a schizophrenic illness. They did not, however, consider the assessment to be complete and this is reflected in the hand written conclusion to the core assessment report '*Get old notes. See Dr RN in OPA [outpatients], meet him and mum separately'*. These action points were confirmed in the minutes of the multi-disciplinary team meeting of 6 October 2005.

5.8 Although she acquired responsibility for him following this referral, Dr RN did not actually meet Mr SN in person until 23 February 2006, Mr SN having failed to attend an appointment in December 2005, a not unusual occurrence. A follow up letter of 6 March 2006 to his GP describes Mr SN as *'currently well'*, stable on medication which he was then taking regularly, and in touch with Ms DS, a Second Step Housing worker-though this last assertion was later denied by Ms Spearman. A review in July 2006 was routine. Dr RN saw Mr SN for the last time on 23 November 2006 when Mr TG (CPN) was also present. Mr SN was awaiting a court appearance, but the CPA letter to him dated 6 December 2006 records that he was *'basically well enough…..you are doing well….you still hear voices at times'*. Throughout her engagement with Mr SN, Dr RN appeared to accept a diagnosis of schizophrenia, and the minutes of team meeting on 8 March 2007 refer to '*long history of schizophrenia'*, though the basis of this is not entirely clear, a matter discussed further at Chapter 6. Thus from October 2005 until the phone calls from his family in March and April 2007, the focus on illicit drug use was lost. If it had been given a higher profile, it is possible that Mr SN would have been referred to specialist drug services, but there is little in the evidence of his past behaviour to suggest that this would have been effective.

5.9 Mr SN informed the panel that he was told by Dr RN that he had schizophrenia some time towards the end of 2006. (Though in fact he is quoted in an undated Adult Care Assessment of Need and Care Plan in 2004 as firmly believing that he has schizophrenia, and his mother referred to schizophrenia when Dr SBZ assessed Mr SN in May 2004.)

November 2006-April 2007

5.10 There is evidence from his family to suggest that Mr SN's mental state was deteriorating at or about this time, in all probability because of his use of amphetamines, which is discussed in greater detail in paragraph 5.27 – 5.38 below. His sister-in-law is subsequently recorded as noting aggression towards her eldest stepson in November 2006. His former partner is reported by Dr PC (i.e. after the event) to have noted his conversation becoming noticeably unusual towards the end of 2006, the content often being sexual. His mother described to the panel that he expressed bizarre ideas and behaviour on a family holiday to Butlin's in February 2007. His continued aggression, anger and violence to inanimate objects were a source of anxiety to the family, with particular concern expressed for the welfare and safety of his mother. This prompted both his mother and sister in law to contact the Bristol Inner City Team in March, and on both 17 and 24 April 2007. The second call resulted in the assessment by Dr PS and Mr JW on that day.

5.11 On 13 April 2007 he attended his GP who noted that his condition was deteriorating *'More agitated. Hearing more voices. Withdrawn this week. Certainly more tense….refusing cpn involvement'*.

5.12 Dr PS's conclusions from his assessment, with which Mr JW told the panel he was in agreement, are summarised in his letter to the GP of 27 April 2007. This assessment is analysed in greater detail at paragraph 8.9 – 8.19 below, but in terms of his mental state, Mr SN was described as lacking motivation, with no evidence of hallucinations or first rank symptoms. Insofar as he had, or might again, express bizarre ideas or become violent and paranoid, both the evidence of his mother, and the opinion of Dr PS suggests that this was related to his use of illicit drugs.

5.13 On 28 April 2007, Mr SN was seen in the street by two Police Community Support Officers, to whom he expressed delusional ideas. They described his demeanour as that of a "strange, odd man, who looked rather angry".

5.14 On 29 April 2007, Mr SN committed homicide when he was acutely psychotic.

After arrest

5.15 Ten hours after Mr SN was arrested, there was a Mental Health Act assessment conducted by an approved social worker and two doctors approved under section 12 of the Act. He was said to be *'extremely psychotic'*. Mrs VN told the ASW that her son had been addicted to amphetamine for the last four months and had not slept for the last three nights. It was decided not to detain him that night and that he should be reassessed the next day. This decision was reached for a number of reasons: no history could be obtained because the Trust's computer system was down; Mr SN's presentation was profoundly affected by amphetamine; no secure bed could be found that night; forensic mental health services should be involved; he was not in a sufficiently distressed state to warrant immediate detention and he was able to take medication while in custody.

5.16 Dr SB conducted a further assessment of Mr SN in police custody on 30 April 2007. He noted that Mr SN remembered him from some years earlier, and that from the outset he claimed to have schizophrenia. There was evidence of a well systematised paranoid delusion of several months standing, but no urgent need for treatment requiring admission to a mental hospital. Accordingly, Mr SN was held on remand in prison. Dr AT conducted a further assessment on 10 May 2007 and concluded that as there appeared to be a degree of diagnostic uncertainty, Mr SN should be observed in a therapeutic environment for an extended period. An order for transfer under section 48 Mental Health Act 1983 was made on 17 May 2007 and he was admitted to Fromeside Hospital, a regional secure unit, on 21 May 2007.

5.17 The results of the ensuing assessment are set out in Dr PC's report of 13 December 2007. He records Mr SN's anxiety, lack of thought disorder, low mood and lethargy. He expresses doubt about psychotic symptoms described by Mr SN on the basis that his affect '*is incongruent with these reported experiences*'. Dr PC identifies a number of traits consistent with a diagnosis of Dissocial Personality Disorder such as a protracted history of offending and rule breaking, difficulties in relationships, scheming callous unconcern for others, proneness to blame others, the inability to learn from experience, low tolerance to frustration, persistent irresponsibility and disregard for social norms and obligations. In summary he had reached the view that at the time of the homicide there were grounds for concluding that Mr SN was suffering from an episode of psychosis, and that, as the symptoms had not re-emerged in the absence of drugs or medication, the high likelihood was that the psychosis was generated by the consistent use of amphetamines. While expressing the hope that Mr SN could be kept at Fromeside until his trial, Dr PC was clear that '*despite his range of difficulties, they do not amount to such as are either of a nature or degree as warrant or make appropriate detention in a hospital setting'.*

5.18 Mr SN was returned to prison on remand at HMP Long Lartin on 11 April 2008. The admission report of that date from the prison records his disagreement with the outcome of Dr PC's assessment. He maintained that he still experienced auditory and visual hallucinations, and he wished to recommence anti-psychotic medication. While at HMP Long Lartin, he was seen by Dr K-H who was *'not convinced that his account of symptoms is consistent with mental illness'* and felt that '*forthcoming legal proceedings may be influencing his presentation'*. In this observation Dr K-H echoed the sentiments expressed by Dr JT as early as October 2003 when she concluded '*in my opinion Mr SN may have benefited from his period in prison because he is now aware that Mental Health Services will not provide excuses for his antisocial behaviour'*.

5.19 He was also seen again by Dr AT on 8 May 2008, at the request of the defence. He found Mr SN's account of symptoms to be *'unconvincing'*; in other respects his conclusions broadly concurred with Dr PC.

5.20 When Mr SN appeared at court in June 2008, he informed his legal team that during the apparent drug and medication free period at Fromeside he had in fact taken antipsychotic drugs, obtained from other patients. He had also secured antipsychotic medication from other prisoners while at HMP Long Lartin.

5.21 Accordingly, to facilitate another trial period off medication Mr SN was readmitted to Fromeside on 5 September 2008. He tested positive for benzodiazepines on admission and again on 23 September 2008 and 3 October 2008. Nearly a month after this admission and notwithstanding regular searches of his belongings, Mr SN was found to have olanzepine tablets concealed in a box of tissues. On this admission he appeared to adopt the symptoms of other patients as his own, and again his behaviour was not consistent with the strange and bizarre symptoms of which he complained. Dr PC reached the same conclusions as in his earlier report.

5.22 The key issue at Mr SN's trial was that of diminished responsibility on the grounds that he was suffering from an abnormality of mind at the time of the homicide. In addition to Dr PC, Dr AT was called on behalf of the defence. In his further report dated 10 October 2008, Dr AT was of the view that Mr SN's description of his symptoms was '*not in line with what would be expected of psychotic phenomena'.* He concluded that '*despite his attempts to impress on me that he is experiencing a range of psychotic phenomena at the current time I do not regard him as suffering from a mental illness within the meaning of the Mental Health Act 1983, neither do I regard him as suffering from mental impairment or severe mental impairment'.*

5.23 A further Consultant Forensic Psychiatrist, Dr AA was instructed on behalf of the prosecution. There was general agreement that at the time of the homicide Mr SN was suffering from an abnormality of mind. The point at issue was the nature of that abnormality in relation to the legal test for diminished responsibility. Dr AA held the view that it was the result of the voluntary ingestion of psycho-active illicit substances, whereas Dr PC and Dr AT sought to draw a distinction between intoxication and a free standing illness, albeit one generated by drugs. Mr SN's defence was rejected and he was convicted of murder on 16 October 2008. He received a life sentence with a minimum term of 16 years and in the absence of any evidence that he was detainable under the Mental Health Act he returned to HMP Long Lartin where he remains.

5.24 Notwithstanding the subtlety of the arguments advanced at the trial about *'stand alone psychosis'* (though this was of considerable significance within the criminal proceedings), with regard to diagnosis, it is important to note that both Dr AT and Dr PC described Mr SN's mental state at the time of the homicide as one of a paranoid psychosis linked to misuse of substances. At no time did they suggest that he was suffering from schizophrenia or any other mental illness; indeed from their evidence it is clear that they carefully avoided any such terms. Their oral evidence to the panel confirmed this view. They both found Mr SN to be untruthful - in the words of Dr PC '*capable of quite considerable dissimulation*', and they found significant elements of personality disorder.

5.25 According to the post-sentence report dated 16 January 2009 prepared by Ms RF (probation officer/offender manager), Mr SN was not then receiving treatment for any mental disorder. In interview by the panel on 4 November 2009, Mr SN asserted that he had not used illicit drugs since being sentenced and that he was taking only prescribed anti-depressant medication, paroxetine, with no antipsychotic medication. He told the panel that the strange thoughts that were

troubling at the time of the homicide had stopped *'2-3 weeks after the murder'* and that the voices now come and go, often after an interval of several months. Mr SN told the panel, that he had last heard a message from God about six months ago telling him that '*you are in the right place'*, though the panel did not find this account to be either credible or convincing.

Misuse of substances : Alcohol

5.26 Drinking alcohol regularly and to excess is a consistent feature of Mr SN's history. In a report for Bristol Magistrates Court dated 9 October 2003, Dr JT asserts that *'Mr SN has a long history of heavy alcohol abuse since the age of 15'*. From his teens onwards it seems that he maintained a consistent regular intake, usually in the company of others, punctuated by episodes of binge drinking, such as 10-15 Bacardi Breezers. Probation records show that on occasions he was under the influence of alcohol when he attended supervision appointments. Advice to reduce his drinking is a constant refrain in the notes, but there is no record that he ever received treatment from specialist services. Dr JT recorded that '*Mr SN refused to accept that he has serious alcohol problems, saying, "everybody is drinking in this country*"'. Following his release from HMP Guys Marsh in 2005, he appeared to be making progress in reducing his intake of alcohol. There is no evidence to suggest that alcohol contributed to the commission of the homicide.

Misuse of substances : illicit drugs

5.27 According to Mr SN's replies to the panel, he started to use drugs only after his father died. While admitting to dealing in cannabis on occasions, he was non-committal about how often he used it, commenting that he didn't like it and didn't smoke it very much. He did admit to using crack cocaine about 15 years ago, and to experimenting with ecstasy, which he didn't enjoy, about five years before the homicide. He claimed that *'most'* of his offending was drug-related, and specifically being under the influence at the time of the dangerous driving in 1995 but he denied that substance misuse contributed to the assault on his girl friend in 1991. On the question of amphetamine, he did not disagree that he had started to use it with greater regularity towards the end of 2006, but he maintained that he only took *'a little bit, not a lot'*. He agreed that his mother took him to get his supply, which he estimated to be 3½ grams, about £40 worth, every month. He could not explain the very high reading of amphetamine in the sample taken shortly after the homicide. He denied ever using drugs in prison.

5.28 With reference to illicit drugs generally, Mrs VN's account was broadly consistent with that of her son, but she referred to him being *'on and off'* amphetamines for many years. She gave a graphic description of the escalation in its use in the months leading to the homicide, and of the effects on Mr SN's demeanour, which were entirely consistent with acute amphetamine psychosis. Her requests for assistance in April 2007 were prompted by his becoming paranoid and threatening when he was using drugs, and she admitted driving him to collect his supply. When Dr PS and Mr JW conducted the assessment on 24 April 2007 she showed them a bag of white powder to substantiate her concerns,

but when asked directly Mr SN denied using illicit drugs, and Dr PS could not detect any indication to the contrary in his examination.

5.29 It is perhaps surprising in view of his long-term use of various illicit substances, that there are so few references to drugs in the records of Mr SN's engagement with psychiatric services. On 4 October 2001, Dr GU noted *'Drugs; nil. Prev[iously] amphetamine. Not for 6 months'.*

5.30 In her report in October 2003, Dr JT described '*a long history of taking amphetamines'* and noted that Mr SN declined help regarding his alcohol and amphetamine intake. She observed that he had received treatment in the past on the basis that the paranoid symptoms and auditory hallucinations he reported may have been psychotic, but that '*treating doctors appear to have been unaware that he was also abusing amphetamines at the time.*

5.31 In the undated Adult Care Assessment of Need and Care Plan in 2004, Mrs VN is said to have described her son taking speed regularly although not daily, and that the mixture of speed, alcohol and medication had a very negative effect on his state of mind. Mr SN categorically denied then that he was currently taking speed. In May of the same year, he admitted to Dr SBZ '*that he had been abusing up to a gram of amphetamines on a daily basis but he is insistent that he stopped abusing amphetamines about a week ago'.*

5.32 At the assessment in October 2005 following release from HMP Guys Marsh, Mr SN is recorded as telling Dr LH that he took amphetamines about ten years ago, but otherwise he does not take any illicit drugs. This was clearly untrue.

5.33 On 3 March 2006 when completing the Department of Work and Pensions form with regard to Disability Living Allowance, Dr RN asserted *'has not any alcohol or drug problems for 10 years or more'*. When asked why she had responded in this way she replied *'it was not a feature at that point*.' In the letter following the consultation of 27 July 2006, she *recorded 'apart from 4-8 or so beers on a weekend you do not use any substances'*.

5.34 In view of this persistent misrepresentation and reticence on the subject of drugs, it is not surprising that he was never referred to specialist drug agencies for treatment.

