

# **An independent investigation into the care and treatment of a mental health service user (L) in Greater Manchester**

**November 2018**

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Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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## Statement by Mo Lound, Will's mother

L's crime devastated my life. At Christmas 2016 I had two children who I loved dearly. This Christmas I was alone. My future should have been with my family, my two wonderful children, both at the beginning of their lives.

Will was thirty years old. Having left school with three A levels, Will joined the merchant navy as a deck officer travelling the world for a number of years. He served on bulk tankers, bringing Bacardi from the Caribbean and delivering fuel to Saint Helena among other things. He then decided that a life on the ocean wave was not for him.

He had finally found his path in life, information technology was to be his future. He worked very hard to achieve this goal spending two years gaining the qualifications needed to start his degree. Will was awarded a chancellor's scholarship to study computer science at the University of Salford.

Will was a very bright guy and had made a very promising start to his studies. He was enjoying student life. I have a book of condolence from the University in which staff and students wrote the most wonderful comments. They told of how he was a happy smiling individual, an interesting conversationalist and always ready to help others.

It was this very willingness to help others which cost him his life. L was homeless. Will invited him to use his shower. L's response to Will's kindness was to stab him to death.

I bear no malice towards L. He is a very sick man and was moved within days of arrest to Ashworth hospital where he remained until conviction. I understand that having spent a brief period in prison L has been transferred to Ashworth. There are only 800 beds in high security hospitals for the whole of England and Wales. This illustrates how dangerous a man L is. I do not blame L for Will's death. I blame the system which allowed it to happen.

Gini, my beautiful 28 year old daughter, took her own life four months after her brothers passing, almost certainly as a consequence of L's crime. The two people Gini loved most in the world were dead. Her father died in 2009 and her beloved brother's life was ended by L in February 2016. Gini had so much to live for. She had a thriving business of her own and was respected and loved by many. Over 300 people attended her funeral in July 2016.

Will and Gini's many friends were seriously affected by these events. For the first time in their young lives they have had to come to terms with the loss of a friend, for some two friends. My children's untimely deaths were like the ripples on a pond and affected so many people.

My view that the system starved of cash as it is was to blame has been confirmed firstly by the inquest findings and then by this report. Will's death although perhaps not predictable was certainly preventable.

The thread running through L's care was lack of information. The clinicians who treated him failed to look into his medical history, inexcusable in the age of electronic communication. Fortunately his social worker did take the trouble to make this information available. Still it was ignored. The fact that he had spent

years in Ashworth followed by years in medium secure accommodation should have alerted the authorities to how dangerous L was.

L's section was lifted by a tribunal against clinician's advice. Perhaps the L's of this world should remain on some kind of licence for life, particularly if treating clinicians are not in full agreement with a tribunal's decision.

Once released into the community L stopped taking his medication and reconnected with illicit drugs. His illness returned. There followed numerous visits to A& E where L told how he heard voices commanding him to kill people. Still he was not taken seriously. He was admitted to various in-patient facilities from which he absconded. Rather than a serious attempt to get him back on his drugs, which were vital to his well-being, astonishingly doctors questioned the diagnosis and accepted what L said without question. No attempt was made to detain him in spite of his repeated absconding. He was returned to the hospital by the police or emergency ambulance, a waste of scarce resources. The most surprising fact to emerge regarding L's treatment by mental health services was that in spite of failures in treatment L was discharged in his absence.

At the time of the murder L was on bail for a petty crime. Human error and lack of information led to L being free. Had the police and magistrates known L's history he may have remained in custody. Police have an indication of whether someone has mental health issues. Perhaps there should be an additional symbol marking out the L's of this world from harmless people who have gone missing from EMI care homes.

L's crime was perhaps predictable and certainly preventable. This is the conclusion reached by the coroner, jury and this NICHE report.

More investment in mental health services is vital if tragedies are not to be repeated. More money may result in consistency of care instead of patients being bounced round the system from ward to ward and doctor to doctor due to pressure for beds. The L's of this world would get treatment and our communities would be so much safer.

There must be L's in every town and city. I know from personal experience that there is one young man in Southport whose family have pleaded with mental health services to admit him. He hears voices telling him to kill people. He keeps a machete by his front door. He was promised a bed in a psychiatric ward which unsurprisingly did not materialise. This young man is now at home in the charge of his very worried family. I am only aware of this because his mother having seen me on television talking about mental health thought I may be able to help. This shows real desperation and highlights the failures in the system. Tragedies will continue until mental health services get a fairer share of the NHS budget. Mental illness is increasing funding should reflect this trend.

Perhaps it should be recognised that unless more support is provided in the community there is a minority of mentally ill people for whom institutional care may be the only safe answer. Perhaps the pendulum has swung too far in favour of the ill person rather than the rest of us. We have rights too. We have the right to be protected from people with a history of violence and serious mental illness and whose lifestyle is not conducive to successful treatment in the community.

## 1. Executive summary

- 1.1 NHS England, North, commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user, L. Niche is a consultancy company specialising in patient safety investigations and reviews.
- 1.2 The independent investigation follows the NHS England Serious Incident Framework<sup>1</sup> (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.<sup>2</sup>
- 1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.
- 1.5 The terms of reference for this investigation include the care and treatment of L by the (legacy) Manchester Mental Health and Social Care NHS Trust (MHSC), Pennine Care NHS Foundation Trust (PCFT) and associated agencies. The full terms of reference are at Appendix A. It is important to note that MHSC ceased to provide care as a registered mental health trust in January 2017. The organisation has now been integrated into Greater Manchester Mental Health NHS Foundation Trust (GMMH). This does not in any way affect the detailed level of scrutiny we have applied to the legacy trust, however, we will reflect resultant changes to care and practice as part of the new Trust. Some of the policies and procedures which were in use at the time of L's care have been retired or replaced with policies now reflective of the work of the new organisation.

### The homicide of Will

- 1.6 On the 08 February 2016, L autonomously presented to the Barnabus Centre, Manchester, where he approached a Police Community Support Officer (PCSO) and centre staff to disclose that he had murdered somebody.
- 1.7 L produced a bank card in the name of Will and declared that he had stabbed him [Will]. He was arrested on suspicion of murder, to which he later pleaded guilty and was sentenced to life imprisonment with the minimum term of 23 years.

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<sup>1</sup> NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

<sup>2</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

- 1.8 Uniformed officers arrived at Will's flat in Salford where the victim's body was discovered having been stabbed in the neck; other wounds to his body were also found.
- 1.9 We acknowledge that this investigation has little to say about Will. Although the death of Will and the impact on his family has always been at the forefront of our minds, this investigation has had to focus on the care and treatment provided to L.
- 1.10 The investigation team would like to express our sincere condolences to the family of Will. It is our most sincere wish that this report does not contribute further to the pain and distress of Will's family and that it goes some way to answering their questions.

### **A summary of L's mental health history**

- 1.11 L's first contact with mental health services was in 1996 after a suicide attempt although it was often documented that his first contact with mental health services was in 2007.
- 1.12 On 15 February 2005 L committed the index offence<sup>3</sup> when he approached a lone female shop assistant, threatened her with a pen knife and stole two radios. On the following day he burgled his next-door neighbour's property. Before his eventual arrest he was involved in an altercation with the same neighbour which led to a fight where L was restrained and hit on the hand with a hammer. This resulted in a fracture to his right hand which required extensive reconstructive surgery. Whilst recovering in hospital he was arrested. He was given a custodial sentence of 42 months on 23 March 2005, of which he served 22 months.
- 1.13 This was served between several prisons, and L was frequently transferred between prisons on account of his behavioural disturbances.
- 1.14 L was released from prison on 27 December 2006 subject to a community supervision licence. He was accommodated at an approved premises. However, L was recalled to HMP Durham having only spent nine days in the community. On L's return to prison he was involved in several altercations, one of which involved taking a fellow inmate hostage; this led to further prison relocations.
- 1.15 L was eventually referred to a forensic consultant psychiatrist at the Edenfield Centre, Prestwich<sup>4</sup> on the 26 June 2007, after the prison psychiatrist had written seeking advice about who could they contact to refer L to for an assessment of treatment prospects. The referral included "You will see that he

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<sup>3</sup> Index Offence – The offence which the patient has been convicted of and which has led to their detention.

<sup>4</sup> The Edenfield Centre provides medium secure treatment for men and women in Greater Manchester. At the time it was provided by the then Bolton, Salford & Trafford NHS Trust, which then became Greater Manchester West NHS Foundation Trust in 2008, one of the former organisations now within Greater Manchester Mental Health NHS Foundation Trust

seems to be a substantially dangerous man. It is unconceivable as things are that he will not be presenting high risks as and when he is released".

1.16 Following assessment L was admitted to Ashworth High Secure Hospital (AHS) on 15 November 2007 under section 47 / 49 of the Mental Health Act (1983).<sup>5</sup> Although he was later diagnosed with Paranoid Schizophrenia, at that time he was variously diagnosed as suffering from:

- Paranoid Personality Disorder;
- Antisocial/Dissocial Personality Disorder;<sup>6</sup>
- Narcissistic Personality Disorder;
- Emotionally Unstable Personality Disorder – borderline; and
- He also fulfilled some of the criteria for a diagnosis of psychopathy.

1.17 During his first two years at AHS he often presented as hostile, abusive, threatening to other patients and to members of staff despite the various support programmes that he had been enrolled in. In March 2009 L disclosed that he had been accessing illicit clozapine<sup>7</sup> from fellow patients at workshops and social evenings. Since he had begun using clozapine in this way, he described experiencing symptoms such as hearing voices, persecutory beliefs about others and the experience of intrusive violent thoughts with reduced intensity. Following discussions with his responsible clinician, it was agreed that he should be formally prescribed clozapine. L's diagnosis was changed to a primary diagnosis of paranoid schizophrenia although there remained elements of personality disorder.

1.18 Over the next few years L made good progress and by 2011, it was agreed that he no longer required detention in high secure care, and he was transferred to the Edenfield Centre on the 2 April 2012. Following sustained progress in this setting he was transferred to Heathfield House, Stockport in 2014, under a notional section 37 MHA.<sup>8</sup>

1.19 On the 20 December 2013 L attended his automatic Mental Health Tribunal (MHT), and he was discharged from detention under the MHA. He remained at Heathfield House as an informal patient until his supported placement at Upper Chorlton Road (UCR), Manchester, was confirmed on the 21 February 2014. His presentation remained relatively stable in this environment until December 2014 when he started to use illicit drugs whilst away from the unit.

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<sup>5</sup> Section 47 of the Mental Health Act is used to transfer sentenced prisoners from prison to hospital if the person has a mental illness that the prison cannot manage. Section 49 of the Mental Health Act is a restriction order, which means that permission is required from the Ministry of Justice before the person can leave hospital.

<sup>6</sup> Antisocial personality disorder is a particularly challenging type of personality disorder, characterised by impulsive, irresponsible and often criminal behaviour. Someone with antisocial personality disorder will typically be manipulative, deceitful and reckless, and won't care for other people's feelings.

<https://www.nhs.uk/conditions/antisocial-personality-disorder/>

<sup>7</sup> An antipsychotic drug used as a sedative and in the treatment of schizophrenia.

<sup>8</sup> When a prisoner is transferred for mental health treatment under s47/49 but, on the release date, the restriction direction has ceased to have effect, he will be left with the s47 on its own and the notional s37 begins when the restrictions cease. Generally, therefore, the term refers to a patient who is notionally treated as if subject to a hospital order under s37.

- 1.20 Between December 2015 and December 2016 L's compliance with his medication, presentation and corresponding treatment became increasingly chaotic. Over this time period L had at 9 visits to various A&E departments many of which followed a period of absence without leave (AWOL) from a previous admission to an acute ward, and which then led to a further readmission. During this time there was variable medication compliance and many attempts to re-titrate L on clozapine.
- 1.21 Throughout this time period L often reported that he felt unwell, was hearing voices and had been struggling to cope at UCR, as he felt institutionalised. On several occasions L reported that he needed more structure and wanted to return to an inpatient setting as he felt he could not live independently.
- 1.22 Through the same time period it was clear that mental health services considered a MHA assessment twice, although on both occasions that this was considered, this did not take place. Instead L's status as an 'informal patient' was preserved because he would often say he was willing to be admitted. L's care coordinator was relentless in her attempts to try and support L. However, due to his continued absconding and disengagement with services, they could only place reliance upon police sightings of L, who often "appeared settled in his mental state".
- 1.23 Whilst L had been escalated to a 'patients causing concern' agenda on the Multi-Disciplinary Team (MDT) meeting, L was discharged from the ward in his absence on the 8 October 2015; no decision making regarding this was recorded on AMIGOS.<sup>9</sup>
- 1.24 On the 8 February 2016 L handed himself to police stating that he had murdered W.

## **Relationship with the victim**

- 1.25 From information obtained after the homicide, we know that L had met Will on two occasions prior to the day when he killed him.
- 1.26 On the first occasion, Will had turned up at the tent village for homeless people in Manchester, where L was staying. L believed that Will had seen him assault another person with a brick. L had been acting as a 'hard man' for a drug dealer.
- 1.27 L said he was angry with Will as he had 'ran his mouth off' about the alleged assault with the brick and believed that he must have witnessed it.
- 1.28 When Will turned up at the tent village for the second time, two days later, L decided he would kill him. He asked if he could go back to W's flat and use his shower.

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<sup>9</sup> AMIGOS is the electronic patient record used in Manchester Mental Health & Social Care NHS Trust. It is to be replaced in the new organisation.

1.29 L then went into the kitchen, got a knife and stabbed Will several times.

## Offence and sentence

1.30 On the 08 February 2016, L presented to the Barnabus Centre, Manchester where he approached a police community support officer (PCSO) and staff to disclose that he had murdered somebody. L produced a bank card in the name of Will and declared that he had stabbed him. L was arrested on suspicion of murder, to which he later pleaded guilty.

1.31 L was sentenced to life imprisonment for murder with a minimum term of 23 years on the 1 August 2016. L currently resides at HMP Long Lartin.

## Findings

1.32 We have reached a number of conclusions related to L's care and treatment which contributed to the incident. These are outlined in detail later in this report, but are listed in the following paragraphs below:

- L's risks were well known and well documented.
- There were care plans in place to mitigate these risks, but through 2015 efforts to ensure he received appropriate treatment were not tried for long enough or assertively enough. This meant he didn't get the in-patient care he needed, nor the medication that would help.
- This is set against a backdrop of a mental health system that appeared to be stressed and stretched with a high number of complex patients many of whom had forensic histories, along with issues related to violence and drug abuse.
- L's care coordinator strove to ensure he maintained contact with mental health services, and when he was initially admitted to the acute inpatient wards during April and May 2015 the impression was that he was experiencing a relapse of his psychosis. However, during his second admission to SAFIRE in May 2015, because of the absence of hallucinations and no obvious signs of relapse of his psychosis since his stopping clozapine, it appears that some mental health professionals began to reconsider his diagnosis. They either ignored or weren't aware of L's forensic history, and didn't consider his behaviours as symptoms of a relapse of his psychosis but were his choices made with full mental capacity.
- We believe that the homicide of Will was not predictable, but that L being involved in a violent attack was.
- Had L been maintained on a Community Treatment Order and not discharged from his section, and later if he had received more assertive treatment to admit him, keep him in hospital and ensure he received his

clozapine it is much more likely that he would not have relapsed. We believe the death of Will would have been preventable if these steps had been taken.

## Internal Investigation

- 1.33 Manchester Mental Health and Social Care NHS Foundation Trust (MHSC), now the 'legacy trust',<sup>10</sup> undertook an internal investigation that has been reviewed by the independent investigation team.
- 1.34 The internal investigation made seven individual recommendations and the new Greater Manchester Mental Health NHS Foundation Trust (GMMH) has carried this action plan forward to implementation. We have also reviewed the implementation of these actions.

## Independent investigation

- 1.35 This independent investigation has drawn upon the internal process and has studied clinical information, police information, internal reports, and organisational policies (for both the legacy and the new trust). We met with clinical staff who had been in contact with L, and senior staff from the trust and L's supported housing provider.
- 1.36 We met with L on the 14 November 2017.
- 1.37 We have not met with any of L's biological or adopted family as part of this investigation as they declined to be involved.
- 1.38 We did not meet with Will's mother until we had completed our investigation as this was her wish; however, she did ask to be kept informed of the progress and outcome of the investigation and also asked that he be referred to as Will throughout the report. Will's mother, along with her solicitor, did submit some additional questions which she would like to be covered within this independent investigation. We have included a full list of these questions at the rear of this document and have also indexed where, within the report, these questions are answered.
- 1.39 We find that the recommendations made in the internal report did not adequately address the contributory factors found through this investigation.
- 1.40 We consider that it was not predictable that L would murder Will on that day, although the likelihood of a violent attack as a consequence of his illness relapsing was predicted by most professionals in contact with him.

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<sup>10</sup> In this case, Manchester Mental Health & Social Care NHS Trust is referred to as the 'legacy trust' because it was the predecessor organisation. Mental health services in Manchester are now provided by Greater Manchester Mental Health NHS Foundation Trust.

- 1.41 Our view is that the homicide of Will was preventable, taking the longer-term view of L's journey through mental health services. We believe that the decision to discharge L from his notional section 37 by the tribunal, and the failure to manage his care assertively once in the community by ensuring he remained on clozapine, forensic opinions were sought, and when admitted he received Mental Health Act assessments all contributed to the breakdown in his care.

## Good Practice

- 1.42 We wish to highlight the following areas of good practice as follows:
- 1.43 We have found all staff in the new organisation, GMMH to be open and extremely receptive to the lessons learned from the independent investigation. They are also able to show evidence of proactive improvements in services which were previously led by the legacy Manchester Mental Health and Social Care Trust (MHSC) above and beyond taking forward the recommendations from the initial internal investigation.
- 1.44 The Care Coordinator's (CCO) who were involved in L's care in both Stockport and Manchester were clearly trying to support L in his care and his Manchester CCO worked particularly tirelessly to coordinate with the police and to try to make contact with L during his periods of absence. Both Stockport and Manchester CCO's maintained excellent communication regarding L's care until his discharge from Stockport CMHT in September 2016.
- 1.45 We understand that staff who were involved in L's care have been deeply affected by the outcome of this case and were working under a difficult set of circumstances, particularly in terms of the volume, complexity and acuity of patients they were seeing at the time. All staff have been seen to be candid and honest in their approaches with the external investigation team and all were clearly committed to ensuring that lessons were learned.

## Recommendations

We have made 6 recommendations within this report.

### Recommendation 1:

Both PCFT and GMMH should clarify the MAPPA status at the point of transfer to other services for patients with forensic histories. This should also include identification and involvement of probation/ NOMS for appropriate patients.

**Recommendation 2:**

- a. The Trust must provide clear guidelines for risk assessment and care planning for the titration of clozapine in the community.
- b. The Trust and NHS Manchester CCG must develop and agree guidance for GPs on the administration of clozapine and the limited function of blood tests for titration.

**Recommendation 3:**

The Trust AWOL policy should be amended to ensure that any decision to discharge an AWOL patient in their absence is explicitly risk assessed, supported by a detailed decision making tool, and reported on centrally to ensure practice is monitored.

**Recommendation 4:**

The Trust should assure themselves and commissioners that arrangements are in place to provide appropriate medical cover on the acute adult in-patient wards to ensure medical oversight and continuity of care.

**Recommendation 5:**

The Trust must ensure that discharge planning arrangements on the adult acute in-patient wards comply with Trust policy, and that arrangements are made to appropriately grade those patients with complex needs and often forensic and/or substance misuse histories who are at high risk of disengagement from mental health services, and who should receive assertive and proactive care to prevent them being lost to services, even if discharged whilst AWOL.

**Recommendation 6:**

NHS Manchester CCG should assure themselves that the Trust is identifying the cohort of patients at most risk of disengagement from services, who have complex needs and often forensic histories with a background of drug abuse. This identification should then lead to the Trust being able to provide an assertive care pathway for this group with escalation routes into appropriate inpatient beds and access to appropriate clinical and forensic support and advice when needed.

## 2. Independent investigation

### Approach to the investigation

- 2.1 The independent investigation follows the NHS England Serious Incident Framework<sup>11</sup> (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.<sup>12</sup> The terms of reference for this investigation are given in full in Appendix A.
- 2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents.
- 2.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.
- 2.4 The investigation team at Niche Health and Social Care Consulting comprised:
- Nick Moor, Partner, Investigations and reviews;
  - Carol Rooney, Head of Investigations;
  - Kate Jury, Partner, Governance and Assurance; and
  - Dr Huw Stone, Forensic Consultant Psychiatrist.
- 2.5 The investigation team will be referred to in the first-person plural in the report.
- 2.6 The report was reviewed by Nick Moor, Partner, Niche Health and Social Care Consulting.
- 2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.<sup>13</sup>
- 2.8 The independent investigation team would like to offer their deepest sympathies to the family of Will. It is our sincere wish that this report does not contribute further to their pain and distress.
- 2.9 We have used information from L's clinical records provided by:

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<sup>11</sup> NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

<sup>12</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

<sup>13</sup> National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

- Ashworth High Secure Hospital (now part of Mersey Care NHS Foundation Trust);
- Manchester Mental Health & Social Care NHS Trust (legacy);
- Greater Manchester West Mental Health NHS Foundation Trust (former Trust, now Greater Manchester Mental Health NHS Foundation Trust);
- Pennine Care NHS Foundation Trust; and
- GP practice records where L was registered.

2.10 We also reviewed information from Greater Manchester police, including the police case summary.

2.11 A profile of the Trusts are at Appendix B and a list of documents accessed and reviewed is at Appendix C. A list of those staff interviewed is provided below and at Appendix D.

