Independent review into treatment and care provided by Oxford Health NHS Foundation Trust

Confidential

East of England Collaborative Procurement Hub

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EXPERIENCE, KNOWLEDGE AND EXPERTISE IN MANAGING RISK

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EXECUTIVE SUMMARY

1. Introduction

1.1. This is the report of an investigation commissioned by NHS England into the care and treatment provided by Oxford Health NHS Foundation Trust for `B' who was a patient of the Trust when he killed Mr Justin Skrebowski and injured two other people in the centre of Abingdon on 7th December 2015 using a knife he had picked up from a display shelf in Poundland.

1.2. We would like to extend our sincere condolences to Mr Skrebowski's family for the tragic loss of a much loved partner and father.

1.3. We would also like thank the family members and staff who agreed to participate in this investigation; the Police for sharing a report of their own internal review and Turning Point for the information that they provided about their support to help B manage his substance misuse problems.

1.4. Our primary aim, as with all investigations into NHS treatment and care, is to learn lessons from this case and help to improve services and make them safer. Appendix 1 of the main report contains Terms of Reference for the investigation and Appendix 2 contains brief details about the investigation team. The team reviewed the NHS case notes written by the Trust about B; notes and files provided by the Police for the Court, including assessments undertaken at that time by forensic experts; Trust policies; guidance on Care Planning, Lone working, Risk Assessment and management, and joint working (see Appendix 3). Our team also interviewed individual witnesses about the care and treatment they provided for B (see Appendix 4). There are no significant inconsistencies in the information that they provided and the team has no reason to doubt its reliability.

2. Findings

Care and treatment provided for B

2.1. B was first referred to mental health services in 1997 when, at the age of 18, his GP asked for support to manage his substance misuse problems. He was initially treated within the Trust addictions service and at the age of 26 he was given a formal diagnosis of paranoid schizophrenia exacerbated by substance misuse. The records indicate that B admitted to taking crack cocaine, heroin, ketamine, steroids, cannabis and so-called legal highs (Spice, Mamba, Insane Joker, etc.). `Roads to Recovery', the local Turning Point service commissioned by Oxfordshire County Council (Public Health Oxfordshire) in 2015 to provide substance misuse services also saw B regularly.

2.2. B was admitted to psychiatric hospital on four occasions, including three times under a Section of the Mental Health Act. His admissions were characterized by acute deteriorations in his mental state exacerbated by substance misuse. B's behavior at these times was sometimes violent and he reported aggressive thoughts. B also had a significant history of offending. In all, the records show 23 incidents involving the police that were related to alcohol and/or misuse of so-called `legal' highs and there were ongoing disputes between B and neighbours.

2.3. B's fourth admission (informal) came at the end of October 2015. The notes relate that B's symptoms diminished quickly once the effects of illicit drugs wore off and he was discharged after 4 days although the community team who had sought the admission had expressed a wish that he should stay. Unable to contribute to the decision owing to a miscommunication about the timing of a meeting, the community team therefore arranged to provide a significant level of `stepped up' care for B. The discharging doctor's assessment says: "At this point in time B is able to take responsibility for his actions, and appreciates that his drug-taking affects his mental state to a nature and severity that puts his safety and the safety of others at risk."

2.4. During November B's care was delivered as planned. However, B was under stress due to an impending move to a new flat to get away from drug dealing friends; he had appeared in Court on charges of damage he caused at the John Radcliffe Hospital and given Conditional Bail, a curfew and a tag. Although the Support, Time and Recovery (STR) worker allocated to support B was a stable presence throughout this period, B's Community Psychiatric Nurse was also about to change for the fifth time and B reported that this made him feel unsettled. Perhaps most significantly, B's illicit drug taking escalated dramatically. A drug-using friend came into a significant sum (£3,000) which he and B then spent on a drug binge.

2.5. On December 3rd, the STR worker became very worried about B's mental ill health. B had had thoughts of killing himself by electrocution with a phone charger (sic) and by cutting his throat; he had not slept and was agitated. Whilst the STR worker was speaking to the doctor, B left the building and she subsequently found him in Abingdon having cut his hand on a knife obtained from Poundland. B said he thought that the customers had been making fun of him due to his upcoming move to a new flat, and he'd had thoughts about injuring them. The STR worker brought him back to see the doctor. The doctor had not seen B before, but he was aware of his case and had access to the notes, even though he had not personally been able to attend the Monday team meetings where B's case had been discussed. He did not believe that B met criteria for detention under the MHA and did not seek a MHA assessment. Nor did he believe it would be appropriate to admit him. Instead, he supplemented B's medication and although a referral to step up care was considered, it was not acted upon as the following day, the CPN felt B had improved.

2.6. For the next two or three days, the plan for B's care appeared to be working. However, on December 7th, the STR worker spoke to B on the telephone: he wanted to see her to discuss worries about being remanded; she said she would meet him at 12.30 and B confirmed that he felt safe to wait until then. However, the Court Liaison and Diversion Team then contacted the Adult Mental Health Team to say that B had been arrested for an attack on members of the public, and that Mr Justin Skrebowksi had died.

2.7. When B was arrested and detained by the Police following what was shown on the CCTV record to have been a very violent and frightening display of aggression, B was nonetheless able to engage and communicate. He reported having used heroin (which he reported not having used for four years, being on a Methadone programme), crack cocaine, and he had taken something called `clockwork orange' which he had not used before.

2.8. B was sentenced in June 2016 at the Old Bailey, after pleading guilty to manslaughter by way of diminished responsibility, using a Section 45A Mental Health Act "Hybrid Order" which imposed a hospital treatment order and a life sentence for manslaughter with a minimum term of 18 years. He was transferred to Broadmoor with the expectation that when his treatment there is complete, he will return to prison to serve out the remainder of his sentence.

Contact and communication between teams

Inpatient and outpatient teams

2.9. Community and inpatient teams are managed and led separately in the Oxford adult mental health service although they are contained within the same clinical Directorate with overarching senior leadership. Judgements about admission are made by the team that knows the patient best and an admission is arranged if a bed is available. The investigation team does not believe there is evidence that this division presents difficulties in the normal course of events. The investigation team was also unable to find any evidence that the miscommunication about the time of B's discharge meeting was anything other than simple error.

2.10. It is possible that pressure on beds and staff shortages may have had a bearing on the decision to discharge B. It is also possible that the separate nature of mental ill health and drug services militated against the delivery of `joined up care'. B was thought by the ward staff to have a primarily drug-induced psychosis (for which the sympathy of some staff was allegedly limited) rather than relapsing schizophrenia with substance misuse overlaid. But whilst B himself, B's parents and the community mental health team staff believe that a longer admission would have been more helpful, the investigation team does not believe that this would have prevented Mr. Skrebowski's tragic death in December.

Drug services

2.11. `Roads to Recovery', managed by Turning Point (TP) was commissioned in April 2015 to provide the substance misuse services formerly delivered by the Trust. Whilst B did not participate in the various daily groups and treatment sessions that were offered, he did keep his fortnightly appointments regularly and the records show that his Methadone programme was managed effectively. The records show that the change in provision of substance misuse services led initially to some uncertainty about communication and joint working, and information provided by the Trust about B was limited. However, TP had contact with B's Community Psychiatric Nurse after B's October discharge and they found this helpful. A new protocol on joint working between TP and the Trust has now been developed and TP staff say that communication has improved.

The Police

2.12. B had a significant history of offending. In all, there were 23 incidents involving the Police that were obviously related to alcohol and substance abuse, including an escalation in B's use of legal highs. Most of these incidents occurred in the last 6 months of 2015. At the time of the index offence B was awaiting a Magistrate's Hearing related to an incident in July when he was involved in an altercation with a man on the street. B had been electronically `tagged' and was bailed on the condition that he did not go into the centre of Abingdon.

2.13. Partner agencies (Police, mental health services and housing) had discussed B as a `vulnerable adult' and arrangements had been made to move his accommodation so he would be less exposed to exploitation by drug dealers. This appears to have been a good example of inter-agency working and communication.

Documentation and record keeping, policies and protocols

2.14. Information contained in B's clinical notes was of a good standard and contained all the important information, including a Risk Assessment which was up-to-date and had been reviewed regularly. Detailed information was also provided by the Support, Time Recovery (STR) worker and there was good information about discussions that took place at Monday team meetings about B.

2.15. Our investigation team found an appropriate level of good quality documentation of the mental health care provided for B. Trust records are generally of a good quality and meet with national standards. However, B was not formally listed as being subject to the Care Programme Approach (CPA) and, contrary to Trust policy, he did not have a Care Plan. This is a significant omission. CPNs, supported by the team, normally carry

responsibility to write the Care Plan but there had been a high turnover (four) of Community Psychiatric Nurses (CPNs) in the months prior to the incident (a fifth was also just about to leave), which B reported that he found unsettling.

2.16. The absence of a Care Plan does not mean that good care was not provided and this investigation suggests that care was of a good standard. However, a Care Plan provides an essential focus for all those involved in work on a complex case. It helps the patient and his family, to know what is being provided; it can be copied easily with the patient's permission to partner agencies (e.g., Turning Point, Housing) and it helps staff who may not know the patient well (e.g., new staff or trainees) to be aware of issues relating to risk which they would otherwise have to go through the detailed written records to find. Recommendations relating to Care Planning are made below.

The quality assurance framework

2.17. The Trust operational policy for the provision of community mental health care sets out clear principles for the delivery of treatment and support which is person-centred, evidence and needs-based, delivered in partnership with the patient and his/her family, risk assessed and managed. In January 2016, a decision was taken to review this system to lessen the chance that the most complex patients would see staff with whom they were relatively unfamiliar, as was the case for B. The new policy also strengthens guidance on CPA and sets out the need for formal CPA reviews at least every six months**.**

The Trust internal report

2.18. The internal report (`the RCA report') prepared for the Trust in Spring 2016 describes the care provided for B and the circumstances leading up to the 7th December 2015 when the index offence took place. Overall, our investigation team believes this investigation to have been completed in a timely manner and, with some exceptions (see main report) which concern the way in which it was conducted and two recommendations regarding forensic referrals and lone working, its conclusions and recommendations are fair and follow from the evidence.

3. Was the incident predictable and/or preventable?

3.1. During our investigation, questions were raised about whether the tragic death of Mr. Skrebowski could have been avoided if his admission in October had been longer. Our team spoke at length on this point with the doctors involved in his assessment. However, B's symptoms were not so severe, his insight not so limited, nor the threat of harm to others so great that detention under the Mental Health Act (MHA) was warranted. Doctors and clinical staff from the inpatient and community services who discussed this at the time, and afterwards, were agreed on this point. As B was willing to be admitted to

hospital and then apparently willing to leave, the question of use of the MHA did not arise.

3.2. Questions were raised about whether it might have been possible to detain B under the MHA at the point when his mental state deteriorated at the beginning of December, but the doctor who saw B was clearly of the opinion that he did not warrant detention and he remains of this view today. Unfortunately, and as he pointed out, threats and behavioural disturbances are common amongst drug users with mental health problems; prediction of actual harm is highly inexact, and the requirements of the MHA are very specific.