5.35 Mr SN may have been more forthcoming in his dealings with his GP. On 20 April 2004 there is a reference to *'amphetamine dependence-intermittent use for several years'*. It is not clear if mental health services had access to the GP notes, but as it happens, in May 2004 this was known to Dr SBZ as a result of the consultation on the 7th.

5.36 In the very detailed pre-sentence report prepared by a probation officer dated 31 October 2006, the author records that Mr SN told her that *'he had experimented with amphetamines in his mid-twenties coinciding with the onset of mental health problems which are likely to have exacerbated the situation. He*

categorically denies any illegal drug misuse now'. Accordingly, drug misuse is not registered as a factor contributing to his offending at that time.

5.37 In his report of December 2007, Dr PC records that Mr SN began using various illicit drugs in his teens and that he used them in a variety of mixtures throughout his teen and adult life. Specific reference is made to the intermittent use of cannabis ever since, and to past use of crack and ecstasy, but '*his most usual drug of abuse appears to have been amphetamine'.* It seems that Mr SN admitted to using 1-2 tablets two or three times per week, but that his mother's account suggested considerably more regular usage, especially in the period leading to the index offence.

5.38 What is not in doubt, is that when tested on 29 April 2007 Mr SN's blood was analysed and found to contain amphetamine at 0.82 micrograms per 100 millilitre of blood, a very high concentration which is consistent with chronic heavy use. It can reasonably be assumed that at the time of the homicide itself the reading would have been even higher.

Conclusion

5.39 Taking into account all the written and oral evidence, the panel finds that at the time of the homicide, Mr SN was suffering from acute paranoid psychosis generated by the use of substantial *('industrial'* was the term appearing in the trial transcript) quantities of amphetamines over several months.

5.40 There is nothing to suggest that the psychotic symptoms present at the time of the homicide were other than genuine. Mr SN had firm, fixed delusions over time, and this is well documented.

5.41 The evidence that the psychosis was precipitated by the use of drugs is overwhelming; principally the correlation between his increasingly bizarre behaviour and consumption of amphetamines, the quantity of drugs in his possession at the time, and the results of the drug test on 29 April 2009. This view is further supported by the relatively rapid decline of the psychotic symptoms (whether within 2 or 3 weeks as claimed by Mr SN, or the 2-3 months noted by Dr PC and Dr AT), in the apparent absence of illicit drugs, and the fact that they have not reappeared in any convincing form.

5.42 The panel also concurs with the opinion of Dr PC and Dr AT that personality disorder is the other principal feature in Mr SN's diagnosis, the symptoms of which are described in 5.17 and were previously observed by other psychiatrists, see 5.5 above.

5.43 Mr SN's behaviour and presentation to psychiatric services after his release from Guys Marsh in September 2005 were entirely consistent with his past engagement, and characterised by personality disorder, associated low mood, and substance misuse-latterly drugs rather than alcohol.

5.44 The panel found little reliable evidence in either the notes or in oral evidence that Mr SN was suffering from schizophrenia then, now, or at any other

time. Until its emergence in documentation from prison medical services in 2004/2005, such a diagnosis was hardly mentioned. Its origin is not clear, but as noted in paragraph above, it is likely to have been self-attributed. Both Mr SN and his mother are said to have used the term during 2004, though the basis on which they did so is unclear. Mr SN appears to have embraced the diagnosis with some enthusiasm, which is itself somewhat unusual in a condition in which lack of insight is a common feature, not least when he was in trouble. For instance as early as 2003, when he was remanded in custody for the charges of harassment and battery, Dr JT recorded that he was *'very keen to have a 'label' of mental illness'*. He told his probation officer in October 2006 that he was a paranoid schizophrenic, and when in police cells after the homicide he was quick to tell Dr SB that he was mentally ill. The consultant forensic psychiatrists who assessed Mr SN after his arrest for the homicide suspected that he fabricated purported psychotic symptoms, the accounts of which were inconsistent over time, and strongly suspected that his presentation was influenced by his predicament. Dr AA told the court that Mr SN had pointed out to him that mental illness would offer him the opportunity of the defence of diminished responsibility and that it would put into play the possibility of a disposal under the Mental Health Act.

5.45 Mr SN's willingness to disclose mental illness is in stark contrast to his repeated denial and minimisation of his use of amphetamines, notably to Dr LH, to Dr RN, and to Dr PS. There can be little doubt that Mr SN had been using street drugs since his teens, that this use had increased after the death of his father (at about the same time that he as first referred to mental health services), that he had continued to use amphetamine on and off since that time, and that he started to use increasing quantities of amphetamine, with bingeing from time to time, in the six months before the homicide. It has not been possible to discover why his consumption increased at that time, though Mrs VN thought it coincided with the release of one of his friends from prison.

5.46 The panel sought independent expert advice from Dr SMcL, FRCPsych, Consultant in Addiction Psychiatry, South Devon Drug Service. His observations reinforce the panel in their conclusions about Mr SN's mental state at the time of the homicide. At paragraph 8.1 of this report, Dr SMcL reviews the research into violent behaviour amongst amphetamine users from which it can be concluded that in the cases that formed the basis of the research that *'the events leading to the homicide were directly related to amphetamine induced paranoid thinking, panic, emotional liability or lowered impulse control'*. Other factors present in those cases included predisposing personality, environmental circumstances and the use of other drugs. Three stages leading to a violent act could be identified; chronic amphetamine use which may predispose the perpetrator to paranoid thinking and possibly carrying a weapon, an acute change in emotional arousal, and a trigger event often a perceived threat or danger. Dr SMcL also notes the strong evidence of people with personality disorders representing a very significant risk of violence, and research which shows that childhood aggression and conduct problems are both precursors to adolescent drug use and later violent behaviour. *'In particular anti-social personality disorder with the marked feature of impaired impulse control and strong association with drug use may amplify the effect of amphetamine on violent behaviour*". (Paragraph 8.3). In answer to a specific enquiry from the panel about the effect on presentation of a

heavy amphetamine user ingesting a '*top-up*', he concludes that *'some subjects with drug-induced or drug-exacerbated states could indeed maintain relatively intact insight and either deny or disguise their symptoms to others, particularly in forensic settings where questions of guilt may arise'.* (Paragraph 14). . It would seem, therefore, that Mr SN's behaviour was entirely typical of a long-term user of amphetamine both in the nature and duration of psychotic symptoms, its association with personality disorder, and in his acting out of paranoid delusions.

Mr SN's GP

5.47 As is apparent from the chronology, Mr SN saw his GP regularly over many years. The communication between GP and mental health services was generally good, with appropriate referrals from the GP and informative follow up letters in response. In addition to his mental health problems, Mr SN had a number of physical ailments such as asthma, weight gain, and an injury to his knee. He was diagnosed with epilepsy in 2004, though evidence heard by the panel cast some doubt on this as more recent tests were inconclusive. There is little to suggest that this condition contributed to the commission of the homicide. The treatment and monitoring of Mr SN by his GP, including in the months before the homicide, appears to have been exemplary.

Management by the Probation Service

5.48 As a frequent offender, Mr SN had extensive contact with the probation service over many years. The panel had the benefit of seeing a chronological account of his engagement in the period 2004-2005 supported by copies of pre-sentence reports in 2004, 2005 and 2006, and by the relevant Records of Contact, in addition to hearing evidence from his current offender supervisor. The reports are detailed and include risk assessments using recognised tools such as OGRS (Offender Group Reconviction Scale) and OASys (Offender Assessment System). Proper account is taken of the influence of his mental health on Mr SN's behaviour, and further psychiatric assessments for the purpose of sentencing were recommended in 2004 and October 2006.

5.49 Mr SN's attendance at supervision appointments in the period for which the panel had probation records was generally more reliable than his dealings with mental health services. In that he was not convicted of any offence and complied with the requirements of his supervising officer, he successfully completed his period of supervision on licence following release from HMP Guys Marsh in September 2005. The focus of supervision was his lack of suitable accommodation, ongoing alcohol misuse, and referring him back to mental health services. After a shaky start, including turning up for one appointment under the influence of alcohol, the records in the early part of 2006 (about the time of his first meeting with Dr RN) describe progress; independent accommodation, enjoyable contacts with his children, settled on medication, and cutting *'right down'* on his drinking. There is no reference to amphetamine use or to any suspicion that he was using illicit drugs.

5.50 Mr SN's licence expired on 28 February 2006. The next contact with the probation service was the pre-sentence report in October 2006 in proceedings for

which he was conditionally discharged in January 2007. He was not under the supervision of the probation service at the time of the homicide. Their next contact with him was at or around the time of his trial. The probation service acted entirely appropriately in their dealings with Mr SN, and the written and oral evidence its officers supplied to the panel was of great assistance in the investigation.

Chapter Six

Findings : Professional Practice

Diagnostic formulation

6.1 It is very clear from the analysis of Mr SN's engagement with psychiatric services in Chapter 5, that after he was released from HMP Guys Marsh the focus of diagnosis and treatment shifted from personality disorder, low mood and substance misuse to schizophrenia. The means by which this erroneous diagnosis might have emerged have already been discussed above in some detail. The greater concern, however, is that this error was not corrected until after the homicide and the subsequent forensic psychiatric assessments.

6.2 Dr RN did not meet Mr SN in person until February 2006. In her earlier dealings with his case, when she had some of the notes available to her, she appeared to concur with the view that prevailed until 2004/2005. For instance, in June 2003 she wrote to his GP stating that Mr SN did not have serious mental illness, and that he may be better served by seeking help for his drinking. In an undated letter in 2004, in response to a request from Mr SN's solicitors for a report following a court hearing on 10 February of that year for possession proceedings, she replied that she had not met Mr SN personally and referred to the report of Dr JT in October 2003, which she summarised; '*Dr JT notes that he has a past history of frequent offences, but has had infrequent contact with mental health services. She reports that he has reported having paranoid symptoms and auditory hallucinations but received treatment for that, but was also using amphetamines at the time*'. Dr RN went on to conclude that '*he has had a previous diagnosis of personality disorder and does not have a diagnosis of schizophrenia or bipolar affective disorder.'*

6.3 By 3 March 2006, however, when she completed the form from the Department of Work and Pensions concerning Disability Living Allowance, she wrote '*schizophrenia onset 1992, numerous relapses until 3-4 years ago, has been in remission…..does not have epilepsy….had not had any alcohol or drug problems for 10 years or more*'. The means by which she reached this conclusion, are far from clear. Neither the notes of the consultations on 23 February 2006, nor 23 November 2006 contain a diagnostic formulation. There is little if any evidence that the diagnosis of schizophrenia inherited from HMP Guys Marsh was tested. It may well be that Dr RN relied on the core assessment of October 2005, which as Dr LH told us was incomplete in the absence of the notes. The extent to which Dr RN was able to study the clinical notes is uncertain although they were a crucial resource for corroborating Mr SN's and his family's account of his symptoms. When asked by the panel why she had accepted the diagnosis of schizophrenia, it was apparent that she had relied on the assessment by Dr LH reinforced by the fact that Mr SN reported hearing voices. She has since added '*my impression during the time that I was seeing him was that he did suffer from schizophrenia. This was not because he and his mother said so but because from his history he spoke of hearing voices whilst denying recent amphetamine abuse. Although his history is now known to have been unreliable,*

at the time his description of hearing voices sounded plausible and was taken seriously. He had also had a psychotic episode which was indistinguishable from schizophrenia, as Amphetamine Psychosis is.'

6.4 Having accepted responsibility for Mr SN as the de facto care-co-ordinator, it is surprising that Dr RN did not cross check the clinical records before reaching her own diagnostic formulation, all the more so because she is an experienced and highly regarded practitioner. It seems to the panel that there are a number of reasons for this omission, such as the time available for each consultation, the heavy caseload carried by the Inner City team, and the lack of time to scrutinise the notes, which were themselves incomplete and disorganised to a significant degree (see below).

6.5 In the view of the panel, although poor practice and not compliant with CPA, this omission did not materially affect the outcome. By whatever name it was called, Mr SN's presentation remained the same. While it might be argued that it caused the focus of attention to shift away from his substance misuse (and even if Dr RN had remembered Dr SBZ's conclusion almost two years earlier), there would have been little prospect of identifying and treating the root cause of Mr SN's behaviour at the time of the homicide, namely heavy use of amphetamine, unless and until he was prepared to admit that he had a problem. It is recorded in the notes that Dr RN asked him about his use of alcohol, and she told the panel '*I have asked [him] myself about amphetamine use and he minimised it, he denied it, or he would say that he had a bit but not much*'. Ironically, if Dr RN had properly explored the diagnosis, and discovered the true nature of Mr SN's condition, most particularly that substance misuse was a principal factor in his mental state, it is likely that he would have been referred to specialist drug and alcohol services and that he would have been discharged from the care of the community psychiatric services some time before the homicide. Furthermore, in the light of his past reluctance to admit or address the issue of substance abuse, the prospects of success of such a referral would have been doubtful.

Drug Screening

6.6 One of the means by which the true level of Mr SN's consumption of illicit drugs might have been detected was by the use of drug screening, by testing urine, saliva or hair. With regard to testing generally, it was suggested to the panel that some practitioners in general psychiatry, where the emphasis is on forging a therapeutic relationship, might regard routine drug screening as judgemental or punitive. But it must be recognised that the possession and consumption of illicit drugs are unlawful, and that substance misuse is often the precursor to involvement in acquisitive offending, and in some cases to more serious crime. Amphetamine is a Class B drug with a maximum sentence on indictment for possession of up to five years, and/or an unlimited fine. It is a serious criminal offence. The panel agrees with Dr PC and Mr RE who were of the view that consideration should be given to baseline drug screening as part of the overall baseline assessment. Nevertheless, the grounds for such testing in this case appear to have been weak on the information available to those responsible for his treatment and supervision. Ms RF (probation officer) told the

panel that drug and alcohol testing had never been a requirement of his supervision by the probation service. Mr SN did not meet the threshold; 'e*ven now someone like S, how he presented, probably would not be put on a DRR, which is a Drug Rehabilitation Requirement, which will deal with people with heavy alcohol and drug use.'*

6.7 In the opinion of Dr SMcL 'd*rug testing has a modest but nonetheless important role in the clinical assessment and subsequent monitoring of those with joint mental health and drug-use disorders….Drug testing may have particular place where there is reason to think that self-report may not be accurate……there is evidence to suggest that in the context of the criminal justice system up to 52% of those tested for illicit drugs under report use'.* After further detailed scrutiny he concludes that although the use of routine drug testing is currently probably rare in mental health services, '*In psychiatric teams drug testing should form part of the patient assessment process and in certain high risk treatment population (those with first episode psychosis, those who frequently relapse and in psychiatric inpatients) drug screening should be regarded as routine.'*.