## Interviews

2.12 We conducted a telephone interview with a community consultant psychiatrist, who was L's responsible clinician, CP2, from when L was transferred to Central West CMHT in October 2015.

2.13 We have also interviewed the consultant psychiatrist who provided cover for CP2 whilst she was on maternity leave.

2.14 We interviewed the following staff:

### **Pennine Care NHS Foundation Trust:**

- |  |      |
|--|------|
| • Rehabilitation consultant psychiatrist | CP1  |
| • Care Coordinator and Social Worker     | CCO1 |
| • Patient Safety Lead                    | PS   |

### **Greater Manchester Mental Health NHS Foundation Trust**

- |   |      |
|---|------|
| • Responsible clinician, consultant psychiatrist, Central West CMHT | CP2  |
| • Care Coordinator, and Social Worker, Central West CMHT            | CCO2 |
| • Interim consultant psychiatrist                                   | ICP  |
| • Area Team Manager, Central West CMHT                              | ATM  |
| • Assistant Area Team Manager, Central West CMHT                    | AATM |
| • Ward Manager, Mulberry ward                                       | WM1  |
| • Named Nurse, Mulberry ward  | NN   |
| • Consultant Psychiatrist, SAFIRE                                   | CP3  |
| • Consultant Psychiatrist Mulberry ward                             | CP4  |
| • Internal investigation report author                              |      |
| • Service Manager and member of internal investigation panel        |      |

- Specialist Registrar and member of internal investigation panel
- Deputy Director of Nursing
- Executive Director of Nursing
- Executive Medical Director
- Head of Patient Safety & Governance

**Others:**

- L's GP
- Deputy Manager, Creative Support
- Interim Director of Nursing, MHSC
- Executive Nurse and Director of Safeguarding, Manchester Health & Care Commissioning
- Assistant Director of Quality, NHS Bolton CCG
- Senior Investigating Officer, Greater Manchester Police

2.15 The interviews were recorded and transcribed. The transcripts were returned to the interviewees for review and signature.

2.16 The draft report was shared with all identified stakeholders prior to publication. This provided an opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed to review and comment upon the content and check the factual accuracy.

### **Contact with the perpetrator and their family**

2.17 We wrote to L at the start of the investigation, explained the purpose of the investigation and asked to meet him. We met with him in prison to discuss the investigation and his views on his care. We also met with him to discuss the report prior to publication.

2.18 We have attempted to contact L's adoptive family. They have declined to be involved in this investigation.

### **Contact with the victim's family**

2.19 We did not meet with Will's mother during the investigation process as this was her wish. However, she did ask to be kept informed of the progress and outcome of the investigation. Will's mother, along with her solicitor, submitted some additional questions which she would like to be covered within this independent investigation. We have included a full list of these questions at the rear of this document and have also provided an index placement where, within the report, these questions are answered. We met with Will's mother, her advocate and the family solicitor, and shared the findings of the final report with them once we had completed the investigation.

## Structure of the report

- 2.20 Section 3 sets out L's background.
- 2.21 Section 4 details the care and treatment provided to L from his first contact with mental health services, up to February 2016.
- 2.22 Section 5 examines the issues arising from the care and treatment provided to L and includes comment, analysis and recommendations, with reference to the terms of reference for the investigation.
- 2.23 Section 6 provides a review of the MHSC internal investigation and implementation of actions.
- 2.24 Section 7 reports on the progress made in addressing the organisational and operational matters identified as part of the governance and safety of the new Trust.
- 2.25 Section 8 sets out our overall analysis and recommendations, and comments on predictability and preventability.

### 3. Background of L

#### Personal history

- 3.1 L was born in Manchester at 32 weeks gestation, and after a normal delivery he was eventually allowed home after 6 weeks in special care. L had both an older and a younger biological sibling. L's mother was a lone parent who had separated from L's father just prior to his birth. L's mother struggled to cope with L who was a 'sickly' baby and there were frequent hospital admissions and GP appointments when he was young.
- 3.2 L was taken into care at the age of nearly 10 months and was permanently removed from the family home at the age of 3.
- 3.3 L and his brother were both fostered by a local family when L was 9 months old. After an unsuccessful trial period where L was returned to his biological mother, L was adopted definitively by his foster parents in 1983, just before he was four.
- 3.4 L was then adopted by a family who made every attempt to try and provide him with a stable and loving home. During his teens, however, L's behaviour became more challenging until he was placed in residential care at the age of 15 although he continued to have contact with his adoptive family.
- 3.5 The adoptive family had three other children and they also cared for other foster children at the family home. L was reported to have variable relationships and contact with his adopted siblings. They were by no means a constant presence in his life.
- 3.6 L's biological father, who denied paternity, was said to be a violent man who had served several prison sentences. L had no contact at all with his father.
- 3.7 L's mother sadly died of cancer in October 2004 and L describes this as a pivotal time where his mental health started to significantly deteriorate. He was said to be close to his biological mother.
- 3.8 L has one biological brother who is 18 months older and a half-sister 18 months younger who shares the same mother. L had sporadic contact with his biological brother between 2014 and 2016 although his brother was not seen to be a good influence on L.
- 3.9 Although L's adoptive mother would frequently visit him in Ashworth Hospital and at the Edenfield centre, reportedly every 10 days, she has had increasingly limited contact with L and at times has declined all contact with him. L's adoptive Father is now sadly deceased.

## Childhood and adolescence

- 3.10 L was born on the 17 May 1979 at 32 weeks gestation (2 months prematurely). L's mother was known to the hospital as her eldest son (L's older biological brother) had been admitted several times with 'social problems'. L's mother was identified as a lone parent.
- 3.11 L had several hospital admissions when he was a small baby with frequent bouts of vomiting, diarrhoea and recurrent infections; his mother described him as a 'difficult feeder'. L's biological mother admitted that she found it difficult to bond with L and would frequently request his admission onto hospital wards when she could not cope.
- 3.12 L was first placed in foster care when he was around 10 months old, for 6 months because L's mother had been forced to move from her home because of an argument with a neighbour. Following this time L was returned to the family where his mother continued to find L difficult to cope with, citing his behaviour as frequently 'naughty'. L was seen to be developmentally delayed (by around 3 months) when assessed at the age of 13 months old.
- 3.13 In September 1981 L's mother gave birth to another child and continued to struggle with L. By her own admission she disclosed that she had 'smacked L hard' on occasion and "she did not know how she felt about him". Health services reported frequent bruising on L and he was returned to the same foster carers on a permanent basis in 1983. He was adopted by the same family just before the age of 4.
- 3.14 As well as frequent hospital admissions, L was also taken to the GP frequently. During the first 3 years of his life he was seen over 20 times with a variety of complaints including swollen testicles, measles, ear infections, vomiting and diarrhoea. His GP records from the age of 9 upwards indicate a variety of ailments, continued ear problems and chest problems.
- 3.15 In 1994 at age 14, L burned his right hand in a camp fire. His foster parents were concerned that he appeared to be 'falling in with a bad crowd' and using illicit substances and alcohol. L was said to have suffered from bullying at school, frequently got into fights and appeared to be socially isolated. At secondary school he was placed into a special needs unit for children with learning difficulties and was described as 'having difficulties with concentrating'.
- 3.16 On two occasions L was suspended from secondary school. On the first occasion he started a fire on a school bus and on the second occasion he caused facial injuries to another pupil by making and projecting a dart. He was also cautioned for theft from 'Toys"R"Us'®. L's adoptive parents were finding him increasingly difficult to cope with and he was placed in a children's home in Shropshire in 1995. When he was 16 an allegation of rape was made against him by a 13 years old girl, although this allegation was later withdrawn.

- 3.17 L was placed in foster care closer to his adoptive parents with whom he continued to have contact. This placement was not seen to meet his needs and he was moved to another residential placement in Stockport where he was given his own bedsit but was seen to have difficulties with budgeting and was 'easily influenced by his peers'.
- 3.18 In 1996, aged 17, L moved to supported lodging but reported feeling isolated. L's first contact with mental health services was in October 1996. He was medically referred from A&E for a psychology opinion following an impulsive suicide attempt whilst under the influence of cannabis and alcohol at age 17. L was described at this time as being socially isolated with mild depressive symptoms. L had an initial appointment on 8 October 1996, which he did not attend, but instead attended on the 12 October. L then did not attend two further appointments and was discharged. At the time, the reviewing psychiatrist did not see any clear signs of psychotic illness and did not find evidence of suicidal ideation with L. No GP was identified and therefore no follow-up was ordered.
- 3.19 L attempted further tenancy's, all of which were unsuccessful. In 1997 with the support of his adoptive parents, L moved into a private tenancy but was also unable to sustain this. He resided in hostel accommodation until his first custodial sentence in 1998.

### Offending and contact with criminal justice systems

3.20 L's first convictions date from 1998 when he was 19. He has a history of many offences and convictions between April 1998 and January 2016. These include:

- 6 offences against the person
- 1 offence against property
- 10 theft and kindred offences
- 2 offences relating to prison/police/court
- 1 offence relating to firearms/shotguns/offensive weapons, and;
- 1 incident of hostage taking.

3.21 His convictions and sentences to date have been:

Date	Offence	Outcome/service
November 1998	Theft	12 months' conditional discharge
July 1999	Robbery (stole from two youths in a park)	3 years at young offenders' institute

Date	Offence	Outcome/service
August 1999	Using threatening, insulting words or behaviour with intent to cause fear of provocation of violence	28 days at young offenders' institute
August 2001	Criminal Damage	12-month conditional discharge
September 2001	Handling stolen goods, theft, breach of conditional discharge	28 days imprisonment
October 2001	Criminal damage	28 days imprisonment
March 2002	Robbery and pushed an Asian male over a bridge – described as 'racist attack'	3 years imprisonment Plus 6 months remaining.
March 2004	Having an article or a blade, sharply pointed in a public place.	1 days' imprisonment, fine and forfeiture of pair of scissors
23 March 2005	Robbery <b>INDEX OFFENCE</b>	42 months' imprisonment
24 March 2005	Failing to surrender to custody	1 month imprisonment
April 2005	Burglary and 2 counts of theft	8 months' imprisonment
November 2006	Escaping from lawful custody	28 days imprisonment consecutive to current sentence then released on probation
December 2006	Theft of mobile phone from hostel staff after being released on licence conditions	Returned to custody after nine days
January 2007	Held another prisoner hostage <sup>14</sup> and was moved to category A prison.	Incident whilst in custody
February 2007	Conviction of theft (whilst in custody)	Additional 7 days Imprisonment
August 2015	Charged with stealing alcohol and chocolate from Tesco in Macclesfield	Charged and bailed to attend court
26 December 2015	Theft from a person	Remanded but bailed from court

<sup>14</sup> There are different views about the nature of this incident and it has been described in varying degrees of severity. A version exists that L had threatened to kill and slash the throat of the person taken hostage. Other versions exist where the incident was a collusive act between various inmates and there was never any intended harm. It is also recognised that the matter was dealt with by the prison service and the police were not involved. However, there are reports in the notes that L himself has described this as a kidnapping, and disclosed he had thought to harm the fellow prisoner.

Date	Offence	Outcome/service
15 January 2016	Shoplifting	Bailed from court with conditions of residence.
1 August 2016	L pleads guilty to murder	Life imprisonment with a minimum of 23 years and 4 months.

## 4. The care and treatment of L

### 2007 First contact with adult mental health services

- 4.1 Between 1998 and 2005, when the index offence occurred, L was convicted of a variety of offences ranging from theft to threats of violence and actual harm against a person. During this time L did not have any contact with mental health services. By his own admission L felt he was becoming increasingly 'institutionalised' following his various episodes of custody. Throughout this time L did not appear to have stable accommodation and there are no records of any assisted housing or supported living.
- 4.2 In October 2004 L's biological mother died of cancer and L described himself as having a 'nervous breakdown' at this time. Up until March 2005 L was increasingly using alcohol and illicit substances and seemed to be becoming more unstable. There were reported incidents of him making threats to kill others and violence to animals including actual harm or threats to stab cats and dogs.
- 4.3 In 2005 L approached a lone female shop assistant, threatened her with a pen knife and stole two radios. L cut his hand when he escaped and stated that 'he knew he would be arrested on DNA evidence'. On the following day he burgled his next-door neighbour's property. Before his eventual arrest he was involved in an altercation with the same neighbour which led to a fight where L was restrained and hit on the hand with a hammer resulting in a fracture to his right hand which required extensive reconstructive surgery. Whilst recovering in hospital he was arrested and given a custodial sentence of 42 months.
- 4.4 This was served between several prisons including HMP's Manchester, Forest Bank, Risley, Wymott, Kirkham, Preston and Haverigg. He was transferred between prisons mainly on account of his behavioural disturbances. He escaped from HMP Kirkham (Category D), walked about 12 miles and then handed himself in at HMP Blackpool.
- 4.5 L was released on 27 December 2006 subject to a community supervision licence. He was accommodated at an approved premises. At the time, there were concerns about his mental health, the use of drugs and the risk of self-harm and violence and several complaints were made regarding his behaviour. He was moved to another hostel where he stole a mobile

phone from a member of staff, phoned that staff's wife and told her that her husband was dead. On 7 January 2007 his licence was revoked, and L was recalled to HMP Durham having spent only nine days in the community.

- 4.6 On 24 January 2007 in collusion with other in-mates, he secreted a bladed instrument and was reported to have held another prisoner hostage by making threats to stab him. He later described having intrusive thoughts to kill this cell mate. He barricaded himself in the cell but matters were resolved without the use of the police without any injuries to any party. He was subsequently transferred to HMP Frankland and spent further periods in both HMP Frankland and Durham, with episodes of smashing up his cell, and spending time in segregation.
- 4.7 Whilst L was in HMP Durham, a referral was made to a forensic consultant psychiatrist at the Edenfield Centre, Prestwich<sup>15</sup> on the 26 June 2007, seeking "advice as to whom he should be directed/referred for assessment of treatment prospects for his [L's] personality disorder. You will see that he seems to be a substantially dangerous man. It is unconceivable as things are that he will not be presenting high risks as and when he is released". L was given a scheduled release date of 19 November 2007.
- 4.8 After this referral was made, L was subsequently transferred to HMP Preston. Whilst in HMP Preston, L was then referred by the Edenfield forensic consultant psychiatrist to Ashworth High Secure Hospital (AHSH) for assessment.<sup>16</sup>
- 4.9 L was assessed by a forensic consultant psychiatrist, a clinical psychologist and a social worker from Ashworth High Secure Hospital on 28 September. At this assessment he was reported to be "experiencing symptoms of paranoia, intrusive violent thoughts and is indulging in vivid imagery of violent actions". L also admitted using illicit drugs to combat these symptoms.
- 4.10 He was described as having no past psychiatric history, other than multiple deliberate self-harm attempts whilst in the community and in prison. L himself described having no real positive experiences of life, other than enjoying some short-term jobs and things that have kept him occupied. L described feelings of power and self-worth are achievable through violence and he openly admitted to the cruelty of some of his actions. At this assessment L described, auditory hallucinations or what he called, "voices" in his head from his own subconscious and these had been ongoing for many years.
- 4.11 On 29 October 2007, the admissions panel agreed to his admission, and he was admitted to Ashworth High Secure Hospital (AHSH) on 15

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<sup>15</sup> The Edenfield Centre provides medium secure treatment for men and women in Greater Manchester. At the time it was provided by the then Bolton, Salford & Trafford NHS Trust, which then became Greater Manchester West NHS Foundation Trust in 2008, one of the former organisations now within Greater Manchester Mental Health NHS Foundation Trust

<sup>16</sup> Ashworth Hospital is one of three hospitals in England providing services for patients who require mental health treatment and care in conditions of high security.

November 2007 under section 47 / 49 of the Mental Health Act (1983) with a diagnosis of personality disorder.

- 4.12 At this stage L was deemed to pose a significant risk to others, had little skills to live in the community and was seen as likely to re-offend if released from prison. This was thought likely to take the form of a street robbery or burglary to support use of illicit substances and was also likely to use a weapon to assist in committing these offences.

### **2007 – 2011 Ashworth High Secure Hospital (AHSB)**

- 4.13 L was admitted to AHSB on the 15 November 2007. His original sentence expired on 19 November 2007 and L's detention was continued under a 'notional section 37'.
- 4.14 By December L was being confrontational and abusive to staff over lunch when asked to wait for second helpings until after the other patients had been served their first course. L was reported to be abusive to staff when he entered the dining room when meals were being served with a newspaper in his hand against hospital policy.
- 4.15 Shortly after admission, L was dismissive and abusive in the day area and needed to be restrained by staff whom he had attempted to assault by throwing a punch. He was reported to be hostile and struggling, he spat and issued threats to a particular member of staff. L continued to present within seclusion as hostile, abusive, threatening to members of staff and kicking the door with some force.
- 4.16 In January 2008 L was noted to be jealous and negative towards a fellow patient that had won a number of games and he had not won anything. Staff also noted that L had expressed racist views about the patient. L was also said to become hostile and aggressive in tone and manner against staff when he wanted to smoke and staff did not have a lighter.
- 4.17 L's adoptive parents were interviewed in February 2008 and they advised that L's behaviour began at the age of 14/15 when he 'fell in with a bad crowd' and started drinking and taking drugs. They thought they were helping by encouraging contact between L and his biological mother but in hindsight, they felt it was perhaps a worse decision as she was unreliable and inconsistent in her relationship with him.
- 4.18 In February and March 2008 two further incidents were noted when L made derogatory remarks about a fellow patient who had dropped a piece of toast on the floor. L also became disgruntled that nursing staff read a letter addressed to him, although this was in line with the hospital policy. He became insulting towards staff, although 20 minutes later he apologised for his behaviour.
- 4.19 In March 2008, L became upset and abruptly left the room when discussing his behavioural difficulties with the responsible clinician (RC).

When the same RC was leaving the ward later, L approached him in a threatening manner and became abusive, nursing staff intervened and he was led away.

- 4.20 L was interviewed on the 1 April 2008 in relation to his Mental Health Tribunal (MHT).<sup>17</sup> L had requested consideration for transfer to conditions of low security and made an application to the tribunal. The tribunal noted that L was currently detained under section 47 MHA with Psychopathic Disorder. L's disorder was of a degree that warranted detention in hospital that could not be contained in a medium secure environment. In L's case it was thought unlikely that treatment in hospital would result in a complete cure but would alleviate the manifestation of his disorder and prevent a deterioration in his condition.
- 4.21 On the 17 April 2008 L was issued a Renewal of Authority for Detention under section 20 of the Mental Health Act 1983. This permitted his continued detention under the notional section 37. The reasons provided included commentary that "L suffers with narcissistic and antisocial personality traits and displays paranoid ideation, suspiciousness, irritability and behavioural outbursts. These symptoms are not amenable to treatment in a setting which lacks structure and boundaries which are available in a high secure setting".
- 4.22 On the 23 June 2008 the MHT made their decision with L in attendance. It was noted that L had undertaken several psychological assessments and his then diagnosis was confirmed as Anti-Social Personality Disorder, Paranoid Personality Disorder, Narcissistic Personality Disorder and Borderline Personality Disorder. The benefits of medication were outlined to L but he declined to take medication. The tribunal felt that there was an indication of a risk of future violence and Schema Therapy<sup>18</sup> was recommended followed by substance misuse and cognitive skills work. L was referred to Macaulay ward, AHSW for a trial period of 3 to 4 months but with no discharge and no reclassification of his condition.
- 4.23 L complained of flawed judgement in relation to the MHT decision, his presentation was noted to have deteriorated and he was seen to be extremely verbally aggressive to staff.
- 4.24 In July 2008 L told his social worker he did not feel he should be in a place where he had to mix with murderers and sex offenders as he did not

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<sup>17</sup> A Mental Health Tribunal is an independent quasi-judicial process, which in England and Wales exists to safeguard the rights of persons subject to the Mental Health Act 1983. It provides for consideration of appeals against the medical detention or forced treatment of a person who was deemed to be suffering from a mental disorder that was associated with a risk to the health or safety of that person or others. The whole tribunal system changed in 2008. As a result, in England, the previous Mental Health Review Tribunal as a standalone process was technically abolished and became one part of a Health and Social Care Chamber of a newly established national level of hearings called the First-tier Tribunal. It is now technically known as the First-tier Tribunal (Mental Health), but in practice is often called the Mental Health Tribunal.

<sup>18</sup> Schema Therapy (or more properly, Schema-Focused Cognitive Therapy) is an integrative approach to treatment that combines aspects of cognitive-behavioural, experiential, interpersonal and psychoanalytic therapies into one unified model. Schema Therapy has shown remarkable results in helping people to change negative ("maladaptive") patterns which they have lived with for a long time, even when other methods and efforts they have tried before have been largely unsuccessful.

regard himself to be in that category of dangerousness. L advised his social worker that he was transferred to AHSB due to an incident described as hostage taking but this was a misunderstanding as he only barricaded himself in his cell along with another cell mate. L said he was not happy with current medication and would like to be put on antidepressant medication as this has helped in the past.