3.3. We have no evidence that the doctor's judgement was incorrect and we cannot know whether a MHA assessment would have led to a different outcome. However, evidence from staff witness statements indicates that opinion about B at this point in his presentation was divided and our team believes that in these circumstances it would be wise to trigger a Review and/or a team discussion. In this way, everyone involved with the patient can contribute to the decision about how to proceed.

3.4. Questions were raised about the electronic tag which B wore as a condition of his bail after his Conditional Discharge. The conditions of his bail were as follows:

- Curfew between 22.00 & 07.00 (electronically monitored)
- Live & sleep at his home address.
- Not to enter Abingdon City Centre as defined by Stratton Way, High St and Stert Street

3.5. Questions were raised about the electronic tag which B wore as a condition of his bail after his Conditional Discharge. Electronic tagging works by the offender wearing a tag and a having a monitor station installed in his home. If B left his home during the curfew hours, the tag would alert the monitor station and indicate a breach. The monitoring station would then alert an external monitoring company which, in turn, notifies the police call centre. An `incident' is then created and officers are dispatched to arrest the offender. Any breach of court bail will result in an arrest and the offender must appear back at the Magistrates Court within 24 hours. In this case, the capability of the electronic tag B wore was limited only to identify if B was out of his house during the curfew times. It did not have the capability of monitoring B's location which is why he was able to enter Abingdon Town Centre without triggering any alerts.

4. Conclusion and recommendations

4.1. Together with evidence gathered during our investigation about the quality of care that was provided for B, our team believes that the tragic incident which resulted in the death of Mr. Skrebowski can be associated with a certain degree of predictability. This is because the predictive factors identified in research on homicides by people in contact with mental health services such as recent discharge from hospital, medication non-

compliance, substance misuse, poor self-care, and previous detention and/or hospitalization(s) for violence, many of which were present in B's history. However, the research also shows that prevention in an individual case is extremely difficult, and this is consistent with the evidence we have gathered about B.

4.2. There is no doubt that there were failings in the way that the Trust delivered care: for example, the absence of a Care Plan was a significant omission. It is also possible, had a Complex Case or MAPPA review been triggered at the point when B's symptoms were deteriorating again in early December that a team discussion of the impact of what proved to be a complex combination of severe mental ill health exacerbated by substance misuse might have led to a different management plan. However, the quality of B's general care was good; we have no evidence that the doctor's judgement on that day was incorrect, or that a further assessment would have led to a different outcome. We cannot therefore say that the tragic death of Mr' Skrebowski was preventable.

4.3. That such events are very rare can provide no consolation for the members of his family and is unlikely to reassure members of the public who witnessed the events of that day.

4.4. Our team believes that steps have been taken by the Trust to reinforce their policies and clinical practice and we think that inter-agency communication and joint working are both much stronger than they were. We have made five recommendations to strengthen Care Planning to improve the quality of communication and inter-agency working. We believe that progress on this should be audited, and the operation of a new service model to improve care pathways should be monitored carefully. Our recommendations are as follows:

Recommendation 1. Dual diagnosis and management of risk
The Trust should ensure that all staff (community and inpatient teams) are supported to develop an appropriate level of knowledge about the management of patients with mental ill health and substance misuse problems, and that Care Planning, Risk Assessment and inter-agency communications in relation to such patients is of a good quality.

Recommendation 2. MAPPA and complex care reviews
We recommend that the Trust provide additional information and/or training for community mental health staff so that they understand the use of MAPPA and/or complex care reviews and can trigger a referral to bring teams and/or agencies together to discuss the management of risk

Recommendation 3. Care Planning
We recommend that the Trust ensures through its routine audit of clinical procedures that all patients with complex needs who are in contact with secondary mental health services have a written Care Plan, agreed with, and copied for the patient and relevant partners in the delivery of care. Team leaders should then ensure through their routine

management that Care Plans are appropriate and contain information about the patient's mental, physical and social care needs, diagnosis, risks and relapse profile, carers and treatment including drug treatments.

Recommendation 4. Changes in Care Coordinator

A certain level of staff turnover is normal and unavoidable, but very frequent changes are disruptive particularly for someone with complex mental health needs. Change should be kept to a minimum, as Trust policy states, but where changes occur, a review of the Care Plan and risks should always be undertaken to ensure that risks are assessed and communicated effectively. It will also be important for the Trust to monitor the impact upon effective care coordination of changes in level of resources such as inpatient beds.

Recommendation 5. Monitoring change

We recommend that the Trust review carefully the operation of the new service model which, whilst it appears to be sound and should support the delivery of a more seamless care pathway it is, as yet, untested. Our team would also like to arrange a further short visit to the Trust in 6 months' time to discuss progress with this and other recommendations

REPORT OF THE INDEPENDENT INVESTIGATION INTO CARE AND TREATMENT OF `B' BY OXFORD HEALTH NHS FOUNDATION TRUST

1. Introduction

1.1. This is the report of an investigation commissioned by NHS England into the care and treatment provided by Oxford Health NHS Foundation Trust (`the Trust') for `B' who was under the care of the Trust on 7th December 2015 when he killed Mr Justin Skrebowski and injured two other people in the centre of Abingdon. Mr. Skrebowski was a member of the public who was not known to the patient; he was an innocent bystander who was shopping at the time he died.

1.2. We would like to extend our sincere condolences to Mr Skrebowski's family for the tragic loss of a much loved partner and father. We hope that our report will help them to understand the background and assist all those who were involved in providing treatment and support for B, including his family. Our primary aim is to learn lessons from this tragic case, help to improve mental health services and help to make them safer.

1.3. In April 2013 NHS England became responsible for commissioning independent investigations into homicides by people in contact with mental health services. Guidance provided by NHS England for their conduct emphasizes the importance of rigour and independence and[1] states that in addition to establishing what happened and making any necessary recommendations for learning and change, services must be open and transparent with families and patients. This is because reports from families themselves suggest that they are not always as closely involved as they would like to be[2]. We would like to express our thanks to the family members and to the staff who agreed to participate in this investigation.

1.4. NHS investigations are normally carried out separately from any police, legal and Coroner's proceedings although steps are always taken to liaise with the authorities that have any involvement and sometimes investigations are undertaken in partnership with the instigators of, for example, Domestic Homicide Reviews. We would like to express our gratitude to the Police for sharing a report of their own internal investigation and to Turning Point who provide services in the locality for people with substance misuse problems for the information they provided.

[1] `Serious Incident Framework: Supporting learning to prevent recurrence' (March 2015) NHS England Patient Safety Domain. Gateway reference: 03198.

[2] Casey, L. CB, Commissioner for Victims and Witnesses, `Review into the Needs of Families Bereaved by Homicide' (July 2011) Ministry of Justice. London. www.gov.uk/

1.5. Core Terms of Reference form the basis for NHS investigations of this kind. However, specific Terms of Reference were developed for this case and they can be found in Appendix 1.

1.6. Appendix 2 contains brief details about the investigation team who were appointed by NHS England following a competitive tender from a group of independent `preferred providers' of investigations with the appropriate level of seniority and relevant experience.

2. Methodology

2.1. An initial `scoping' meeting was held in July 2016 with the commissioner of the investigation (NHS England) and representatives from the Trust and local commissioning team to agree the methodology for this investigation and to review the Terms of Reference. Agreement was reached concerning the use of an approach based upon Root Cause Analysis to examine the facts of the case, identify ways in which care might have been altered or improved, and to understand how systems for delivering care and managing risk are currently working. Copies of the Case Notes were received at the end of September and arrangements were then made to meet with individuals.

2.2. In addition to reviewing the case notes written by the Trust about B and his care, the team reviewed notes and files provided by the Police for the Court, including the assessments undertaken at that time by forensic experts from Broadmoor. Copies of current policies used by the Trust were also examined, including guidance on Care Planning, Lone Working, Risk Assessment and management, and joint working. Appendix 3 contains a list of the documents and policies that were reviewed.

2.3. Appendix 4 contains a list of all the individuals who were interviewed about the care and treatment provided for B, including B's parents, and the victim's bereaved partner. The investigation team also spoke with staff who had worked with B and with partner agencies such as the Police, substance misuse services, and B's General Medical Practitioner.

2.4. Adapted Salmon Principles[3] were used for this non-judicial investigation meaning that all those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference. They were offered the opportunity to be accompanied to the interviews, if they wished. All the interviews (except two telephone conversations, one with the GP, now retired, and one with the Detective Chief Inspector

[3] The Salmon Principles are six requirements set out under the Tribunals and Inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations. Although the current investigation was not judicial (solicitors were not directly involved) the investigators ensured that all those being interviewed were informed and invited to participate; they were given the TOR, and they were offered the opportunity to have someone accompany them.

who led the Police investigation, and the conversations we had with families) were recorded and transcribed. Written accounts of the interviews were verified for accuracy by each witness before being `signed off.' All witnesses were assured that their testimony would be confidential and that no personally identifying information would be included in the report. In all but three witness interviews (one of which was a telephone conversation) at least two interviewers were always present.

2.5. The team would like to thank all those who gave us information about B's circumstances and his care in the period immediately before the death of Mr. Skrebowski. The investigation team is very grateful for their willingness to help, and for their honest and open approach to our team, despite significant levels of continuing distress amongst some of them as a result of the shocking events of that day. There are no significant inconsistencies in the information they provided and the team has no reason to doubt its reliability.

3. The incident

3.1. A chronological account of the events that led up to the sad death of Mr. Skrebowski is provided in Appendix 5. The incident and its immediate antecedents is also described below.

3.2. Four days before Mr Skrebowski's death, on December 3rd, the STR worker had become very worried about B's mental ill health and she arranged an urgent appointment for him to see the duty doctor. B had had thoughts of killing himself by electrocution with a phone charger (sic) and by cutting his throat. He had allegedly not slept for four days and was agitated. It later became clear that he had taken a number of non-prescribed illicit drugs. The STR worker took B to keep this appointment. However, he left the building whilst she was speaking to the doctor and she subsequently found him in Abingdon having cut his hand on a knife he took from a shelf in Poundland. B said he thought that the customers had been making fun of him due to his upcoming move to a new flat, and he'd had thoughts about injuring them. The STR worker brought B back and after he had seen the doctor, she then took him to A&E to get his hand stitched. B subsequently went home to sleep.

3.3. The assessment made by the doctor (the specialist who would formerly have been known as a `staff grade' doctor) on duty on 3rd December was clearly central to the plan for B's management. The doctor had not seen B before although he was aware of his case, and he had not personally been able to attend the Monday team meetings where B had been discussed routinely. The investigation team interviewed the doctor in detail to understand his decision making on that day. He described B's behavior as having been somewhat erratic. However, he did not (and does not now) think that B met criteria for detention under the MHA; he therefore did not seek a MHA assessment. Nor did he believe it would be appropriate to admit B informally.

3.4. With hindsight, and with reference to critical points made in the earlier investigation report, the doctor wondered whether, if he'd had the opportunity to complete a much longer interview with B, it might have been possible to elucidate his mental state in a manner which made any threat or risk clearer. But it had seemed to him that anxiety relating to a series of life stresses, including an imminent move, was at the root of the problems B was presenting. He asked him about his thoughts and plans to hurt himself and/or others. He was satisfied that there appeared to be no imminent threat. He did not think B was `admittable' and he considered that it would be appropriate and sufficient to continue to provide the ongoing level of stepped-up care as previously agreed and increase B's medication.