6.8 Another method of establishing the relevance or otherwise of illicit drugs to a patient's mental state and behaviour is the use of a drug free trial, that is a period free from prescribed medication. There was little to indicate that this might have been helpful in the case of Mr SN. The symptoms he reported and the view of all those who treated him over many years was that anti-depressant and anti-psychotic medication was beneficial. It was his inconsistent compliance with medication which had been the greater concern.

Dual diagnosis

6.9 The treatment of patients with dual diagnosis (i.e. co-existing mental health and substance abuse problems) has attracted much comment in this case. Strictly speaking, Mr SN could not properly be categorised as dual diagnosis during his engagement with psychiatric services as he did not have a co-existing severe mental illness[1]. Insofar as substance abuse was an issue, historically his use of alcohol had attracted more attention than illicit drugs.

6.10 Nevertheless, he might reasonably have been treated as a dual diagnosis patient in view of the diagnosis of schizophrenia that was accepted from October 2005. There is little evidence that a comprehensive drug and alcohol assessment was ever carried out, but as Dr PC rightly pointed out, the accurate assessment and treatment of substance misuse relies heavily on open and truthful disclosure by the patient. Mr SN did not have a high profile to mental health services as a drug user, and as already described he either denied, minimised or distorted his use of drugs when questioned. In October 2003, Dr JT observed that the doctors who had treated him in the past appeared to have been unaware of his use of amphetamine, and also noted that he did not want help regarding his drug and alcohol use. She recommended that he seek treatment for substance misuse and that he should be followed up by his GP, but this was not followed up, probably because the outcome of the hearing for which her report

[1] See Dual Diagnosis Good Practice Guide – DoH 2002

was obtained was a custodial sentence. It is highly unlikely that he would have taken advantage of treatment if it had been offered at any stage in view of his predilection for missing appointments when it suited, his variable compliance with medication, and his practice of mixing psychiatric medication with alcohol and/or street drugs. To his credit, Mr SN did appear to take control of his alcohol consumption in 2004/2005 as noted by the probation service, but he did not demonstrate any recognition of the extent of his drug problem or any motivation to address it. Having had incontrovertible proof of his use of drugs after the home visit in April 2007, it is possible that more rigorous strategies might have been used to persuade Mr SN to engage in drug treatment at his next scheduled appointment on 3 May 2007, but by then he had committed the index offence.

6.11 Unless observed when in the grip of intoxication (acute psychosis can last for up to five days), there is no obvious physical legacy of the use of amphetamine. The panel was told that one of the learning points for the Trust from this case has been the need for staff to be more alert and proactive for signs of substance abuse and its effect on a patient's mental health. This is a positive development, which would be strengthened by training in questioning techniques to challenge denial, especially where there is collateral evidence of substance abuse. Staff should perhaps be less inclined to take "no" for an answer. Nevertheless, in the face of complete denial or habitual minimising, and in the absence of a willingness to accept help, there is a limit to what any intervention can achieve. Even when an offence has been committed and drug treatment is a requirement of a sentence, the offender must be willing to co-operate with treatment for it to be effective.

Risk assessment

6.12 There is no evidence that a risk screen was undertaken at any time by psychiatric services in the community following the referral from HMP Guys Marsh in September 2005. This would have prompted a formal risk assessment to establish the risk posed by Mr SN to himself or to others, and the extent to which he was vulnerable.

6.13 Dr LH told the panel that she would normally have conducted an initial risk assessment in conjunction with the ICPA core assessment. She did not do so on 4 October 2005 as it was customary to await receipt of the case notes before doing a risk screen. The notes of the multi-disciplinary team meeting on 6 October 2005 do not refer to the fact that a risk assessment was still to be done. Nevertheless, Mr SE confirmed to the panel that he and Dr LH did consider the issue of risk, and that he was aware of some violent offences in Mr SN's record, though they did not have a list of previous convictions. Based on the evidence available to them, they concluded that Mr SN then posed no active risk to himself or others.

6.14 Risk was also considered subsequently by Dr RN as is confirmed in her letters following the consultations in July 2006 and November 2006, but she also undertook no risk screen or formal risk assessment as far as can be detected in the notes. At the multi-disciplinary team meeting on 26 April 2007 following the home visit one of the action points was *'to write risk assessment'.* It is possible

that a risk screen might well have brought to light Mr SN's convictions, or at least some of them, and that knowledge of violent offences would have triggered a full risk assessment. On the evidence of his behaviour and mental state at that time, although this might well have revealed additional factors to be monitored, it is unlikely that it would have changed the way in which Mr SN was managed in the community, or to have resulted in his detention. Nevertheless, the failure to complete a risk screen, whatever its likely outcome, is poor practice.

6.15 This would have been of a different nature from the more rigorous assessment of risk routinely conducted in a forensic setting. The internal review contained an HCR-20, a structured assessment of the risk of future violence, conducted retrospectively and using the information that would have been available before the homicide. To the extent that this is helpful, it indicated low risk. HCR-20 was not used widely even at Fromeside in 2005/2006, though it is now used more routinely. The panel shares the view of Dr PC that such tools are appropriate for forensic psychiatric assessments and that their use could not reasonably be expected in general psychiatry even now.

6.16 There was, however, an OASys (Offender Assessment System) assessment completed by the Probation Service on 15 December 2006 in connection with criminal proceedings, a complete copy of which was provided by the probation service in response to a request from the panel. Although not a mental health loaded tool, OASys is a nationally approved risk assessment tool for criminal cases widely used by agencies such as the Probation Service and the Parole Board. It is a comprehensive, detailed, and lengthy document. The OASys conducted in December 2006 indicated the risk of reconviction to be high, inevitable in the light of Mr SN's prolific criminal record and generally poor response to treatment and to other interventions. The risk of serious harm while in the community to the public, a known adult (in this case his mother), and to staff is assessed as medium as defined by the OAYS criteria i.e. '*there are identifiable indicators of risk of serious harm. The offender had the potential to cause serious harm, but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol abuse*'. Using OGRS (Offender Group Reconviction Scale), another nationally recognised assessment tool, Mr SN was said to pose a moderate risk of sexual/violent offending. These formal assessments appear to have been an accurate reflection of the risk posed by Mr SN immediately prior to the homicide. His risk was indeed increasing as a result of drug abuse, but this was not known to those responsible for his treatment.

6.17 As a medium risk offender, Mr SN was not registered with MAPPA (Multi Agency Public Protection Panel). He was managed by a single agency, the probation service, without the opportunity for multi-agency information sharing, which could have clarified the overall picture. His record was not sufficiently serious for him to be treated as a Prolific and Priority Offender and thus he was not subject to the rigorous multi-agency monitoring and mandatory drug testing of that regime.

6.18 The risk factors identified before the homicide included matters such as mental health problems, emotional well being, alcohol, thinking and behaviour,

lifestyle and associates, relationships and criminal attitudes. He had a history of breaching court orders. Mr SN had previous convictions for violence against the person: assaulting a constable in 1987 apparently in the course of being arrested for taking and driving away a motor vehicle, for which he received a community service order; ABH against his then girl friend in 1991; racially aggravated threatening behaviour, possession of an offensive weapon, and assaulting a constable-all directed at a black police officer in 2002 (when he was under the influence of alcohol as recorded by Dr PC); and harassment and battery of his mother in 2003.

6.19 In the post-sentence report dated 16 January 2009, Ms RF (current Offender Manager) addressed the issue of the risk of serious harm. '*Clearly the random and unprovoked nature of this offence gives considerable cause for concern in terms of his risk of serious harm. It is an escalation in terms of the seriousness but does not necessarily form a pattern as this offence unlike previous violent offences, which were instrumental violence against family members was perpetrated against a stranger*'. She identifies current risk factors as poor mental health associated with substance abuse, the use of instrumental violence and aggression, controlling behaviour. She also questions the extent to which Mr SN has taken full responsibility for the index offence and for his past offending history and suggests that '*it may be that he will be resistant to accepting full culpability.'*

6.20 When asked if Mr SN would have been classified as high risk before the homicide, Dr PC, an experienced forensic psychiatrist '*could see nothing that would have caused him to be so classified.'* Dr AT was of the same opinion.

6.21 Ms RF pointed out to the panel that '*statistically medium risk of harm offenders are the ones that tend to commit homicide'.* There are a number of reasons why this might be the case, not least the more rigorous monitoring of offenders assessed as high risk. The question, arises, therefore, whether it might reasonably have been identified that Mr SN was one of those medium risk offenders likely to commit homicide. From recent history, the most imminent risk to the public appeared to be from Mr SN taking vehicles and driving unlawfully, but from his past history of violence, which was not extensive, the risk factor to cause most concern was domestic violence, known to be an indicator of increased risk. The murder was a sudden escalation in the seriousness of his offending; it was different in both nature and degree from previous violence. Impulsive unprovoked attacks on strangers were not part of his previous pattern of violent behaviour which in the past had been domestic-towards a former partner and his mother, or towards the police in response to challenge or arrest, or a manifestation of anti-social behaviour by the use of racist language. Dr PC summarised the position succinctly '*He was a serial offender, but actually low grade in the grand scheme of people whom you might think might ultimately come to commit a homicide. His antisociality seems to be that; antisocial*.'

6.22 Taking Mr SN's history as a whole, on the basis that the best predictor of future behaviour is past behaviour, the most prominent risk factor that could be identified before the homicide was risk of serious harm to his mother or to someone with whom Mr SN was in a relationship. This was the risk factor of

greatest concern to the Inner City Team at that time, and the safety of Mrs VN was uppermost in the mind of Dr PS. On the morning of the homicide, while armed with the murder weapon, and before he left the house, Mr SN entered his mother's bedroom and threw back the bedclothes wanting to know '*where she was hiding the bodies?*'. In all probability it was only her vigorous protest that saved Mrs VN from serious harm. That Mr SN would then proceed to assault two strangers in the street without provocation, one of them fatally, was not a risk that could reasonably have been foreseen on the information available to those concerned with his care and supervision.

Risk assessment in general psychiatry

6.23 One of the features of this case is the contrasting approach to criminal convictions, and to risk assessment, by general psychiatrists and forensic psychiatrists. By definition the latter know that people referred to them have, or are suspected of having, committed offences, often of a serious nature. They are on notice to explore the offending history and to identify risk factors, both the risk of re-offending and the risk of serious harm, and there is now an extensive range of structured risk assessment to inform this process. This is not the principal focus in general psychiatry where the priorities are the health and safety of the patient, and the principal of the least restrictive option. The situation is complicated in the case of the protection of others especially when individuals have a criminal record which includes violence.

6.24 The extent to which those in community mental health services knew, or ought to have known, of Mr SN's previous convictions has already been discussed at paragraph 6.13 above but, to use Dr CV's expression, would it have '*sent their antennae twitching*' if they had known more? Did the fact that they sought no more information about previous convictions indicate acceptance that it was not usually provided or a failure to appreciate its potential significance? For instance, it was known by the multi-disciplinary team meeting on 6 October 2005 that Mr SN had been in prison for carrying an offensive weapon. They were on notice of at least one offence of violence yet, as the internal review team observed in their evidence to the panel, this was not picked up and it did not trigger a risk assessment. In the opinion of Dr CV, one of the lessons to be drawn from this case is the need for more reflective practice and for systems to flag up cases in which risk seems to be escalating, and in this the panel agrees with her.

6.25 That there may have been some lack of awareness to forensic issues is perhaps evident in the relatively few referrals from the Inner City team to forensic services, something which surprised Dr PC. He had set up consultant liaison clinics to facilitate speedy communication between general and forensic services in response to the widespread perception that formal referrals to forensic psychiatric assessment and risk assessment was difficult, time-consuming, and slow. They provided the opportunity to give initial guidance and advice, without the need for a formal referral, but the Inner City team did not make as much use of this service as the services in areas such as Bath and Wiltshire.

6.26 Nevertheless, when asked what advice he might have given at a liaison clinic had it been sought concerning Mr SN, he replied that on the facts as known

he would have advised the community team to continue treating him as they were doing. Both Dr PC and Dr AT were of the view that on the facts as known there was insufficient evidence to warrant admitting Mr SN to hospital.

The Application of ICPA

6.27 The thorough core assessment conducted by Dr LH and Mr SE on 4 October 2005 concluded that on the information then available to them, Mr SN did not meet the service entry criteria for ICPA and they ticked *'no'* in answer to that question. In the light of that finding it is confusing that on the following page of the assessment form one of the *'next steps'* was a referral to Dr RN as an out patient. She saw him regularly as an outpatient and the follow up letter from his attendance on 27 July 2006 for instance is headed 'Standard ICPA care plan-outpatient'. When asked about this apparent inconsistency, Dr RN suggested that either the result of the core assessment was incorrectly recorded, or that she had perhaps reached a different conclusion from Dr LH. The multi-disciplinary meeting on 6 October 2005 did not appear to notice the apparent discrepancy between referring the case to Dr RN and the conclusion that Mr SN did not meet the entry criteria. Nor do those minutes make clear that one of the reasons for the referral was to complete the assessment, and in due course after obtaining the old notes to undertake the risk assessment that Dr LH was unable to conduct. There is nothing to indicate that the process of risk assessment was ever completed. This was a serious omission by the Team.

6.28 As he was thereafter deemed to be on standard level, no CPN or other member of the CMHT was assigned, and Dr RN, a busy consultant, became the de facto care co-ordinator. It appears that at the time this was the default position for standard level patients who attended outpatients. In any event, to her credit, Dr RN accepted Mr SN on her list, though her caseload was already considerable. The panel was told that the reason for Mr TG's presence at the consultation on 23 November 2006 was to review Dr RN's caseload with the aim of reducing it.

6.29 In their evidence, Mr Philip Hendy's family strongly believed that Mr SN should have been on the enhanced level of ICPA. Dr GL took the view *'that there was sufficient there to say that this guy's needs were sufficiently complex, at the time when there was not a clear diagnostic formulation, for him to be subject to the enhanced CPA.*' In the opinion of the panel as the core assessment found that Mr SN did not meet the criteria for standard level, it would be highly inconsistent to think that he would have met the threshold for enhanced level on the context of the way in which ICPA was operated by this team at that time. As it was, although said not to fulfil the criteria for entry level to ICPA, he was treated as an outpatient by a consultant, having already had medical attention at a high level in the form of a senior registrar and a senior CPN, which is a curious paradox. There was clearly an element of confusion in the application of ICPA.

6.30 The involvement of a CPN might well have led to greater contact with family members, and thus to the disclosure of more information at an earlier stage about Mr SN's increasingly risky behaviour when under the influence of drugs. But it is equally possible that when the full extent of his drug misuse was discovered he would have been referred to specialist drug agencies with whom he

may or may not have co-operated, leading, quite possibly to his discharge from mental health services.