- 4.25 On the 15 August 2008 there was a section 117 MHA<sup>19</sup> Effective Care Coordination Meeting, which L did not wish to attend. L had applied for review by MHT not for discharge but for transfer to a low secure unit. The Probation Officer did not attend the meeting, L was on Licence until October 2008. It was agreed that a referral to the Edenfield Personality Disorder assessment team should be made if the MHT recommended that L be transferred.
- 4.26 In October 2008 a further Form of Renewal of Authority for Detention under section 20 of the Mental Health Act 1983 concluded that the risks that L posed were of a nature and severity that made it unsafe to consider treatment as an out-patient as L was not likely to engage with treatment if he were informal.
- 4.27 In March 2009 L disclosed that he had been accessing illicit clozapine from fellow patients at workshops and social evenings. Since he had begun using clozapine in this way, he described experiencing symptoms such as hearing voices, persecutory beliefs about others and the experience of intrusive violent thoughts with reduced intensity. Following discussions with his responsible clinician (RC), it was agreed that he should be formally prescribed clozapine.
- 4.28 Given the improvement in his presentation following commencement of clozapine the presence of his personality disorders was re-assessed using the International Personality Disorders Examination (IPDE). This re-assessment showed that he did not meet the definite criteria for any adult personality disorders although it “does demonstrate some narcissistic traits”. His diagnosis was changed to a primary diagnosis of paranoid schizophrenia although there remained elements of personality disorder.
- 4.29 He had previously demonstrated traits of psychopathy and this too was re-assessed using the Hare Psychopathy Checklist (PCL-R). This too noted a remarkable reduction in his scores, although the assessment concluded that “the previous scores are important as they have implications for how he presents when most unwell”.
- 4.30 Following L’s transfer from L to Macauley ward in June 2008 L’s presentation began to improve. There was only one recorded occasion on Macauley ward where L was aggressive towards staff. Whilst L admitted that his recent attempt to self-medicate by taking other people's clozapine was foolish he described that he had hoped this would dull some of his thoughts of hitting people that he had experienced for many years. L was

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<sup>19</sup> Section 117 MHA states that aftercare services must be provided to patients who have been detained in hospital: for treatment under section 3, under a hospital order pursuant to section 37 (with or without a restriction order) or following transfer from prison under section 47 or 48.

pleased that he had been started formally on clozapine and he had reported being symptom free over the past few months and had also re-established contact with his adoptive parents.

- 4.31 After sustained improvements in mood and presentation L put forward a request to be transferred to a medium secure unit at his upcoming MHT sitting on the 19 May 2009. However, at this tribunal it was decided that L ought not be discharged from detention. The tribunal learnt that L was suffering from intrusive thoughts and rather than sharing these with medical staff, L chose to [instead] self-medicate by obtaining clozapine from other patients. The tribunal noted that this could easily have been illicit drugs that were more readily available at Medium Secure Units.
- 4.32 It was determined that “the risks that L poses are of a nature and severity that makes it unsafe to consider treatment as an outpatient. Whilst L has responded well to clozapine he still has work to do in understanding his mental illness and the risks he presents. L would not be likely to engage with treatment if he were informal as he is in early stages of treatment”.
- 4.33 In January 2010 a report of the Mental Health Awareness Group concluded that L had difficulties processing and retaining information. L scores showed a positive attitude towards medication but scored intermediate for self-esteem. He scored less than 50 per cent for the Positive and Negative Syndrome Scale (PANSS)<sup>20</sup> revealing that he does not experience any current symptoms. L engaged appropriately with other members of the group with an appropriate sense of humour. He acknowledged that he is now able to approach staff to discuss issues if he is feeling stressed and he described stopping taking medication, stress, negative thinking and substance misuse as triggers of becoming unwell, showing much improved insight.
- 4.34 In April 2010 L was diagnosed with diabetes after putting on a significant amount of weight with clozapine. At the end of April L attended his first session of Substance Free Futures Group and was also accepted on a move to Ruskin ward because he had been seen to make excellent progress in the last 12 months. In that, he had been able to cope with therapies, interact with fellow patients and staff and enjoyed unsupervised garden access with no problems.
- 4.35 At the tribunal hearing on 28 September 2010, L’s solicitor directed that L did not seek to be discharged and accepted that the legal criteria for detention was satisfied, however, he requested a recommendation for a transfer to a medium secure unit. The tribunal, having considered the written evidence which was uncontested, were satisfied that the legal criteria for continued detention had been established and L would not be discharged from his section. However, the tribunal recognised that L had

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<sup>20</sup> The Positive and Negative Syndrome Scale (PANSS) is a medical scale used for measuring symptom severity of patients with schizophrenia. It was published in 1987 by Stanley Kay, Lewis Opler, and Abraham Fiszbein. It is widely used in the study of antipsychotic therapy. The name refers to the two types of symptoms in schizophrenia, as defined by the American Psychiatric Association: positive symptoms, which refer to an excess or distortion of normal functions (e.g., hallucinations and delusions), and negative symptoms, which represent a diminution or loss of normal functions.

made significant progress and now requires a step-down approach and it was agreed that L was to be transferred to a medium secure unit once he had completed a thinking minds group. No further recommendations were made.

- 4.36 He continued to make good progress and by 2011, it was agreed that he no longer required detention in high secure care, and he should be considered for a medium secure placement at the Edenfield Centre, Prestwich. After a six month period of trial leave, he was formally transferred to the Edenfield Centre on the 2 April 2012.
- 4.37 Prior to his transfer, his then responsible clinician (RC) noted that “L has responded well to clozapine and has engaged in some psychological therapies. He continues to require treatment to address his risk of non-compliance with medication or substance misuse, which would lead to deterioration in his mental health and a subsequent increase in his risk to others. The risks that he presents are of a nature and severity that make it unsafe to consider treatment as an outpatient”.<sup>21</sup>
- 4.38 It was also noted that if “L were not detained, he is at risk of disengaging from treatment. He is likely to return to his previous chaotic lifestyle, thus increasing the risk of substance use. It is likely that his mental health would deteriorate rapidly resulting in illness and increasing the risk to others. He continued to require treatment for his personality disorder which is treatment interfering in the management of his schizophrenia”.

### **October 2011 to January 2013 Edenfield Centre**

- 4.39 On the 13 October 2011 a bed became available at the Edenfield Centre (Medium Secure Unit). L was apprehensive but pleased to be transferred (initially for a 6-month trial period) so quickly. L was formally transferred in April 2012.
- 4.40 Following the move L began to smoke again after 4 years of not smoking and was seen to be anxious and agitated. His clozapine was increased as his presentation was thought to be due to the stress of the move.
- 4.41 L was seen to demonstrate good insights since his admission, he was compliant with his treatment plan and demonstrated good interpersonal skills with his peers and staff. L had 1 incident in May 2012 where he made rude gestures behind a member of staff's back but this was seen to be an isolated incident. L coped well with unescorted leave to Prestwich village and Bury and it was felt that consideration should now be given to moving L towards a step-down service at the next MHT.
- 4.42 A Social Circumstance report dated 8 August 2012 noted that L remained “detainable under section (47) of the Mental Health Act 1983 in terms of the nature of his illness”. The author also noted that “I would also

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<sup>21</sup> Noted in Form H5, section 20, Renewal of Authority for Detention, 11 October, 2011.

recommend that should L be discharged, that a Community Treatment Order be considered which would allow the Clinical Team to effectively manage this transition into the community”.

- 4.43 The MHT social circumstances report from August 2012 described that L's adoptive mother was in agreement with the plans for L to go to a step-down rehabilitation service prior to discharge. L's adoptive mother also expressed concerns about L's smoking and put this down to the social aspects of L mixing with other smokers in the grounds. L advised that he was offered illicit substances by a fellow patient shortly after admission but he had declined this. L had mild anxiety about transfer but these resolved.
- 4.44 The CPA report August 2012 describes L's transfer to Ullswater ward and his continued good progress. L had extensive dental surgery to remove many of his remaining teeth due to tooth decay and was awaiting dentures.
- 4.45 A mental state assessment in October 2012 noted him to be polite, appropriate with no evidence of hostility. The report noted he had good insight into the need to continue taking his medication, but he had limited understanding of the risks to his mental health if he were to resume misusing drugs in the future.
- 4.46 Whilst waiting for his assessment to Heathfield House in Stockport L was assaulted by a peer in October 2012. However, he made no adverse response to this and expressed no animosity. L was then on stage 1 of self-medication and had made a request for stage 2 self-medication to be considered when at Heathfield House.
- 4.47 His responsible clinician (RC) at the Edenfield Centre, forensic consultant psychiatrist FCP1, concluded that whilst continued detention was still necessary, L could be considered for transfer to step down rehabilitation rather than Low Secure care. He was referred to Heathfield House, Stockport in October 2012.<sup>22</sup>
- 4.48 In November 2012 a summary psychology report concluded that L met the criteria for at least 3 personality disorders stating that “It was evident that L experiences some sensitivity in relation to the wish to convey a positive image of himself and the discrepancy of his past behaviour and offending. On PCL-R L's ratings were significantly reduced to well below the cut-off point to meet the criteria for Psychopathy. In relation to IPDE where behavioural evidence is required, L did not now meet the criteria of any DSM-IV personality disorder. Highest obtained ratings were for schizoid, schizotypal, antisocial and narcissistic scales but these were below diagnostic thresholds. Intimate interpersonal relationships will bring new stresses and challenges to L and he will need support to navigate these challenges”.

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<sup>22</sup> Heathfield house is step down rehabilitation unit for males aged between 18 and 65 based in Stockport that provides 24 hour nursing inpatient care. It is provided by Pennine Care NHS Foundation Trust.

- 4.49 L received a planned discharge date to Heathfield House on the 17 January 2013 and his orientation visit was completed on the 14 January 2013. The CPA summary suggests that since his visit to Heathfield House L had become more anxious regarding the move and had started smoking again. On the 17 January 2013 L was moved to Heathfield House under a notional section 37 MHA.
- 4.50 As in his previous transfer from AHSH, the move caused a similar anxious response with L.

### **January 2013 to May 2014, Heathfield House**

- 4.51 On the 17 January 2013 L was transferred to Heathfield House under section 47/ notional section 37 MHA. L's assessment on admission found him to be settled and co-operative and admits to some anxiety from the transfer. L advised that he has been free from psychotic symptoms for 4 years since starting on clozapine. L was seen to have good insight of medicine, awareness of the risk associated with illicit substance misuse and had excellent recall of previous symptoms experienced when unwell. His initial management plan included 15-minute observations overnight. L was re-graded to general observations the next day.
- 4.52 On the 28 January 2013 L disclosed to staff that he would not usually approach them autonomously when he feels anxious and would prefer dedicated one to one time to discuss his thoughts and feelings.
- 4.53 L had now progressed to stage 3 of self-medication and was able to collect 3 to 4 days' supply of medication which he self-administered. On 25 March 2013 L stated that he would like to appeal against his continued detention and he was given a list of solicitors. L identified that he would eventually want to live in his own flat in the Bredbury or Romily areas of Stockport to be close to his family although he was anxious about seeing people from his past of criminal activity and would not want to live in Brinnington, Stockport for this reason.
- 4.54 His new RC prepared a psychiatric report for L's forthcoming MHT on 14 May 2013. This stated that "since his admission L had remained extremely settled in mental state. L can appear unhappy when discussing aspects of his care plan which he is not fully in agreement. L commenced unescorted leave to the local area but reports some concern when on leave in Stockport, in particular that he may see people who associate him with criminal behaviour from the past. The nature of L's mental disorder warrants continued detention, there is history of him becoming worse in the context of excess alcohol and abuse of illicit substances days after being released on licence in 2006. Discharge or being made informal at this early stage of therapeutic process would result in relapse".
- 4.55 At this time L's social circumstances report also indicated that the care coordinator felt that L's current engagement was superficial and his social isolation a historical risk factor. There was a need for testing out in the

community for risk of relapse if L was exposed to stressors. L was reported to find it difficult to interact with his peers in communal areas and he had stated that he was not in hospital to make friends. L was also thought to be easily influenced by others and may try to buy friendship.

- 4.56 In June 2013 L visited Redcroft supported accommodation and on return expressed reservations and described it as the same as Heathfield. L asked what other options may be available.
- 4.57 In July 2013 L was less anxious in general and was able to shop independently in the local area. He had had a meeting with Pure Innovations<sup>23</sup> for assistance with his CV and in seeking paid employment. At this stage L was not engaging with rehab groups. L had made contact with his biological brother via Facebook but did not want to meet him at that stage due to his brother's drug issues. L recognised that he needed to take medication and acknowledged the effect of drugs on his mental health.
- 4.58 L had his first overnight leave to his adoptive parents on 13 June 2013 and made contact with his biological brother on the 19 June 2013. L was accepted by Pure Innovations on the 16 August 2013. In September 2013 he completed his CV and was informed of a job at Dixons Farm in Heald Green, a small family run business, working in an abattoir. He commenced work there in early October 2013.
- 4.59 In October 2013 L expressed that he would stay at Heathfield house under an informal admission and agreed that ultimately, he may benefit from being discharged on a community treatment order. L was seen to be fully compliant with his treatment plan and accepted he will have to take medication for the rest of his life. L was able to go to the gym three times a week, he was on stage 5 of the self-medication programme and there had been no incidents of violence and aggression and no episodes of AWOL. He had been abstinent from illicit drugs for five years.
- 4.60 The MHT in October 2013 was adjourned because the judge felt that as L's care coordinator could not attend the tribunal there was a lack of satisfactory evidence of steps taken to identify suitable accommodation for L. This was considered a significant omission that would have assisted in the assessment of risk. The Judge felt that the report dated 10 October 2013 was already a month old and was silent on important issues of the options for accommodation. The tribunal was adjourned until 20 December 2013 to allow for preparation of this report.
- 4.61 In his report to the MHT of 10 October 2013, CP1 recommended that L remained under his current detention to provide effective risk management on his discharge, and receive a Community Treatment Order (CTO). It was planned that L move gradually into more independent living via supported housing.

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<sup>23</sup> Pure Innovations supports people with disabilities and disadvantaged groups to get into work and access community and leisure activities in Stockport area.

- 4.62 In November 2013 L described his disappointment about the experience with his job placement as he admitted he didn't like cleaning out pig intestines and removing hair, although he was determined to find another job.
- 4.63 On 2 November 2013 L was unhappy that he was not able to do his laundry as the laundry room was closed until 11.00pm due to a fire risk. L decided to stay up to do his laundry at 11.00pm. This was seen as evidence of a lack of problem solving skills and difficulty coping with change.
- 4.64 In November 2013 discharge planning was underway for L although there were still concerns that he would not approach staff if he started to feel anxious or unwell. L was able to articulate his key triggers of becoming unwell. L had now declined a placement in Stockport and decided that he wanted to move to Manchester to avoid links with his criminal past.
- 4.65 L attended his tribunal on the 20 December 2013 and was discharged from his section and was now able to reside as an informal patient at Heathfield House.
- 4.66 In February 2014 L was declined for a placement at Upper Chorlton Road (UCR) because of a reported previous history of arson. The CCO emailed UCR asking for the rationale for the decision and eventually his placement was confirmed on 21 February 2014.
- 4.67 His care was also transferred to the Central West Community Mental Health Team (CMHT) provided by Manchester Mental Health & Social Care NHS Trust and he had a new Care Coordinator (CCO) although 'section 117 responsibility would be retained by Stockport, and a new responsible clinician, the consultant psychiatrist for the Central West CMHT, CP2.

### **May 2014 to April 2015, Upper Chorlton Road (UCR)**

- 4.68 L was discharged from Heathfield on 22 May 2014 and a 7 day follow up at UCR was arranged.
- 4.69 L's UCR monthly report in July stated that L had remained settled and stable and no concerns or issues were reported. L had now stated that he was still keen to move back to the Stockport area and although he had no negative issues or concerns residing at UCR, he felt he didn't require the level of support that was provided and would like to move onto independent accommodation.
- 4.70 In July 2014 L attended his outpatient appointment (OPA) at the Rawsley Building with his CCO. No psychotic symptoms were apparent or reported and no alcohol or drug use was noted. L was receiving clozapine from Stockport and he felt well and did not report any side effects. He was attending regular blood monitoring and all was within the normal limits. The

plan was that the monitoring of his blood levels was to be transferred to the clozapine clinic at the Rawnsley Building in Manchester.

- 4.71 In the UCR monthly feedback form Report for July 2014 staff had noted that when discussing L's move-on with him, he could have unrealistic expectations that everything was going to fall into place:

“L can appear overly confident but also quite fixed in his thinking and at other times overly anxious and fixated about making a phone call or receiving a phone-call relating to his move-on/ benefits/ PIP application”.

- 4.72 In November 2014 L attended the Rawnsley Building for his routine clozapine blood test. The result was green and his medication was collected.<sup>24</sup> During the same month L had been asked to attend an interview for housing and he indicated he will take his time to make a decision as he wants to ensure that he will be happy. L had been purchasing new items for his new flat in anticipation of the move. L had a visit from his previous support worker as she would continue to work with him when he moved back to Stockport. L denied any anxiety about the pending move.

- 4.73 In December 2014 L attended the Rawnsley Building for his routine clozapine bloods. The result was green and his medication collected. L advised his CCO that following his interview for housing, he had been refused due to his previous criminal record. L advised that he had no problems at the moment and would be spending Christmas with his family.

### **The commencement of changes in L's presentation (December 2014)**

- 4.74 Later in December L's CCO received a call from L's key worker at UCR. They had noted a change in presentation over the last four days and L's speech has been slightly slurred, and he had been unsteady on his feet. L was complaining of a sore neck and was feeling very tired. Staff spoke with L and discussed their concerns and he stated that he was just tired although he became belligerent to staff and this was out of character. UCR staff spoke to the GP out of hour's service and after hearing L's symptoms described (which may have been related to his diabetes), it was recommended that staff call for an ambulance.
- 4.75 Paramedics took L's observations including his blood glucose level which was 7.9 mmol/l, the ambulance staff contacted the out of hours GP who

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<sup>24</sup> There is a standard Full Blood Count testing regime for patients on Clozapine, as it can have serious side effects if blood levels are over the therapeutic level. It is tested initially weekly, then two weekly, then monthly. Routine tests are undertaken in clozapine clinics at each of the three hospital sites. Each result is assigned a RED, AMBER or GREEN result. Green results enable the pharmacist to dispense the medication without any further action, AMBER results allow dispensing but necessitate closer monitoring and RED results mean that the patient must stop treatment.

From Community Clozapine Guidelines -Appendix P, Manchester Mental Health & Social Care NHS Trust  
<http://www.mhsc.nhs.uk/media/73126/community%20clozapine%20appendix%20p%20clozapine%20gp%20pack.pdf>

recommended that L attend A&E for further tests. Despite speaking with the GP, L showed great reluctance to attend A&E, although eventually he agreed to go. On arrival at Manchester Royal Infirmary A&E a blood test was recommended but L decided to leave, signing a disclaimer and discharging himself against medical advice. L returned to UCR by public transport.

- 4.76 On 28 December 2014, L was observed coming out of another tenant's room. This tenant was not allowed to have other tenants in his room due to risks so this was noted as unusual. L attended his GP on 30 December 2014 and he minimised the concerns raised by UCR staff to the GP. L declined to provide a blood sample stating fear of needles as a cause for this. He did agree to provide a urine sample. The GP was given contact details for the clozapine clinic at the Rawnsley Building in Manchester so that when L went on the 7 January 2015, he could provide a blood sample for investigation. However, the clozapine clinic do not take blood for any other tests other than clozapine levels, a fact unknown by the GP, and so this was not pursued.
- 4.77 On the 7 January 2015 L attended the Rawnsley Building for his routine clozapine blood test. The result was green. However L also disclosed to UCR staff that he had been taking class A drugs.
- 4.78 On the 9 January 2015 L's CCO telephoned UCR. L was presenting as paranoid and would not leave his room. An attempt was made to contact his GP although the GP was unavailable at this time. Later that day the CCO also visited L and he advised that he felt terrible, his head was seen to be stooped and his eye contact was poor. L described feeling low in mood and paranoid although he denied any thoughts of self-harm or harm to others. L said he had "done something stupid" and reported that he had been smoking heroin for the last two weeks and had started just before Christmas. L reported that he had got it from an acquaintance and not any of the other tenants. L stated that he did not want to take it again, and felt like he had let himself down and those who support him and he felt ashamed.
- 4.79 On the 13 January 2015 L attended his out-patient appointment at the Rawnsley Building with his CCO where they had a long discussion prior to his appointment. L reflected on his use of heroin and described being curious and wanting to see "how he felt after ten years of abstinence". L was seen in clinic by his RC and was noted to have good presentation although he was slightly guarded. L was warned of the dangers of using drugs and clozapine and he seemed to take this on board. L's sleep was reported as erratic and his mood was up and down although he had no thoughts of self-harm or suicide and there were no psychotic symptoms. He was prescribed zopiclone 3.75mg for two weeks to help with sleep and L was to continue with his other medication. L had also been offered a flat with a housing association but decided to put this on hold for 3-6 months due to his current difficulties.
- 4.80 The UCR monthly report for January described that L stated that he has been having up and down days but does not disclose to staff when he is

having a down day. L wanted to see his consultant and be prescribed a mood stabiliser. Staff at UCR were, at this time, also suspicious that L was drinking alcohol more often than he disclosed. L did not want to explore his move at present as he identified this as an area of stress.