3.5. For the next few days, this plan appeared to be working. However, on December 7th, the STR worker spoke to B on the telephone: he wanted to see her to discuss worries about being remanded; she said she would meet him at 12.30 and B confirmed that he felt safe to wait until then. However, the Court Liaison and Diversion Team then contacted the AMHT to say that B had been arrested for an attack on members of the public in the Poundland shop, and that Mr Justin Skrebowksi had died from stab wounds. B had been moderately well known to people in the locality where he had a history of causing public disturbance. He was detained outside the shop following action by members of the public and the police and he was taken to Woodhill Prison. After this, in March 2016, he was transferred to Broadmoor, a high secure psychiatric treatment facility where he currently remains.

3.6. When B was detained by the Police following what was shown on the CCTV record to have been a very violent and frightening display of aggression, he was nonetheless able to engage and communicate. He reported having used heroin (which he reported not having used for four years, being on a Methadone programme), crack cocaine, and he had taken something called `clockwork orange' which he had not used before.

3.7. Reports prepared for the Court also indicate that B had been feeling `on edge'. He had been *en route* to collect his Methadone prescription, and he was being troubled by persecutory voices with whom he was having a dialogue about what he subsequently described as others' "envy of his youth and good looks". He said he was seeking revenge from people in general, urged by the derogatory voices, and he disclosed that the night before, he had smoked `Spice' (a synthetic cannabinoid) which made him feel violent.

3.8. Judged fit to plead in June 2016 at the Old Bailey, B pleaded guilty to manslaughter by way of diminished responsibility. The forensic report prepared for the Court by a specialised Consultant Forensic Psychiatrist made it clear that B would likely remain a danger to the public without treatment because his limited insight and/or his unwillingness to desist from taking non-legal drugs made it likely he would not comply with treatment unless he was detained. B was sentenced using a Section 45A Mental Health Act "Hybrid Order". This imposed a hospital treatment order and a life sentence

for manslaughter with a minimum term of 18 years. B was transferred to Broadmoor with the expectation that when his treatment there is complete, he will return to prison to serve out the remainder of his sentence.

3.9. In Court, Judge Zoe Smith said: "The shock of Justin Skrebowski's killing has traumatised his immediate and extended family. The sheer random horror is proving very hard and painful for his family to cope with." "The real concern in [this] case is that even though [B] had been treated for schizophrenia over the last decade, [he] in no way moderated [his] taking of illegal substances". The judge said to B "Whilst it is said your psychotic state was becoming more difficult for you, it is clear at the time the amount of drugs you were consuming was also on the increase. And you knew that such drug-taking was going to exacerbate the symptoms you have."

4. Background and findings

4.1. Appendix 5 contains the detailed chronology of the events leading up to 7th December 2015 when Mr. Skrebowski died. This is based upon a review of the case notes written by the Trust, the chronology of events prepared by the Police, interviews with staff and B's parents, and the records kept by Turning Point, the substance misuse service. The information broadly mirrors that which was contained in the Trust's internal report

4.2. In this section, for ease of reference, findings are presented in the order that the Terms of Reference (Appendix 1) sets them out. Overall, our team believes that the Trust has taken many steps to improve the quality of their services since the tragic death of Mr. Skrebowski, including changes to the medical duty rostering so that staff can attend team meetings as a matter of routine. However, our team wishes to make several recommendations to strengthen the services provided by the Trust; these relate to Care Planning, improvements in the quality and ease of inter-agency communication, and staff training, particularly as regards the care of patients with dual diagnosis (mental ill health and substance misuse) who present a risk.

4.3. We believe that progress on these recommendations should be audited, and the operation of a new service model to improve care pathways should be monitored carefully. Our team would like to arrange a further short visit to the Trust in 6 months' time to discuss progress.

(a) The assessment, treatment and care provided for B (TOR ref. 2.1)

4.4. B was first referred to mental health services in 1997 when, at the age of 18, his GP asked for support to manage B's substance misuse problems. B's parents indicated that his difficulties appeared to begin after he went to `Raves' at around the age of 15 and took drugs (`weed' and ecstasy) with his friends. They reported no history of mental ill health in the family and they thought that B had been well up until this point, although they described him as `a soft lad who was easily led'. B initially worked with his father in

the building trade but he was unable to sustain this as his drug-taking lifestyle began to impair his mental and social functioning. Both B's parents provided a significant level of support for their son but by the age of 24 he had been fired from his job.

4.5. The record of B's contact with the Trust show that he was initially diagnosed with drug-related psychotic symptoms and anxiety and depression. He was treated and supported within the Trust addictions service which was initially provided from within the Trust rather than by an independent provider, as now. Although it appears that there was some initial uncertainty about whether B's symptoms were wholly drug-induced or whether he also had an underlying psychotic illness which could persist in the absence of drugs, in 2003 (when B was 26) he was given a formal diagnosis of paranoid schizophrenia exacerbated by substance misuse. He took overdoses in 1997 (age 17) and 2011 (age 32) and he occasionally self-harmed.

4.6. B was admitted to psychiatric hospital on four occasions. First, to an acute admissions ward, in August 2003 for a month on Section 2 of the Mental Health Act (MHA). At this time, he was admitted for 28 days for assessment and potential treatment following an assessment by the Crisis Resolution Team who assessed him to be suffering from an acute exacerbation of his psychotic symptoms. B was reported to be carrying a Stanley knife and had cut himself. His substance misuse had also escalated and his symptoms of mental ill health had worsened at that time. The records indicate that he admitted to taking crack cocaine, heroin, ketamine, steroids, cannabis and so-called legal highs (Spice, Mamba, Insane Joker, etc.). B subsequently told the forensic psychiatrist preparing a report for the Court that he tended to use whatever drug he could afford and he would `binge' about once per week.

4.7. A year later in July 2004, B was admitted for the second time to a Psychiatric Intensive Care (PICU) bed under Section 4 of the MHA (an admission in an emergency for assessment) which was subsequently converted to a Section 3: a treatment order potentially lasting up to 6 months. He had disclosed to a Mental Health professional that he had thought about stabbing an elderly male in a supermarket queue. He was discharged in the September of that year on Methadone 30mg daily, Olanzepine (an anti-psychotic) 15mg at night and Depixol 50mg (also an anti-psychotic) by injection every two weeks.

4.8. On the third occasion that B was admitted, in June 2015, B was assessed by a Consultant Psychiatrist from the Emergency Department Psychiatric Service after B's parents had alerted staff because they were very worried about him. But whilst waiting for transfer to Littlemore Psychiatric Hospital, B left and took ketamine, a short-acting anaesthetic associated in some people with delirium and hallucinations. He was brought back to the A & E by his sister but, in a disturbed state, he destroyed an expensive blood analysis machine at the hospital. B was then admitted to Littlemore under Section 2 of the MHA and his prescribed drugs included Depixol 100mg every 4 weeks, Quetiapine (also an anti-psychotic) 25mg daily, and Methadone 85mg daily. A 7-day

follow up was completed and a key worker from `Roads to Recovery', the Turning Point service also saw B. In addition, he was also referred for assessment to the genito-urinary medical (GUM) clinic and a new Community Psychiatric Nurse (CPN) or care coordinator was allocated.

4.9. B's fourth admission came at the end of October 2015 when he was seen in Outpatients at the request of the CPN who was concerned about his mental state. B appeared to be much more distressed and delusional than he had been. However, because the FY2[4] psychiatrist could not initially be certain whether his symptoms were primarily drug-related (and would therefore soon wear off) or whether he was showing signs of a relapsing psychosis. The doctor therefore arranged to see B again two days later. By then B was much worse, suffering from a range of delusional beliefs, hallucinations (a voice called `Daryl') as well as aggressive thoughts.

4.10. After discussion with the consultant, the doctor arranged an admission to hospital which B agreed to on an informal basis. The doctor's assessment report says: B's `escalating behaviour and escalating drug use/criminality may indeed be a sign of relapsing disease, as opposed to relating to his drug use alone.' He also comments: "At this point in time B is able to take responsibility for his actions and appreciates that his drug-taking affects his mental state to a nature and severity that puts his safety and the safety of others at risk."

4.11. During this admission, B was aggressive and sexually inappropriate and he displayed a range of psychotic symptoms. He was treated for his symptoms of mental ill health and, in addition, his care plan indicated that he would be discharged if he used drugs or alcohol whilst he was on the ward (he had formerly been injecting heroin and taking steroids). In the event, B was discharged after 4 days as his psychotic symptoms had, according to the notes, diminished very quickly once the effects of the drugs wore off. The discharge plan describes B as suffering from a "drug binge-related psychosis".

4.12. This was a very short admission and it is clear from the clinical notes and from interviews with staff that the community mental health team remained very concerned about B. The doctor from the community team therefore escalated his concerns to the consultant in an appropriate way, and they discussed the case at length together. Further information about this decision and the inter-team communications is provided below. Suffice to say, at the point he was discharged from hospital, the community team arranged to provide a significant level of `stepped up' care for B. His drugs were increased (Depixol from 100mg to 150mg monthly), a `Support Time and Recovery[5]'

[4] This is a term used to describe a doctor who is completing a psychiatric specialist training rotation who would formerly have been called a Senior House Officer or SHO.

[5] STR workers provide practical support to adults and young people who have mental health issues or a learning disability. More information about their role can be found in DH best practice guidance at. webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/

(STR) worker was allocated who saw B most days, and she was supported by the Deputy Team Leader of the adult mental health team and the Community Psychiatric Nurse (CPN). Outpatient appointments were made and kept and B's care was discussed each week in the Monday team meeting at which the Consultant was present. In addition, the FY2 doctor and the Consultant Community Psychiatrist made a request for an assessment by a Trust forensic psychiatrist although it subsequently became clear that B's symptoms and record did not reach the threshold to be given an assessment by that team.

4.13. During November B's care was delivered as planned. However, B was due to move to a new flat to get away from the drug dealing friends who were using his accommodation, a move which was triggered following B's identification as a `Vulnerable Adult'. He appeared in Court in relation to the damage he caused at the John Radcliffe Hospital and was given Conditional Bail, a curfew and a tag. He owed money to his drug dealer and feared that he would be shot; a fear that perhaps related to a shooting in Abingdon that was allegedly drug-related but it is also possible (because it was 5th November) that B had misinterpreted the sound of fireworks. B's CPN and care arrangements were also about to change again and although the STR worker was a stable presence throughout this period, B reported feeling much more unsettled.

4.14. Other pressures for B at this time included the fact that his appointments had moved from the `Roads to Recovery' (substance misuse) hub in Abingdon to Didcot, at least half an hour away by bus. He was restricted from accessing his gym; he had to change the pharmacy supplying his Methadone, and it was difficult for him to visit his parents. Perhaps most significantly of all, B's illicit drug misuse (something which he had previously admitted doing in part to gain short term relief from his psychiatric symptoms even though he knew that there were long term consequences for his mental ill health) escalated dramatically. A drug-using friend came into a significant sum (£3,000) which he and B then spent on a drug binge.