Clinical Audit and Clinical Supervision

6.31 Clinical audit is defined as the evaluation of clinical performance against standards or through comparative analysis, to inform the management of services[2]. In *Good Medical Practice*[3] the doctor is required (14c) to take part in regular and systematic audit and 14(e) to respond constructively to the outcome of audit. In regard to *Working in Teams* 14(d), a doctor is required to participate in regular reviews and audit of the standards and performance of the teams, taking steps to remedy any deficiencies.

6.32 Clinical audit is the process of setting standards, collecting data relevant to the standards, analysing the results, making suggestions for change and as part of the audit loop revisiting the data at a later stage to determine any changes. This requires a framework for regular sessions, presence of the relevant team, and time to carry out the process. Collection of data in itself is not clinical audit, which is a dynamic system aimed at improving delivery of care.

6.33 Dr SB, Associate Medical Director for Bristol from 1998, said in his evidence, '*The people who were working in the hospitals where the audits were being done ..... would be able to turn up and the others would be so bombed out in the community that you would not'.*

6.34 Ms MH in her evidence stated there was not at the relevant time or currently a formal clinical audit meeting, although data was collected for upward transmission. She did recall *'auditing*' notes with individuals to see if the standards were being adhered to.

6.35 Mr TG who was looking at Dr RN's caseload in November 2006 stated that this was not part of a clinical audit. Dr RN in her evidence said that data was collected but no systematic analysis took place within a team process as *'we do not have time*'. In his letter of 4 January 2010 Dr AT clarified Dr RN's involvement in audits of unexpected deaths and critical incidents as well as mentioning her *'audits*' of case loads in May and June of 2004, but it was unclear if this was part of a formal audit process, rather than a review of her workload.

6.36 Dr PS, who was appointed to the Inner City Team in Bristol in March 2007 told the panel that he never attended a clinical audit meeting though he did attend a team meeting. In his current post, in London, there are regular clinical audit meetings.

6.37 In summary, the clinical audit system at the relevant time was rudimentary or non-existent.

6.38 Dr AT, Medical Director of the Trust, in his letter of 4 January 2010, describes the current structure of the clinical audit programme. The panel did not

[2] Confidentiality: Protecting and providing information – G.M.C., April 2004
[3] Good medical practice – G.M.C., 13 November 2006

have the opportunity to question witnesses about the implementation and effectiveness of this structure.

Record keeping

6.39 When the panel received the clinical records, they were, to be blunt, in a chaotic state. The two volumes were incomplete, out of order and it appeared that two, and quite possibly, three sets of notes had been conflated. From the evidence of Dr PC, who reviewed the notes in May 2007, and the comments of the Root Cause analysis team who reported in September 2007, it appears that this was the condition in which they too had found them. Although it made examination of the notes time-consuming, it was highly instructive to see them in their original state.

6.40 Insofar as it is possible to judge, there appear to have been two sets of notes probably separated by a long gap when Mr SN was in prison. The position was further complicated by there being one set from the Inner City team, and another from the Bristol East team.

6.41 When Dr LH and Mr SE conducted the core assessment in October 2005, they did not have any records, which put them at a grave disadvantage. Had they done so, they would have been aware that of his history, and specifically the earlier diagnoses. They would also have been aware of the inconsistency in his claim that he had not used amphetamine for ten years. Dr RN could not recall having seen Dr SBZ's letter of May 2004 when she completed the DWP form in March 2006, or indeed if she had seen it at all, another factor that contributed to the perpetuation of an erroneous diagnosis. She had, however, seen Dr JT's report in October 2003 which she quoted in a letter to Mr SN's solicitors, see 4.28, in which there is mention of amphetamine, but she may not have remembered this over two years later. When Dr PS was asked to visit Mr SN as a matter of urgency in April 2007, he did not have the complete record, nor did he have time to scrutinise the substantial documentation that was available in any detail.

6.42 The chaotic state of the records clearly contributed to the difficulty in practitioners gaining a full and accurate history, especially to the shift of emphasis in diagnosis after 2004/5, with the consequent loss of focus on substance abuse. Mr SN's involvement with services was long, low level, and intermittent. A troubling feature is that at no time did anyone take control of the case and no-one was ever in a position to have an accurate overview. One of the principal reasons for this was the state of the records. Dr PC told the panel that it had taken him a week '*actually to go through them and draw them all together chronologically because they were when I first had them quite messy*.' As he rightly observed, general psychiatrists do not have the luxury of such time to examine the records.

6.43 The panel was told that the Trust is working towards a unified electronic case record, though it seems that access to the system is restricted. It is imperative that such a record is filed logically, is capable of being viewed and searched in its entirety, and that the current set should include all key documents. Hard-pressed, busy practitioners called urgently to respond to a crisis cannot reasonably be expected to sort through vast detail to obtain key information. As

Mr RE told the panel '*teams are very busy and they have to react very quickly and they have to respond quickly. It is about getting that information available in an accessible form for clinicians to be able to make sense of it and be able to use it meaningfully as well'.* There should be a regularly updated summary giving a brief history of the patient's involvement with psychiatric services and highlighting the principal risk factors easily available in urgent or emergency situations. If an electronic system is to be relied on, there must be proper back up when the system is down, as was the case when Mr SN was seen in the police station.

6.44 In response to the findings of an earlier Independent Inquiry, there is now a record of the meetings of multi-agency team meetings. These minutes include reference to a number of patients, but they were held separately from the clinical notes. This was a significant feature in this case as the minutes contain the only record of the reported phone call from Mrs VN in March 2007. The panel saw a number of sets of minutes when Mr SN's case was discussed. They are concise, indicate who was present, what was talked about, and what further action was necessary. They do not identify who was to take action, and there is no evidence of an audit trail or of any check to confirm that action had been taken; an example of this is described in paragraph 7.3 below. Ms MH, who was at the time the Team Manager of the Inner City Support & Recovery Team, was surprised to be informed of the reference to Mr SN in the minutes of 8 March 2007. She told the panel that any action points would be carried forward by the care co-ordinator unless specifically allocated to the team leader, but this is not clear from the minutes themselves.

6.45 Keeping track of Mr SN in his intermittent contact with mental health services over many years would have been difficult in any circumstances, but this case was complicated further by the fact that in the early part of 2004 while he remained in the care of the Inner City team, at or shortly after Dr RN was asked to prepare a report for eviction proceedings against Mr SN in the County Court, he was also seen by Dr SBZ of the Bristol East team. Dr SBZ's explanations for this were that he was running an "on demand" service so he was available at short notice, and that the boundaries between the two teams were not firmly fixed. There were ongoing discussions about which GP practices would be attached each team. He therefore felt it appropriate to see Mr SN when he was referred by Ms JP, the CPN.

6.46 Neither Dr SBZ nor Dr RN was aware of the involvement of the other, and between September and December 2004, when Dr SBZ attempted to arrange an appointment to follow up the consultation in May 2004, there was also an appointment request from Dr RN. Dr SBZ did not have access to the previous clinical notes when he saw Mr SN in May 2004, though the notes appear to have been transferred in their entirety to the Bristol East team later in the year. It took some time for the notes to return to the Inner City team following Mr SN's release from prison, and when they were returned, Dr RN had no memory of seeing Dr SBZ's notes and correspondence. Without knowledge of their mutual interest in the case, they were unable to share their knowledge and opinions. The overlap in Mr SN's care contributed to the disorganised state of the notes and the fragmented nature of the history.

Recommendations

6.47 Baseline drug screening should form part of the initial core ICPA assessment where the use of illicit drugs is reasonably suspected to contribute to a patient's mental disorder, whether or not the patient admits to using illicit substances.

6.48 Practitioners in general psychiatry should receive training to raise awareness of forensic issues and risk factors.

6.49 There should be a unified case record for every patient that is filed logically, is capable of being viewed and searched in its entirety, and is accessible to all who might reasonably require to refer to it. The current set of records should include all key documents. There should be a regularly updated summary giving a brief history of the patient's involvement with psychiatric services and highlighting the principal risk factors.

6.50 There should be a clear audit trail of the decisions and action points agreed at multi-disciplinary team meetings and of their implementation and outcome.

Chapter 7

Findings : Communication

Engaging with carers

7.1 Mrs VN, Mr SN's mother, has been supportive of her son throughout. She and her family have also been victims of his behaviour, and in her case in the past she was a direct victim of his offending on more than one occasion. She remains firmly of the view that Mr SN was mentally ill at the time of the homicide, and that if he had been sectioned, as she requested, the murder would not have happened. She took an active part in his dealings with mental health services, being present for instance when he was assessed by Dr SBZ in May 2004. In a telephone call in September 2004, she confirmed that Mr SN was taking his medication, and was reasonably well but putting on weight, and she appeared to welcome the intervention of mental health services.

7.2 Mrs VN was present for part of the examination on 4 October 2005. According to Dr LH, it was Mrs VN who first mentioned schizophrenia and talked about split personality. She made a significant contribution to the discussion and Dr LH quite rightly identified the need for Mrs VN to be seen separately from her son by Dr RN in outpatients. There is no record of such a meeting, and Mrs VN told the panel that she had never spoken to Dr RN.

7.3 Mrs VN witnessed at first hand the increasing use of amphetamine and Mr SN's increasingly erratic and bizarre behaviour towards the end of 2006, including paranoid delusions and angry outbursts. As far as can be established from the notes, the first time this was brought to the attention of mental health services was in a phone call from Mrs VN, referred to in a multi-disciplinary team meeting on 8 March 2007. The advice/plan column records *'to listen to mother when she calls. Mr JD to see him*'. It is not possible to trace what action was taken in direct response to this call. There was also an undated typed record of a phone call from Mrs VN some time later. Dr RN very fairly said that she had only a hazy memory of this second call but she did remember that Mrs VN was distressed. This note appears to have been misfiled at the time. Dr RN's secretary recalls that it was received on or before her letter to Mrs VN of 17 April 2007, in which she offered Mrs VN an appointment.

7.4 On 24 April 2007, Mrs GN, Mrs VN's daughter-in-law rang the Inner City team to ask for help. She was very concerned about Mr SN's behaviour since the previous weekend. She described him as paranoid, and bullying, threatening, and physically aggressive towards his mother. Although it was Mrs VN who was the nearest relative under the Mental Health Act, it appears that the team quite properly treated Mrs GN's call as if it had been made on behalf of her mother-in-law. They did not, however, interpret it as a request for a formal Mental Health Act assessment. Their response was to arrange an urgent home visit for later that day, of which Mrs GN was informed by telephone.

7.5 The panel did not have the benefit of hearing evidence from Mrs GN but it is clear from her letter of 11 June 2007 and from the evidence of Mrs VN, that they were both under the impression that the home visit was in fact for the purpose of an assessment under the Mental Health Act. The team took the view that the first step should be to respond urgently to the family's distress after which a decision could be made about a formal intervention. There is no direct account of how this misunderstanding occurred, but it was a failure of communication that contributed to the strong feelings of the family that they were let down by mental health services.

7.6 Mrs GN was not present at the home visit, the conduct and consequences of which are discussed below. The panel is satisfied that Dr PS and Mr JW did have the opportunity to talk to Mrs VN alone out of earshot of her son. They took careful note of what she said, because as Dr PS emphasised, '*the main issue that I have gone there for was to ensure his mother's safety'.* According to his account, supported by Mr JW, although anxious about his mental state, Mrs VN told them more than once that Mr SN was not a risk to her; '*she was not concerned about her own physical safety from him……she was ambivalent about whether she wanted him to leave the house or not.'* Mrs VN's account is rather different. She told the panel that the visit was very short, that she '*begged….please take him away*', and that '*he needs to be sectioned*'. She recalled being told '*we can't section him, he is not self-harming*'. The panel has no doubt that when she was giving evidence some two and a half years later Mrs VN was giving a truthful account of what she believed to have taken place, but on balance they consider that Dr PS and Mr JW gave a more accurate version of events. There were important differences in their versions of events, which would argue against any suggestion of collusion. Even more persuasive is that their evidence was consistent with the handwritten notes taken at, or shortly after, the visit.

7.7 It is not disputed that Mrs VN showed them a bag of white powder, which she rightly identified as illicit drugs. She also told Dr PS that she drove Mr SN to get his speed because he could not drive. The response to this was to advise her not to do that again. She was also advised to leave the house if she felt threatened, which was entirely proper advice. Dr PS formed the view that a carer's assessment was necessary, and this was an appropriate decision. It is concerning that there was no assessment of carer's needs post October 2005 as recommended in the ICPA core assessment, an omission for which the panel found no explanation.

7.8 It cannot be said that mental health services failed to listen to carers in this case, but the response to Mrs VN's two reported communications in March and April 2007 was not as prompt as it ought to have been. This delay did not materially affect the outcome; the timing of the eventual assessment was not the determining factor in its outcome. The fact that Mrs VN had asked not to be rung at home as she did not want her son to know about it may have presented some practical difficulties, but it was also another indication of her need for help. With so little background information, and no knowledge of those two contacts in particular, Dr PS was not in a position to challenge the inconsistency between Mrs VN's ambivalent attitude at the time of the visit and her earlier requests for help.

Close relatives often minimise the violence of loved ones, especially those with whom they live. The gist of the content of the call from Mrs GN was known to Dr PS, and some challenge to Mrs VN's account on the basis of that information would have been appropriate. It does not appear that there was any attempt to inform Mrs GN of the outcome of the home visit, which is unfortunate as in all probability she would have been less protective of Mr SN. Nor is there any evidence that Mrs VN was advised of her rights as nearest relative under the Mental Health Act 1983.

7.9 With regard to communication with carers, the panel's finding is at variance from the conclusion of the Trust's Root Cause Analysis at 10.1.6 that '*the reluctance of Mrs VN to disclose information because of Mr SN's threats made it difficult for the team to access a full collateral history*'.

7.10 The evidence we have received demonstrates that Mrs VN and Mrs GN made repeated attempts in March and April 2007 to communicate by telephone their increasing concerns regarding Mr SN's mental state and disturbed behaviour. That Mrs VN might be diffident about repeating that information in her home as the scene of that disturbed behaviour with him present or nearby was to be expected.

7.11 As to collateral history, the panel has seen little evidence other than in the earlier court reports that any systematic running record of Mr SN's personal and clinical history was compiled, against which to compare information from collateral sources. It would have been impossible in the time available for Dr PS to do so before the home visit on 24 April 2007. If he had so attempted, he would probably have been as hampered by the state of the clinical records as indeed were the Root Cause Analysis team, Dr PC, and this Investigation panel.

7.12 This case highlights the risks inherent in the extent to which practitioners in general psychiatry may rely primarily on self-disclosure from patients, especially when there is, for whatever reason, little other available information. This handicapped Dr LH and Mr SE in October 2005 and continued to be an impediment to decision-making by members of the CMHT through to April 2007.