- 4.81 On the 3 March 2015 L attended his OPA with a support coordinator from UCR as his CCO was on annual leave. L described having an increasingly low mood since Christmas and his episode of heroin use but denied having taken any heroin since then. He admitted at his appointment that he had not taken clozapine for over a week and said that he had thrown this away. He also advised that he felt like he was becoming unwell again and everything was on top of him, he was at rock bottom and he was fearful that he would go out and do something stupid as he had impulsiveness. L suggested that he may need to be admitted to hospital for a couple of weeks "for a break". L's RC decided that they would refer L to the Home Treatment Team (HTT) and write to his GP for a prescription of olanzapine to be administered that evening.
- 4.82 On the 5 March 2015 L was accepted by the Central Manchester Home Treatment Team who came to visit him at UCR. L confirmed that it had been 10-11 days since he stopped taking medication but he did not feel that he has experienced any symptoms. L wanted to speak about himself and gave an account of the last 17 years of his life since the age of 19. L advised that he was "pretty institutionalised" and that he had been "locked up" since 2005. L said that his jail years were "all he knew" and he was around "lifers" (people who had been in prison for 15 years). L advised that he "wants the structure back" otherwise he may "go off the wire". Home Treatment Team (HTT) staff put it to L that there was a pattern of, as he put it, "doing something stupid" to stay in the system. L accepted that looking back now at episodes over the last 4 months, that these had been a continuation of this pattern for him and that he wants to change it. HTT staff would now support him to do a weekly planner to gain a greater sense of structure. The HTT stated that L was not presenting with any signs of psychotic symptoms but did present with signs of depression and low mood.
- 4.83 On 11 March 2015, L was supported by UCR staff to attend an appointment with a consultant psychiatrist with the HTT. The consultant discussed with L his recent concerns around non-concordance with prescribed medication, his relapse to heroin use in December and his fears around move on towards greater independence from UCR.
- 4.84 On the 23 March 2015 L did not attend day 1 for clozapine titration. A telephone call to UCR was made and it was reported that L was in bed suffering from diarrhoea and vomiting.
- 4.85 On the 24 March 2015 L's CCO telephoned UCR and spoke to his key worker. L went out over the weekend with four other tenants and returned inebriated. L went to bed but later came down to the communal lounge wearing just a T shirt and he was urged to go back upstairs and dress appropriately. The following morning L appeared very embarrassed, although said he could not remember much.

- 4.86 On the 30 March 2015 UCR contacted the clozapine clinic to say that he would not be attending the titration session as he had been taken to A&E due to an overdose. Staff at UCR had contacted L via the intercom to remind him of his titration appointment. L stated that he would be unable to attend due to feeling unwell. The deputy manager went to L's room to check on him immediately afterwards and L informed him that he had taken an overdose of all his prescribed medication. An ambulance was immediately called, L presented as drowsy and sluggish and he was accompanied to A&E at the Manchester Royal Infirmary. L had numerous physical tests and was also assessed by a mental health nurse where L stated that he wanted to be admitted to a psychiatric unit. L was declared medically fit and referred to the mental health liaison team for an assessment. UCR put a management action plan into place for when L returned.
- 4.87 Over the following 48 hours L was checked regularly by UCR staff to ensure his wellbeing and safety. On the 31 March 2015, L discussed with the service manager that he was not experiencing any suicidal thoughts and that the overdose related to his move on from UCR. L again stated that he felt that he was institutionalised and that he would be lonely in his own flat and unable to cope.
- 4.88 A follow-up letter in relation to L's OPA was received which detailed that L had no thoughts to harm himself or others at present and no suicidal ideation and that the risk of harm to self or others was low. There was some deterioration of mental state and there was risk of this deteriorating further. L had been referred to the Home Treatment Team (HTT), however, as he was not willing to be re-titrated with clozapine he was discharged by the HTT.
- 4.89 On the 22 April 2015 L wanted to give notice on his UCR tenancy and had received help completing a termination letter. L was reported to have turned up with a male whom he called 'Uncle Wayne'. This man took a number of belongings including a television, stereo and games console. L advised that he was planning to move in with 'Uncle Wayne' which was why he was taking his belongings and this man was going to be his main carer.
- 4.90 L then came in the following day and said he had met a girlfriend on the bus and would like to move in with her, although the previous day he advised that the relationship had finished. L advised the UCR service manager that he wanted to be admitted to hospital but had not been able to give a reason as to why. L advised that he wanted to move on as he felt that he has had bad luck at UCR, mentioning the heroin, stopping clozapine and the overdose.

### **April 2015 to February 2016 - Inpatient stays and homelessness**

- 4.91 On the 24 April 2015 L was reported as a missing person to the police as required by UCR care protocols (a Datix entry was also recorded). The

police visited UCR and searched his room at 4.00am that morning. Staff advised that L had received his benefits the previous day and were concerned that he had been abusing substances recently.

- 4.92 UCR contacted the police again later that day for an update and to check that they are aware of his current risks which were associated with violence and aggression and he was also deemed to be a suicide risk. The police reported that they were following up addresses that they had received from staff at UCR.
- 4.93 On the 25 April 2015 L contacted the police to say that he was hearing voices telling him to kill people. The police attended and an ambulance was called and L was taken to the Manchester Royal Infirmary (MRI) with auditory hallucination and expressed risk to self and others. L denied any drug use over the last two days, however he reported that he had been drinking cider throughout the day to cope with the voices. L reported feeling unwell over the last few weeks and struggling to cope at UCR as he had always been in prison or in hospital. L reported that he felt that his mood has become low, he was isolating himself, felt lonely, had no motivation, poor sleep and poor diet. He reported that over the last five days particularly, he felt his mental health had deteriorated and had expressed that there was a daily constant voice inside his head telling him to harm others. L expressed that last night he went into a shop and picked up a bottle of wine with the plan to hit a staff member over the head when they approached him as the voices told him to. He stated that this scared him and he did not act on the voice but left the shop and called the police telling them that he had plans to hurt others. L had expressed increased suicidal ideas over the last few days and on the previous night had placed his jumper around his neck with the intent to hang himself, however, he removed it himself.
- 4.94 His risk of harm was identified as moderate and the plan to make an urgent care referral/gate keeping referral to the SAFIRE Unit<sup>25</sup> to recommence his medication was agreed. L's accommodation at UCR was also to be reviewed as this was felt to be a contributory factor in his deterioration.
- 4.95 L had admitted being in debt to UCR for up to £200, and he had also been collecting money from other tenants up to £400. L disclosed that since he moved to UCR things had not worked out well for him and he blamed the accommodation for his relapse. L stated that under no circumstances would he return to UCR and would therefore require re-housing. L was seen to have difficulty rationalising responsibility for his own actions.
- 4.96 On the 28 April 2015 L was admitted from the SAFIRE Unit to Bronte ward, Laureate House, Wythenshawe Hospital, as an informal patient. On his admission checklists L scored high on the alcohol dependency sheet (36 of 40) and scored 10 on Drug & Alcohol Scoring Tool (DAST). He is

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<sup>25</sup> The Swift Assessment for the Immediate Resolution of Emergencies (SAFIRE) Unit provides support to individuals who are suffering from mental health crisis. The aim of the nine-bed unit is to provide an environment where further assessment can be carried out in order to find an alternative inpatient admission

documented as being a diabetic with hypertension. Drug use was recorded as heroin, crack cocaine and subutex.

- 4.97 On the 8 May 2015 L re-commenced clozapine and was also noted to be compliant with all other medication. It was felt that he would be on the ward for around a further 2 to 3 weeks. L made it clear that he will not return to UCR and stated that he needed to go back to a rehabilitation unit although it was explained that he did not need rehab. L felt strongly that he could not live independently.
- 4.98 On the 15 May 2015, only seven days later, there was a discussion with L that the Home Treatment Team can undertake the remainder of his clozapine titration in the community and he need not necessarily be an inpatient. L stated that he was "worried" that he was not ready for this as he was not yet on the dose of clozapine he was on previously and he stated he felt unstable.
- 4.99 On the same day L left the ward and missed his evening medication. He returned at 7:25pm and when he attended for his medication, alcohol could be smelt on him. L reported that he had one pint with his family and friends earlier in the evening and he did not appear to be intoxicated, therefore his medication was still given.
- 4.100 On the 16 May 15 in an AMIGOS entry L stated that he has worked with many consultant psychiatrists in the past but none had "unlocked the code to his brain". L discussed experiencing auditory hallucinations in the past of a male voice telling him to harm others and then harm himself. L then went on to say he has only ever harmed "bad people (drug dealers)" but would not harm "any good people". L denied experiencing any voices whilst on this admission and that he was happy to remain an informal patient.
- 4.101 On the 20 May 2015 L was discharged from Bronte ward. He was noted as settled, with no signs of low mood and was looking forward to his discharge. Clozapine titration was to be continued in the community and discharge medication was given to L. He then left the ward and reported that he would be making his own way back to his accommodation to UCR. This information was passed to UCR. L also took his prescription card for the CMHT to collect when they attend.
- 4.102 As he had not arrived by 6:50pm on the 20 May 2015, L was reported missing to the police by UCR.
- 4.103 On the 22 May 2015 an AMIGOS entry suggests that L's whereabouts were still unknown. The duty Approved Mental Health Practitioner (AMHP) and Specialist Registrar on call advised that if L was found, he should be assessed under the Mental Health Act as soon as possible. They stated that "whilst L's mental state may have appeared superficially settled when he was last seen, he has not done as he said he would do, to return to UCR. L had also not engaged with the Home Treatment Team. L's clozapine had not been supervised and given his history, it is not going to be possible to safely continue this initiation in the community. L clearly had

a significant major mental disorder, posed a risk to others and is in need of treatment in the interests of his health and the less restrictive option of intensive MHHT (mental health home treatment) has failed. It is therefore appropriate to consider admitting L under the Mental Health Act if he will not come back in to hospital informally". This was never followed up as L later was admitted informally.

- 4.104 On 22 May 2015 the police were contacted by a security guard in Manchester. L had disclosed that he had a knife and has not been taking his medication. An ambulance and the police both attended and L was taken to MRI A&E. This was later followed up as a public protection incident by the police, who checked that L had been assessed and was in contact with mental health services.
- 4.105 L agreed to be admitted to the SAFIRE unit as an informal patient. L said of his recent discharge from hospital that he "put a front on" as he could feel he was "wanting to target someone and harm them" so decided that it was "better to be discharged". L also states that he was a "danger to the public". He said that whilst he was walking round town he could feel himself "targeting people" who he could hurt. L felt that he "needs locking up for the safety of the public" and is "sick of putting a front on when deep down I want to hurt people". L again stated that he had been in hospital for the majority of his adult life, he was recently discharged from Bronte ward three days ago and reported that the staff assumed he was okay and that he did not really tell staff what he was thinking or feeling.
- 4.106 On the 26 May 2015 L was discussed in the SAFIRE ward round by the consultant psychiatrist, and joined by his CCO. This meeting suggested that L had no objective evidence of responding to hallucinations. Whilst the impression was that this was a relapse of L's previous diagnosis of schizophrenia, it was also felt L's presentation was driven by social stressors and inability to cope in the community and his maladaptive coping skills. The plan was to admit L to an inpatient bed whilst awaiting accommodation in Stockport, although this was said to be "not ideal use of hospital bed" but necessary due to the almost certain chance of re-presenting if discharged from hospital. L's diagnosis of schizophrenia was thought to need reformulation given that there was no evidence of relapse since being off clozapine. L to continue olanzapine 10mg for now.
- 4.107 On the 27 May 2015 L was transferred to the Mulberry ward, Park House, North Manchester General Hospital, where he was compliant with prescribed medication and allowed staff to complete his physical observations. L spent time with the allocated nurse and engaged appropriately, he reported his mood had improved since being in hospital and he denied thoughts of harm to self or others. L reported feeling safe in hospital.
- 4.108 On the 2 June 2015 another patient accused L of taking money from his account when buying cigarettes. L reported that he had learnt from his mistake and was no longer going to complete shop runs for other patients. Following lengthy discussions with the staff nurse, L was able to recognise how this may put him in a vulnerable position and open to accusations.

Following the accusation, L became irritable and was visibly distressed. During a one to one with staff, L stated that 'I want to ring his neck out' although expressed no active intention to act on this thought. Later that day at 8.00pm, L returned to the ward with a fellow patient and concerns were raised that L may have been drinking whilst off the ward. L was breathalysed and a moderate alcohol intake was indicated. Despite initially denying any drinking L then admitted to having 'one can of Stella 5.5%'. UDS completed showed positive for ketamine which L reported that he had 2 weeks prior to admission.

- 4.109 On the 4 June 2015 L's CCO attended York House CMHT with his former CCO from Stockport, and staff from Stockport Council to discuss options once L was discharged. It was agreed at this meeting to seek a forensic psychiatrist opinion, but this does not appear to have happened. It was planned for L to also attend this meeting, and he had left Mulberry ward to do so, but he did not arrive. As L did not return to the ward either, he was again reported as a missing person to the police.
- 4.110 On the 5 June 2015 L remained missing from the ward. Police attended to take some information but there were no new updates.
- 4.111 On the 6 June 2015 a telephone call was received from a staff nurse at MRI where L has been admitted by ambulance into the acute medicine receiving unit. L had taken an overdose of 40 x 500mg paracetamol and 40 x 300mg aspirin with alcohol.
- 4.112 On the 7 June 2015 L returned back to the Mulberry ward at midnight via ambulance. L was informed that due to alleged overdose of medication he was be maintained on '1:15' (i.e. observed every fifteen minutes) safe and supportive observations until review by MDT. It was reported that L was in agreement and stated on 1 to 1 interaction that he "just had enough / just snapped" while on leave. The notes record L stated that he has done this before. Staff questioned that he had stated that he wanted to go to a hospital in Stockport, he had replied that "I'm just embarrassed".
- 4.113 On the 8 June 2015 L reported that he felt settled on the ward although he was concerned about the future. He was reassured regarding discharge that his feelings of anxiety about discharge were normal because of his prolonged stay in hospital. L asked about clozapine as he wished to be on it, however, the ward consultant psychiatrist was not present so L could not commence clozapine at that time.
- 4.114 On the 13 June 2015 L was approached whilst in the toilet and smoke was observed coming out of his mouth and nostril. He initially denied using any substance but later owned up to it. L advised that he wanted to self-discharge and was told to wait until Monday and speak to the consultant psychiatrist but he refused. L was advised to wait for the duty doctor, which he did and the duty doctor was informed of the circumstances. The duty doctor reported that she was held up in A&E. L later said that he had changed his mind and he was willing to stay on the ward.

- 4.115 On the 15 June 2015 L's CCO requested the discharge summary from Edenfield following the consultant ward round. This was to support the forensic opinion and the plan was to then put this information onto AMIGOS. L reported that he tried to take heroin and crack "the other day, like an idiot". Clozapine was again explored as a treatment option by the ward consultant psychiatrist. L reported that he was 'very well' on clozapine and described this as 'the wonder drug'. L understood the risks associated and interactions with clozapine and drug use and said 'I would be willing to do a drug test everyday'. The plan was to commence clozapine and to instigate random UDS testing.
- 4.116 On the 17 June 2015 L was transferred to Redwood ward at approximately 7.00pm. L was very pleasant and appropriate when approached and he reported that he was 'fine' with the transfer.
- 4.117 On the 24 June 2015 L was stated as saying that "he can't get close to anyone as he starts to target them and wants to hurt them". L tested positive for benzodiazepines and ketamine whilst on the ward, and was again non-compliant with his clozapine regime. However, over the next few days he settled again and titration was continued in line with the policy.
- 4.118 On the 30 June 2015 the CCO contacted the housing inclusion officer in Stockport who advised that L would not pass a risk assessment for social housing unless he had a period of stability. The need for a forensic assessment was discussed with the care team at the ward round. It was now felt that this would not help as they will only suggest the type of placement rather than specific suggestions and this could also take up to 6 weeks. Coping strategies were discussed for L so that he can contact the ward if he felt anxious, impulsive or unsafe.
- 4.119 The nursing care plan entry on the 6 July 2015 stated that staff will now complete a mental state assessment prior to L leaving the ward. Following this, the nurse can make a decision as to whether it is safe for L to leave. It was felt important that L engaged with staff and was open about his thoughts and feelings. L's named nurse was working collaboratively to evaluate his progress whilst on leave and to ensure the agreement remained proportionate to his risk behaviours, and that it worked in the least restrictive manner to protect L's risks as an informal patient.
- 4.120 On the 7 July 2015 the ward round entry reported that L's mood was "low", that he felt like he has hit "rock that bottom" principally because he is disappointed in himself for using drugs and he fears that his consultant will go "mad". L expressed that although he has been anxious in the past, he had "never felt like this before". L expressed that he "might do something bad", however, he could not elaborate what this meant but stated that he can do horrible things when he is unwell. L denied that he will make any attempts to harm himself whilst on the ward and reported that the ward and staff are like his "comfort blanket". L expressed that he wished that he was on a section because this would stop him from utilising substances whilst off the ward. L has been informed that if any substances were found upon him being searched, he would be discharged and if there were

concerns in relation to his mental state a MHA assessment should be arranged.

- 4.121 On the 15 July 2015 L's referral was received for dual diagnosis input. An alcohol and drugs screen was also completed by the substance misuse practitioner on Redwood ward of Park House. Fortnightly 1 to 1 sessions were planned and L was to attend and engage with appointments focusing on: Harm reduction; Coping Strategies; Trigger Recognition; Craving Management; and Relapse Prevention.
- 4.122 On the 19 July 2015 L appeared more elated than noted previously, engaging more with others and he was noted to be louder and joking. There was suspicion of drug use whilst L had been on leave the day before. L also refused to provide a UDS when asked by staff and expressed anger about this given that he has already provided 4-5 clear UDS's already that week. L expressed that he went to visit his family yesterday and claimed that he has not taken any substances. He reported that he had not had a nice day, however, he was unable to identify why when asked.
- 4.123 On the 22 July 2015 L attended Brydon Court (a new accommodation option) for his planned assessment to see if it was suitable for him to move there. L was anxious about going that morning but eventually agreed to get a taxi there and back unescorted. L provided a UDS that morning, which was positive for morphine and cocaine. L stated that he had taken cocaine whilst out on leave on the previous Saturday.
- 4.124 On the 28 July 2015 it was agreed that there were no grounds to detain L currently, as he had mental capacity although staff were to check his mental state before L leaves the ward. It was felt that if he returned from leave and his mental state was of concern, a section 5(2) could be considered and put in place by the duty doctor.
- 4.125 On the 31 July 2015 L had not returned to the ward since leaving the previous afternoon. Staff left voicemails on his phone encouraging him to let the ward know he is okay. The police were contacted and a cause for concern had been raised.
- 4.126 On the 3 August 2015 L was arrested while intoxicated for stealing alcohol and chocolate at the Tesco supermarket in Macclesfield. The forensic nurse practitioner in Middlewich in Cheshire phoned the ward to say that L was ready for discharge and awaiting accommodation. The nurse asked if the ward were happy to let him make his own way back to the hospital himself if his mental state was stable. However, the police later contacted the ward to say that they would arrange for him to be brought back to the ward due to his past risk. L was re-admitted at around 10.30pm and appeared fairly subdued on approach. L reported that he went shopping and met a girl that he had known for some time and he decided to stay out. L stated that he went to Tesco in Macclesfield and had stolen bottles of spirit (and was later charged for this offence). L said that he was drunk and was disappointed about his own behaviour and was remorseful. L

acknowledged that this has set him back as he would have to start clozapine titration all over again.

- 4.127 On the 6 August 2015 L was recommenced on clozapine and was keen to be discharged to Brydon Court. L expressed that he had had a blip this weekend and he felt that he wanted to get on with his life
- 4.128 On the 12 August 2015, Brydon Court advised that there was a place now available for L. Brydon Court were advised that L was still in hospital being titrated on clozapine. Brydon Court advised that L has to sign up for the tenancy as soon as possible, or he would lose his room. L's CCO telephoned the ward to advise that she had arranged for L to attend Brydon Court at 11:30am the next day to sign up for the tenancy. Brydon Court were aware that L would not be discharged immediately and were happy to wait as long as he was signed up.
- 4.129 On the 13 August 2015, L attended the clozapine clinic for his regular bloods but then did not attend Brydon Court to sign for the property as planned. He did not return to the ward and staff were unable to make contact with him via telephone. It was agreed that if L had not returned by 9.00pm he would need to be reported to the police as a cause for concern.
- 4.130 On the 15 August L was still AWOL from Redwood ward and was reported as a missing person. His bed had been given away and bed management were in the process of trying to find a new one for him.
- 4.131 Later that day the ward received a call from A&E at the MRI, who reported that L was in the department with superficial self-harm wounds to his arms. A bed was found on Mulberry ward (a patient had gone absent without leave) and his admission was agreed.
- 4.132 For the next few days L remained compliant with his medication and was titrated on clozapine with no issues. He was seen to be settled on the ward and engaging well with both staff and peers. On the 31 August 2015 L stated that he felt his mood fluctuated, explaining that one moment he felt happy and sometimes he had days where he did not feel like he could face the world. He asked if this could be bi-polar disorder.
- 4.133 On 5 September 2015 L was pleasant in the morning when approached and he was happy to speak to staff. However, that afternoon L went out on leave in the afternoon and did not return. Numerous attempts were made to contact L via his mobile phone, without success and the police were informed.
- 4.134 On the 8 September 2015 Macclesfield A&E contacted the ward to report that L had presented at the department and was being treated for hypothermia. He had been found intoxicated by a member of the public under a railway bridge. They had called an ambulance as they were concerned for his welfare. L was pronounced medically fit and left the ward at 3.00am in the morning and was still missing. The police were continuing to look for him.