(b) Contact and communication between teams (TOR ref. 2.2)

Community and inpatient teams

4.15. Community and inpatient teams are managed and led separately in the Oxford adult mental health service, although the teams are managed within the same clinical Directorate with overarching senior leadership[6]. Judgements are made by the team that knows the patient best and an admission is arranged if a bed is available. Although the

[6] Clinical/professional judgement determines priority for care and treatment and admissions are focused on people with severe and enduring mental health problems associated with significant disability or risk, reflecting the requirements of the Trust's "Joint Care Programme Approach (CPA)" policy and Care Clustering needs assessment.

investigation team does not believe there is evidence that this division presents difficulties in the normal course of events, there was clearly a breakdown in communication between the two parts of the service regarding the decision to discharge B after his fourth brief admission at the end of October.

4.16. Decisions about discharge are normally taken by inpatient teams and in this case, representatives from the community team had asked to also be involved. Unfortunately, they arrived on the ward at what they thought was the right time only to find that the meeting had already happened; B was discharged and expecting to go. To understand the reason for the decision to discharge B, the investigation team looked closely at the notes and spoke to staff. Firstly, the notes make it clear that the inpatient team thought B was suffering primarily from a drug-related psychosis that would resolve quite quickly; they thought that there was little to gain from extending his stay. Some thought B would simply return to his drug abuse as soon as he left, so there was little point in keeping him; others that he was trying to `play the system' to avoid an upcoming Court appearance.

4.17. It is true that there was pressure on beds and staff shortages, as can sometimes be found elsewhere as NHS resources are constrained. This may have had a bearing on the decision to discharge B. It is also possible that the separation in management and organizational terms of substance misuse and mental health services (also widespread in the NHS) reinforced a widely-held belief that a general mental health inpatient bed is never the place to manage a drug-related psychosis, especially as specialised addictions services, including an inpatient addictions service, albeit with a long waiting list, are provided locally. It is therefore possible, and this point was made to our investigation team, that the division in services militated against the delivery of `joined up care' for B who was seen as having a primarily drug-induced psychosis (for which the sympathy of some staff was allegedly limited) rather than relapsing schizophrenia with substance misuse overlaid.

4.18. Providing good quality substance misuse services alongside mainstream mental health services is a challenge that all localities face. Increasingly, substance misuse services are contracted out to expert `independent' providers who typically deliver open access information and support, comprehensive assessment of needs, substitute prescribing, psychosocial support and interventions/counselling, detoxification support, community based alcohol support, relapse prevention, harm reduction services including needle exchange and overdose prevention, criminal justice support programmes, peer support initiatives and support for carers.

4.19. The investigation team was unable to find any evidence that the miscommunication regarding the timing of the meeting when the discharge was discussed was anything other than a simple error. However, it remains the case that B's parents and the community mental health team staff felt that a longer admission (as had been provided in the past when B's behaviour escalated) would have been warranted. B

himself also reports that the admission was too short and that it was curtailed because `they needed the bed.' The community team were still worried about B, so they stepped up his level of community care as described in paragraph 4.12 above.

4.20. The investigation team believes that B's community care was delivered to a good standard at this time. However, it is possible that a `Complex Care Review' or MAPPA review would have further increased levels of understanding about the risk that B presented. MAPPA stands for Multi-Agency Public Protection Arrangements whereby "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sex offenders and offenders who pose a serious risk of harm to the public come together to address how to manage anti-social behaviour effectively in a `joined-up' way. The case notes contain a note to indicate that MAPPA had been discussed as an option. However, it is also noted in the record that there was uncertainty about whose responsibility it would be to trigger such a review.

4.21. The investigation team believes that it is essential for staff to take an effective inter-agency approach to the management of risk. This is especially important when views about diagnosis and formulation or management are divided, as they were when B was discharged in October when there was disagreement about whether his problems were predominantly drug related or due to mental ill-health. For these reasons, we make the following recommendation.

Recommendation 1 MAPPA and complex care reviews

We recommend that the Trust provide additional information and/or training for community mental health staff so that they understand the use of MAPPA and/or complex care reviews and can trigger a referral to bring teams and/or agencies together to discuss the management of risk.

Roads to Recovery, the Turning Point substance misuse service

4.22. `Roads to Recovery', managed by the Turning Point was commissioned from April 2015 by Oxfordshire County Council Public Helath Department to provide substance misuse services in Oxford which had previously been provided by the Trust. Turning Point were therefore responsible for this aspect of B's care at the time Mr Skrebowski died. A Consultant Psychiatrist who is an addictions specialist also works as part of the TP team although they do not offer mental health treatment and care. B's key worker from the Trust substance misuse services from that time (M) had been transferred to Turning Point when they took over.

4.23. Examination of the TP records and conversations with staff in the Trust and at TP suggest that the change in substance misuse service provider led initially to some general uncertainty about communication, joint working and information sharing. For example, Turning Point received relatively little formal written information from the Trust about B when his case was handed over and, although they received a summary of B's care from the Trust after his June admission, no summary was sent after the admission in October. Whilst B did not participate in the various daily groups and treatment sessions offered by Turning Point (these are voluntary and not all patients choose to attend) he did keep his fortnightly appointments reasonably regularly and the records show that his Methadone programme was being managed effectively.

4.24. Turning Point also had some contact with B's Community Psychiatric Nurse, particularly in the weeks after B's most recent discharge and it seems that they found this helpful. However, they were not aware of whether B was being managed under the Care Programme Approach (CPA) or had a Care Plan, and they were not aware of the full extent of his contact with the Police. Nor was Turning Point aware of the degree to which B was using so-called `legal' highs because although B did discuss this to some extent with his Senior Recovery Worker, it only became clear later that he'd had a major drug binge as a consequence of a friend, also a drug user, having come into a significant sum of money.

4.25. There was a robust framework of Trust policies with respect to the care of B. For example, the dual diagnosis policy operating at the time makes it clear that when coordinated care is required for a person with both substance abuse and mental health problems, the lead role lies with the mental health service. However, several staff commented that the separation of mental health and substance misuse services (commonplace in many NHS settings, as indicated above) can militate against a common and shared approach being taken to the care of patients with comorbid (combined) mental ill health and substance misuse.

4.26. A new protocol on joint working between TP and the Trust has now been developed and TP staff say that communication has improved. But whilst Trust policy is clear that the lead role lies with the mental health service, staff may still feel uncertain about their role. We therefore recommend that the Trust take steps to provide appropriate information and/or training for staff now that substance misuse services are no longer provided `in-house'.

Recommendation 2 Dual diagnosis and management of risk

The Trust should ensure that all staff (community and inpatient teams) are supported to develop an appropriate level of knowledge about the management of patients with co-morbid mental ill health and substance misuse problems, and that Care Planning, Risk Assessment and inter-agency communications in relation to such patients is of a good quality.

The Police

4.27. B had a significant history of offending which began in 1998 at the age of 18. The records show that between1998 and 2015 prior to his arrest for the index offence he received 4 convictions for 10 offences, mostly in relation to assaults and public disorder and 4 reprimands/warnings/cautions, two of which were for drug offences including Class A drugs. After 2012 there were also warning markers/flags placed on Police record systems for Violence, Mental Health, Weapons, Officer Safety, Drugs, Suicidal and Ailments such as Hepatitis C and liver cirrhosis. At the time of the index offence B was awaiting Magistrate's Hearing related to an incident in July when he was involved in an altercation with a man on the street. The conditions of his bail were as follows:

- Curfew between 22.00 & 07.00 (electronically monitored)
- Live & sleep at his home address.
- Not to enter Abingdon City Centre as defined by Stratton Way, High St and Stert Street

4.28. In all, there were 23 incidents involving the Police that were obviously related to B's alcohol and substance abuse, including an escalation in his use of legal highs. Most of these incidents occurred in the last 6 months of 2015. They almost all involved repeated anti-social behaviour complaints or reports of B and his neighbours in the same block of flats making counter-allegations about noise disturbance and harassment. Up until the index offence, B was living with a flat mate (a drug dealer) and he was known to have drug debts, one reason why he had been due to move. Partner agencies (Police, mental health services and housing) had discussed B as a `vulnerable adult' and arrangements had been made to move his accommodation to be less exposed to exploitation by his drug dealing acquaintances. This appears to have been a very good example of inter-agency working and communication across different teams.

4.29. Evidence from the notes, from witnesses during the early part of 2016 suggest that a range of helpful communications took place between the Trust and the Police, and between the Police and B's family. For example, B's parents commented very

positively about the warmth and care shown to B by the police, albeit in the context restraining him or detaining him. Trust staff also commented that B was usually very open about his drug use and about coming into conflict with the law. Trust staff also had some direct contact with the Police although this was not as structured as it would have been for someone subject, for example, to a Community Treatment Order (CTO)[7].

(c) Documentation and record keeping, policies and protocols (TOR refs. 2.4 and 2.5)

4.30. Evidence from the records of the care provided for B, reinforced by accounts from the staff, B's parents, and B himself, also shows a good quality of documentation of the mental health care was provided for B over the years he was in contact with the Trust. Records are generally of a good quality and, apart from the absence of a Care Plan, which is a notable omission, they meet with national standards. There is also evidence in the notes and from interviews with staff who carried responsibility for B's care, that there was a formal written Risk Assessment which was up-to-date and had been reviewed regularly. Risks to others and B's thoughts were discussed regularly at the Monday team meetings when the Consultant was present.

4.31. The records show that in the months which immediately preceded the incident, and although B had been on CPA before, he was not formally subject to the Care Programme Approach (CPA). The Care Programme Approach or CPA is a framework for assessing, planning, coordinating and reviewing treatment for someone with severe mental health problems and/or complex needs. It outlines how a Care Coordinator will work to develop a Care Plan and a Risk Assessment. Care Plans summarise issues such as diagnosis, care, next of kin, crisis plan and risk which may otherwise be spread throughout the case notes.

4.32. Trust policy and DH guidance make it clear that all patients with B's level of complexity who are taken on for treatment are subject to the CPA, and the Trust guidelines contain information about this process. This was therefore a significant omission. In other respects, B's notes contain a full and clear account of a good level of stepped-up care during October, November, and the early part of December 2015 and they contain a good account of full discussions at team meetings, so it is somewhat surprising that a Care Plan is missing. In fact, we understand that the STR worker did complete a basic Care Plan that could be forwarded to the Housing Department dealing with B's accommodation move in November so that his move would not be delayed, but this task would not normally fall to an unqualified STR worker and it seems that this was a helpful expedient on her part rather than normal effective team practice

[7] A CTO may be applied after an initial period of detention in hospital under the MHA. 'Conditions' specified in the CTO may focus on aspects of treatment and/or risk management, including restrictions regarding place of residence. The patient must meet with a second opinion appointed doctor (SOAD) for authorisation of medication treatment within a given time (usually 1 month). If the patient fails to comply with the conditions of the CTO, they can be 'recalled' to hospital for up to 72 hours.

4.33. Whilst the absence of a formal Care Plan does NOT mean that an appropriate level of care was not provided (and our team believes that other evidence shows it was) a Care Plan provides an important focus for all those involved in work on a complex case. It helps the patient and his family, to know what is being provided; it can be copied easily with the patient's permission to partner agencies (e.g., Turning Point, Housing, Police) and it helps staff who may not know the patient well (e.g., new staff or trainees) to be aware of issues relating to risk which they would otherwise have to go through the detailed written records to find. The explanation for the omission possibly lies in the high turnover (four) of Community Psychiatric Nurses (CPNs) in the months prior to the incident, and a fifth was also just about to leave, which B also reported that he found highly unsettling and was apparently going to complain about. Current CPA policy identifies the need for changes in Care Coordinator to be kept to a minimum, and that any changes must be part of the CPA review and include the service user and their carer.