Information sharing between services

7.13 Mr RE aptly summed up this aspect of the case '*everyone had pieces of information about Mr SN and it is about how they are brought together*'. The voluminous and disorganised clinical notes made a significant contribution to the difficulties in conveying information to practitioners, but the fact that different agencies did not share information was also a contributory factor.

7.14 Information, and most particularly the record of previous convictions is key to risk assessment and to alerting attention to risk factors. The core ICPA assessment in October 2005 was not informed by Mr SN's full record, and it seems that until the forensic assessments after arrest, the details of his criminal history were known only partially, if at all, by mental health services. Some practitioners knew about at least one violent offence, some knew about his use of drugs. Even when on notice that he had a record, as was evident from a referral

from prison, full details were not requested. Dr PC observed that in his experience a referral from a prison mental health Inreach team to a community team rarely comes with a record of previous convictions. It seems that they do not have access to those records within the prison. The requirements of confidentiality and of data protection quite rightly apply to those convicted of offences as to anyone else, but a proper balance must be struck to enable agencies in the criminal justice system to share information with community services. In the absence of such disclosure, those making future assessments in the community have no basis on which to gainsay what Mr SN or any other patient tells them.

7.15 The panel agrees with the opinion of Dr GL – '*I would recommend that on receipt of referrals from prison or probation service the receiving member of the team requests a full history of the patient's offence record from the referrer, and that a member of the team is allocated to the patient to liaise with the prison or probation service about the release date and timing of follow up'.*

7.16 The communication between the probation service and mental health services was sparse. Pre-sentence reports such as those in March and December 2004 and October 2006, indicate the need for psychiatric assessments. The only report provided for court in this period appears to have been obtained by the defence prior to the custodial sentence imposed in February 2005, as there is reference in an addendum pre sentence report to a psychiatric report by Dr RR, who it is said did not make a formal diagnosis. There is nothing to indicate that community mental health services were aware of this report, or that it had been requested. There was more extensive contact in the latter part of 2004, when the probation service was in touch with social services and the Inner City team at Brookland Hall but this required persistence from the probation service, and it came to an end when Mr SN was remanded in custody.

7.17 Practitioners in mental health services were not always aware of Mr SN's court appearances unless he chose to tell them. Ms RF told the panel that even when psychiatric assessments had been undertaken, they were not routinely supplied to the probation service, and that obtaining information was difficult e.g. the pre-sentence report in March 2004 refers to past psychiatric reports, to which the author did not have access. Although referral to mental health services was one of the features of his supervision on licence from September 2005, it did not appear that his supervising probation officer was invited to contribute to the ICPA assessment or at any time thereafter, even in the period when he was being supervised on licence. It seems that Mr SN reported the outcome of that assessment to his external probation officer.

7.18 Psychiatric services were at a similar disadvantage. Dr RN was not supplied with a copy of the pre-sentence report of October 2006, which contained information that would have been of value to her. It is not the practice for court reports to be shared with other agencies. As his current Offender Manager, Ms RF had to be persuasive to obtain copies of the three expert psychiatric reports prepared for the murder trial and it cannot be assumed that the probation service would receive such papers at a later date. In the case of a long term prisoner, this

would put a future offender manager at a serious disadvantage when preparing a risk management plan.

7.19 There was contact between services, as is reflected in the probation contact log, sources of information set out in pre-sentence reports, and in the accurate references to Mr SN's mental health in those reports, but in other respects there was little consistent communication. It was as if the two services were running on parallel lines that met fleetingly from time to time. The panel was encouraged to hear from Ms LMcM, the Chief Executive of the Trust, that liaison with the prison service had increased as the Trust now has contracts to provide Inreach services in some prison establishments.

7.20 The observations made by the panel about information sharing are not intended to convey criticism of any individual, or of any of the services, but rather to draw attention to the constraints imposed by current accepted practice. It is tempting for agencies to rely on MAPPA procedures alone as the means to exchange information and intelligence, but this case illustrates the need for better communication in those cases where risk is deemed not to be high enough to trigger the involvement of formal multi-agency working.

Support for bereaved families

7.21 After the homicide, on 30 April 2009, Dr RN wrote to Mrs VN to express her sympathy and regret about what had happened, and to offer to her the opportunity to meet her or another colleague. This was an appropriate, sensitive and professional response to what had happened. One of the aspects of the situation that caused Mr Philip Hendy's family offence was the lack of any similar communication with them. The panel received conflicting evidence on this point. One witness suggested that any such contact would be difficult because it would necessarily breach the requirements of confidentiality by disclosing that the perpetrator of an offence had been receiving treatment from mental health services. Dr CV told the panel that she believed there was provision for the Chairman of the Trust to write a letter of condolence in such circumstances, though it was not formal Trust policy. Ms LS, Director of Operations for the Trust, was of the view that such contact was a matter of courtesy. There is a serious lacuna in the AWP Serious Adverse Incident Policy and Procedure (dated 24 February 2006) with no reference to the victim's family in Section 9- Communication, and only an oblique reference to '*appropriate others*' in Section 10.4. There appears to be no reason to prevent the sending of a suitably worded letter, though it is recognised that there will be difficulties to surmount where the victim has no connection with the patient/offender. This omission appeared both insensitive and discourteous on the part of the NHS and it has understandably caused Mr Philip Hendy's family considerable and enduring distress.

7.22 Mr JH described how he had to instigate contact with the Trust (he understandably took particular exception to being asked how he knew that Mr SN had been a patient). Ms LH, as Head of Risk and Compliance, outlined how contact was eventually established with the family, notably by Dr SO'C, the then Medical Director of the Trust, in order to offer explanation and support in their bereavement. Not surprisingly, they rejected this offer from the service that they

held responsible Mr Philip Hendy's death. The family have relied on each other, and his three sons have had to cope with their bereavement in different ways and without independent support.

7.23 It should be anticipated that bereaved relatives will not wish to accept support, whether in the form of bereavement counselling or other means, from the service involved in the care and treatment of the perpetrator of homicide. But this does not absolve the Trust concerned, or the NHS as a whole, from providing help in a more appropriate manner. This is a subject that appears to have attracted little attention. Even the comprehensive report '*Redefining Justice'*[4] makes little reference to the adult relatives of victims of stranger homicide. There should be a system whereby a Trust from another area in a different part of the country would step in on a reciprocal basis, or alternatively a consortium could be established to offer bereavement counselling, preferably through an external provider under contract. This would put a suitable distance between the victims and the Trust concerned and it would make it easier for victims to receive the support they might need in a manner that they would find acceptable.

Recommendations

7.24 Communication with carers should be prompt and clear. Action to be taken in response to a referral by carers should be confirmed in writing as soon as possible.

7.25 On receipt of referrals from prison or probation service the receiving member of the team should request a full history of the patient's offence record from the referrer, and a member of the team should be allocated to the patient to liaise with the prison or probation service about the release date and timing of follow up.

7.26 NHS Trusts, the Probation Service, and the Court Service should review the protocols concerning the sharing of information and in particular pre-sentence reports and psychiatric reports in the case of patients who are receiving treatment at a time when they are before the court, and/or under supervision on licence.

7.27 AWP should amend its Serious Incident Policy and other procedures so that a letter of condolence is written as soon as possible to the bereaved family of the victim of a homicide perpetrated by a patient.

7.28 In partnership with other Trusts, APW should establish the means of providing appropriate and acceptable bereavement counselling and support for bereaved families following a homicide perpetrated by a patient.

4 Redefining justice: Addressing the individual needs of victims and witnesses – HMSO 2009

Chapter 8

Was this homicide avoidable?

8.1 Mr Philip Hendy died because Mr SN was at liberty in the community on 29 April 2007 in a state of acute amphetamine psychosis. Were any opportunities missed either to deprive Mr SN of his liberty or to identify and treat his substance misuse effectively?

Dr SBZ's Assessment in May 2004

8.2 The occasion on which mental health services came closest to observing the cause and effect between Mr SN's mental state and his use of amphetamine was in May 2004. At that time Dr SBZ noted significant psychosis, and he was able to establish recent use of amphetamine from information obtained from Mrs VN, and from Mr SN's admissions, albeit he claimed to have stopped a week earlier. Dr SBZ could not be certain of nature of the psychosis and his priority was treatment, whatever the cause, but he thought it worthy of further exploration. This opportunity was lost because Mr SN was in prison from June 2004-August 2004, and from November 2004-September 2005. He did not keep the appointments made when he as at liberty during 2004, and his swift return to custody frustrated any attempts to follow him up.

Re-engagement with mental health services following release from HMP Guys Marsh in 2005

8.3 When Mr SN was released from prison in September 2005 and referred to mental health services, he was treated in effect as a new patient. Dr LH and Mr SE conducted a thorough core assessment in accordance with ICPA. They did not know of Mr SN's extensive past involvement with mental health services. They did not know the details of the last contact with Dr SBZ. They did not know of Mr SN's history of substance misuse. They had only the briefest of details about his previous offending. They did not conduct a risk assessment for the very good reason that the old notes were not available. Dr LH identified the appropriate action to be taken and this was minuted at the meeting of the multi-agency team on 6 October 2005. Dr LH acted entirely properly.

Absence of psychiatric report for court in late 2006/early 2007

8.4 Mr SN's last conviction before the homicide was for driving without due care and attention, taking a vehicle without consent and using a vehicle without insurance, after he had used his mother's car. The pre-sentence report recommended that a psychiatric report be prepared or that a conditional discharge be imposed in the light of his mental health problems. Although the case was adjourned on at least two occasions for a psychiatric report, after extensive examination of the evidence, including the probation logs and clinical notes, the panel found no trace of any such report or of any request having been made to Dr RN, and concluded that no such assessment was ever prepared.

8.5 The sentence eventually imposed on 29 January 2007, a conditional discharge for one year, would not have required such a report, and it is probable that the court concluded it was unnecessary for the purpose of sentencing, which would have been the its only proper concern. The thinking behind the sentence imposed cannot now be established but it is likely that the court was informed that Mr SN was already known to mental heath services and that they deemed this to be sufficient. Mindful of his presentation at the appointment with Dr RN on 23 November 2006, it is unlikely that a psychiatric report for the court would have made much difference to the outcome.

8.6 It is of particular interest that just as he appeared relatively well to Dr RN in November 2006, in the few entries in the probation log dealing with the court appearances in November and December 2006 there is nothing to indicate that Mr SN was showing signs of the increasingly bizarre behaviour observed by family members at that time. Nor is there any indication of such symptoms in the GP records of this period.

Appointments/Missed appointments Feb 2006-April 2007

8.7 The last appointment Mr SN attended with Dr RN was on 23 November 2006. The next appointment was arranged for 22 March 2007. He did not keep that appointment. He did keep appointments with his GP on 21 December 2006, 25 January 2007, and 2 March 2007 at which his mental health was reviewed, medication renewed and advice given concerning his gain in weight. There was no discussion about amphetamine and nothing to arouse concern. Mr SN admitted to missing three doses of olanzepine. All this was entirely typical of his engagement with mental health services over many years. It was also typical for him to miss the appointment on 22 March 2007. This was nothing new. Mr SN had drifted in an out of contact with the services, returning when his symptoms were particularly distressing, or in connection with court proceedings, throughout. His absence from one appointment was not pursued, nor was it a requirement to do so; Trust policy was to follow up after two missed appointments. Mr SN cannot be characterised as one of those patients who slipped out of the net and was lost from the services; he always came back. As indeed he did on this occasion, when he attended his GP on 13 April 2007. He was offered an outpatient appointment for 3 May 2007, which had added point after the home visit by Dr PS on 24 April 2007. The fact that Mr SN missed the appointment on 22 March 2007 and that it was not followed up immediately is not something for which the services can be criticised, and it did not materially affect the outcome of this case.

Appointment with GP 13 April 2007

8.8 As described in the preceding paragraph, Mr SN attended four appointments in the period from November 2006-April 2007 when his increased use of amphetamine and troubling behaviour was apparent at home. There was nothing in his presentation at those appointments to suggest that his mental state was deteriorating to the extent noted by his family. On 13 April 2007, GP, Dr WK noted that Mr SN was more withdrawn, tense and that he admitted hearing more voices. He saw no indications of the effects of amphetamine, and Mr SN's use of illicit drugs was not discussed, there being apparently no reason to do so. Mr SN

declined CPN input but was granted his request for an increase in Olanzepine. While Dr WK was on leave, a colleague wrote to Dr RN on 24 April 2007, to advise her of his recent consultation. It appears that this letter crossed with Dr RN's letter of 23 April 2007 notifying his GP of the missed appointment on 22 March 2007, the concerns expressed by Mrs VN, and the date of his next appointment as an outpatient. The panel considers that Dr WK dealt with the issues arising from the appointment on 13 April appropriately.

Dr PS's assessment 24 April 2007

8.9 Dr PS was asked to undertake the home visit on 24 April 2007 in response to Mrs GN's phone call earlier that day. It was deemed to be an urgent matter and as both Dr RN and Mr SE had commitments to see other patients that afternoon, the task fell to Dr PS. Although relatively new to Bristol, having worked there for about a month, it would be incorrect to say that he was too inexperienced for this task. He was an approved practitioner under section 12 Mental Health Act 1983, and he had undertaken two three-year periods of specialist psychiatric training, one in India and one in Yorkshire. Mr JW, who accompanied him, was on only the second day of employment by the Trust, but he was an experienced care worker in the field of mental health with good local knowledge. They were both competent to undertake what was asked of them. There is nothing to suggest that they missed anything or that more experienced practitioners would have detected more information, though in view of the behaviour described by Mrs GN it would have been preferable for Dr PS to have been accompanied by an approved mental health professional (AMHP) i.e. an expert in the field of mental disorder. As it was Dr PS was left with the sole responsibility of assessing the nature and degree of any mental disorder. If an AMHP had been involved it is also likely that communication with the family after the visit would have been crisper and more informative, as liaising with the nearest relative is one of the duties within their area of expertise.

8.10 Dr PS and Mr JW received a short briefing in haste from which they understood that the concern was for Mrs VN's safety, and that Mr SN was said to be getting paranoid and using drugs. Dr PS had seen the large bundle of notes but did not go through them in any detail. He did glean that Mr SN missed appointments, did not always comply with medication, and '*he does not want to do anything*'.

8.11 The accounts of Dr PS and Mr JW differ in the order of events at the home. They are consistent in describing the whole visit as lasting 45 minutes to an hour, and, of great importance, that they were able to speak to Mrs VN alone out of earshot of her son. She had every opportunity to tell them of her fears, had she chosen to do so. The disparity between her account of that interview and theirs is discussed at paragraph 7.6 above, as are the panel's reasons for preferring the evidence of Dr PS and Mr JW on this point. They were quite clear that she was ambivalent, that she told them that she did not feel threatened by Mr SN, and that he had never been physically violent towards her.