- 4.135 On the 14 September 2015 L's continuing absence from the ward was discussed with the consultant. The plan was to consider discharging L from the ward in his absence following discussion of a management plan and follow up arrangements with his CCO. The consultant advised that L should be assessed with regard to his mental state and attendant risks and whether further admission was indicated. A Mental Health Act assessment should also be considered if appropriate at this time also.
- 4.136 On the same day L re-presented at A&E in Macclesfield when they telephoned Redwood ward. There was no longer a bed on Redwood ward and so an informal admission was agreed to the SAFIRE unit and L was asked to attend at 9.00pm, as they were going to instruct a Mental Health Act assessment. L arrived on the SAFIRE unit at around 9.00pm and appeared to be relaxed in mood and warm and appropriate in his interactions with staff. L was given his regular prescribed medication (omitting clozapine as he had been away for 10 days) and he provided a UDS. This was positive for cocaine, opiates and benzodiazepines.
- 4.137 On the 15 September 2015 L appeared relaxed and was able to reflect upon his absence from the ward. He said he had had suicidal thoughts on two occasions, once to throw himself off a bridge and another to hang himself in a church yard. L could not recall the exact reasons why he felt suicidal, except that he was cold and uncomfortable. He reported he felt glad to be back in hospital as he knew he needed to be back on his medication. L reported that he started to experience hallucinations after three days of missing his clozapine. These included seeing a man attacking him. He remembered fighting with this man and stated the experience was very vivid. L also reported seeing a dog standing over him growling.
- 4.138 On the 16 September 2015 L reported that he wanted to go to a different ward (not Redwood) and to go onto a depot<sup>26</sup> injection rather than clozapine. L reported ongoing 'confused thoughts of violence'. Staff discussed with L that he was not currently psychotic and whilst he continued to have violent intrusive thoughts, he did have capacity to make decisions. L was to be transferred to an acute ward to discuss longer term medication and depot medication with his CCO to continue with further plans for assessment in supported accommodation.
- 4.139 On the 19 September 2015 L was admitted onto Mulberry ward from the SAFIRE unit at around 10:35pm. He had already been given his medication for the night by the time he arrived on the ward. L presented as settled, watched television with other patients and he retired to bed around 11:00pm.
- 4.140 On the 22 September 2015 the manager at the proposed Heaton Lodge placement advised that he was on his way to see L to assess him earlier than planned and he should be able to be discharged soon.

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<sup>26</sup> Depot antipsychotics are administered by deep intramuscular injection at intervals of 1 to 4 weeks. Long-acting depot injections are used for maintenance therapy especially when compliance with oral treatment is unreliable

- 4.141 On the 24 September 2015 L was more vocal than usual, facially reactive and engaging with other peers. He was asked for a UDS sample and /or breathalyser but he refused both and became defensive. There was a strong suspicion that L was under the influence of drugs or alcohol. L reported that he felt targeted on the ward and it was explained to him that UDS checks were routine for anyone who spends time off the ward.
- 4.142 On the 26 September 2015 L approached staff requesting to utilise his time off the ward. At around 1.00pm staff attempted to contact him on his mobile but this went straight to voicemail. The ward team decided that if L did not return to the ward by 10.00pm then night staff should contact police to raise a carer's concern and start the AWOL procedure. A telephone call was then received from Greater Manchester police at 5.00am requesting more details in order to log L into the missing persons system.
- 4.143 On the 28 September 2015, L was still AWOL at the time of the ward round. The CCO spoke with the manager of Heaton Lodge prior to the ward round who confirmed that they had accepted L and there was a bed available for him immediately. L was contacted and seemed very pleased at the assessment and felt Heaton Lodge was appropriate for him and that he wanted to return to Stockport.
- 4.144 As at the 7 October 2015, L remained AWOL. The police had contacted the ward informing staff that they have managed to locate L, however, he was refusing to return to the ward voluntarily. The police reported that L appeared settled in his mental state and was also reported as being safe, well and with a friend in Chorlton. He had not been seen by a mental health professional since 26 September before he went AWOL.
- 4.145 On the 8 October 2015, L was discharged in his absence by the ward. There is no record of how this decision was reached recorded on AMIGOS.
- 4.146 On the 13 October 2015, the police advised that L had been seen at a flat in Chorlton. The police did not enter the property at that time but they advised that it looked dilapidated and the flat was in fact a garage on the side of a house. The police advised again that they had no concerns about L's mental state, although apparently L was not aware that he was a missing person and also an in-patient. L did not appear intoxicated, he was cooperative and polite. The CCO later attempted to visit L at the address in Chorlton. As there was no answer they left a note asking L to contact them by the following Thursday (two days later).
- 4.147 On the 15 October 2015, the CCO contacted L's adoptive mother who said she had not had any contact with L and would prefer not to be contacted again in relation to him.
- 4.148 On the 21 October 2015, L was escalated to the 'clients causing concern' agenda item on the MDT.
- 4.149 By 11 November 2015, the police had not had any reported sightings or any further information of L's whereabouts. They were aware of the risks L

presented when he was drinking alcohol to excess or taking illicit drugs and they were aware he was unlikely to have any medication.

- 4.150 On the 18 November 2015, L attended his GP surgery for an appointment and to collect his medication. The GP was asked to keep him at the surgery so that the CCO could meet with him. The CCO was called and she saw L with the GP. His mental state appeared stable and he was friendly and chatty. L appeared relaxed and he said that he had been living with his friend. L's main concern was accommodation. He said he could not stay long term at his friend's flat and would like some support in this area. L stated that he had not been taking illicit drugs or drinking alcohol but his presentation did not correlate with this. He had constricted pupils and bizarre facial expressions. L picked up two weeks' worth of medication and arranged to see the GP within the next two weeks for more medication. L gave the CCO a new phone number which has been put on the system. The plan was to see L the next day at the Kath Locke Centre (the CMHT base) and an OPA had been arranged for review.
- 4.151 On the 19 November 2015, L attended the Kath Locke Centre (the CMHT base) as arranged. He presented as slightly erratic in his behaviour. His personal care was noted to be acceptable though not up to his usual standards. L said that his mental health was good and he has been taking his medication. He intended attending an appointment with the GP next week to collect the next prescription as he was only given two weeks-worth of medication. L's drug use was discussed. He admitted using heroin but said he was not using it daily and does not think he was addicted. L admitted he did need the money for drugs and would be suffering if he was not able to buy any, which suggested he was taking more than he was admitting to. L planned to continue staying at his friend's house for the short term and stated he was helping him out financially rather than paying rent on a formal basis.
- 4.152 On the 23 November 2015, L did not attend his scheduled appointment at the Kath Locke Centre although did attend later that day. L's presentation suggested that he may have been intoxicated. He became agitated and irritable at times, other times he would be amenable and he was slightly erratic in his behaviour. L stated that he was no longer able to stay at his friend's house in Chorlton, as his friend had problems with his mental health and he does not want to intrude any longer. L was advised that the only option was to present himself as homeless in Stockport. L had presented at Manchester but they did not have a duty to accommodate him as L's links were to Stockport.
- 4.153 Stockport housing advised that L could come and see the housing officer the next day at 9:30am and they would complete a homeless assessment. L then became verbally hostile and said the CCO was doing nothing to help him and had a bad attitude. He calmed down and eventually agreed to attend the housing office the next day. It was suggested to L that he should stay at his friend's house one more night and then he should temporarily be housed tomorrow. L stated that he wouldn't stay there as there was no electricity or gas and it was freezing and the environment was affecting his mental and physical health. The CCO apologised to L but

this was the only option at the moment as there was no housing or money for accommodation. L became very hostile and abusive towards the CCO and said that she was useless and shouldn't be in this job, and he walked off.

- 4.154 On the 2 December 2015, the police informed the CCO that L had taken an overdose and had been taken to Stepping Hill Hospital in Stockport. L had not stayed in hospital, discharging himself, and hospital staff reported this to the police.
- 4.155 By the 4 December 2015, L had been placed in temporary accommodation, helped by his CCO, at the Buxton Road Hostel, Stockport but he was also intermittently sleeping rough. His presentation had changed, he didn't appear to have any possessions and had not been taking any medication. It was suggested that a plan was needed due to concerns about L becoming chaotic/aggressive and losing his hostel placement.
- 4.156 On the 18 December 2015, the Housing Officer from Stockport phoned the CCO and reported that L had left the Buxton Road hostel. Apparently, he was due to be evicted but went missing before this could happen. There were a number of incidents over the previous weekend, L had been bothering various residents, knocking on their door throughout the night and asking for money. L had taken £200 from a vulnerable adult and had managed to get various amounts of money from other people. L also went to another tenant's family home and asked for money, it was suggested to the family that they needed to contact the police but they had not reported the incident. L had picked up his prescription but it was unclear whether he was taking his medication. L had no Out Patient Appointment booked and the CCO was unable to book one at that time as he had no address and his whereabouts were not known.
- 4.157 On the 23 December 2015, L was discussed under 'clients causing concern' at the MDT meeting as he was still missing.
- 4.158 On the 29 December 2015, the CCO contacted the police to report concerns about L being missing. The police advised that they were aware of L's location, although could only give limited information over the phone. L had appeared in court on the 28 December and was bailed to an address in Chorlton with a further court date of the 7 March 2016. The police were unable to provide precise information or details of the crime. We now know he had been arrested for theft of a mobile phone. The CCO was advised to email and request the information. L was placed on a curfew and would be having the police check on him through the night at his bail address. He would be remanded if he broke the conditions of his bail.
- 4.159 On the 30 December 2015, L was again discussed on the MDT 'clients causing concern' agenda.
- 4.160 On the 8 January 2016, the CCO attempted to see L at the bail address given by the police. There was no answer and the CCO left a note asking

L to contact the team. An email was sent to police requesting information about whether they had seen L or whether he had breached conditions and had been remanded. The police advised by email that there had been no change in conditions and L still lived and slept at the address in Chorlton and was adhering to his bail conditions.

- 4.161 On the 12 January 2016, L's CCO commenced 4 weeks of annual leave. Plans had been put in place to allocate an interim care coordination but these were not adhered to.
- 4.162 On the 13 January 2016, L's adoptive mother contacted the team duty worker advising that she had been telephoned from an acute ward at the MRI. She had had little or no contact with L recently but he had rung to say that he had 'anthrax poisoning'. Contact was made with the medical unit and staff advised that L had an infected wound site (not anthrax) and had been on antibiotics for cellulitis. L was to have further antibiotics intravenously for 24 hours. A telephone call was made to L and he said that he was going to remain in hospital for the course of his antibiotics although L did not wish for any further help from the duty worker.
- 4.163 On the 15 January 2016, L was again arrested for shoplifting and was charged and bailed to sign-in at the Central Park police station 3 days a week, however, these dates were not entered onto the police computer. This was the last known contact with L by statutory services prior to the homicide. His last known contact with mental health services was 4 December 2015
- 4.164 On the 8 February 2016, the CMHT were contacted by Greater Manchester police who informed them that L had been arrested and charged with murder.

## **5 Arising issues, comment and analysis**

- 5.1 We have reviewed L's care from first contact with adult mental health services, in order to provide background context and understanding of his presentation. We have however focused in detail on the periods between 2013 his arrest on 8 February 2016.
- 5.2 We have grouped the issues of concern regarding B's care into the following headings:
- Compliance with local and national policies.
  - Risk assessment and risk management in relation to harm.
  - Effectiveness of the Care Plan.
  - The involvement of family in planning care.
  - Safeguarding.
  - Interagency working.

- Wider commissioning issues.
- 5.3 However we start this section by identifying those factors that will have impacted on L's mental health and safety.

## Factors that affect L's mental health and safety

### Predisposing factors

- L had a very difficult childhood after a premature birth and he suffered with chronic ill-health as a child. L's mother struggled to bond with him and he was taken into care first at the age of six months and then permanently at the age of three.
- L was seen to be developmentally delayed as a child although no evidence of learning difficulties was seen on his initial psychology assessment in 2007. That said, it was noted that L did have difficulties in processing and retaining information and so, in all likelihood, the extent of his learning difficulties were underestimated throughout his care and treatment.
- L's mother by her own admission was violent towards L at a very young age and she saw him as 'naughty'; L also reported sexual abuse at a young age by his adopted brother although this either was not picked up early enough or this was not carried through in reports.
- L has described being bullied at school and was socially isolated. He was also seen to be easily influenced by his peers a fact which was evident at various points in his care and treatment particularly in his use of illicit substances.
- It appears that L began abusing drugs and alcohol from a young age and was predisposed towards their recurrent use.
- L's first contact with mental health services was in 1996 after a suicide attempt although it was often reported that his first contact with mental health services was in 2005. Whilst it was reported that L had no signs of mental ill health this conclusion was made after one assessment and L did not engage with mental health services after this point until he was in the prison service, despite his chaotic life and increasing forensic episodes.

### Precipitating factors

- His continued abuse of drugs and alcohol undoubtedly worsened his illness and precipitated relapses. It could be seen as an attempt by L to self-medicate. It would also have contributed to his chaotic lifestyle which would have reduced his compliance with treatment and supervision.
- He has also been able to guard his symptoms and not disclose them at times, which has led to the belief in some mental health professionals that he was not suffering a relapse of schizophrenia, even though it was likely that this had occurred.

- His poor engagement with supervising community services, contributed to his continuing mental illness.
- He cannot cope with emotional distress because of poor coping strategies.
- Moving accommodation and the increasing expectation that he would become more independent gave L anxiety and meant he became increasingly more unsettled.
- L was clear that he wanted some increased support as he felt institutionalised and unable to cope in the community and he would often 'self-sabotage' in a bid to achieve this end.
- There have been a number of instances when his illness has relapsed as a result of non-compliance with medication and non-engagement with community mental health services.

### **Perpetuating factors**

- L's continued abuse of drugs and alcohol undoubtedly worsened his illness and precipitated relapses. It would also have contributed to his chaotic lifestyle which would have reduced his compliance with treatment and supervision.
- L was said to be easily influenced by his peers and this was often a factor in his decisions to use drugs and alcohol and to absent himself from his place of care.
- He did not always seek out support when he felt his risks were elevated and would often fail to disclose to staff how he was feeling.
- L was often very contrite when returning to the ward or place of care after he had gone AWOL. He often used the phrase I'm so embarrassed to reflect on his behaviour which seemed to close down a more assertive response from staff.
- Whilst L clearly had capacity there was often a query around his learning capacity and the extent of his ability to retain information and make decisions. Once in the community L continuously reverted to the same coping strategies of drugs, alcohol and aggression and staff reverted to the same re-education processes over several years; and other more assertive approaches were not implemented. Given his history, these could have included detention and treatment under the Mental Health Act (considering the degree of his illness not just the nature), and a much more assertive approach with more frequent contact in the community to ensure he took his medication.
- L was known to use racist and abusive language when in conflict situations and there had been an allegation that he raped someone when he was 16. He may also have had some unresolved issues around sexual abuse that he declared but this was not revisited in the therapeutic environment.

### **Protective factors**

- His most stable periods have been when in a secure environment, treated as an inpatient and whilst on clozapine.
- He remained stable while in Heathfield House, a step down rehabilitation facility.
- It was clear that he did not have sufficient internal coping mechanisms to manage in conditions of more independence.

## Compliance with local and national policies

### NICE Guidance

- 5.4 L had a primary diagnosis of paranoid schizophrenia, and a secondary diagnosis of antisocial personality disorder. The relevant national guidance for evidence based treatments are NICE guidance for the treatment of psychosis and schizophrenia (updated 2014)<sup>27</sup> and antisocial personality disorder (updated 2013).<sup>28</sup>
- 5.5 The sections of the NICE ‘guidance for the treatment of psychosis and schizophrenia’ relevant to L’s care are: promoting recovery and long-term care, preventing and treating physical health problems, and support for carers.
- 5.6 Promoting recovery and long term care: this should involve the provision of psychological and pharmacological interventions, social and occupational interventions and family intervention if possible.
- 5.7 From his time in Ashworth L was able to access a range of cognitive behavioural interventions such as violence reduction, thinking skills and substance misuse work.
- 5.8 At Ashworth L disclosed that he had been trading with other patients for clozapine, and was able to demonstrate that this had a beneficial effect on his symptoms. A revised PCL-R was conducted after treatment on clozapine, and this showed a markedly reduced score, which supported the view that his violence was linked to his mental state, and the symptoms of psychosis he experienced manifested as violent thoughts, paranoia and urges to harm himself and others. Treatment with clozapine was successfully carried on until he stopped taking it regularly in December 2014, whilst at UCR.
- 5.9 In 2012 a psychology report at Edenfield noted that he no longer met the formal criteria for diagnosis of any personality disorder, but remained vulnerable to stressors particularly in interpersonal relationships. Work continued on the recognition of early warning signs of relapse, and L was

<sup>27</sup> Psychosis and schizophrenia in adults: prevention and management.  
<https://www.nice.org.uk/guidance/cg178>

<sup>28</sup> Antisocial personality disorder: prevention and management.  
<https://www.nice.org.uk/guidance/cg77/resources>

supported when he experienced raised anxiety after transfer from Edenfield and later to Heathfield House.

- 5.10 There were attempts to involve his adoptive family in his care, and he was encouraged to keep in contact with biological family, with variable success. His adoptive family remained in sporadic contact with professionals, only occasionally attending meetings when invited.
- 5.11 Throughout his care at Edenfield L was encouraged to maintain family contact, and visited them in Stockport regularly when he had gained sufficient independence.
- 5.12 L had a number of physical health problems as outlined earlier, and care plans and interventions were in place throughout his care pathway for these.
- 5.13 There is a focus in the NICE guidance on preparation and support during any transfers, where care is transferred to another trust or service. L was well supported during the transfers from Ashworth to Edenfield, Edenfield to Heathfield House, and to UCR. The requirements of Section 117 MHA were carried out by PCFT, including maintaining oversight of his housing needs while he was an inpatient and in the care of the CMHT in Manchester.
- 5.14 L had a care coordinator (CCO1) from Stockport CMHT allocated whilst he was in Heathfield House after transfer from Edenfield, and continuity was maintained after handover to the Manchester care coordinator (CCO2) in Central West CMHT. These care coordinators remained in regular contact throughout 2014 and 2015, until it was decided that L was to be discharged from the Stockport CMHT caseload, as L was no longer in need of services that could be provided or paid for by Stockport. These could be accessed however, should his condition change and be in need of further aftercare.
- 5.15 The discharge summary from Edenfield was lengthy and provided a comprehensive overview of L's forensic history, nature and degree of his mental disorder, risk assessment, and early warning signs and relapse prevention factors.
- 5.16 The discharge summary from Heathfield House also contained a detailed summary of his history to date, including what treatment he had received at PCFT. An up to date risk assessment (TARA) was also provided.
- 5.17 During his time at UCR, L was supported to access community facilities, but preferred to attend the gym several times a week rather than engage in other activities. He had worked through a self-medication programme whilst at Heathfield House, to the extent that he was collecting his medication from the pharmacy and administering it independently. He maintained regular blood tests for clozapine monitoring.
- 5.18 There was also a concerted effort to help him to address his substance misuse, and he was seen for assessment by a dual diagnosis worker in

June 2015, while an inpatient at Park House. L did not take advantage of this opportunity at the time.

- 5.19 In our opinion, L was provided with appropriate and high quality evidence based care for his paranoid schizophrenia, and had a comprehensive treatment plan up until his admission to Park House in 2015. Following his admission to Park House we consider that the questioning of his diagnosis and the focus on personality issues alone served to limit the treatment options available. It also appears that there was a failure to take into account the previous risk assessment, especially related to relapse in drug abuse, non-compliance with treatment and increase in aggression

### **Multi Agency Public Protection Arrangement (MAPPA)**

- 5.20 L had a long history of offending, and his most recent sentence was in 2005, in respect of robbery with a knife, for the duration of 3½ years with six months concurrent for burglary of a dwelling. This was added to during his sentence for offences committed while he was out on licence, and after his return to prison. Notably he held a prisoner hostage. Psychiatric reports prior to his transfer from prison in 2007 note that he posed a high risk of harm and of reoffending, and recommend that Multi-Agency Public Protection Arrangements (MAPPA)<sup>29</sup> be in place should he be released. It was noted at the Edenfield discharge summary in 2013 that his MAPPA status while at Ashworth was unclear. This was never clarified at Heathfield House, nor whilst under the care of Manchester mental health services.
- 5.21 In our opinion it is reasonable to expect that a forensic service should incorporate the question of a MAPPA referral in its risk assessment and care planning when transferring a patient to another service, and this should have been in place for L.
- 5.22 It is also not clear what, if any, Probation services were involved in any after care planning arrangements for L, both from Edenfield and Heathfield House.

#### **Recommendation 1:**

Both PCFT and GMMH should clarify the MAPPA status at the point of transfer to other services for patients with forensic histories. This should also include identification and involvement of probation/ NOMS for appropriate patients.

### **Local Policies**

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<sup>29</sup> Multi-Agency Public Protection Arrangements.<https://mappa.justice.gov.uk/connect.ti/MAPPA/view?&objectId=26296>

- 5.23 The planning and review of L's care plans, and the approach to risk assessment have been reviewed in the relevant sections elsewhere.
- 5.24 In this section we will discuss the application of the legacy Trust's policies and procedures relevant to L's care.
- 5.25 The MHSC 'guidelines for antipsychotic drug treatment of schizophrenia' (2002) indicates that clozapine is the medication of choice in treatment resistant psychosis, and if it has been shown to be effective, should be reintroduced. This was the treatment approach for L, but the process of re-titrating him back onto clozapine in 2015 was not managed well. It was considered on several occasions, and even requested by L, but was not properly restarted until 6 August 2015. However, due to his continued AWOL it was not consistently taken for a sustained period. By 14 September, he had gone AWOL twice, and on readmission on that day the clozapine was not restarted. Given his previous history of responding well to clozapine a period of detention and treatment under the Mental Health Act would have benefited L.
- 5.26 In the 'Shared Care Protocol for Atypical Antipsychotics' (2013) it is expected that clozapine prescribing should be maintained by secondary care. The 'Clozapine Guideline - Community' (2011) focusses on physical health and physical observations, but does not provide guidance to support risk assessment and decision making in titrating clozapine in the community. In this case the GP was under the impression that clozapine clinics would also test for illicit drugs, which is not the case. It would be helpful to amend this guidance and produce information for GP's to clarify the nature of clozapine monitoring in the community and the purpose and limit of blood tests.