4.34. CPNs normally carry responsibility to write the plan in consultation with the other members of the team but there was no plan in what otherwise appears to be a set of comprehensive notes. Whilst staff `churn' is unavoidable, it can have a significant impact upon people with severe complex mental ill health. Our team has therefore made two further recommendations relating to Care Planning and care coordination.

Recommendation 3 Care Planning

We recommend that the Trust ensures through its routine audit of clinical procedures that all patients with complex needs who are in contact with secondary mental health services have a written Care Plan, agreed with, and copied for the patient and relevant partners in the delivery of care. Team leaders should then ensure through their routine management that Care Plans are appropriate and contain information about the patient's mental, physical and social care needs, diagnosis, risks and relapse profile, carers and treatment including drug treatments.

(d) The quality assurance framework and monitoring CPA (TOR ref 2.6)

4.29 The Trust operational policy for the provision of community mental health care (see Appendix 4 for a list of all the policies reviewed) sets out clear principles for the delivery of treatment and support which is person-centred, evidence and needs-based, delivered in partnership with the patient and his/her family, risk assessed and managed. The policy describes the challenges inherent in any model of care that divides services

between different clinical teams. It also contains statements about the personal safety for staff and there is a lone working policy which makes it clear that where individual service user presents significant risk to personal safety of staff, a written assessment will be undertaken. Our team interviewed the staff who saw B alone and we were satisfied that risks to them were managed effectively.

4.30 At the time (2015) in Oxford, `crisis resolution' and `assertive outreach' functions were incorporated into single multi-disciplinary Adult Mental Health (AMHT) teams in the interests of providing services more seamlessly. However, at the South Oxon AMHT Away Day in January 2016 a decision was taken to review this system to lessen the chance that the most complex patients would see staff with whom they were unfamiliar. This policy also strengthens guidance on CPA and sets out the need for formal CPA reviews at least every six months. The investigation team also recommends that changes in Care Coordinator be monitored carefully (see below).

Recommendation 5. Monitoring change

We recommend that the Trust review carefully the operation of the new service model which, whilst it appears to be sound and should support the delivery of a more seamless care pathway it is, as yet, untested. Our team would also like to arrange a further short visit to the Trust in 6 months' time to discuss progress with this and other recommendations

4.31 These and other changes in the way that the Trust delivers care, including progress with the recommendations made by those who led the initial investigation and recommendations made here, will need to be monitored carefully. A further recommendation is made in relation to this below. Our team suggests that another brief visit should be made to the Trust in six months' time.

(e) The Trust internal report (TOR ref 2.7).

4.32 The internal report (`the RCA report') prepared by the Trust signed off by the Clinical Commissioning Group in May 2016 describes the care provided for B and the circumstances leading up to the 7th December 2015 when the index offence took place. Overall, our investigation team is content to report that the initial investigation was

completed in a timely manner and we believe that its conclusions and recommendations are generally fair and follow from the evidence.

4.33 The RCA report concluded that the significant deterioration in B's mental state which occurred after a several years of relative stability was managed in a skilled and generally thorough way; our investigation team agrees with this. We concur with authors of the internal report that the absence of paperwork associated with a formal CPA process, a Care Plan and risk assessment were very important omissions (see above). Our team also agrees that it was undesirable that the work schedule of the doctor who saw B on December 3rd prevented him from attending team meetings where patients such as B were routinely discussed. We are therefore pleased to note that plans developed in January 2017 to alter the way that South Oxon AMHT schedules its workload, and the adoption of an approach called F.A.C.T. in July 2016, reviewed in January 2017, is designed to mitigate this problem.

4.34 The initial report recommended development of a joint working protocol between forensic services and adult mental health teams (AMHT); between AMHTs and Turning Point; to improve communication and joint working with the local police, and establish a risk panel in Oxfordshire. We note that referral protocols are now in place for these services and Complex Care Panel arrangements are now in place. However, we do not agree with the report's conclusion that senior medical oversight of B's case was poor, or that risks to staff working alone were not properly managed.

4.35 Evidence from the testimony of witnesses suggests that senior oversight of B's case was provided to a good standard and that appropriate levels of supervision and support were provided for staff. B's case was discussed most weeks in the team meeting; appropriate levels of supervision was provided for junior doctors, and witnesses commented particularly on the quality of their internal communication. Furthermore, the doctor who saw B in December was not alone in the building at the time, and appropriate steps were taken to manage risks that were potentially posed to the STR worker who met frequently with B by himself.

4.36 Our team notes the recommendation made in the initial report concerning forensic reports for the Courts. It suggests impropriety in the actions of staff who had been trying to expedite a forensic assessment for B which, owing to a combination of high thresholds and waiting times was thought unlikely to be possible. Whilst the notes do contain a letter from the consultant forensic psychiatrist to B's solicitor to say he could provide a specialist report for the Court if requested to do so, our team is clear that there was no intention to do other than help the patient and we therefore suggest that this recommendation be ignored.

4.37 Lastly, it is important to note that our investigation team heard from several staff about the process of gathering information for the initial report: they felt that the experience was punitive and adversarial. The NHS England Serious Incident

Framework states clearly that blame is an ineffective tool if 'incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working'. Staff usually share a compassionate and caring attitude towards their clients and they can be affected by a patient's sudden unexpected death or when a patient seriously harms someone else. We were therefore encouraged to learn that appropriate levels of individual support were provided by the Trust for them in this case. However, we also discovered some staff for whom the experience of participating in the initial investigation had exacerbated the levels of distress and concern that they were already feeling. Although they did cooperate fully with us, we were concerned about potential future damage to the reputation of the investigation process and would urge the Trust to monitor this carefully in future.

(f) Was the incident predictable and/or preventable?

4.38 Questions were raised about whether the tragic death of Mr Skrebowski could have been avoided if his admission in October had been longer. Our team spoke at length on this point with the doctors involved in his assessment. In October, B's symptoms were not so severe, his insight not so limited, nor the threat of harm to others so great that detention under the Mental Health Act (MHA) was warranted. Doctors and clinical staff from the inpatient and community services who discussed the case at the time were agreed on this point and, as B was willing to be admitted to hospital and then apparently willing to leave, the question of use of the MHA did not arise in practice.

4.39 Research shows that there are predictive factors associated with homicide after discharge from hospital which include medication non-compliance, substance misuse, poor self-care, and previous hospitalization(s) for violence, all of which were present in B's history. Our team discussed with B's parents, Trust staff, B's GP, and the forensic psychiatrist at Broadmoor the challenge of making an accurate diagnosis of B's condition, and the challenge of predicting what happened. Whilst B's parents (and B himself) thought that the October admission would ideally have been longer, they were deeply shocked by what happened in December and would not have predicted it.

4.40 Questions were also raised about whether it might have been possible to detain B under the MHA at the point when the STR worker alerted her colleagues to a worrying deterioration in B's mental state on 3rd December, especially given that B had been in Poundland on that day; he had cut himself and had had thoughts of hurting others not only on that day, but previously. Whilst a MHA[8] assessment would have had the benefit of involvement by others in the decision and had been used in the past, the doctor who saw B was clearly of the opinion that B did not warrant detention under the Act and he remains of this view today. Unfortunately, and as he pointed out, threats and behavioural disturbances are common amongst drug users with mental health

[8] A Mental Health Act assessment requires an Approved Mental Health Professional to coordinate the assessment and (depending on the Section) requires at least one Approved Clinician (e.g., psychiatrists, trained according to S.12(2) of the MHA.

problems; prediction of actual harm is highly inexact, and the requirements of the MHA are very specific.

4.41 We have no evidence that the doctor's judgement was incorrect. We also cannot know whether a Mental Health Act assessment would have led to a different outcome. We are aware that the prediction of risk is very difficult and that risk can never be eliminated altogether. However, opinion on this point is likely to be divided, especially given B's history and the tendency for his warm, apparently rational manner to bely the degree to which he could be volatile. We believe that if opinion is likely to be divided on these points, then it would be wise to trigger a MHA assessment and/or a discussion within the team so that those who are very familiar with the patient can contribute to the decision about how to proceed. This is particularly important if a doctor who is unfamiliar with the patient is taking the decision alone.

4.42 Despite evidence that there are potentially risk factors with which homicide is associated, the research shows that the degree to which a homicide can be predicted accurately is very low. This means that prevention is unlikely to be possible in all but the most extreme cases. B's parents certainly thought the incident was wholly unexpected, as did B's GP and the staff of the Trust who knew B well. All concurred that, when B was not under the influence of drugs he had no intention of harming himself or anyone else. Indeed, B was described as warm, likeable and friendly – something which may have led to an underestimation of the level of threat he posed, even though he may not have been eligible for detention.

4.43 Our team was critical of the clinical team for failing to use the CPA framework to manage the care provided for B. However, we do not believe that the presence of a Care Plan would have prevented the death of Mr Skrebowski. Care Plans are designed to aid formulation and communication within and between agencies and to assist in the management of complex cases; they are especially useful for staff who may not know the patient well, or they provide information about problems presented by patients whose initial appearance belies their level of disturbance. However, it is also true that the information contained in the general notes was of a good standard and there was information in the Risk Assessment Tool on CareNotes (the electronic records); detailed information was provided by the STR worker, and there was information about discussion at Monday team meetings. All of this was accessible to those who had the most contact with B around the time of the index offence, although it was not available to outside agencies.

4.44 The Court which had the benefit of a forensic assessment undertaken at a time when B's mental ill health could be observed over a period in the absence of illicit drugs concluded that the trajectory of B's psychotic illness coupled with the consequences of his very significant drug binge were sufficient to account for his behavior on the 7th December. The forensic psychiatrist further reported that B had limited insight and that he would be unlikely in future to resist using illicit drugs or comply with his medication.

Indeed, the fact that B was aware of the effects of illicit drugs on his behavior and mental ill health was the reason that the judge considered him to be at least partially culpable and was the reason for the hybrid order she imposed.

4.45 Questions were raised about the electronic tag which B wore as a condition of his bail after his Conditional Discharge. Electronic tagging works by the offender wearing a tag and a having a monitor station installed in his home. If B left his home during the curfew hours, the tag would alert the monitor station and indicate a breach. The monitoring station would then alert an external monitoring company which, in turn, notifies the police call centre. An `incident' is then created and officers are dispatched to arrest the offender. Any breach of court bail will result in an arrest and the offender must appear back at the Magistrates Court within 24 hours. In this case, the capability of the electronic tag B wore was limited only to identify if B was out of his house during the curfew times. It did not have the capability of monitoring B's location which is why he was able to enter Abingdon Town Centre without triggering any alerts.

4.46 In conclusion, it seems that the tragic incident which resulted in the death of Mr. Skrebowski can be associated with a certain degree of predictability. However, our team does not believe that Mr. Skrebowski's death was preventable. That such events are very rare can provide no consolation for the members of Mr Skrebowski's family, and is unlikely to reassure members of the public who witnessed the events of that day. However, our team would hope to reassure them that steps have been taken within the Trust to reinforce their procedures and inter-agency communication and joint working are both now much stronger than they were. Recommendations to strengthen these areas further have been made and will be followed up.