8.12 They saw Mr SN in his bedroom. He was lying on his bed and uninterested. Dr PS's principal observation was of negative symptoms-lack of

interest and social withdrawal. He looked into Mr SN's eyes. He saw no indication of amphetamine intoxication. Mr SN denied hearing voices and denied using amphetamines even when challenged by his mother to tell the truth. There were no signs of florid psychosis. '*He did not speak much, but he was able to tell us that he just wants to be left alone'*, but he did not object to the suggestion of a further appointment either in outpatients or at home.

8.13 Dr PS conducted as thorough a mental health assessment as was reasonable in the circumstances. He concluded that there was no evidence to support formal MHA assessment, or to justify admission to hospital either voluntary or compulsory. The panel agrees. On the evidence available to him Dr PS could not reasonably have concluded that Mr SN was suffering from a mental disorder of a nature or degree that required detention for assessment or treatment. He did not elicit symptoms of a mental disorder, other than possible negative symptoms. There was no indication of the consumption of amphetamine, no evidence of florid psychosis, and no evidence of hearing voices. Dr PS did not know Mr SN's history. Even if he had been aware of the past and present diagnoses it is unlikely that he would have concluded that the mental disorder was of a nature to warrant detention. Mr SN had never been sectioned or admitted as inpatient. It must also be noted that he was not deemed to meet the criteria to be sectioned when he was assessed some ten hours after arrest, or after lengthy assessment in a forensic unit thereafter, or at the time of sentence. On all those occasions he was ostensibly exhibiting more obvious signs of mental disorder than at the time of the home visit. There was little if any reliable evidence of risk to his own health and safety, or, in the light of the conversation with Mrs VN, that detention was need for the protection of other people.

8.14 On his return, Dr PS discussed the visit with the team manager, Ms MH, and they decided that it was not necessary to conduct a formal Mental Health Act assessment. They referred the case to the multi-disciplinary meeting on 26 April 2007 with a view to putting a treatment plan in place before referring the matter back to Mr SN's GP, following the principle of the least restrictive option. The panel considers that this was an appropriate outcome on the evidence that was available at the time.

8.15 In his evidence Dr GL told the panel that he thought there were enough indications at least to trigger formal assessment under the Mental Health Act, though he recognised that it was by no means certain that the outcome would have been that Mr SN would have been detained in hospital. He remarked in particular on the dissonance between what Dr PS might have expected to see from the information that he knew, and what was actually before him. In the opinion of the panel, Dr PS was aware of this dissonance and he challenged and tested what he was told as far as he thought was reasonable. As noted in paragraph 7.8 above, he might have been more challenging to Mrs VN but it is hard to see that she would have changed her stance.

8.16 Another possible concern about the home visit was the apparent failure to challenge Mr SN and his mother based on collateral information, but Dr PS had very little such information available to him. This is a cause for grave concern, in one area in particular. The reason for the home visit, and for its urgency, was

concern for the safety of Mrs VN. In other circumstances, the fact that Dr PS did not know of Mr SN's previous convictions for domestic violence, including battery of Mrs VN, and the increase in risk that this indicated, might have had very serious consequences indeed.

8.17 Although Mr SN maintained his denial of using amphetamine, Dr PS proceeded on the basis that he had been using recently. He had the evidence of Mrs VN and of the bag of white powder, and he based his proposed further action on that knowledge. There was no need to undertake drug testing on that occasion; the use of drugs was assumed. As there was no immediate and grave risk to the safety of Mr SN or other people, it would have been a breach of his professional duty to disclose information about the possession and use of drugs to the police.

8.18 It has been suggested that Dr PS was too ready to comply with the patient's wishes in this case, and that in some way it was a manifestation of "patient led" assessment. If this had been the case it would have been highly inappropriate. In fact, it is a misrepresentation of what took place. Dr PS conducted his own examination and assessment. There was no choice for the patient other than whether or not the next appointment would be in outpatients or at home. He was not given the choice about being detained, as this was not proposed.

8.19 The panel considers that Dr PS acted properly. There was insufficient evidence to warrant a formal Mental Health Act assessment. The action he proposed, namely outpatient appointment and review of carer's needs, was proportionate and appropriate to the risk as he perceived it after proper enquiry, as was his advice to Mrs VN on what to do if the situation deteriorated. The panel's conclusion on this point was confirmed by Mr JM, an experienced social worker and AMHP, from whom they sought expert advice.

Encounter with Police Community Support Officers on 28 April 2007

8.20 The last engagement between Mr SN and the statutory services before the homicide, and the only opportunity to witness his psychotic symptoms at first hand, was on 28 April, the day before the homicide, when two Police Community Support Officers (PCSOs) encountered him in the street. The panel saw the statements of evidence used at trial, but it was unable to obtain further written evidence or to question them in person; they have now left the force. Nor was the panel able to obtain the information it sought with regard to the training of PCSOs, and in particular the training given about awareness of mental health issues, and the protocols and procedures to be used in such cases.

8.21 Under section 136 Mental Health Act 1983, '*if a constable finds in a place to which the public have access a person who appears to him to be suffering from a mental disorder and to be in immediate need of care and control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety*'. PCSOs are not police constables and they cannot exercise this power. The panel enquired of the Avon & Somerset Constabulary what procedures were in place for PCSOs to

follow in a s136 situation, to which the reply was that there are no specific procedures, although there is a procedure to call for a police unit to attend which covers all situations where PCSOs do not have the necessary powers. As PCSOs do not have any powers under the Mental Health Act, their five-week training programme does not include dealing with people who are mentally unwell. We note with interest that this matter was referred to in an address to the Police Federation conference in May 2010. [5]

8.22 Mr SN was well known to the local police, who called him by his first name, but he was not known by these officers. They describe as him as '*very serious and stern faced…..a very strange and odd man who looked rather angry as his eyes were fixed to one point throughout the entire conversation'.* Mr SN's reported conversation revealed evidence of delusions - that his daughter was missing, that she was a clone, and that there was a shallow grave under his mother's car. The response of the officers, in their own words was revealing; *'I thought we had better seemingly take his words seriously…..I did not want to upset him by dismissing it, due to it being an apparent fabrication of someone with an overactive imagination. I thought that SN might be pulling our legs as a lot of people like to do……We decided that it might be best just to listen to Mr SN and not challenge him so to avoid upsetting him'.* It is recorded that the officers '*briefly discussed this bizarre encounter as we resumed our patrol of the area'.* The content of that conversation is not known, but they clearly did not treat the incident as serious, and it appears that they did not log the incident or think it necessary to seek advice about how to deal with it.

8.23 From the perspective of a forensic psychiatrist, Dr PC told the panel that in his view such bizarre behaviour '*should have triggered a further forensic medical examiner assessment. Whether that would have influenced or changed things in any way, shape or form, I don't know, but I think that could have easily altered the pattern of events, is the answer.'*

8.24 It is possible that these officers were insufficiently alert to signs of mental disorder, or that they were unsure or uneasy how to handle such a situation, but it is more likely that they did not attach too much importance to the incident because it was not, in fact, particularly serious. Even inexperienced officers working in that area at night would see a high incidence of people under the influence of alcohol and illicit drugs, and this encounter would have been at the less serious end of the spectrum of such events. Mr SN was exhibiting and articulating delusions but he was not violent or aggressive, and he was not presenting as a risk to himself or to other people. Of greater significance is that his mother intervened, as she confirmed. She came out of the house to ask him why he was talking such *'rubbish*'. He was biddable and went back home with her, i.e. to a place of safety, without any argument. Mrs VN's conversation with the officers was good-humoured and there was no indication that she was seriously concerned or fearful; she did not ask for their help. On the evidence available, the panel considers that the officers acted understandably in all the circumstances.

5 P. Fahy, Chief Constable, Greater Manchester Police – Police Federation 2010

8.25 In 2004-2008, Central Bristol accounted for 33% of referrals under section 136 in the city.[6] In the city as a whole in those years 31.80% resulted in no further action, which suggests the overall the power was used appropriately. 2007 marked the high point for referrals in those four years, which does not indicate reluctance on the part of the police to use their powers. The tone of the notes made by the PCSOs in this case does, however, suggest the need for some training in mental health issues. The panel was interested to hear from Dr AT that in the past year two consultants had been appointed in Bristol, with a similar post in Wiltshire, who devote part of their time to constabulary liaison including the whole issue of section 136 and its application. He did not know if the role of PCSOs had been part of their discussions, but in the opinion of the panel it might usefully be discussed in the future.

Recommendations

8.26 Police Community Support Officers should be given additional training in how to identify and respond to people with mental disorder.

8.27 There should be clear guidance to Police Community Support Officers on the procedure to be followed if an arrest under section 136 Mental Health Act 1983 is indicated.

6 Approved Social Work Services Report on Integrated ASW Service responses to referrals in Bristol during 2008. Andy Preston, Senior Practitioner in Mental Health Services. NHS Avon and Western Wiltshire Mental Health Services. February 2009

Chapter 9

Organisational Issues in Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Introduction

9.1 The panel heard from several witnesses of different disciplines about the effect of organisational change on the health and welfare of patients and staff since the time of Mr SN's case and subsequently. Some of these observations were unsolicited, many were deeply felt. The panel has been careful to be objective in its consideration of these issues, and it is expressing its own opinions on matters arising from this investigation. Nothing that follows should be interpreted as the panel favouring any particular view within the Trust, where it appears that strong disagreements remain.

9.2 It is clear that for much of the latter part of Mr SN's engagement with AWP it was an organisation in transition. This process continues. Dr AT, the medical director of the Trust, told the panel that '*we are in the midst, as we seem to have been for at least two years, of major redesign of the services'.* AWP itself was formed in 2001, not without opposition from those who questioned its size and scope. From its inception it seems that the Trust has been beset by internal disagreement on matters of policy and practice, with resistance on the part of some operational staff to many of the changes introduced by managers. It has already been noted that organisational issues affected this case as in overlap between the Bristol East and the Inner City teams in 2004 with the ensuing confusion about Mr SN's clinical notes, see 6.39 – 6.46.

CPA (Care Programme Approach)

9.3 The Care Programme Approach was introduced nationally in 1991 by the Department of Health as a model for the delivery of treatment and care for all users of mental health services. In 2000 it combined with Care Management, the model operated by Social Services, to form an integrated assessment and delivery process[7]. In the Trust's area the term Integrated Care Programme Approach (ICPA) was adopted in 2001, when comprehensive policies, procedures and guidance were issued.

9.4 The documentation defines the 'Purpose of Policy' as:- '*To describe the Trust ICPA framework including the assessment and management of risk, and to ensure it is used effectively to identify needs and eligible* needs *in order to safely manage, record, communicate, and deliver care and treatment to service users with mental illness that meets all eligible needs.*

7 Effective care co-ordination in mental health services: modernising the Care Programme Approach. Department of Health (1999)

To direct staff in the use of ICPA and the assessment and management of risk, of the standards required, and of their responsibilities in implementation of this policy, procedures and guidance'. Relevant Staff are defined in the following terms:- *'As the overarching framework within the Trust for the delivery of care and treatment for service users with mental illness, this policy and procedure applies to any member of staff involved in or supporting the delivery of care and treatment for service users with mental illness.*'

9.5 As has already been noted in paragraph 6.27 – 6.30 there appeared to be a lack of clarity about the application of the ICPA policy within the Trust. Some witnesses described it as a paper exercise that contributed to a poor service, and adversely affected the role of the consultant. Ms LS, Director of Operations, had some interesting observations about the implementation of the CPA locally when she was appointed. She described it as '*a cumbersome, non-operational approach'* with some limiting factors, such as restrictions on the caseloads of non-medical staff which resulted in '*the residue falling into the lap of the consultant'.*

9.6 Mr SN was among those patients who became part of the outpatient clinic caseload of a busy consultant psychiatrist, having been deemed not to meet the entry criteria for ICPA, see 6.28, though if the policy had been applied consistently it is highly likely that he would have been discharged back to the care of his GP. Ms MH told the panel that under the current system a patient would not now be supported as was Mr SN by outpatient appointments with a consultant psychiatrist, not least because the caseload that this generated, together with the demand for urgent medical assessments and acute cases, was unsustainable. The panel heard from more than one witness that the volume and nature of the caseload in the Inner City team in Bristol was more acute, intense, and pressured than in Central London. Problems such as racism, poverty, substance misuse, criminality, and an itinerant population contributed to the difficulties, and tha clinical issues were not helped by stresses and strains within the management of the team, some of them historic. The attrition rate amongst consultants in the team remains a matter of deep concern; the panel heard of at least three experienced and able psychiatrists who left the team because of the adverse effects on their health and/or in anticipation of such an outcome.

The functional model

9.7 In 2006 AWP reconfigured its service by the introduction of the functional model, which one witness defined as '*where you just do one job at a time and you try to do it really well'.* A consequence of this has been the demise of generic mental health teams and the creation of different teams for in-patients and for out-patients, the latter being further sub-divided. These include a crisis team, an assertive outreach team, a home treatment team, and a support and recovery team. It is likely that patients will be treated by more than one team during their engagement with mental health services, depending on their situation and the level of their need. While this has some advantages in terms of specialisation, more than one witness expressed concern at care being delivered on a task by task, or compartmentalised, basis. As this system develops, the episodic nature of the treatment and engagement with the services that must surely follow can only increase the risk of what Dr PC described as '*information loss*", something

which created such difficulty in the diagnosis and treatment of Mr SN, see 6.39-6.46. This makes it even more vital that records are accurate, comprehensive, and accessible, and that there is a well established practice of case review at each and every engagement with a patient. There are also serious implications for risk assessment, which depends on knowledge of the patient and information about his or her history. One of the underlying principals of NOMS (National Offender Management Service) is the desire to provide continuity of supervision to offenders in order to improve risk management. This principle should surely apply equally in mental health.

9.8 Where the consultant sits in this model and finding the appropriate level and degree of engagement is a key factor in meeting the needs of patients, and in protecting the public. The extent to which Dr RN and her colleagues were overloaded was unacceptable. They were described to the panel as exhausted. The evidence shows that they had little if any time for reflective practice. The panel was told that the consultant case load as an ICPA care co-ordinator in the Inner City team had reduced from a hundred or more in 2006 to an average of ten by July 2009. It is argued that the time and expertise of a consultant can best be used not by being the point of continuity, and linking with external agencies including the patient's family, but in supporting teams generally, supporting teams in the management of risk, developing clinical formulations, and understanding diagnosis as well as other roles according to demand. This may well be the case, and something had to be done to relieve the consultant workload, but it was also argued that the process of assessment and clinical diagnosis need not be undertaken by a consultant and that it could properly be done by a range of professionals in the team. Dr RN told us that every case that is assessed is discussed by the psychiatrist who would be the one to make the diagnosis, but when asked if that might be at second hand i.e. without seeing the patient, she agreed that this might well be the case; though it was not so in the case of Mr SN whom she saw at first hand.