#### **Recommendation 2:**

- c. The Trust must provide clear guidelines for risk assessment and care planning for the titration of clozapine in the community.
- d. The Trust and NHS Manchester CCG must develop and agree guidance for GPs on the administration of clozapine and the limited function of blood tests for titration.

- 5.27 The AWOL policy in place at the time (2010, reviewed 2016) allows a decision to be made about discharging the patient in their absence, subject to there being 'no concerns'. We question this from a risk management perspective, and suggest that the policy should be amended to ensure that discharge in the patient's absence is not a routine practice. This should be strengthened with a decision support tool that requires a detailed risk assessment to be made, and recorded clearly.

### Recommendation 3:

The Trust AWOL policy should be amended to ensure that any decision to discharge an AWOL patient in their absence is explicitly risk assessed, supported by a detailed decision making tool, and reported on centrally to ensure practice is monitored.

## Risk assessments and risk management in relation to harm

- 5.28 As would have been expected, L was assessed using the HCR-20<sup>30</sup> risk assessment tool during his time in Ashworth and Edenfield.
- 5.29 In the transfer information provided from Ashworth his responsible clinician wrote:

“L has responded well to Clozapine and has engaged in some psychological therapies. He continues to require treatment to address his risk of non-compliance with medication or substance misuse, which would lead to deterioration in his mental health and a subsequent increase in his risk to others. The risks that he presents are of a nature and severity that make it unsafe to consider treatment as an outpatient. His coping strategies remains untested and he needs to develop his coping and problem solving in order for him to remain substance free. He has used substances to manage symptoms of mental illness in the past. He has been impulsive in the past and found it hard to accept supervision. If L were not detained, he is at risk of disengaging from treatment. He is likely to return to his previous chaotic lifestyle, thus increasing the risk of substance use. It is likely that his mental health would deteriorate rapidly resulting in illness and increasing the risk to others. He continues to require treatment for his personality disorder which is treatment interfering in the management of his schizophrenia. L is due to transfer to conditions of medium security for a 6 month period of trial leave on 14 October 2011 this will allow him to learn to manage in a different environment and begin to test out his coping strategies.”

### Edenfield Centre risk assessment

- 5.30 An HCR 20 was carried out in January 2013. Relationship instability was graded as definitely present due to L having been institutionalised for a significant amount of time. Substance misuse was also graded as definitely present as L whilst not in prison and living in the community, quickly resumed use of drugs and alcohol.

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<sup>30</sup> Version 3 of the HCR-20 is a comprehensive set of professional guidelines for violence risk assessment and management based on the Structured Professional Judgement (SPJ) model. Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). HCR-20 V3: Assessing risk of violence – User guide. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

- 5.31 Psychopathy was graded as definitely present but under review and reassessment, this also applied to L's personality disorder. L's presentation was settled and compliant, he now endorsed a pro-social view in which he identified a wish to avoid returning to criminal and violent behaviour. L identified maintaining good mental health and avoiding illicit substance use as the primary area of future intervention and expresses a wish to work closely with services in order to achieve and maintain this in the future.
- 5.32 At discharge from Edenfield in 2013 it was noted that he had an extensive history of violent, criminal and antisocial behaviour, with convictions for a number of acquisitive offences involving the instrumental use of aggression and intimidation.
- 5.33 Factors seen likely to increase risk were:
- Deterioration in mental state.
  - Non-compliance with medication.
  - Use of illicit substances.
  - Increase in stress or instability in life circumstances.
  - Association with negative peer group.
- 5.34 Factors seen as likely to reduce risk were:
- Maintaining effective relationships with services and supports.
  - Developing positive coping strategies to manage stress and challenge.
  - Adherence to medication in order to maintain stability in mental state.
- 5.35 This formulation was clearly described in a lengthy discharge letter from Edenfield in January 2013.
- 5.36 Prior to his transfer to Heathfield House, his then responsible clinician (RC) noted<sup>31</sup> that "L has responded well to Clozapine and has engaged in some psychological therapies. He continues to require treatment to address his risk of non-compliance with medication or substance misuse, which would lead to deterioration in his mental health and a subsequent increase in his risk to others. The risks that he presents are of a nature and severity that make it unsafe to consider treatment as an outpatient".

### **Heathfield House risk assessment**

- 5.37 Within the PCFT Clinical Risk Assessment & Management Policy (v 5, dated November 2013) the approved Trust Risk Assessment Tool (TARA) is described, and it is emphasised that this assessment should be fully integrated into the CPA process. The TARA is a standard tool for

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<sup>31</sup> Noted in Form H5, Section 20, Renewal of Authority for Detention, 11 October, 2012.

assessment of risk which should be used for all service users. This is a locally developed risk tool that will not have been validated on an appropriate population of patients.

- 5.38 Since his visit to Heathfield House L became more anxious regarding the move and started smoking. It was recognised that the move has the potential to destabilise L for a short time and could potentially increase the risk of substance misuse and this could increase other risks such as aggressive/violent behaviour.
- 5.39 TARA documents indicate risks to include; anniversary of his mother's death (October) stressful events; and peer pressure. L is seen easily influenced.
- 5.40 Risk factors were summarised as non-compliance with medication leading to deterioration with mental state and increased risk to others, substance misuse which has an effect on L's mental state and increased risk to others.
- 5.41 L's mental state had previously fluctuated when exposed to stress, and this was evident when he was transferred from Ashworth to Edenfield and following the death of his biological mother. L was previously influenced by his peer group which has led to him displaying undesirable behaviours. L no longer required a medium secure placement given his progress and current presentation. The admission was accepted as a step-down along a secure pathway.
- 5.42 In the November 2013 TARA it was noted that L made it clear that he will not approach staff if he is feeling anxious and would rather they approached him. Discharge planning was underway.
- 5.43 Factors increasing risk were clearly listed as: deterioration in mental state / mood. Non-compliance with prescribed medication, changes in environment, disengagement from services and support, use of alcohol and illicit substances.

### **Manchester Mental Health & Social Care NHS Trust assessment of risk**

- 5.44 Risk assessment updates were completed on:
- 3 March 2015;
  - 30 March 2015;
  - 25 April 2015;
  - 23 May 2015; and
  - 24 June 2015.
- 5.45 The June update was a comprehensive overview by his care coordinator, providing a thorough summary of his risk history before and after inpatient admission.

- 5.46 There is a discussion in the internal investigation report about the care coordinator obtaining L's Edenfield discharge summary to support the care planning/discharge planning process. This was a comprehensive summation of his criminal and risk history, passage through the secure and rehab services, and his care and treatment to date, and included detail of how his diagnosis had changed from one of personality disorder to one of schizophrenia. His presentation was an unusual one for a psychotic illness, with little or no evidence of formal thought disorder or delusional ideas, but with clear reference to hearing voices and instruction to harm others.
- 5.47 The internal investigation report notes that this report was uploaded to 'AMIGOS' as a document and not flagged as important to share. We disagree with the significance of this finding, because the team had already had access to CP1's comprehensive discharge summary, which reviewed his forensic history and previous offending, risk and mental health history in detail. The TARA was also provided by L's Care Coordinator in Stockport, CCO1, which included a clear articulation of his risks, and factors which would increase or decrease risk.
- 5.48 The 24 June 2015 risk assessment provided a detailed overview of L's history, and was readily available in the AMIGOS case records. In particular it is noted that his relapse signs are intrusive violent thoughts, persecutory beliefs, anxiety and mood swings. His chaotic drug use was thought to be partly due to his mental state.
- 5.49 Recent episodes of self-harm were noted: possession of a blade in March with thoughts to harm himself or others, and overdose in May 2015.
- 5.50 Risk of violence was rated as 'high'. He was admitted in April 2015 after having thoughts of hitting a shopkeeper over the head with a wine bottle, and thoughts of harming himself or others with a blade in his possession.
- 5.51 He was admitted again in May 2015 after being brought to A&E by police with a blade in his possession. At this time L said he thought he was a 'danger to the public'. He was also seen as at risk of exploiting others in the ward, and it was suspected that a vulnerable patient had allowed him to draw money using his bank card.
- 5.52 In the structure of AMIGOS, the risk mitigation plans that follow this risk assessment are part of the CPA care plan, in the section 'safety to self/others'. The 'safety to self/others' inpatient care plan goal was for 'L to remain safe/risk to others remain low' and the action plan is:
- To remain on the ward informally while suitable accommodation is found, ward to do UDS, police to be called if there is any indication that L is exploiting others.
- 5.53 In the community the goal was for "L to remain compliant with medication in the community' and the plan was for L to be monitored closely by CMHT/support agencies for risk to himself or others, L to access support

for his drug/alcohol use, support to develop positive coping strategies to manage stress”.

- 5.54 The Crisis and Risk Management plan from April 2014 detailed that L would know things aren't going well when he experienced: Paranoia, low mood and suicidal thoughts, violent thoughts about others, that he may become confrontational and aggressive, experience visual and auditory hallucinations, an increase in anxiety, and isolation. This was available in AMIGOS.
- 5.55 The 'how others might know' section is: 'although I like my own company and will often spend time on my own, when unwell I avoid people and isolate myself. I will lose my appetite and my sleep pattern will be disrupted. I generally internalise these feelings and won't often show them, I will avoid others'.
- 5.56 The 'service response to crisis' had not been updated, and referred to L approaching staff at UCR, contacting his GP, an urgent outpatient appointment, HTT contact if needing extra support. 'Out of hours' response was to call the crisis service, out of hours GP or attend A&E in an emergency.
- 5.57 There were ward nursing care plans which addressed risk of harm to himself or others, and of abusing drugs. They appear person centred and refer to L in the first person. These are lengthy and repetitive but appear to have been developed in conjunction with L. For instance, he asked that he should always be accompanied if going off the ward so he is not tempted to use alcohol or drugs. He had a thorough assessment by a dual diagnosis worker at the end of July 2015, and he expressed a desire to work on his substance abuse, but did not follow this through.
- 5.58 His participation and compliance was regarded as 'superficial'; that is he would appear to be agreeing with care plans, and remain superficially pleasant on the ward, then abscond and use drugs or alcohol to harm himself. In our view this was indicative of the underlying issues as highlighted in his risk assessment.
- 5.59 It appears that when he was admitted, ward staff provided day-to-day support that help L to remain superficially settled in presentation. This was however frequently undermined by the underlying long term issues which manifested by frequent substance abuse and absconding.
- 5.60 In our opinion the forensic assessment should have been sought as planned in June 2015, and this would have informed future care options. The plans to discharge him to the community were carried forward, despite the risk assessment clearly showing that he would be unable to cope in this environment and risk would increase. Put simply, an acute ward was the wrong place for him.
- 5.61 There is of course the question of L's responsibility to take the opportunities offered to him, and there were many of these, notably the

Manchester care coordinator who continued to source placement options for him, working in conjunction with the PCFT care coordinator.

- 5.62 His inability to take advantage of these supportive interventions can be seen to be attributable to his underlying mental illness and personality disorder.
- 5.63 The risk assessment which rated L's risk of harm to others as 'high' was in place and known in October 2015 when he was discharged in his absence.

### **Formulation**

- 5.64 L appears to have a complex mental disorder. This includes evidence of chronic schizophrenia, which required treatment with clozapine. His symptoms of schizophrenia are however unusual in that the more common disorders of thought and perception are not manifest, but are demonstrated as the expression of violent thoughts, paranoid beliefs and agitation and aggression.
- 5.65 In addition, when psychotic he scores highly on measure for the diagnosis of antisocial personality disorder and as a child would have also fulfilled the criteria for conduct disorder. He has had substance misuse problems with abuse of alcohol and drugs. In addition, it is likely that L would have complex post traumatic symptoms resulting from his childhood experiences. These include his mother's drug and alcohol problems, bullying at school and allegations of sexual assault and rape.
- 5.66 It is difficult to attribute his offending behaviour, especially his previous violent offences, to specific aspects of his complex mental disorder, for example his schizophrenic illness. However, it does appear that at times when he has been treated effectively with an appropriate dosage of clozapine, that his violence towards others and his agitation and mood swings have been significantly reduced.

### **Effectiveness of the care plan (including diagnosis)**

- 5.67 A gradual pathway out of secure forensic mental health services took place in a planned way over a number of years. L was admitted to Ashworth High Secure Hospital at the end of his sentence on 15 November 2007, and spent four years in Ashworth.
- 5.68 During his first two years at AHSH he often presented as hostile, abusive, threatening to other patients and to members of staff despite the various support programmes that he had been enrolled in.
- 5.69 He was variously diagnosed as suffering from:
- Paranoid Personality Disorder;

- Antisocial/ Dissocial Personality Disorder;<sup>32</sup>
  - Narcissistic Personality Disorder; and
  - Emotionally Unstable Personality Disorder – borderline.
- 5.70 At that time he also fulfilled some of the criteria for a diagnosis of psychopathy. It is important to note that these were preliminary diagnoses, which were later amended to paranoid schizophrenia as this became recognised.
- 5.71 In March 2009 L disclosed that he had been accessing illicit clozapine<sup>33</sup> from fellow patients at workshops and social evenings. Since he had begun using clozapine in this way, he described experiencing symptoms such as hearing voices, persecutory beliefs about others and the experience of intrusive violent thoughts with reduced intensity. Following discussions with his responsible clinician, it was agreed that he should be formally prescribed clozapine.
- 5.72 Given the improvement in his presentation following commencement of clozapine the presence of his personality disorders was re-assessed using the International Personality Disorders Examination (IPDE). This re-assessment showed that he did not meet the definite criteria for any adult personality disorders although it “does demonstrate some narcissistic traits”.
- 5.73 He had previously demonstrated traits of psychopathy and this was also re-assessed using the Hare Psychopathy Checklist (PCL-R). This too noted a remarkable reduction in his scores, although the assessment concluded that “the previous scores are important as they have implications for how he presents when most unwell”.
- 5.74 His diagnosis was changed to a primary diagnosis of paranoid schizophrenia although there remained elements of personality disorder.
- 5.75 He continued to make good progress and by 2011, it was agreed that he no longer required detention in high secure care, and he should be considered for a medium secure placement at the Edenfield Centre, Prestwich. After a six month period of trial leave, he was formally transferred to the Edenfield Centre on the 2nd April 2012.
- 5.76 Prior to his transfer, his then responsible clinician (RC) noted<sup>34</sup> that “L has responded well to Clozapine and has engaged in some psychological therapies. He continues to require treatment to address his risk of non-compliance with medication or substance misuse, which would lead to deterioration in his mental health and a subsequent increase in his risk to

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<sup>32</sup> Antisocial personality disorder is a particularly challenging type of personality disorder, characterised by impulsive, irresponsible and often criminal behaviour. Someone with antisocial personality disorder will typically be manipulative, deceitful and reckless, and won't care for other people's feelings.

<https://www.nhs.uk/conditions/antisocial-personality-disorder/>

<sup>33</sup> An antipsychotic drug used as a sedative and in the treatment of schizophrenia.

<sup>34</sup> Noted in Form H5, Section 20, Renewal of Authority for Detention, 11 October, 2012.

others. The risks that he presents are of a nature and severity that make it unsafe to consider treatment as an outpatient”.

- 5.77 L was formally transferred in April 2012, after demonstrating good insight, compliance with treatment plans and good engagement. At this stage it was suggested that discharge under a community treatment order would be beneficial for him in the future.
- 5.78 It was agreed that a gradual package of rehabilitation would be appropriate, and the transfer to Heathfield House took place in January 2013. L was discharged from Keswick Ward, Edenfield as planned to Heathfield House on 17 January 2013, after an orientation visit. He was transferred on a notional Section 37 MHA.

### **Heathfield House January 2013 to March 2014**

- 5.79 On admission L experienced increased levels of anxiety and recommenced smoking. It is known that smoking diminishes the psychotropic effects of clozapine. L has requested smoking cessation. L had disclosed to staff that he worries about what to say to peers and how they would react. This is addressed in psychological sessions and L has been asked to initiate conversations with his peers, to be discussed in future sessions. He engaged in some structured rehabilitation groups.
- 5.80 The RC CP1's report in April 2013 noted that since his admission to Heathfield House L remained extremely settled in mental state. L can appear unhappy when discussing aspects of his care plan which he is not fully in agreement with.
- 5.81 He commenced unescorted leave to the local area but reports some concern when on leave in Stockport, in particular that he may see people who associate him with criminal behaviour from the past. He has considered in future to relocate to another area in Greater Manchester, and considers that supported accommodation in the community would be the appropriate next step.
- 5.82 In an interview with L in April 2013, he appeared to the CP1 to be overly confident about his readiness for discharge and expressed his frustration on the slow discharge process. L stated that if he is made informal he will stay at Heathfield until accommodation is found and would consider attending Stockport Homeless Service who have been useful before. The nature of L's mental disorder warranted continued detention, there was history of him becoming worse in the context of excess alcohol and abuse of illicit substances days after being released on licence in 2006. CP1's opinion was that discharge or being made informal at this early stage of therapeutic process would result in relapse.
- 5.83 In May 2013 L had progressed to stage 4 of the self-medication process and would now collect seven day's supply of medication to be stored in a locked box in his room. Side effects were to be monitored through formal assessments and nursing observations.

5.84 His RC noted in his report to the MHT in May 2013 that:

“In terms of these risks he presents when suffering from florid delusions and hallucinations affecting his mood state, actions and behaviour toward himself and others. He has previously shown threats with weapons, physical violence and hostage taking of others including both known and unknown members of the public and peers even endangering other’s lives. These risks are likely to increase from their present very well controlled levels to then place his health and consequently others safety at risk if he were suddenly no longer in such a suitable environment where he can be supervised and conditions are able to continue to be imposed to maintain his present level. If discharged and then subsequently electing to leave Heathfield at short notice for instance where personal events he insisted on attending or slow progress with acquiring suitable accommodation prompted him to do so then there would be an increased likelihood of these risks leading to further offences as a result of relapse in a sudden discharge.

Therefore, I respectfully recommend that his detention is continued to allow us to complete his assessment, test him out in this lesser security level and work toward his discharge on CTO in the near future in a gradual safe manner to the most appropriate supported placement Conditions discussed and agreed with L today are likely to include residing at the designated placement, engaging to an adequate degree with all members of his community team including attending outpatient appointments, continuing prescribed medication and having regular tests to ensure compliance with this and with refraining from alcohol or drug use. Without such interventions at this stage of relative stability, if discharged today it is unfortunately in my experience more likely that L would relapse in the future. On balance such conditions I believe are necessary and proportionate on his future discharge given his history, the duration of this admission and the expected considerable decline in his mental health and attendant increases in the risks he would present to other persons without these conditions being in place as a safeguard.”

5.85 In July L was noted to be less anxious in general and shops independently in the area, but tended not to attend ward based therapeutic group activities. By August 2013 he was less anxious, feeling good and shopping independently in local settings. No current psychological input was being provided as he could not identify any goals. It was noted he would like to have had tattoos removed from both hands as this would be a new beginning for him. In October 2013 L commenced relapse prevention work with named nurse. L extremely positive about his potential move but he tends to underestimate any potential stressors associated with this. Staff to monitor any evidence of stress and re-emergence of symptoms including anxiety during the transition period towards discharge. In October 2013 he applied for voluntary work and was placed in a farm which had an abattoir, which he found unpleasant and stressful.

5.86 On reflection, we do wonder if working in an abattoir was the best work placement for someone like L with his forensic history.

- 5.87 His notional Section 37 was due to expire in November 2013. The tribunal<sup>35</sup> hearing was scheduled for 5 November 2013 at Heathfield House.
- 5.88 L expressed that he would stay at Heathfield House informally and agreed he may benefit from being discharged on a Community Treatment Order under Section 17E MHA (CTO)<sup>36</sup> into the community. L was regarded as fully compliant with his treatment plan and accepting he will have to take medication for the rest of his life. He attended the gym three times weekly, and was on stage 5 of the self-medication programme. There had been no incidents of violence and aggression, and he had never tried to abscond, and never gone absent without leave (AWOL). The tribunal in November was adjourned for more information on placement options, until December 2013.
- 5.89 L was offered an independent flat in Stockport but turned this down, and expressed a desire to move to Manchester to move away from old associates. L was discharged by the Tribunal from the notional Section 37 on 20 December 2013 but agreed to stay informally at Heathfield House.
- 5.90 **Comment:** Although he agreed to stay in Heathfield House and continue his rehabilitation, the levers and controls for managing his future care were now considerably weakened, and we respectfully suggest that the members of the tribunal fully reflect on the decision to disagree with the recommendations of two previous forensic consultant psychiatrists and Ls current psychiatrist who all recommended discharge via CTO.
- 5.91 This crisis plan prepared at this stage appears to us to lack detail, and does not describe what contingencies should be followed in a crisis.
- 5.92 It was noted that L had engaged well in psychological work in Edenfield and was initially keen to engage with psychology at Heathfield House and met three times. After these sessions he was unable to set any goals, although in one to one session with nursing staff he stated he felt less anxious in general. It was left open that he could access psychology in the future. The plan was to continue with structured individual sessions with nursing staff and encourage him to ventilate feelings, acknowledging that L was unlikely to volunteer if his anxiety was increasing and would tend to use 'bravado' to hide his feelings. Random urinalysis and swab tests for illicit substances were taken.
- 5.93 He functioned well in activities of daily living and personal care, and had started cooking meals regularly. He verbalised that he found it difficult to interact with peers in a social setting and his interactions with other patients was superficial.

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<sup>35</sup>The First Tier Tribunal are responsible for handling applications for the discharge of patients detained in psychiatric hospitals. <https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health>

<sup>36</sup> The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E.