(g) The Trust's Duty of Candour, contact with families and relevant policy (TOR refs 2.9 and 2.10)

4.47 Our team looked at whether Trust practice in supporting patients and carers meet with national standards and whether the Trust's Duty of Candour[9] was met in this case. The Trust has for some time had an effective range of appropriate guidance for staff and is also now developing a new role (a Carer's Lead) who will take responsibility to ensure that carers' interests[10], including their rights to have an assessment of their own needs[11], are met appropriately by clinical teams.

[9] The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. This is a Statutory Duty and requires compliance from 1st April 2015 by all bodies registered with the Care Quality Commission. www.cqc.org.uk/content/regulation-20-duty-candour

[10] The Care Act 2014 sets out carers' legal rights to assessment and support and it came into force in April 2015.

[11] B's parents were not formally carers as B was an adult living independently in his own flat, even though he had been classified as a `Vulnerable Adult'.

4.48 It is policy, for example, that a carers pack is provided for the person whom inpatients identify as their carer and (where someone is identified) a named nurse makes weekly telephone contact to provide an update on care and obtain feedback from the carer on how they feel the patient is doing. This is documented in the electronic Clinical record under `Carer perspective'. Carer's views are also documented on the patient's Care Plan (if they have one) and carers are provided with relevant explanations if the patient requests no disclosure.

4.49 At the time of writing, our investigation team has been unable to speak directly with Mr. Skrebowski's partner. However, we understand that contact from the Trust was initiated by a senior member of the medical team. We are also aware that the victim's partner has been in contact with one of the very independent supporters[12] of families bereaved due to homicide and we hope that this has been helpful.

5. Conclusion and recommendations

5.1. Together with evidence gathered during our investigation about the quality of care that was provided for B, our team believes that the tragic incident which resulted in the death of Mr. Skrebowski can be associated with a certain degree of predictability. We conclude this because the predictive factors identified in research on homicides by people in contact with mental health services such as recent discharge from hospital, medication non-compliance, substance misuse, poor self-care, and previous detention and/or hospitalization(s) for violence, were all present in B's history. However, the research also shows that prevention in an individual case is extremely difficult, and the evidence we have gathered about B's individual case supports this.

5.2. There is no doubt that there were failings in the way that the Trust delivered care: for example, the absence of a Care Plan was a significant omission. It is also possible, had a Complex Care or MAPPA review been triggered at the point when B's symptoms were deteriorating again in early December that a team discussion of the impact of what proved to be a complex combination of severe mental ill health exacerbated by substance misuse might have led to a different management plan. However, the quality of B's general care was good; we have no evidence that the doctor's judgement on that day was incorrect, or that a further assessment would have led to a different outcome. We cannot therefore say that the tragic death of Mr. Skrebowski was preventable.

5.3. That such events are very rare can provide no consolation for the members of his family and is unlikely to reassure members of the public who witnessed the events of that day.

5.4. Our team nonetheless believes that steps have been taken by the Trust to reinforce their policies and clinical practice and we think that inter-agency communication and

[12] Hundredfamilies.org is an organisation established by Julian Hendy whose father, age 75, was killed by a psychiatric patient which provides support and information. http://www.hundredfamilies.org/help-for-families/

joint working are both much stronger than they were. We have made five recommendations to strengthen Care Planning to improve the quality of communication and inter-agency working further. We believe that progress on this should be audited, and the operation of a new service model to improve care pathways should be monitored carefully. Our recommendations are as follows:

Recommendation 1. Dual diagnosis and management of risk
The Trust should ensure that all staff (community and inpatient teams) are supported to develop an appropriate level of knowledge about the management of patients with mental ill health and substance misuse problems, and that Care Planning, Risk Assessment and inter-agency communications in relation to such patients is of a good quality.

Recommendation 2. MAPPA and complex care reviews
We recommend that the Trust provide additional information and/or training for community mental health staff so that they understand the use of MAPPA and/or complex care reviews and can trigger a referral to bring teams and/or agencies together to discuss the management of risk

Recommendation 3. Care Planning
We recommend that the Trust ensures through its routine audit of clinical procedures that all patients with complex needs who are in contact with secondary mental health services have a written Care Plan, agreed with, and copied for the patient and relevant partners in the delivery of care. Team leaders should then ensure through their routine management that Care Plans are appropriate and contain information about the patient's mental, physical and social care needs, diagnosis, risks and relapse profile, carers and treatment including drug treatments.

Recommendation 4. Changes in Care Coordinator
A certain level of staff turnover is normal and unavoidable, but very frequent changes are disruptive particularly for someone with complex mental health needs. Change should be kept to a minimum, as Trust policy states, but where changes occur, a review of the Care Plan and risks should always be undertaken to ensure that risks are assessed and communicated effectively. It will also be important for the Trust to monitor the impact upon effective care coordination of changes in level of resources such as access to beds.

Recommendation 5. Monitoring change
We recommend that the Trust review carefully the operation of the new service model which, whilst it appears to be sound and should support the delivery of a more seamless care pathway it is, as yet, untested. Our team would also like to arrange a further short visit to the Trust in 6 months' time to discuss progress with this and other recommendations

APPENDIX 1

Terms of Reference for the investigation

1. Purpose

To identify whether there were any gaps or deficiencies in the care and treatment that B received which were relevant to the prediction and/or prevention of the incident of 7th December 2015. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could prevent similar incidents from occurring.

The outcome of this investigation will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

2. Terms of Reference

2.1 Review the engagement, assessment, treatment and care that B received from Oxford Health NHS Foundation Trust from his first contact with services to the time of the incident on 7th December 2015.

2.2 Review the contact and communication between teams within Oxford Health Services (i.e. Inpatient Services, Forensic Services and Community Services) to assess if B's treatment plans and risk management plans were fully coordinated, understood, addressed B's needs and that those plans were implemented appropriately.

2.3 Review the contact and communication between multi agency teams within Oxfordshire and Oxford Health Mental Health Services (i.e. Police, GPs Turning Point) and assess if B's treatment plans and risk management plans (to self and others) were fully coordinated implemented appropriately.

2.4 Review the documentation and record keeping of key clinical information by Oxford Health NHS Foundation Trust against its own policies, best practice and national standards and comment on any identified variances.

2.5 Review the application of key Trust Policies and Protocols (e.g. Risk Assessment and Management Policy, CPA Policy, Forensic/AMHT Protocol) in this case.

2.6 Review the quality assurance framework within Oxford Health Trust with particular reference to the monitoring of the full application of CPA.

2.7 Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- If the investigation was completed in a timely manner.
- If the investigation satisfied its own terms of reference
- If all root causes and lessons have been identified, actions identified and shared
- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt and root causes.
- Review whether the action plan reflects the identified root causes, and that actions are comprehensive.
- Review progress made against the action plan.
  Review processes in place to embed any lessons learnt

2.8 Having assessed the above, to consider if this incident was predictable, preventable or avoidable and comment on relevant issues that may warrant further investigation.

2.9 Review the trusts application of its Duty of Candour to the perpetrator, family of the perpetrator and the victim's family.

2.10 To assess and review any contact made with the victim and perpetrator families involved in the investigation of this incident. To review the Trust's family engagement policy for homicide and serious patient incidents, measured against best practice and national standards and its application in this case.

3. Level of investigation

Type A: Awide-ranging investigation by a panel examining a single case

4. Timescale

The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter.

5. Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved including influencing the terms of reference
- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this investigation (provisional dates in June 2016)
- Seek full disclosure of the perpetrator's clinical records to the investigation team

6. Outputs

A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care

A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome

A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed)

Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference

At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation and engage the clinical commissioning group with these meetings where appropriate

A concise and easy to follow presentation for families

A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

We expect the investigators to include a lay person on their investigation panel to play a meaningful role and to bring an independent voice and challenge to the investigation and its processes. NHS England will seek to review the input of the lay person at the end of the investigation.

We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England that the report's recommendations have been fully implemented by the provider trust and monitored by the Clinical Commissioning Group. The investigator should produce a report for NHS England and families which may be made public.

We will require monthly updates and where required, these to be shared with families, CCGs and Providers.

The investigator will deliver learning events/workshops for the Trust, staff and commissioners.

APPENDIX 2

The investigation team

Anne Richardson Consulting Ltd (ARC) is a group of senior professionals, including people with lived experience of mental ill health and of providing care (lay members) who come together with a unique combination of knowledge, skill, and experience in delivering investigations under HSG (94) 27 and other related work. We share a passion about the quality and safety of mental health services; about supporting staff constructively, and about the importance of involving families and carers who often feel very excluded from the investigatory process.

Anne Richardson, Director of ARC, is a clinical psychologist by training. Specialising in work with adults with severe mental ill health and long term needs, she is an experienced clinician, trainer and communicator. As head of mental health policy at the Department of Health, she was instrumental in the development of the National Service Framework for Mental Health and for the development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008). Anne has worked on a number of investigations into the quality of NHS care and treatment provided for people who lost their lives unexpectedly, or for those who were themselves responsible for a death whilst in contact with services.

Lawrence Moulin has over 30 years' experience working in the NHS and at the Department of Health. His most recent post in the NHS was as the West Midlands Strategic Health Authority Lead for mental health and learning disabilities, with oversight of homicides and suicides, safety and service performance. Prior to this he worked as a clinical psychologist, a service manager and, in London, as a commissioner of services for people with mental health problems and/or with a learning disability. In addition, he worked on the delivery of national policy with the National Institute for Mental Health in England, in the Department of Health and more recently with the Care Quality Commission as a Specialist Advisor.

Hugh Griffiths is a former consultant psychiatrist in the North-East of England where he carried responsibility for in-patient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework.

Lisa Haywood (a lay member of the team) has worked as a Mental Health Act Tribunal Member since 2006. She also has a formal role as an appraiser within the tribunal service. Lisa has lived experience of mental health services and extensive experience in the field of service user and carer involvement and services. She has worked on a number of serious incident inquiries and for the Health and Social Care Advisory Service. Lisa was Vice Chair of national MIND for 12 years and has held roles with several local Service User Networks. Lisa supports the team to bring an independent voice and challenge to our methodology and findings.

APPENDIX 3

Policies and other documents reviewed

Comprehensive Investigation Report STEIS 2015-37663 Incident number 48685 dated 22/02/16 (the `internal' Root Cause Analysis)

Adult Directorate Clinical Model and Operational Policy for Community Mental Health Care, and South Oxon Implementation Plan and Operational Guidance (developed Aug 2016, reviewed Jan 2017)

Terms of Reference for the Adult Directorate Complex Case Panel (July 2016)

Personal Safety and Lone Working Policy (last reviewed 07/07/15)

Dual Diagnosis Pathway: policy on referrals to and from Turning Point (2017)

Policy on Non-Attendance for Appointments (last reviewed 20/08/15)

Discharge Policy (last reviewed 13/06/16)

Clinical Risk Assessment and Management policy (last reviewed 19/06/14)

Care Programme Approach Policy (including non CPA) (last reviewed 20/08/15)

Patient, Service User and Carer Information Policy (last reviewed 02/09/15)

Policy on Safeguarding Adults (last reviewed 25/0615)

Thames Valley Police Individual Management Review (03/08/16) authored by: ZH of the TVP Serious Case and Domestic Homicide Review Team and associated chronology of contact between the patient and police.