9.9 The panel was prompted to ponder what role is left for the doctor. It was, therefore, instructive to hear the response of Dr AT, the medical director of the Trust. '*The model that I very much want to promote and that I think we will get to is ensuring that consultant psychiatrists are very much more at the front end, if I can put it that way of a patient's care pathway to do what they are specifically trained to do, which is, with sufficient time, make diagnostic formulations of the case, and they are the ones, in my view, with unique skills around that and, with those kind of higher order skills, I am actively trying to establish a position where consultants do not carry huge caseloads in follow up in outpatients as some kind of notional default for the rest of the team, but their skills are right at the start of a very thorough assessment of mental health needs and clinical risk as the first thing we do when any individual presents to us. And then use their other skills later in the care pathway in support of teams but as free agents really so they can be consulted by teams in order to provide something of added value for the whole of the team's functions*'.

9.10 Another witness identified the need for the service to be more responsive to information about change or deterioration in a patient and thus '*to clear more head space for the consultants and the senior people so that when the phone call*

comes in you have a system whereby the people with the power to execute things …have their thinking caps on to be able to respond to that change'.

9.11 The panel would simply observe that at whatever stage consultants become involved in a case, and however their skills are best used, the validity of a diagnosis, risk assessment or any other action depends on the quality of information available to them, as demonstrated by the substance of this investigation. Clearly these would require more than the half hour appointment referred to in 4.45 above, particularly for any consultant at their first direct contact with a patient.

The recovery model

9.12 The Trust's most recent review of ICPA was completed in 2009.[8] This followed new national NHS guidance. The new AWP policy is intended to '*implement this national guidance and to ensure that there is a new emphasis on maximising recovery and/or well being for service users, by putting service users and carers at the centre of the design and planning to maximise individualised and effective care and support, and to promote independence'.* The previous Enhanced and Standard level ICPA care plans are discontinued, to be replaced by *'two new types of care pathways - Care Programme Approach (CPA) and Standard Care (Non CPA)'.*

9.13 The need to use resources sensibly will require that many patients, where it is appropriate, will be treated in the short term by specialist services before being discharged to primary care. The emphasis in secondary care now appears to be in '*actively engaging with people*' as one witness put it. It is assumed that during periods of recovery, patients will be discharged to their GP or the voluntary sector. The emphasis is on recovery, and there is a new leaflet for service users giving guidance on '*preparing for your personal recovery plan meeting'.* The concept of the recovery model is something with which the panel struggles. What does it mean for the patient? Can it be safely assumed that all patients will recover? Some patients with mental disorder might reasonably receive treatment from community mental health services for a short period before being discharged back to primary care. Others, who have an enduring mental illness, as Dr RN believed to be the case with Mr SN, might reasonably expect to continue in the care of specialist psychiatric services where their mental state and treatment could be monitored by a consultant as an outpatient. It is common for secondary services to treat people with certain physical illnesses in the long term, and there is no obvious reason why the needs of patients with mental illness should be treated differently. It is at least arguable that long-term, low-key intervention has a place in the treatment of some patients, especially if they derive therapeutic benefits.

9.14 There can be no doubt that the patient is at the centre of the new policy. One of the principal concerns of Mr JH was that the needs of the service user had become too central, with practitioners too inclined to take what a patient said at face value. Dr AT acknowledged that this area was '*one of the most challenging*

8 Integrated Care Programme Approach (ICPA) and the Assessment and Management of Risk, Policy, Procedures and Guidance, AWP, (March 2009)
Refocusing the Care Programme Approach; policy and positive practice guidance. Dept of Health (2008)

areas of modern psychiatric practice.' The panel endorses his response, namely the need to balance the needs and wishes of service users and to formulate care plans that focus on their expectations with the responsibility to the wider community. The panel was troubled by some of the views expressed to the effect that the emphasis now tends too much towards working with the difficulties of service users to improve their functioning, rather than on reaching a diagnosis and giving treatment accordingly. Dr GL commented on the dislike of the concept of diagnosis by patient pressure groups, which can compromise diagnostic formulation phraseology. The panel shares his concern and very firmly believes that differential diagnosis is the basis for treatment and case management, but while he detected signs of the contrary philosophy in the failure to reach a diagnosis in Mr SN's case, the panel do not think it accounts for Dr RN's omission, which owed much more to misunderstanding, incomplete records and the pressure of time and workload, see 6.2-6.4, 6.41-6.42.

Resources

9.15 It was suggested to the panel that one of the consequences of change in the organisation and culture of AWP was interference by managers in the clinical decisions that should properly be made by doctors, and that for instance, whether or not a patient was admitted could be governed by the availability of beds rather than medical need. The panel saw no evidence of this and, while it may have played a part in other cases, it does not appear to have influenced any part of Mr SN's treatment. In fact there was a significant increase in the number of patients in Bristol detained under section 2 Mental Health Act 1983 from 2006 to 2007; from 188 to 258 in total; and from 73 to 86 in the central area.[9] The panel did, however, observe that health as a criterion for detention appears to have been a lower priority than safety and protection of others, with the objective being to treat people in the community consistent with the principals of ICPA. This causes confusion to relatives who feel that their loved ones need to be assessed in hospital, and it does not take account of the fact that the acute mental disturbance is itself a major component of the other two criteria. Nevertheless, in April 2007, Dr PS was unable to elicit any florid symptoms that would have indicated deterioration in Mr SN's mental health similar to those described by Dr SBZ in 2004.

Risk assessment

9.16 The current ICPA policy contains comprehensive procedures for the assessment and management of risk. With reference to the practice of risk assessment the panel formed a clear impression of the demands on the Inner City Team, notably patients with a high level of need, multiple pathology in individuals and families, high levels of dual diagnosis, and a significant proportion of high risk patients. As one medical witness put it '*Bristol is probably the worst in terms of patients that we have. Probably the worst I have worked in. Every patient that you saw you went back and thought what to do; there is so much risk here*'. Mr SN with all his history was said not to meet the criteria for a Mental Health Act

9 Approved Social Work Services report on Integrated ASW Service responses to referrals in Bristol during 2008. Andy Preston, Senior Practitioner in mental Health Services. Avon and Western Wiltshire Mental Health Services. (February 2009)

Assessment. The panel was told that in other more rural parts of the Trust area someone presenting as Mr SN did would have been on Enhanced CPA. This raises important questions. Is there a post-code lottery with regard to risk, in which practitioners are de-sensitised because of the generally higher threshold of risk with which they are dealing? Is risk assessment influenced by the need to allocate local resources to even more serious cases? The panel has already addressed risk assessment with regard to Mr SN above, see 6.12 - 6.22. In general, the panel was reassured by the response of those managers from whom it heard. The Trust's Chief Executive, Ms LMcM asserted that '*I would hope and expect that clinical assessment was made on the basis of clinical risk and not on the basis of resources*'. Other witnesses expressed the desire to offer the highest quality of service throughout the wide and diverse area served by the Trust, but the panel has lingering concerns lest the perception of risk becomes relative depending on geography. Vigilance is required to ensure the consistent application of good practice in risk assessment throughout AWP.

Governance

9.17 Ms LMcM told the panel that she was '*extremely concerned'* about the control the Trust's Board had of the organisation and of the governance arrangements within the Trust when she took up her appointment in April 2006. She is now of the view that '*we are on very solid ground in many areas'* in relation to, among other things, the Board carrying out its duties, the executive structure, policies and the understanding of key issues. She recognises the importance of '*maintaining an unbroken line of accountability*' to and from the Board and the Chief Executive.

9.18 With regard to particular aspects of governance, comment has already been made, see 6.31 – 6.38, about the rudimentary state of clinical audit at and before the time of the homicide. Although the panel was interested to hear of the shift in culture that the current senior managers have instigated with regard to audit, compliance, and governance, there is clearly a long way to go in promulgating such good practice. Practitioners did not seem to have great awareness of such issues, and there was some confusion between clinical audit as defined by the GMC, which is a dynamic process, and routine case review.

9.19 The current Trust policies seen by the panel cannot be faulted in their scope and detail. As is often the case with such documents in many organisations they are for the most part counsels of perfection. They are also for the most part long, complicated and heavy going. It is inconceivable that a busy practitioner would be able to refer to them usefully in a crisis. This is particularly true of the current Integrated Care Programme Approach (ICPA) and the Assessment and Management of Risk Policy Procedures and Guidance in which is acknowledged '*that this Policy is a complex document. Therefore, additional guidance on its implementation will be issued and updated on a regular basis.'.* The panel was greatly encouraged to hear from Ms LS of a new approach to writing policies that are based on clinical audit, which separates policy from procedure, and which will ensure standard operating procedures will be thoroughly tested before being recommended for use. '*We need to get to a point where the policy and the procedures that we are implementing are able to be*

picked up by a CPN at 12 midnight on a Saturday night in a crisis situation and they know immediately and very quickly what they can do with it. And they cannot do that with a 30 page document". The panel commends this robust and sensible approach and its implicit acknowledgment that what senior management specifies in operational policies must actually aid their colleagues on the ground.

Response to serious incidents

9.20 One of the submissions from Mr JH was that a Service Improvement Team should be established for the AWP Trust. He noted the number of homicides in the area served by the Trust, and the apparent failure to remedy deficiencies identified in previous investigations, both internal and external, which had not prevented further deaths.

9.21 The panel was certainly mindful of the findings of those previous investigations, not least through the direct involvement of one of their members in two of them, notably the case of MN, which reported in 2007 and was reviewed in 2008. The panel's intention has been to build on the conclusions and recommendations of the whole sequence of investigations.

9.22 After the cluster of homicides in 2001-2007, the Trust commissioned internal research from Dr WJ and Dr TA[10], which concludes that in fact none of the eight cases it considered fell in the '*most preventable*' categories, and that '*on average one of the eight homicides in the AWPT area since 2001 could have been prevented.'* The authors acknowledge the traumatic effect on all concerned of four cases within six months and summarise the action taken in response.

9.23 Since the scope of that review related closely to this Investigation's Terms of Reference, see 5iv page 101, regarding the lessons learned for practice guidelines as well as for reporting, managing and investigating serious incidents, its findings were examined with Ms LH, Dr AT and Ms LMcM. There now appears to be a culture of self-examination, with thematic reviews of practice on different topics such as racial discrimination and ethnicity, slips, falls and medication, in addition to suicide and homicide. The panel was told that the standard of internal investigations following homicides had received praise from the Strategic Health Authority. Within AWP there is a system of review where patients commit serious offences such as assault or rape. The outcome of the initial incident report dictates whether or not it is followed up by a critical incident review. The Trust is now on a contract with the commissioners under which there are financial penalties if such investigations are not completed on time.

9.24 Ms LMcM told the panel that in response to serious untoward incidents in the last two years, the Trust had commissioned an external review by Mr CD, a non-executive director of an NHS Trust in the north west of England. Both this review and the internal thematic review of suicide, homicide and serious incidents have been distributed to all Primary Care Trusts, to Overview and Scrutiny

10 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. (January 2008)

Committees and the Strategic Health Authority. There are monthly reviews by the Lead Commissioner and the Strategic Health Authority on a range of items and these have included monitoring of the action plans in relation to homicide and suicide. The Strategic Health Authority has also attended meetings of the Clinical Incident Overview group.

9.25 Dr AT observed '*I think that what we have learnt more recently from our discussions with the SHA is that they have full confidence that our system of reporting all these things is robust and captures everything that we need to be capturing.'* He recognised that there was more to do, and in the last six to nine months he had identified a significant shift in the pattern of episodes of homicide towards people with whom the Trust had just made contact through very recent referrals, in some case between the referral and the first contact. '*This is frequently young men with substance abuse problems and psychosis, very like the presentation of Mr SN…..and we are just at the point of trying to work with them [when] there is a killing*'.

9.26 From analysis and reflection such as this it cannot be said that there is currently a lack of self-examination within AWP.

9.27 Following the review published in January 2008[11], the critical incident overview group was established, chaired by the Medical Director of the Trust. It produced a Homicide Action Plan. The panel had to request a copy of the plan and was made aware of it only late in the investigation. It was not available at the time of questioning most witnesses. The plan identifies many of the aspects of practice and procedure highlighted in this report, such as engagement with carers, information keeping, multi-agency information keeping and formulation. In some areas, policies have been reviewed and amended and in other areas the work is in progress. The panel has concerns that in many of the targets the measurement of the success is about '*throughput actions*' rather than the impact and efficacy of those actions. Success seems to be predicated on the fact that the action was delivered but without tangible, measurement of service/practice improvement. For example, with regard to the new comprehensive clinical care programming policy and procedures launched on 11 March 2009, the giving of training is the evidence of outcome rather than the positive impact on service or practice.

9.28 The panel does not find evidence of complacency or lack of awareness within the current leadership of AWP. Those of its members who spoke to the panel are only too well aware of the need to take effective action in response to the incidence of homicide and the findings of this and of previous investigations. On balance the panel does not think that AWP requires the additional focus of a Service Improvement Team. The potential for such a measure to undermine the remedial action and the culture of review and improvement already in hand outweighs the likely benefits. The panel does, however, consider that the Trust should be held to account about the action taken to implement both the Homicide Action Plan, and the recommendations of this Report, and it has made a recommendation to that effect.

11 See paragraph 9.21 above

9.29 The test of the effectiveness of the Action Plan and of the Trust's leadership in implementing it will be measured in the extent to which standards of operation performance by staff on the ground conform more fully to those which are clearly described in the Trust's policies and procedures and in guidance issued by the NHS nationally.

Recommendation

9.30 There should be an independent review of the implementation of the Homicide Action Plan, and of the recommendations in this report no later than 6 months from the publication of this Report. Such a review will wish to see evidence of the effectiveness of action taken, not only by reference to aspirations expressed in policy, but by evidence in improved practice on the ground, and manifest in the care of patients and the better protection of the public.

Chapter 10

The Investigation Process

10.1 Mr Philip Hendy was fatally stabbed on 29 April 2007. The Trust's Root Cause Analysis internal review report was dated 4 September 2007. The trial of Mr SN was not completed until October 2008. The Independent Investigation team was appointed by the SHA in February 2009. Mr SN's consent to the release of his records was received in June 2009. The Investigation panel first met in July 2009. The hearings began in October 2009.