<https://www.legislation.gov.uk/ukpga/2007/12/section/32>

- 5.94 In January 2014 he had turned down an independent flat in the Stockport area, after initially accepting. He said he felt he would be unable to manage financially and unable to furnish the flat in time for an impending discharge.
- 5.95 Upper Chorlton Road offered him a place in January 2014 and he visited in February 2014. He did not wish to have a graded approach with overnight leaves as he felt this would be too disruptive, and went on four weeks leave in March 2014, to return to Heathfield house for the April CPA review.
- 5.96 The CPA review in April 2014 noted overall stability in his mental state, but with episodes of irritability in November and December 2013 over practical issues, which staff saw as evidence of difficulty with problem solving. He described his mood as good and he had no thoughts of harming himself for others. He had a very rigid routine at Heathfield and could become disgruntled if this was interrupted. He went to the gym three days a week, met his support worker at specific times, and visited his family in Stockport weekly, helping his parents around the house.
- 5.97 L had progressed to stage 5 of the self-medication programme, meaning that he was collecting his medication from the pharmacy independently, and was staying overnight in the pre discharge flat.

### **Upper Chorlton Road**

- 5.98 A formal transfer to UCR was agreed, and incorporated into PCFT care plans, acknowledging his express wish to transfer to Manchester. A three month handover to his Manchester care coordinator was agreed, and CCO1 was to visit him at UCR weekly initially then gradually extending visits to between two and six weekly, depending on need. Clozapine blood level monitoring was to be maintained through Stepping Hill Hospital, changing over to Manchester when registered with a new GP and contacts were established locally. The crisis plan remained unchanged, but a contingency plan was added which was for UCR staff to inform the care coordinator and new RC, to arrange urgent consultant review, visit by care coordinator or other team member in her absence, contact out of hours crisis support service in Stockport, or attend A&E in an emergency.
- 5.99 At the April CPA meeting L reported that he was 'doing really well' and enjoying staying at UCR. He had joined a gym and was keeping in touch with family. CP1 referred him to MHSC and he was accepted at the Central West Community Mental Health Team (CMHT) in Manchester and allocated a care coordinator, CCO2, and it was agreed he would be offered an out patients appointment with his new RC, CP2.
- 5.100 Information was shared by CCO1, his clozapine monitoring was transferred to Manchester. CCO2 met L and he told her he only wanted to stay at UCR for one year because the level of support was too high and he wanted to be more independent. It was agreed that L would see CCO2

every four weeks, and an outpatient appointment was booked for July 2014.

- 5.101 L had clear CPA care plans in place at the point of transfer from Heathfield House in March 2014. He appears to have responded well to the level of support provided to him until December 2104, when he stopped taking medication and started taking heroin. The only apparent trigger to this appears to be his increasing anxiety about a potential move to less supported accommodation, but this move towards independence was largely driven by L himself.
- 5.102 On Bronte ward in April 2015 titration back on to clozapine was started, and he was persuaded to return to UCR with CCO2's involvement.
- 5.103 We question why he was discharged back to UCR before the clozapine titration was completed. It was stated that the HTT had capacity to support him. We consider that, particularly given his history, his anxiety and reluctance to return to UCR should have resulted in a decision to stabilise him on treatment before discharging him back to the community.
- 5.104 He went missing from UCR on the day of discharge in May 2015, and the HTT consultant stated he should be assessed under the MHA when he was found. This did not occur, after he was picked up by police when presenting as threatening to harm others with a bladed weapon. This appears to be because he agreed to be admitted informally to SAFIRE ward in May 2015. This was a missed opportunity to assertively manage L's mental illness.
- 5.105 Whilst in Ashworth L was given a primary diagnosis of paranoid schizophrenia<sup>37</sup> and this is clearly articulated in the Edenfield discharge summary in January 2013. He was also noted to have a history of harmful polysubstance misuse<sup>38</sup> and opiate dependence.<sup>39</sup> Before he was prescribed clozapine, he fulfilled the criteria for psychopathy, and on testing after treatment with medication, his score using the PCL-R<sup>40</sup> tool was markedly reduced, to 18. This assessment concluded that "the previous scores are important as they have implications for how he presents when most unwell".
- 5.106 This was seen as evidence to support the clinicians' view that his previous challenging presentation was due to untreated schizophrenia.
- 5.107 A diagnosis of paranoid schizophrenia was recorded at admission to Heathfield House, along with some traits of 'personality issues'. At a care plan review in June 2013 there was no evidence of positive symptoms of psychosis (paranoia, intrusive thoughts, hallucinations) and little evidence of negative symptoms (lack of motivation, low mood low energy).

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<sup>37</sup> ICD 10 F20.0

<sup>38</sup> ICD 10 F19.1

<sup>39</sup> ICD 10 F11.21

<sup>40</sup> Hare Psychopathy checklist <http://www.hare.org/scales/pclr.html>

- 5.108 After transfer to MHSC he was rated at HONOS PbR cluster 11 in May 2014, indicating 'ongoing recurrent psychosis, low symptoms' and it was a clear he had a diagnosis of schizophrenia.
- 5.109 A MANCAS review<sup>41</sup> in June 2014 noted Cluster 12 'ongoing or recurrent psychosis, high disability'. There were no documented reasons for this change.
- 5.110 It is clear that L was regarded as suffering from schizophrenia up to and during his first admission to the SAFIRE unit in April 2015, and he was transferred to Bronte Ward to start titrating him back on to clozapine.
- 5.111 At his second admission to SAFIRE in May 2015 the diagnosis of schizophrenia is questioned. He is noted to have a 'previous potential diagnosis of schizophrenia' with no evidence of relapse currently and that his presentation was driven by social stressors and an inability to cope in the community. It was acknowledged that he had a very high risk of re-admission if he was discharged, and therefore was to be admitted to an inpatient bed. This was noted to be 'not an ideal use of a hospital bed but necessary due to almost certain chance of representing if discharged from hospital'. Olanzapine 10 mg was prescribed 'for now'. He was described as 'bed blocking'.
- 5.112 It was further stated that the diagnosis of schizophrenia may need reformulation given that there is no evidence of a relapse since being off clozapine. This appears to be a particularly important juncture, where the SAFIRE clinical team questions the diagnosis that has been well formulated and described since 2008. There was clear evidence that in April 2015, on his first admission to SAFIRE, he had relapsed, 2 months after discontinued clozapine. The early warning signs of relapse that had previously been identified were all present, such as isolating himself from his peers and family, getting into arrears with rent, abusing drugs, having thoughts of causing violent harm to himself or others. SAFIRE ward operated as a short term assessment ward within a 'flow and capacity' structure that had oversight of all acute admissions in the (MHSC) Trust. According to the Trust procedures in the 'Adults of Working Age Service Description and Standard Operating Procedure' (October 2015), the flow and capacity team's role was to 'identify an inpatient bed for admission when required, provide oversight to the whole admission and discharge pathway and ensure that demand is managed within existing commissioned capacity'.
- 5.113 The Trust policy on 'Urgent Care Services Service Description & Standard Operating Procedures for Individual Service Components under Urgent Care Services' (May 2015) describes the 'flow & capacity' team as:

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<sup>41</sup> The Manchester Care Assessment Schedule (MANCAS) is a 20-item generic screening tool for mental health needs, incorporating a guide to interviewing. It is based on the 'developmental, biopsychosocial' model of mental health which describes the interaction of various influences (biological, psychological, interpersonal and environmental) on mental health and the 'vulnerability', 'precipitating' and 'maintaining' factors. MANCAS tries to redress the balance by focusing on external factors when needed.

“...provides all the core functions of bed management and oversight to the admission and discharge pathway to ensure flow and maximize Inpatient capacity. This team will oversee all out of area reviews, all delayed discharges and work collaboratively with the Inpatient Housing Advisors, Trust’s Inpatient Rehabilitation Services and Inpatients in the management of complex discharges. In addition core functions of this team are early identification of patients for supported discharge to MHHTT and booking transport”.

- 5.114 At interview for this investigation, clinicians raised concern about the degree of priority given to early discharge by this team, and to the focus on moving patients through wards, even to the degree of questioning consultant psychiatrists about diagnosis and care plans in ward rounds. This was described as part of a culture of questioning and challenging consultant decisions, including those where a diagnosis and a treatment plan was already in place.
- 5.115 This also goes some way to demonstrating the difficulties Manchester’s mental health services have had for some time with excessive demand for acute in-patient beds. Whilst the original intention of the management response was based on sound reasons to help manage a scarce resource, the focus seems to have shifted to a focus on managing flow, and not clinical needs.
- 5.116 In our view the approach to L’s relapse on this occasion did not follow the expectations of the care plan, and it appears that L’s presentation was seen purely through the lens of personality disorder, with a resulting focus on discharging him, regardless of his CPA plans. This appears to have been influenced by the approach taken by the ‘flow & capacity’ team to free up bed capacity.
- 5.117 On transfer to Mulberry Ward he voiced his concerns about being institutionalised and not being able to cope in the community, and his mental state was described as ‘stable’. During this admission attempts are made by CCO2 to find alternative accommodation for L, he is turned down by many because of current issues and support needs and he began to use alcohol and illicit drugs and go missing from the ward. In June 2015 there is a discussion between CCO2 and the Stockport CCO and CMHT members about requesting a forensic assessment. The discussion about a forensic assessment appear to have occurred at several ward rounds, until in July 2015 it was thought that a forensic opinion would advise only rather than help with placement, and an action point from ward round was to check if CCO2 had made the referral.
- 5.118 L had by now been treated by three separate clinical teams and different in patient consultants on SAFIRE, Mulberry and Redwood wards (twice) after his various absences. In our view this contributed to a fragmented approach to his care and treatment, with a lack of medical oversight of his in-patient care, and an inconsistent approach to his diagnosis and treatment with clozapine. A forensic assessment at this point would have provided an opportunity to review L’s presentation, current risk profile and suitable treatment options.

- 5.119 The lack of continuity of care and medical oversight for forensic and complex patients was identified as an issue in the internal investigation and a recommendation made that 'consideration should be given to reviewing medical management arrangements to provide greater continuity for cases where the forensic or risk history of the patient give rise to significant concerns over risk to self and/or others'.
- 5.120 We discuss the internal investigation and the implementation of the recommendations later in the report. We recognise that a significant factor affecting the provision of continuity of medical care is the high vacancy rate for consultant psychiatrists in Manchester, and the high use of locums, and the new Trust is taking steps towards addressing this. However, this recommendation has only been partly addressed.

#### **Recommendation 4:**

The Trust should assure themselves and commissioners that arrangements are in place to provide appropriate medical cover on the acute adult in-patient wards to ensure medical oversight and continuity of care.

- 5.121 At this time in July 2015 L presented as low in mood and was requesting to be sectioned so that he could remain in hospital with active treatment. Accepting that clinicians were attempting to treat him in the last restrictive environment, we consider that there should have been at least a professionals meeting which took a longer term view of his care, taking his history into consideration, and recognising that the current approach was not working. Such a meeting could also have resurrected the question of a forensic assessment.
- 5.122 He was located again after going missing in August 2015, in Macclesfield and was seen by mental health liaison in A&E after presenting as intoxicated. Redwood ward staff are noted to have agreed that L could make his own way back to Manchester when he was sober and medically fit, although the police intervened and brought him back because of past risks. Further absences resulted in his bed being given away, and when re-presented after self-harming in Manchester, he was admitted to Mulberry ward in August, and SAFIRE ward in September after the Redwood bed was again given away, and later back to Mulberry. L went missing on 26 September and was not seen again as an inpatient. His care coordinator CCO2 continued to try to locate accommodation, despite L not cooperating with visits and assessments. A bed was located at Heaton Lodge, Stockport which was available at the time of his absence in September.
- 5.123 The in-patient consultant psychiatrist for Mulberry ward was on two weeks' leave, and was planning to hold a CPA review meeting to plan next steps with L.

- 5.124 L was located by police in September and was refusing to return to the ward. The message recorded in the notes from police was that he was not detainable. The police in fact located L in early October at his friend's address and he appeared safe and well. There is no message on the police log that they indicated to ward staff that he was 'not detainable', but that he appeared safe and well and staying with his friend. It appears that L was discharged in his absence, while the in-patient consultant psychiatrist was still on leave.
- 5.125 The Trust AWOL policy (November 2010) includes a flowchart for the management of 'low risk patients' (Appendix 1 c), for use with missing informal patients and detained patients). The expectation is that:
- "daily contact would be attempted, the care coordinator to attempt a home visit with police if available. If a patient is low risk and whereabouts were known, an MDT review would be carried out after 48 hours, reviewing the level of risk, possible effects of non-compliance with medication, physical health. A home visit with police should be attempted. If concerns have increased, there should be consideration given to a MHA assessment. If there are no concerns, 'consider discharge or continue to make contact'".
- 5.126 There is no evidence of a considered decision to review L's risks or weigh up the potential risks of discharge. The discharge letter was written by a junior doctor and there was no apparent knowledge of this by the consultant. This is identified as an issue in the internal investigation report, and it is noted that it was not known who actually made the decision to discharge him, although it was noted that it was discussed at the bed management meeting by the flow and capacity team.

#### **Recommendation 5:**

The Trust must ensure that discharge planning arrangements on the adult acute in-patient wards comply with Trust policy, and that arrangements are made to appropriately grade those patients with complex needs and often forensic and/or substance misuse histories who are at high risk of disengagement from mental health services, and who should receive assertive and proactive care to prevent them being lost to services, even if discharged whilst AWOL.

### **Physical health**

- 5.127 L had a number of long standing physical health issues, including type 2 diabetes, managed with metformin 500 mg, and suffered from high cholesterol and high blood pressure which were treated with simvastatin 40 mg and ramipril 10mg. His gastritis was treated with omeprazole. L had a history of previous operations to his hands after assaults, and had undergone inguinal hernia surgery. He had a BMI of 35 on admission to Heathfield House, and said he wanted to lose weight.

- 5.128 He had all his teeth removed in 2013 because of recurrent abscesses. He began smoking again after experiencing anxiety on admission to Heathfield.
- 5.129 There is good evidence of the involvement of the GP in L's physical health care, with invitations to attend the practice for assessments and also they were copied in to letters from the various mental health teams regarding L's progress and admissions.

### **The involvement of the family in care planning**

- 5.130 An interview with L's relatives for assessment was recorded at Heathfield House in 2013,
- 5.131 His biological mother had a history of poor mental health. L and his half-sister had not spoken since their mother's funeral. L has adoptive parents, he was fostered at the age of nine months and has two adopted sisters and a brother with varying contact.
- 5.132 There were previous allegations of sexual assault and rape on L, in several children's homes, and special school. Family think L enjoys the structure of prison. L's family said that no one had spent any time with them to discuss L's condition or diagnosis but they were aware of the clozapine. L was close to his mother, his adoptive mother suggests that his mother gave him mixed messages about moving back to the family home and at around this time L starts abusing illicit drugs. His adoptive mother suggests L is institutionalised from being in prison and hospital and likes the structure of prison and concerned about his ability to budget and plan for expenditure. L made contact with his biological brother via Facebook but said he did not want to meet him yet due to his drug issues and it was early days.
- 5.133 A home visit was carried out at his parents in March 2014 to discuss L's discharge arrangements, his 'staying well plan' and relapse prevention.
- 5.134 In October 2015 L's mother was contacted about him being missing, and asked not to be contacted again because she was very stressed and her husband needed constant care for his Parkinson's' disease.
- 5.135 L had complex familial relationships and the frequency of contact with family members, both adoptive and biological was sporadic. There was no material input from family members in relation to his ongoing care planning and L did not maintain any long-term friendships.
- 5.136 L's biological mother died in 2004 and L was said to be very close to her. He had limited contact with his biological brother and sister over the years. His biological brother was thought to suffer from 'mental health issues' although this is likely because of an extensive head injury sustained when he was 3 years old. L's biological brother was also a frequent user of illicit substances.

- 5.137 L's adoptive parents struggled to cope with L and at the age of 15 L was placed into residential care. L's adoptive family continued to maintain contact with him and at times provided him with intensive support, for example, helping him to furnish his own flat when he received a tenancy. L's adoptive father was diagnosed as suffering from Parkinson's disease in 2009. L's adoptive siblings had little or no contact with L and there had, on occasion, been significant family arguments about the impact of L's behaviour upon the adoptive family.
- 5.138 L's adoptive family feature very infrequently in his care notes and there is very little input from them in relation to his care planning. L had threatened to kill his adoptive mother at the time of his index offence in 2005 and the family had broken contact with him at that point.
- 5.139 L was often keen to resurrect relationships with his adoptive family and would on occasion contact his adoptive mother via telephone and arrangements would be made for L to visit them. There are no reports in L's record of visits from his adoptive or biological family.
- 5.140 In August 2012 L's family was contacted in relation to L's proposed move to a step-down facility and they seemed to be in agreement with this move. His family did not attend review meetings, although they were thought to be highly likely to spot any evidence of relapse or deterioration at an early stage with L.
- 5.141 On the 15 January 2013 a discharge CPA meeting forwarded the list of approved visitors to Heathfield House and L's parents were informed of the move.
- 5.142 On the 25 February 2013 there was a telephone call with L's adoptive mother where she advised that L may experience difficulty with his finances. She advised that L might try to buy friendship and says what people want to hear. This fact was transferred to his care record and did appear to follow L through on his patient journey.
- 5.143 On the 22 April 2013 L's adoptive family attended for a relative assessment interview. This was the most input that his family had had at any stage of his patient journey and at that time they were fairly supportive. His adoptive mother felt that when L is using illicit drugs he becomes very secretive and disengages from the family. L's parents were not aware of his diagnosis until the week of the assessment interview; L's adoptive mother said that at no point had any professionals spent any time with her to explain the diagnosis and she had not been given any information or support.
- 5.144 On the 6 May 2013 L had progressed to stage 4 of the self-medication process. L's adoptive parents indicated that although they remain close to him, they did not want to attend his CPA/ CTM as they want him to be able to manage his care independently. L had agreed to stay overnight with his adoptive parents in preparation for a holiday with them in Wales, although it later transpired that they went on holiday for 4 weeks without L.

- 5.145 On the 27 July 2013 L made contact with his biological brother via Facebook but did not want to meet him at that time due to his drug issues and 'it is early days'.
- 5.146 On the 16 December 2014 L advised that he had no problems and will be spending Christmas with his adoptive family.
- 5.147 On the 13 January 2015 it was planned for L to continue to see his adoptive family regularly, and the notes recorded the family do not like to be involved in professional meetings but are supportive. L was offered emotional support if there were any issues with his family which had happened in the past.
- 5.148 On the same day a call from L's adoptive mother was received advising that she had been telephoned from an acute ward at the MRI. She had had little or no contact with L but he had rung this time to say that he had Anthrax poisoning. This was the last contact that L had with his family before the homicide.

## Safeguarding

- 5.149 L adopted siblings were known to have young children. There are frequent mentions on various care planning documents, that the risk to them had been considered. It was documented that L was never allowed to visit the children unsupervised.
- 5.150 There are two other issues with potential for being considered safeguarding concerns.
- 5.151 The first is the risk of L 'borrowing' money from fellow residents and patients who may be vulnerable themselves. There is one incident where L used another patient's bank card, but this patient refused to take it further. We are not aware of how this was taken forward as a potential safeguarding issue.
- 5.152 We are also aware that when L moved out from UCR, concerns were raised about 'Uncle Wayne' and the possibility that he was preying on L's potential vulnerability. We have seen evidence that this was raised as a safeguarding referral and discussed with his CCO and Team Manager. It was also discussed that he had mental capacity.
- 5.153 The outcome of the referral was not to proceed to investigation, but to continue to monitor the situation and undertake a full safeguarding process if either L made allegations or there was other information to suggest L was being abused.

## Inter-agency working

- 5.154 From his initial admission to Ashworth in 2007, L had been closely involved with several agencies providing his care. This started with the

referral to a forensic psychiatrist when he was in HMP Durham, and his resulting admission to Ashworth Special Hospital.

- 5.155 We have already discussed the lack of clarity surrounding the Multi-agency Public Protection Arrangements and the gap in the involvement of the Probation Service when he was transferred to Edenfield Unit and then to Heathfield House.
- 5.156 Whilst in Heathfield House, L was engaged with a range of agencies and organisations involved in his care arrangements. These included Pure Innovations, the enabling support service that helped him secure a work placement and also Stockport Borough Council who retained Section 117 after care responsibilities.
- 5.157 Once planning for discharge following the MHT in 2013 began in earnest, L's care team were in routine contact with many services. In seeking accommodation, his Stockport Care Coordinator, CCO1, contacted the following services to consider a future place for L:
- Creative Support at Bredbury, Offerton, Woodley
  - Redcroft, Heaton Moor
  - Making Space, Adswood
  - Simon House, Heaton Norris
  - Stockport Supported Tenancies,
  - Contour Homes, Hillgate and Buxton Rd
  - Your Houses Heaton Norris
  - Heald Green
  - Stonham Housing
- 5.158 L was eventually found a place in supported accommodation in Upper Chorlton Road, Manchester, provided by Creative Support.
- 5.159 We have seen evidence of good shared discharge care planning and communication between Heathfield House and Central West CMHT. There was an extensive letter from his RC in Heathfield House sent to the RC in Central West CMHT. This was also copied to his new GP.
- 5.160 His new Care Coordinator, CCO2, accepted responsibility for coordinating L's care whilst he was in Manchester, but both CCO 1 and 2 remained in regular contact.
- 5.161 This was because Stockport Borough Council retained responsibility for funding aftercare under Section 117 after care arrangements. This was exercised in various ways, with regular email updates provided to CCO1 by CCO2.
- 5.162 In June 2014 when it was considered that L might move back to Stockport, a joint case conference was held which considered future housing options for L and how best to access these.