Policy on practice to improve patient and carer experience: `the Triangle of Care'. A Guide to Best Practice in Acute Mental Health Care http://static.carers.org/files/caretriangle-web-5250.pdf

Service User and Carer information policy (last reviewed Sep 2015 and next due for review March 2018) and job description for the Carer's Lead Professional role.

APPENDIX 4

Witnesses

Consultant Psychiatrist CP1 (inpatient team)

Consultant Psychiatrist CP2 (community team)

Community Psychiatric Nurse (CPN)

STR worker (STR)

Junior doctor 1 community team (JD1)

Junior doctor 2 inpatient team (JD2)

Representative from the management team at Turning Point, Didcot (A)

General Medical Practitioner (GP)

Mr. and Mrs. J. (parents of the patient)

Ms A (partner of the victim)

Detective Inspector B (DI B)

B (the patient)

Consultant Forensic Psychiatrist (Broadmoor)

B's post-sentence Probation Officer

APPENDIX 5

Chronology of Care

DATE	CONTACT WITH SERVICES
Aug 1997	B (age 18) was first referred by his GP to the drug and alcohol service having been in trouble with the Police for motoring offences. He was using amphetamine and MDMA at this time. B was given the phone number of an advice line and referred back to his GP.
Nov 1997	Following an overdose of paracetamol, B was referred again to the drug and alcohol service; he was taken on for treatment and he showed signs of improvement.
Jan 2000	B was treated within the addictions service for heroin addiction. He participated in a community detox programme, but he did not attend for follow-up and subsequently relapsed.
May 2000	Following an episode of self-harm, B was again accepted for treatment by drugs services for treatment which included family support. It appears that this contact lasted for about a year but it ended in March 2001.
Aug 2001	B was referred to a Community Mental Health Team (CMHT) psychiatrist with ongoing problems of heroin use and depression and he was re-directed to the addictions service. On this occasion, he reported hearing voices present for about 7 months which offered a running commentary on his behavior. He was prescribed 10 mg Olanzepine (an anti-psychotic) to take at night and 25mg of Methadone (a heroin substitute).
Mar 2002	B's case was reviewed and the notes record major improvement in his mental health. It was planned that the addictions team should follow him up. There is a note in the record (unconfirmed) of an arrest for assault.
Jul 2002	B was reported to be using crack cocaine at the weekends. He had apparently threatened a neighbour with a sword; it appeared that his psychotic symptoms were worsening.
Nov 2002	A specialist registrar saw B in outpatients and reported that he was `reasonably stable' on 25mg of Methadone and 15mg of Olanzepine at night. It is not clear why contact with community mental health services then stopped but B was being supported by the addictions service at this time.
Jun 2003	Six months later, the consultant psychiatrist in the addictions team referred B back to mental health services because he was complaining of hearing voices. B's father had found a knife in his room and he was worried that his son seemed very unwell. B was seen on 26th June 2003 and diagnosed with paranoid schizophrenia and drug misuse; he was prescribed 30mg of Methadone and 20mg of Olanzepine; placed on enhanced CPA (the Care Programme Approach). He was seen regularly in outpatients by a specialist registrar.

Aug -Sept 2003 1st admission	B was admitted to Phoenix ward, 24.08.03 Littlemore, on Section 2 of the Mental Health Act (MHA) for 28 days for assessment and potentially treatment following an assessment by the Crisis Resolution Team who assessed an acute exacerbation of his psychotic symptoms. B was reported to be carrying a Stanley knife and had cut himself. After this admission, B was followed up in the psychiatric outpatients' clinic. He was on enhanced CPA and there is a clear Care Plan in the notes. By now, B was taking 30mls daily of Methadone and 25mg of Olanzepine and it was reported that he had gained four stones in weight (a common side-effect of the drugs he was taking). B continued to be seen by the specialist registrar in outpatients and an application for Disability Living Allowance was made. B's diagnosis was: "paranoid schizophrenia and harmful drug abuse, partly in remission."
May – Sep 2004 2nd admission	At an outpatient review B was reported to be carrying a knife with a 7" blade and that he had threatened "to kill the people involved." Following assessment by the Crisis Resolution Team, on 28.05.04 he was admitted to a Psychiatric Intensive Care (PICU) bed under Section 4 of the MHA (an admission in an emergency for assessment) which was subsequently converted to a Section 3 (a treatment order potentially lasting up to 6 months). In June 2004 B disclosed to a Mental Health professional that he had thought about stabbing an elderly male in a supermarket queue. He was discharged in September on Methadone 30mg daily, Olanzepine 15mg at night and Depixol 50mg (also an anti-psychotic) by injection every two weeks.
Oct 2004 – 2007/8	B was seen by his Consultant Psychiatrist in the outpatient clinic in October 2004 and reported to be compliant with treatment. Over the next two to three years, B was seen regularly and followed up in outpatients; he was also being seen by the addictions team. In Aug 2006, the Consultant psychiatrist comments that B had come off his heroin and cut down on cocaine and that he was compliant with his prescribed drug treatment regime. He seemed quite stable. However, in 2008, the CPN attached to the addictions team commented that B was now injecting crack cocaine rather than just smoking it. This was associated with poor sleep and an increase in his hearing voices, as well as command hallucinations telling him to hurt others. In July 2007, the Consultant Psychiatrist left and a locum was appointed. B's Depixol was doubled to 80mg every two weeks. He was also diagnosed with Hepatitis C. B remained on enhanced CPA. By now, aged 27 he was living in his own flat, near his parents. The locum consultant psychiatrist described B as experiencing tactile and auditory hallucinations and paranoia. Despite this, B's behavior was relatively stable.
Feb 2010	B missed an outpatient clinic appointment.
Apr-Nov 2011-	Care Notes suggest that B was discharged from CPA in April 2011 and, in a review in November 2011, he is noted to have been `mentally well for the past few years.'
Jan 2013	CPA reviews are, once again, evident in the written records of B's care at this time. B maintained his mental stability, although he was also reported to continue to be using non-prescribed illicit drugs including so-called `legal' highs (these drugs are not legal any longer) and there is reference made in the notes to contact with the Police for drug dealing and

	possession of a bladed article.
Jun 2013	An assessment was undertaken by the emergency duty team because B had been arrested for threatening a female neighbour. It seems that he had missed his Depixol injection in May, the previous month. B was assessed by an Approved Mental Health Professional (AMHP) but was not detained under the MHA and charges were dropped. By this time, B's dose of Methadone was 85mg per day and his new Consultant Psychiatrist had increased his Depixol to 160mg every 4 weeks.
Jul 2013	B failed to attend a CPA review meeting.
Jan 2014	Clinical notes (a report from the Housing Department) suggest that B was again involved in anti-social behavior involving his neighbours. However, no signs of mental disorder were reported or observed. He saw his `harm minimization key worker'[13] afterwards.
Jun 2014	A new Consultant Psychiatrist reduced B's Depixol from 160mg to 120mg every 4 weeks.
Apr/May 2015	Following an altercation with his neighbour, B was arrested and again assessed by an AMHP. He was not detained under the MHA having been able to satisfy the team that he was feeling better and would behave himself. It appears that he had been using so-called `legal' highs. B was then reviewed by the Consultant Psychiatrist and Deputy CMHT Manager having been bailed by the police following an arrest for aggressive and threatening language to his neighbour. He had also cut himself with a kitchen knife. Over the next few days, notes describe how contact was made with B's mother who was also worried that her son was getting worse and that he was also occasionally aggressive towards her.
25th May 2015	A member of the public phoned 999 to report that his young son had called him after becoming scared of a man (later identified as B) who was trying to join in a game of football. The Caller found B with no top on shouting, 'I ain't a fucking paedo, I'll do what I want, I'll fuck you up, I'll go and get a knife and I'll kill you.' There was a suggestion that B had a broken bottle. He was arrested on suspicion of a S.4 Public Order Offence and some kitchen knives were removed from his flat. B was charged with a public order offence and bailed to Court for the 7th July 2015 with conditions not to go to the park. After release, he was taken by police to Abingdon Hospital for an appointment with the Community Mental Health Team (CMHT). He was subsequently given a 6 month conditional discharge. A decision was made not to admit B at this time as he was engaging well and was prepared to take his medication.
Jun 2015 3rd admission	B attended the Day Hospital for an assessment as it was judged unsafe to see him at home. It was clear that his mental state had deteriorated and he reported having taken a variety of illicit drugs, and was hearing voices urging him to kill someone. B's mother felt he had been getting worse and she was worried about him, and about whether he would hurt someone else. B was assessed by a Consultant Psychiatrist from the Emergency Department Psychiatric Service. After this whilst waiting for transfer to Littlemore, B left the hospital and took ketamine illegally (a short-acting anaesthetic associated in some patients with delirium

[13] Details of this role can be found in documents published by the NHS National Treatment Agency for Substance Misuse. Their aim is to help drug users take steps to reduce harm to themselves and/or others.

	and hallucinations). He was brought back later by his sister and then destroyed a large amount of valuable equipment in the Accident and Emergency Department at the JR. He was admitted on 3rd June under Section 2 of the MHA. He was described as having suicidal thoughts and as having thoughts of killing someone. The Police had also charged him with public order offences, electronically tagged him, and released him on bail on condition he did not go into the centre of Abingdon. Turning Point staff then took steps to help him change the pharmacy supplying his Methadone (which was in the centre of Abingdon).
29th June 15	B was discharged from his Section 2 after a month, during which time he behaved in a very disturbed and sometimes threatening manner. However, he eventually settled and the discharge letter indicates that in their opinion, B's behavior was not driven by an enduring psychotic illness but rather by substance-induced symptoms. His prescribed drugs at this time included Depixol 100mg every 4 weeks, Quetiapine (also an anti-psychotic) 25mg daily, and Methadone 85mg daily. After his discharge, a 7-day follow up was completed and a key worker from `Roads to Recovery', the Turning Point service which had taken over management of the addictions service in April of that year saw him regularly. B attended the Didcot Turning Point `hub' (where on at least one occasion it was noted that he was intoxicated); he was also referred to a genito-urinary medical (GUM) clinic, and a new care coordinator was allocated.
Jul/Aug 2015	B missed his Depixol depot injection and three collections of Methadone. B was living at this time in a social housing flat/sublet within a block of private flats in Abingdon. Turning Point records show that B typically took £50 heroin and £50 crack smoked or injected, plus £5-worth of `Spice' daily although he was showing some signs of withdrawal, indicating that he was trying to reduce his use. Turning Point held a complex case review on 26/8 and discussion also took place about whether an Adult Safeguarding referral should be made. This was triggered because B was in debt to his drug dealer, whom he allowed to stay in the flat in return for Crack cocaine and he was being exploited.
Sep 2015	B attended Didcot Turning Point hub on 21/9. He missed his depot injection. The Social Worker (by now, B's Care Coordinator) and the Consultant Psychiatrist visited B at home, but he was not in. Turning Point records show that B's Methadone was recommenced.
5th Oct 2015	B attended the Didcot hub for a prescribing review. His NHS key worker was not present. He was described as having been sleeping rough occasionally to avoid conflict with drug dealers. Notes describe someone who is `unstable, lacks recovery skills, seeking higher dose.'
14th Oct 2015	A member of the public phoned 999 to report a man ranting and swearing; it was suspected to be a Mental Health matter. On arrest B told Uniformed Patrol Officers that he was going to 'fucking stab them'. He was later charged with a S.5 Public Order offence.
15th Oct 2015	Two separate members of the public reported a series of incidents involving B behaving in a threatening manner with a brick and being abusive to members of the public in the centre of Abingdon. Officers attended immediately and arrested him behind Poundland after a chase