10.2 The panel entirely agrees with Mr Philip Hendy's family that such a process does not meet the requirement for a '*prompt'* effective investigation. Such delay, for which the Strategic Health Authority has apologised, adds to the suffering of bereaved families and the family of the perpetrator. It makes the task of the Independent Investigation more difficult in that the events under discussion are far from fresh in the memories of witnesses, and in some cases witnesses central to the investigation have moved on and are no longer available. Any poor practice that may be discovered by an Investigation remains unaltered for too long, with the consequent risk to patients, staff and the public.

10.3 The current dual process of an exhaustive internal review followed by an independent investigation duplicates work and is wasteful of precious resources. It risks double jeopardy for witnesses, while providing an opportunity for evidence to be rehearsed.

10.4 In oral evidence the members of the internal review team suggested that an internal review with some external membership might be sufficient in most cases of homicide, saving fully independent investigations for more complex matters. However, the panel considers that the need for public accountability, and for a process that is open and transparent requires a fully independent team for all investigations of this nature.

The panel therefore makes the following recommendations to improve the inquiry process

10.5 As soon as possible after an adverse health care event, there should be a swift internal review for the purpose of preserving all relevant documents and other evidence, and of identifying any urgent remedial action necessary for the protection of patients, staff or the public. (It might be possible for one of the independent investigation team to be identified even at this early stage, to provide an external presence from the outset, and to provide an element of continuity, but this may not be practical and is a detail that could be examined more closely as part of a thorough review of the system.)

10.6 There should continue to be a comprehensive independent investigation with a similar remit as at present.

10.7 The members of the independent investigation team should be appointed as soon as possible after the event that is the subject of the investigation. New tendering procedures of which the panel has now been informed, are likely to expedite the process and this is a welcome development. Early appointment will give victims and bereaved families the confidence of knowing that the process had begun. It would also enable the early identification of witnesses, reports, inspections and other evidence, including case notes, thus saving time when the oral hearing stage is reached.

10.8 In the opinion of the Panel, the commissioning of an Independent Investigation need not be delayed pending the completion of any criminal proceedings. There is no reason why the panel appointed could not start to scrutinise the established written evidence, such as policies, procedures, internal review reports etc. as soon as possible while they await the outcome of criminal proceedings. Early appointment would enable the panel the take control of the process, to give initial consideration to questions to be put to witnesses and to plan ahead with an outline timetable thus avoiding undue delay when criminal proceedings were over. It would not be appropriate however for the team to request written statements from witnesses or to hear any oral evidence before the outcome of criminal proceedings. As in this case the evidence given at trial and the psychiatric and psychological assessments prepared for trial may be important and significant, as is the outcome of such proceedings. The papers required for court, notably witness statements, may well produce relevant additional material and in some cases the result may alter the complexion of the case.

10.9 The issue of the disclosure of case notes and other information is one of the principal causes of delay. There should be a tight timescale for the disclosure of documents and information required by the panel.

10.10 There should be an equally tight timetable for the response of the internal link contact in the Trust concerned to requests by the Investigation Manager. It is important for Trusts to understand the priority and weight of the independent investigation process, and to impress this on all staff involved. It is likely that this would be an easier task if the requests for information and attendance at hearings are made only once, rather than duplicated as at present.

10.11 The response of a Trust or other agencies to the findings and recommendations of an independent investigation should be monitored, and if recommendations are not implemented within a reasonable time the agencies concerned should be required to account for this failure to an external, independent body.

10.12 If implemented, these proposals would require the amendment of the NHS national guidance governing Independent Investigations. A review of this guidance would be timely and appropriate.

Chapter 11

Conclusions and Recommendations

Conclusions

11.1 In view of the long engagement between Mr SN and the services, and especially in the crucial period before the homicide, it might reasonably be assumed that the failure to detect the deterioration in his condition, and the consequent increase in risk, was the result of one or more individuals failing in their duty to him and in their duty to protect the public. After an exhaustive examination of all the evidence available to the panel, it has concluded, however, that this homicide was not foreseeable and that it cannot be attributed directly to any individual or corporate failing. On this point, and in identifying areas of practice where there were shortcomings, the panel is broadly in agreement with the findings of the internal review, but with some notable exceptions.

11.2 Mr SN had been involved with mental health services for many years, at a low level and intermittently. His presentation was unremarkable; neither his mental state nor his perceived risk caused him to stand out in the caseload of the Inner City Team in Bristol. His condition was characterised by personality disorder, low mood, psychotic symptoms and substance misuse. It was also associated with an extensive record of offending. Only once, in 2004, was his mental state deemed to be acute, but it subsided, and he had never been admitted as either an informal or a compulsory patient. His engagement with psychiatric care was episodic, with long periods of absence, including periods in prison. Before the homicide, he was not deemed to be high risk, correctly on the evidence known at the time. There was little evidence in his history or presentation to indicate that he would commit a random and violent attack on an innocent stranger.

11.3 He had used illicit drugs persistently over many years, but it had rarely been a prominent feature of his presentation to mental health professionals and he had not been assessed or treated by specialist services. He had repeatedly lied about, or minimised, his use of drugs. In the period from November 2006 to April 2007 his use of amphetamine increased, which caused his behaviour to become bizarre and, at times, angry, as witnessed by his family. This increased the risk he posed, but there were few indications of any deterioration in the several encounters he had with the services (mental health, GP, probation and the courts) in that time, and nothing in his engagement with them to suggest that the risk he posed had become critical. It must be borne in mind that this was a period when he was abusing amphetamine regularly and in large quantities. His GP was unaware of this increase until after the event, and mental health services became aware of the family's concerns about it only in March 2007. What happened thereafter has been described and analysed at length in this report. After the fatal assault on Mr Philip Hendy, in the absence of further amphetamine consumption, Mr SN's psychotic symptoms rapidly diminished, were absent at the

time of his trial, and remained so when seen by the panel at HMP Long Lartin in November 2009.

11.4 We do not know why Mr SN chose to ingest so much amphetamine in the days before the murder, but it was his choice to do so. While experiencing paranoid psychosis precipitated by its use, he attacked and killed Mr Philip Hendy. Neither the consumption of drugs to this degree, nor its tragic outcome, could reasonably have been predicted or prevented. The responsibility for the death of Mr Philip Hendy lies with Mr SN.

11.5 Although firm in this conclusion, the panel has nevertheless identified a number of areas of poor practice, serious omissions and concerns about Trust policies and procedures. The panel considers that on the particular facts of this case, the outcome would have been the same even if these factors had been absent, but in other circumstances they might all too easily contribute to a tragedy similar to that which befell Mr Philip Hendy and his family. These have been noted in this report and some of them are the subject of formal recommendations.

Summary of Recommendations

11.6 Baseline drug screening should form part of the initial core ICPA assessment where the use of illicit drugs is reasonably suspected to contribute to a patient's mental disorder, whether or not the patient admits to using illicit substances.

11.7 Practitioners in general psychiatry should receive training to raise awareness of forensic issues and risk factors.

11.8 There should be a unified case record for every patient that is filed logically, is capable of being viewed and searched in its entirety, and is accessible to all who might reasonably require to refer to it. The current set of records should include all key documents. There should be a regularly updated summary giving a brief history of the patient's involvement with psychiatric services and highlighting the principal risk factors.

11.9 There should be a clear audit trail of the decisions and action points agreed at multi-disciplinary team meetings and of their implementation and outcome.

11.10 Communication with carers should be prompt and clear. Action to be taken in response to a referral by carers should be confirmed in writing as soon as possible.

11.11 On receipt of referrals from prison or probation service the receiving member of the team should request a full history of the patient's offence record from the referrer, and a member of the team should be allocated to the patient to liaise with the prison or probation service about the release date and timing of follow up.

11.12 NHS Trusts, the Probation Service, and the Court Service should review the protocols concerning the sharing of information and in particular

pre-sentence reports and psychiatric reports in the case of patients who are receiving treatment at a time when they are before the court, and/or under supervision on licence.

11.13 AWP should amend its Serious Incident Policy and other procedures so that a letter of condolence is written as soon as possible to the bereaved family of the victim of a homicide perpetrated by a patient.

11.14 In partnership with other Trusts, APW should establish the means of providing appropriate and acceptable bereavement counselling and support for bereaved families following a homicide perpetrated by a patient.

11.15 Police Community Support Officers should be given additional training in how to identify and respond to people with mental disorder.

11.16 There should be clear guidance to Police Community Support Officers on the procedure to be followed if an arrest under section 136 Mental Health Act 1983 is indicated.

11.17 There should be an independent review of the implementation of the Homicide Action Plan, and of the recommendations in this report no later than 6 months from the publication of this report. Such a review will wish to see evidence of the effectiveness of action taken, not only by reference to aspirations expressed in policy, but by evidence in improved practice on the ground, and manifest in the care of patients and the better protection of the public.

11.18.1 In order to improve the investigation process, as soon as possible after an adverse health care event, there should be a swift internal review for the purpose of preserving all relevant documents and other evidence, and of identifying any urgent remedial action necessary for the protection of patients, staff or the public. (It might be possible for one of the independent investigation team to be identified even at this early stage, to provide an external presence from the outset, and to provide an element of continuity, but this may not be practical and is a detail that could be examined more closely as part of a thorough review of the system.)

11.18.2 There should continue to be a comprehensive independent investigation with a similar remit as at present.

11.18.3 The members of the independent investigation team should be appointed as soon as possible after the event that is the subject of the investigation. New tendering procedures, of which the panel has now been informed, are likely to expedite the process and this is a welcome development. Early appointment will give victims and bereaved families the confidence of knowing that the process had begun. It would also enable the early identification of witnesses, reports, inspections and other evidence, including case notes, thus saving time when the oral hearing stage is reached.

11.18.4 In the opinion of the Panel, the commissioning of an Independent Investigation need not be delayed pending the completion of any criminal proceedings. There is no reason why the panel appointed could not start to scrutinise the established written evidence, such as policies, procedures,. Internal review reports etc. as soon as possible while they await the outcome of criminal proceedings. Early appointment would enable the panel to take control of the process, to give initial consideration to questions to be put to witnesses and to plan ahead with an outline timetable thus avoiding undue delay when criminal proceedings were over. It would not be appropriate however for the team to request written statements from witnesses or to hear any oral evidence before the outcome of criminal proceedings. As in this case the evidence given at trial and the psychiatric and psychological assessments prepared for trial may be important and significant, as is the outcome of such proceedings. The papers required for court, notably witness statements, may well produce relevant additional material and in some cases the result may alter the complexion of the case.

11.18.5 The issue of the disclosure of case notes and other information is one of the principal causes of delay. There should be a tight timescale for the disclosure of documents and information required by the panel.

11.18.6 There should be an equally tight timetable for the response of the internal link contact in the Trust concerned to requests by the Investigation Manager. It is important for Trusts to understand the priority and weight of the independent investigation process, and to impress this on all staff involved. It is likely that this would be an easier task if the requests for information and attendance at hearings are made only once, rather than duplicated as at present.

11.18.7 The response of a Trust or other agencies to the findings and recommendations of an independent investigation should be monitored, and if recommendations are not implemented within a reasonable time the agencies concerned should be required to account for this failure to an external, independent body.

11.18.8 If implemented, these proposals would require the amendment of the NHS national guidance governing independent investigations. A review of this guidance would be timely and appropriate.

Appendix i

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 Mr SN 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 Mr SN 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 Mr SN 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 death of Mr Philip Hendy, following an assault on 29 April 2007 in the form of

a) a chronology starting from his 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 Mr SN 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 of the commissioning and timings of the Inquiry in relation to national guidance.

Appendix ii

Witnesses and Agencies Providing Evidence

Dr S B	Consultant Psychiatrist (retired)
Dr P C	Consultant Forensic Psychiatrist (AWP)
Ms S E	Senior Nurse Practitioner (AWP)
Ms R F	Probation Officer
Mr T G	Community Psychiatric Nurse (AWP)
Ms M H	Bristol South Community Services Manager (AWP)
Dr L H	Consultant Psychiatrist (AWP)
Mr B H	Force Disclosure Manager, Avon & Somerset Constabulary
Mr J H, Mr P H & Mr S H	Sons of the late Mr Philip Hendy
Ms L H	Head of Risk and Compliance (AWP)
Dr W K	General Practitioner
Ms L McM	Chief Executive (AWP)
Dr R N	Consultant Psychiatrist (AWP)
Mr S N	The subject of this Independent Investigation
Mrs V N	Mother of the above
Ms L S	Director of Operations (AWP)
Dr P S	Associate Specialist (Psychiatrist) South East London
Dr A T	Consultant Forensic Psychiatrist, Executive Medical Director (AWP)
Dr G M U	Consultant Psychiatrist, Gloucestershire
Mr J W	Community Care Worker (AWP)
Dr S B Z	Consultant Psychiatrist, Northamptonshire

Authors of the Root Cause Analysis Report 4 September 2007:-

Dr C V	Consultant Psychiatrist (retired)
Dr G L	Consultant Psychiatrist (retired)
Mr R E	Consultant Nurse Dual Disorder (AWP)
Ms C M	Clinical Risk Manager (AWP)

Expert Witnesses to this Independent Investigation:-

Dr S McL	Consultant in Addiction Psychiatry
Mr J M	Approved Mental Health Professional

Appendix iii

Policies and Procedures 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

- Trust Executive and Management Structure (2007)
- Description of services (revised April 2008)
- 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 January 2010)
- Meeting the needs of carers and their key rights (Undated but to review 31 January 2010)
- Carer information on care pathways (Generic and SBU) (Undated but to review 31 January 2010)
- Children as Carers (Undated but to review 31 January 2010)
- Managing disputes and escalation (Undated but to review 31 January 2010)
- Expert practitioner and expert panels (Undated but to review 31 January 2010)
- Dual diagnosis (Undated but to review 31 January 2010)
- Assessment, risk assessment, assessment tools (core and comprehensive) and recording (Undated but to review 31 January 2010)
- Public protection and safeguarding (Children, adults, MAPPA and MARAC) (Undated but to review 31 January 2010)
- Therapeutic engagement of service users, carers and families (Undated but to review 31 January 2010)
- Diagnosis and formulation (Undated but to review 31 January 2010)
- Caseload and capacity management (Undated but to review 31 January 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 (4 September 2007)
- 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. Related NHS policies and guidance

- Effective care co-ordination in Mental Health Services: Modernising the Care Programme Approach (DoH 1999)
- Mental Health Act 1983 Code of Practice (DoH 1999)
- Dual Diagnosis Good Practice Guide (DoH 2002)
- Refocusing the Care Programme Approach: policy and positive practice guidance (DoH 2008)

4. Other non Trust documents

- Redefining Justice. Addressing the individual needs of users and carers (Published march 2009)
- Confidentiality: protecting and providing information (GMC 2004)
- Good Medical Practice (GMC 2006)