	on foot. B appeared in Court on 30th Oct (he was already on conditional bail) and was fined. He had the illicit substance `Black Mamba[14]' hidden in his sock.
21 Oct 2015 (Wednesday)	B was seen by the (FY2 grade) psychiatrist (formerly known as a Senior House Officer or SHO) and the care coordinator, an appointment which was triggered by what appeared to be an escalation in his behavior and mental ill health due to excessive illegal drug-taking funded by a flat-mate who had come into a significant amount of money. B had been arrested four times during the previous week and had been described potentially as "an imminent threat to safety of local residents". He had also tried to hang himself with his belt whilst under the influence of drugs and alcohol; he was charged with burglary and indecent exposure and because he had resisted arrest. Neighbours at No. 13 were one focus for his anger. The detailed notes and report prepared at this time suggest that an admission was not immediately warranted as B was reasonably calm and rational at the point when he was seen by the psychiatrist. Nor was B judged to be in a mental state that warranted a Mental Health Act assessment. Police were informed that B had been seen by the MH team. Police tasked CCTV operators in the area to look out for him. B's level of NHS care was also stepped up significantly. The FY2 doctor and the consultant discussed the possibility of a referral for a specialized forensic assessment.
23 Oct 2015 (Friday) 4th admission	Two days later, after another appointment with the FY2 grade doctor who was monitoring B carefully, a decision was reached to admit him as B was now more distressed and delusional than he had been two days earlier and he was suffering from a range of delusional beliefs, hallucinations (a voice called `Daryl') as well as aggressive thoughts. He agreed to be admitted informally.  The medical assessment report says: B's `escalating behaviour and escalating drug use/criminality may indeed be a sign of relapsing disease, as opposed to relating to his drug use alone.' He comments: "At this point in time B is able to take responsibility for his actions, and appreciates that his drug-taking affects his mental state to a nature and severity that puts his safety and the safety of others at risk. He also understands that if he acts on his current thoughts of stabbing his neighbour he would be liable for a lengthy prison sentence." During this admission, B was aggressive and sexually inappropriate. The plan for his care indicated that he would be discharged if he used drugs or alcohol whilst on the ward (he had been injecting heroin and taking steroids prior to admission). However, B was discharged after 4 days and the discharge plan in the notes describes B as suffering from a "drug binge-related psychosis" which had apparently resolved once he was drug-free. B's psychotic symptoms had, according to the notes, diminished very quickly once the effects of the drugs wore off, despite his hearing voices two days previously. The FY2 doctor and the Consultant, despite asking to be involved in the discharge decision, were not involved. The FY2 doctor and the Consultant Community Psychiatrist made a request for an assessment by the forensic psychiatrist. They also stepped up the level of community care

[14] Black Mamba is a synthetic cannabinoid (a chemical made to act like the active part of cannabis). Some such substances have been given Class B status but so-called 'Legal Highs', also known as psychoactive substances were made subject to a blanket ban on 26th May 2016. They were therefore still legal at this time.

	and B was seen daily by the STR worker for whom B was a new patient at this time and B's Depixol was increased from 100mg to 150mg monthly. B subsequently reported to the forensic psychiatrist who saw him in prison that this admission was not helpful to him; that it was too short, and that he'd been `thrown out because they needed the bed'.
28/29 Oct 2015	B attended the Didcot hub Turning Point.
2nd Nov 2015	B missed his appointment at Turning Point.
5 Nov 2015	B was identified by the police as a `Vulnerable Adult' due to the pattern of his apparent exploitation by his drug dealing friends. A Vulnerable Adult is defined as someone who is a) aged 18 or over and, b) is or may be in need of community care services by reason of mental or other disability, age or illness and, c) is or may be unable to take care of him or herself or, d) is unable to protect him or herself against significant harm or exploitation.
5 Nov 2015	A police report in the NHS notes indicates that B called the Police to complain he'd been shot at. The notes also show a letter from the consultant forensic psychiatrist to B's solicitor to say he could provide a specialist report for the Court if requested to do so. It appears that this was done in order to try to expedite the forensic assessment which, owing to a combination of high thresholds and waiting times was not likely to be possible within the routine service arrangements.
7th Nov 2015	B was seen in the Abingdon Custody suite in relation to his bail conditions following a shoplifting incident (at around the same time in early October as he caused damage to the JR) and the Police referred him to the Criminal Justice Liaison and Diversion Team who recommended an admission. However, there was no bed available and because it appeared that B's behavior was triggered by drug use, it was thought appropriate to refer to the `step up' team for immediate support.
8 Nov 2015	B was arrested Saturday 8th Nov and went to Court on the 9th for being involved in an incident in Abingdon – he hit a dog that barked at him, and the owner then hit him. B then broke the window of the police car.
9th Nov 2015	Police records show that the Community Mental Health Team were working with B to try to ensure that following his house move the rules around visitors would be more clear cut. This was an attempt to try to reduce the amount of chaos in his life and this appears to have been an example of good practice. B's mother called the team as she was worried about B and concerned that he might harm someone as she had found a knife in his bag.
11th Nov 2015	B told the MH team he'd been arrested the previous Sunday afternoon for an incident in the city centre when he punched a dog, whose owner then hit him. B reported he had accidently broken the police car window when he hit it. He was then tagged and released on condition that he did not go into the centre of Abingdon and required to stay in his flat between 9pm and 6am. Local Police warned their officers of B's escalating behaviour and the threats he was making to his neighbours and Officers were requested to enforce bail conditions and

	deal robustly with any offences.
13-30 Nov 2015	Significant levels of support by the CMHT were continuing to be provided and it is clear that this was delivered to a high standard and with clear notes (although there was no formal written Care Plan). The STR worker visited B most days. She took him to get his Methadone and/or depot drugs. Plans were now also in place for B to move to a new address owing to ongoing concerns for his safety as he owed money to drug dealers. B reported that he had thoughts of suicide. The STR worker phoned the Deputy CMHT manager for advice and an appointment was arranged for B to see the staff grade doctor at the Abingdon base.
17th Nov	B missed his appointment at the Didcot hub.
1st Dec	B attended the Didcot hub to get his Methadone prescription and a urine screen was completed (results were only positive for methadone; negative for cocaine, opiates, THC).
3 Dec 2015	Worried about what appeared to be a deterioration in B's mental health, the STR worker triggered an appointment for him to see the psychiatrist in Abingdon. However, whilst she spoke to the doctor, B left the building. She searched for him, eventually reached him on the phone, and picked him up. She learned that he had been in the Poundland shop (in Abingdon centre which his bail conditions proscribed). B had superficially cut his hand; he felt that the other customers were making fun of him due to his upcoming move to a new flat, and he had thoughts about injuring them. At the outpatient review which followed, B was described as erratic. However, it was not the opinion of the assessing doctor that B met criteria for detention under the MHA. Neither was he admitted informally as he did not show clear signs of psychotic behavior. Rather, his behavior in the centre of Abingdon was interpreted as a `sign of distress' due to a significant level of life stress and anxiety management was the approach taken. B's level of stepped-up care continued to be provided.
4 Dec 2015	B had his last contact with his care coordinator who was also due to be leaving shortly. B was also due to move to his new accommodation shortly.
7 Dec 2015	The STR worker spoke to B on the phone; he wanted to see her to discuss worries about being remanded due to his threats to kill others. She said she would meet him at 12.30 and B confirmed that he felt safe to wait until then. After this, a worker from the Court Liaison and Diversion Team then contacted the CMHT to say that B (now aged 36) had been arrested for killing a man (Mr Justin Skrebowksi) in the Poundland shop by stabbing him in the back, and injuring two others. Two other members of the public were also threatened, one of whom received minor injuries. Whilst B appeared to be experiencing psychotic symptoms, he was still able to engage and communicate. He reported having used an illegal high the previous evening (something called `clockwork orange*') which he had not used before.
21 Dec 2015	B was seen by a forensic psychiatrist and the lead investigator for the Trust's internal Root Cause Analysis (RCA) report at Woodhill prison.

23 Dec 15	B's parents were seen at their home by the RCA team; they described a deterioration in their son's mental state which dated to around 6 months previously (about the time that he missed two Depixol injections and caused damage in A&E). Like B, they thought it would have been helpful if his admission to the ward in October could have been longer although they attributed his deterioration to his use of new illegal drugs. They wondered why the Police tag hadn't worked and why no apparent action had been taken when B went into the centre of Abingdon. The Police IMR also suggests that the terms of B's bail only restricted him during the evening, not the daytime.
March 16	B was admitted to Broadmoor where he presented with marked auditory hallucinations, paranoid delusional ideas, and passivity of thought. He thought the tv was talking to him and that his thoughts were being broadcast aloud. He acknowledged that he was unwell. His behavior was occasionally sexually inappropriate, although he respected social boundaries and he was compliant with medication. Gradually, his mental state improved. He was given a diagnosis of paranoid schizophrenia with comorbid mental and behavioural disturbance due to substance misuse (but no personality disorder).
6th June 2016	Judged fit to plead, B pleaded guilty to manslaughter by way of diminished responsibility at the Old Bailey (he appeared in Court via video-link) in June. He was sentenced using a Section 45A Mental Health Act "Hybrid Order". The forensic report made it clear that B would remain a danger to the public without treatment because his limited insight and/or unwillingness to desist from taking non-legal drugs made it likely he would not comply with treatment unless he was detained.
May 2016	Oxfordshire Clinical Commissioning Group met to receive the internal Comprehensive Investigation Report and Root Cause Analysis completed in February by the hospital Trust. This made six recommendations for the Trust regarding CPA reviews; joint working protocols with Turning Point; establishment of Risk Panels; joint working between general adult and forensic services; joint working between general adult mental health services and the Police, and probity regarding prompts for referral for forensic assessments by the Court.
June 2016	In June 2016 the CIR was advised that Oxfordshire Coroners intend to convene an Inquest into the circumstances leading to the death of the victim.
August 2016	Thames Valley Police (TVP) complete an independent Individual Management Review led by their Serious Case and Domestic Homicide Review Team. It contains individual and systems-level learning points; notes several examples of good practice, and makes recommendations regarding records, review meetings, the use of research tools, risk and safeguarding for people who are bailed, and audit of risk assessments. It does not explain how B's electronic tag might have operated, although normally, an external company would raise an alert if a curfew is breached (i.e. if he home `beacon' which talks to the tag is activated) and local CCTV operators would be notified. The review concludes that there were no obvious failings in the way that the Police managed B and no guarantee that temporary sanctions could have prevented the incident that resulted in Mr Skrebowski's tragic death. It considers that there might have been value in holding a MAPPA review although it notes a lack of clarity regarding whose individual responsibility it might have been to trigger one.

Dec 2016	A Critical Incident Review (CIR) took place in December 2015 chaired by the Local Policing Area (LPA) Commander for Oxon South & Vale.