- 5.163 A significant number were again considered and approached. As L did not attend this meeting and had gone AWOL these options were never fully pursued.
- 5.164 This high level of communication and interagency working continued even after L had been discharged from inpatient care in September 2014. Both CCO's would communicate regularly to try and help L with his accommodation problems and find suitable accommodation for him, especially when he was technically homeless.
- 5.165 We have reviewed the communication and joint care planning for L and have not identified any gaps in inter-agency working.
- 5.166 Our concerns around L's care are in the gaps in inter-service communication between the various acute inpatient wards at Park House and Central West CMHT once he had been admitted.

### **Wider commissioning issues**

5.167 Following the internal investigation being completed, an additional external report was also commissioned.<sup>42</sup> This report raised concerns about the acuity and complexity of many professional's caseloads in central Manchester, and the need for supervision and access to additional appropriate expertise to help deal with the more complex and higher risk patients. This report also noted that Central West CMHT carried a much higher forensic caseload than other teams. The additional investigation made recommendations that:

- Staff working with these complex patients should have access to more advanced risk assessment and risk management training.
- The Trust should review how the caseload weighting system to ensure that there is an equitable distribution of complex cases across the CMHAT.
- Caseloads of very high risk individuals needs to be reinforced with robustly commissioned specialist support, clear team purpose and necessary infrastructure for the treatment of people with complex comorbidities.

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<sup>42</sup> Author: Kate Glenholmes "Independent Review of a Serious Incident": 25 October 2016

- 5.168 We have discussed this aspect with the new Trust. We note they are starting to make significant progress in addressing many of the legacy issues around harmonising caseloads and policy and practice, and increasing medical presence in CMHT's.
- 5.169 However, there is still work to be done in identifying the cohort of patients who present with complex needs and dual diagnoses, who often have involvement with forensic services and history of substance misuse, and that are at risk of disengagement, so that more assertive care and clinical management can be put in place.

#### **Recommendation 6:**

NHS Manchester CCG should assure themselves that the Trust is identifying the cohort of patients at most risk of disengagement from services, who have complex needs and often forensic histories with a background of drug abuse. This identification should then lead to the Trust being able to provide an assertive care pathway for this group with escalation routes into appropriate inpatient beds and access to appropriate clinical and forensic support and advice when needed.

## **6. Internal investigation and action plan**

- 6.1 The terms of reference require that we:
- Review the trust's internal and independent investigation and assess the adequacy of its findings, recommendations and associated action plan
- 6.2 The report is described as a 'Serious Incident Requiring Investigation', as would be expected in the NHS England SiF. It is not graded as any particular level.
- 6.3 The internal investigation report doesn't identify when it was commissioned, nor when it was completed.
- 6.4 The report does contain the CCG questions that arose from their reading of the report, and the Trusts responses to these questions.
- 6.5 The Trust appointed the following panel to review this incident:
- Service Manager, (Chair);
  - Specialist Registrar; and
  - Service manager.
- 6.6 The service managers had all had prior experience in undertaking serious incident investigations, and been trained in Root Cause Analysis investigation techniques.
- 6.7 The panel met on three occasions (21 and 22 April 2016, and 10 May 2016) to discuss the case and agree findings.

- 6.8 Interviews were undertaken with CCO2, and six other staff were consulted, including CCO1 from Stockport. Only one in-patient consultant psychiatrist was consulted, and L's community consultant psychiatrist was not consulted.
- 6.9 The family of Will were not met with as part of the investigation although the intention for a senior member of the Trust to do so was identified. We are not aware this happened.
- 6.10 L's family declined to be involved.
- 6.11 Although the investigation did identify missed opportunities, we have concerns about the adequacy of this investigation. The investigation team were not sufficiently independent from the service. The medical representative was too junior to challenge medical care and leadership.
- 6.12 The investigation is described as applying the principle of 'Root Cause Analysis' (RCA), but there is no evidence of the use of RCA tools such as 'Fishbone analysis', '5Y's' or Contributory Factors framework. Although contributory factors appear in a heading, there is no real consideration of these (such as case load, lack of medical cover etc) as a factor leading to the incident.
- 6.13 No root cause is found for the incident, which we believe is wrong since there were several opportunities to intervene to prevent L's relapse and disengagement from services, starting with the decision to discharge L from his section in December 2013.

### **Internal recommendations**

- 6.14 Our final concern is with the adequacy of the recommendations, in that the seven listed below focus on what individuals should do, with limited recognition of the role that the organisation should play in providing safe systems and assurance.
- 6.15 Phrases such as 'consider' 'review' and 'remind' provide the illusion of addressing the issue with no demonstrable change or outcome to show that systems and care will now be safer, and there is an organisational role in the ownership of ensuring that such a care delivery system provides the right care to the right patients in the right (most clinically appropriate) way to meet their needs.
- 6.16 The internal incident review report noted one lesson learned, and this was developed into seven recommendations, however, these were not prioritised or risk rated within the investigation report.
- 6.17 The recommendations made within the report are as follows:
1. Patients with significant forensic histories and risk should trigger a multi-agency case conference, including external agencies as appropriate in the event of repeated disengagement from services (community or inpatient) to plan a concerted approach to the individual concerned.

2. Consideration should be given to reviewing medical management arrangements to provide greater continuity where the forensic or risk history of the patient gives rise to significant concerns over risk to self and/or others.
3. The AWOL Policy should be reviewed and consideration given to including management of repeated episodes of an informal patient absenting himself from the ward, preventing delivery of therapeutic interventions.
4. The MDT should be reminded of their discharge planning responsibilities and the importance of these when a patient is discharged in their absence. The particular ward from which this discharge occurred to be a focus of management attention to ensure embedding of approved practice.
5. Community Team managers should be reminded of their responsibility to ensure adequate arrangements are made to cover care coordination where a care coordinator is unavailable.
6. When important external documentary information is entered onto AMIGOS it should be flagged up with an entry in special notes to ensure it remains visible to the care team.
7. The Trust to commission and independent review of this case to examine case management and clinical review issues in the case.

### **Assurance on implementation of the actions of the internal investigation recommendations**

- 6.18 Although the action plan was written in a clear format, with timelines and nominated individuals allocated responsibility for carrying out actions, many of the actions (linked to the recommendations) were to be completed when the policy was reviewed or staff had been reminded of their responsibility.
- 6.19 We believe that this does not provide any assurance that lessons have been learned, changes fully embedded and the Trust assured that the outcome is now a safer service.
- 6.20 We have seen the evidence file for the action plan, and have had the opportunity to discuss the action plan status at November 2017 with the Patient Safety Lead, the Director of Nursing and the Medical Director at GMMH. We comment on each element of the action plan in turn below.
- 6.21 GMMH, the newly enlarged Trust, have continued to map their functional care models across to the former MHSC services, as well as to assimilate governance arrangements. Invariably, over the last 12 months they have found many areas which required improvement and have also been dealing with a cohort of legacy MHSC staff who have had experienced significantly low morale.
- 6.22 In relation to the internal investigation action plan, the specific related actions carried forward and progress against these include:

**General:**

- Guidance around the development of trust action plans which follow the new Trust values: Truthfulness, Respect, Understanding, Standards and Togetherness.
- Extensive policy harmonisation has occurred between the legacy trusts and once they have been updated, they are available to staff on a separate section of the intranet so that confusion is avoided.
- A significant programme of work to deliver transformational service change that significantly improves the quality and range of services available and the process to assure quality and safety.

**Internal recommendations:**Recommendation 1:

“Patients with significant forensic histories and risk should trigger a multi-agency case conference, including external agencies as appropriate in the event of repeated disengagement from services (community or inpatient) to plan a concerted approach to the individual concerned”.

**Actions undertaken by GMMH to address the recommendation:**

- Case conference audits are now regularly undertaken to identify when and how discussions are being managed in relation to high risk patients, this has demonstrated that the standard operating process is, on the whole, being used properly;
- There is a new policy covering CMHT and this policy includes the new roles which have been instigated to manage patient pathways. There has also been harmonisation of the legacy CPA policies;
- A further piece of work is currently being done about how to stratify levels of risk around high-risk patients, i.e. at what point does increased risk trigger an immediate response;
- The Trust now has a dedicated strategic lead for patient-flow coordination and to aim to manage the challenges of the most appropriate place of care for patients;
- Medical leadership has now been expanded within the CMHT and all leadership posts have now been filled in north, central and south districts;
- A key piece of work is underway around consultant case load, including a major cleansing of active cases being held with consultants. This review has not yet concluded although potential actions may include ‘zoning’ of cases. Consultant continuity is also included in this work stream; and
- Work to support the acute care pathway is pivotal to support consultant caseloads and vice versa. The Trust have undertaken extensive analysis of

the CMHT and defined the investment need to successfully stratify this service although this is part of the broader strategic change programme for the Trust. The Trust is currently out to formal consultation on the proposed changes and are engaged in detailed conversations with the consultant body about care models and pathways.

**Residual issues:**

- Some of the above actions are in progress and will likely require whole scale transformational change. This is an extensive piece of work and should be fully evaluated at 12 months post completion. In the interim, incidents associated with complex, high-risk patients should be closely monitored.

**Recommendation 2:**

“Consideration should be given to reviewing medical management arrangements to provide greater continuity where the forensic or risk history of the patient gives rise to significant concerns over risk to self and/or others”.

**Actions undertaken by GMMH to address the recommendation:**

- There has been less overall progress in relation to this action as the inpatient standard operating procedure has not yet been adjusted. However, the new strategic lead for patient flow, development and delivery has this as part of her work programme going forward.
- The final business case to secure the PARIS patient management system went to the Board of Directors in November 2017. This will mean that legacy MHSC services will formally adopt the PARIS system in 2019. Early Intervention in Psychosis service staff (from Rotherham, Doncaster and South Humber NHS Foundation Trust or RDASH) who have recently been TUPE'd over to the Trust have automatically been inducted onto the PARIS system.

**Residual issues:**

- Development of the above actions are still underway.

**Recommendation 3:**

“The AWOL Policy should be reviewed and consideration given to including management of repeated episodes of an informal patient absenting himself from the ward, preventing delivery of therapeutic interventions”.

**Actions undertaken by GMMH to address the recommendation:**

- The AWOL Policy has now been aligned between the legacy trusts and the final version is currently being ratified;

- As before, there is the development of a red, amber, green risk rating for higher-risk patients and zoning is also being considered;
- The trust has a new discharge checklist which has been rolled out and is currently being audited for effectiveness; and
- GMMH has now upgraded to version 14 of the Datix incident management system and when full assimilation has occurred between the legacy trusts, then the version will again be upgraded to version 15.

**Residual issues:**

To ensure that all changes are included on the Trusts internal audit plan for 18/19.

Recommendation 4:

“The MDT should be reminded of their discharge planning responsibilities and the importance of these when a patient is discharged in their absence. The particular ward from which this discharge occurred to be a focus of management attention to ensure embedding of approved practice”.

**Actions undertaken by GMMH to address the recommendation:**

- As above

Recommendation 5:

“Community Team managers should be reminded of their responsibility to ensure adequate arrangements are made to cover care coordination where a care coordinator is unavailable”.

**Actions undertaken by GMMH to address the recommendation:**

- There are now a range of updated standard operating procedures in relation to care coordination allocation;
- The Trust is doing work to ensure that ‘teams under stress’ are picked up appropriately using standard reporting procedures, for example, the monthly performance reports, Datix reports, complaints, PMVA and staffing early warning indicators;
- There is improved documentation around staff supervision and the frequency of team meetings; and
- Use of agency staff is monitored monthly through the ‘agency panel’.

**Residual issues:**

- There is still significant staff turnover and use of locums and agency in relation to this team and close supervision of locum use and staff burnout is necessary. More staff will be needed to ensure that the transformation

programme is successful and this will be an ongoing area of concern for the Trust.

#### Recommendation 6:

“When important external documentary information is entered onto AMIGOS it should be flagged up with an entry in special notes to ensure it remains visible to the care team.

#### **Actions undertaken by GMMH to address the recommendation:**

- There is a new protocol for developing special notes on AMIGOS whilst the process to implement the new PARIS system is completed;
- The ‘special notes’ section on AMIGOS was recently audited and 50 notes were found to have notes attached and the Trust is closely monitoring ongoing improvements in this area;
- The PARIS system contains an ‘alert triangle’ to ensure that staff are sign-posted to any special notes which exist in relation to a patient;
- A business case for special ‘alerts’ has also been approved by the Board
- The final business case to secure the PARIS patient management system went to the Board of Directors in November 2017. This will mean that legacy MHSC services will formally adopt the PARIS system in 2019. RDASH staff who have recently been TUPE’d over to the Trust have automatically been inducted onto the PARIS system;

#### **Residual issues:**

To ensure that all changes are included on the Trusts internal audit plan for 2018/19.

#### Recommendation 7:

“The Trust to commission and independent review of this case to examine case management and clinical review issues in the case.”

MHSC commissioned a further independent review of the case. Whilst the recommendations arising from this external review do not appear to have been taken forward, we find there are significant similarities with our findings. In particular we have identified that the cohort of high risk patients such as L do require additional resource and service design to ensure their needs are met without them disengaging from the system.

### **Trust independent investigation.**

6.23 Shortly after the internal investigation was completed the Trust commissioned an external independent investigation.

- 6.24 We heard it was commissioned because the Chief Operating Officer was concerned about the underlying issues of high caseloads and patient acuity and complexity.
- 6.25 The purpose of the report was to specifically consider:
- Areas of clinical care and clinical management specific to the provision of health and social care for this patient. This should include issues relating to the patient himself, systems and pathway processes.
  - The management of high risk in relation to this patient and highlight any issues for the management of care for other patients following similar pathways.
- 6.26 The report author was an experience mental health nurse with over 30 years' experience of the NHS and 14 years as a Community Mental Health team manager. We contacted the author to arrange to interview them and discuss their findings but unfortunately did not receive any response.
- 6.27 The author interviewed nine professional from the CMHT and in-patient services and included Consultant Psychiatrists, community and in-patient nurses, social workers and managers.
- 6.28 As we discussed earlier this report identified a number of concerns that centred on highly complex patients being cared for by an extremely busy CMHT with high caseloads, and a lack of access to forensic and specialist support. It also identified that inpatient care was fragmented, and a more coordinated approach should have been in place, and made recommendations for the Trust and CCG to "jointly consider the treatment model for such high risk patients".
- 6.29 We concur with the report's findings in general, and make similar recommendations.
- 6.30 Because the report was commissioned just prior to the dissolution of MHSC, and that the report had no formal status, we have been unable to identify if any action was taken by MHSC to address the recommendations. Similarly, because of its lack of status, it has not been taken further by GMW.

## 7. Governance and assurance

- 7.1 In this section we review the effectiveness of Trusts internal governance processes. We assess how they support the sharing and embedding of learning from serious incidents and identify any areas for improvement.

### Legacy governance at MHSC

- 7.2 Manchester Mental Health and Social Care NHS Trust (MHSC), or, the “legacy trust” provided mental health services and substance misuse services to adults and older people across the city of Manchester. On the 1 January 2017 Manchester Mental Health & Social Care NHS Trust was formally merged into Greater Manchester West Mental Health Foundation Trust, which subsequently became Greater Manchester Mental Health NHS Foundation Trust (GMMH).
- 7.3 Prior to the acquisition of the services under contract MHSC had a number of long-standing quality, strategic and financial performance issues which were preventing the Trust becoming a foundation trust, hence their next available option was to merge. The then Greater Manchester West NHS Foundation Trust (GMW) was seen to be a high performing organisation and was the preferred partner for this transaction. This was ultimately approved by the Secretary of State for Health. One of the key rationales for the integration was to provide safer, more resilient mental services for people across greater Manchester.
- 7.4 As part of the transaction stages one and two, due diligence work streams were commenced in order to look in detail at the financial reporting arrangements and the quality governance arrangements in both trusts and ultimately to look at the effectiveness of the new trust’s (GMMH) post transaction implementation plans; ultimately, their plans to manage risks arising in the new organisation.
- 7.5 The due diligence phases one and two highlighted some key concerns relating to MHSC which included:
- Historically poor CQC ratings: In October 2015 the Trust were rated as ‘Requires Improvement’ under the Chief Inspector of Hospital’s regime. The CQC found that the Trust was not always providing safe care for people in some services, such as the older people’s wards, some acute wards and psychiatric intensive care unit (PICU). Community based services for older people and the crisis services for adults of working age were also not meeting acceptable standards.
  - Some of the issues found by the CQC related to: risk assessment and mitigation, medicines management, coherent and consistent care pathways as well as systematic issues with MHA documentation and importantly, failing to learn from MHA compliance.
  - The Trust were re-visited by the CQC in 2016 and several improvements were noted in relation to incident reporting, investigations and thematic

review although the CQC were concerned around how the improvement action plan had been monitored.

- Some of the very crucial challenges faced by MHSC were in relation to staff morale and staffing levels (which were often interdependent issues). Certainly, during late 2016 there started to be a lot of attrition in relation to some of the more senior services posts as is a tendency when a merger is underway. Prior to this however, and for at least the two preceding years, MHSC were experiencing ongoing staffing pressures both on wards and in back office services.

- 7.6 In 2016 the vacancy rate at MHSC was running at 18% which vastly exceeded the Trust target at the time. The unavailability of staff also had a detrimental effect on investigations and the Trust's RCA trained staff were unable to divert away from their daily service delivery duties in order to undertake investigations. This meant that a substantial accumulation occurred and this was an ongoing challenge to resolve up until the point of the merger. Only 5% of the serious incidents between 1 January and 31 December 2014 were investigated and closed on STEIS and a sizeable 82% of the serious incidents requiring investigation were overdue for completion as at the 20 January 2015. Whilst MHSC were given a 'significant assurance' opinion in 2015 relating to their learning from outcome processes, there is no doubt, given the staff issues latterly experienced by the Trust that, the prompt and available learning from incidents and the ability of the legacy MHSC to embed change within the organisation was at times, severely lacking.
- 7.7 The external due diligence process did not look in detail at operational issues and for example, case load management, hand-offs between services, service establishment and escalation as (based upon initial due diligence undertaken by GMW) it was accepted that these were particularly complex issues which required significant service redesign to resolve. Detailed work in this area had been ongoing for the last 12 months. It must also be acknowledged that the new Trust has also incorporated some of the good practice found within MHSC into their own processes in a bid to ensure the best of both legacy organisations is retained within the enlarged trust.
- 7.8 Prior to the transaction it was also identified that clinical participation and engagement was decreased because of 'severe staff shortages'. Indeed, recruitment to substantive consultant posts across all mental health services is at times challenging, however, at MHSC there were particular issues with consultant retention. In the case of L, we saw significant churn in relation to medical leadership at points in his care. Loss of continuity was undoubtedly a feature in the oversight on his mental health as well as in more assertive decision making (and following-up) on L having a MHA assessment.

## Staff survey and staff morale

- 7.9 In 2015, the Trust featured in the bottom 20% of all mental health trusts nationally in 25 out of 32 of the national staff survey key findings. The staff engagement score of 3.48 put the Trust in the bottom 20% of Trusts, which shows no improvement from the previous year (2014).
- 7.10 The results of 2016 MHSC staff survey showed that in terms of staff engagement the Trust's score of 3.54 was again below (worse than) average when compared with other similar mental health trusts. One of the lowest ranking scores on the survey was 'staff who recommend the organisation as a place to work or receive treatment'. There were also negative survey results in relation to: effective use of service user/patient feedback; staff feeling motivated at work and staff satisfaction with the quality of work and care they are able to deliver.
- 7.11 This means that for at least three years, there was sustained underperformance in the staff survey results and despite, staff health and wellbeing initiatives that were put into place, the previous Board of Directors had failed to affect any decisive, sustained change in this area.
- 7.12 Certainly, in conversations with staff who were involved with L's care at that time described a near constant sense of 'fire-fighting' where work pressures were seemingly relentless and "there were a lot of things that could have been done [but when you] take into account the whole pressure on the team and just the amount, the workload [it] has to be looked at as a whole". Staff were continually told to record issues on Datix, staff shortages, incidents and near misses, however, staff did not get any feedback on where the Datix reports went, or who read them.

## Governance at GMW and the post-transaction plans

- 7.13 The key findings from the due diligence upon Greater Manchester West Mental Health NHS Foundation Trust (GMW represented a substantially different picture in relation to governance, concluding that "the quality governance arrangements currently in place at GMW will, in general, form an appropriate and robust basis for the arrangements that will apply in the enlarged trust". This statement is material because the aims for at least the first 12 months of the post transaction phase were around ensuring a 'safe landing' for MHSC and to allow a reasonable period of assimilation in the post-integration phase.
- 7.14 GMW was seen to be a high performing organisation at the time of integration with several notable achievements including:
- In 2016 GMW was rated in the top ten in England in the National Patient Survey for helping service users with what is important to them and was in the top 20% for organising care. GMW also consistently receives high ratings from the patient Friends and Family tests.
  - The Trust was in the 'Top 100 NHS Employers', using data from the NHS Staff Survey and independent research.

- 7.15 On the whole, it was the plan to map most of MHSC governance processes over to the existing processes at GMW and to undertake a detailed diagnostic on a service by service basis within the following year to understand how services could be improved across the whole of Manchester.
- 7.16 These plans were described through the post-transaction implementation plan or the PTIP. The Due diligence undertaken identified the most prevalent risks to that plan being delivered and these included:
- The most significant risk to the success of the transaction in quality terms are the staffing issues currently affecting MHSC. These are known to the Management and Board of GMW, and actions are planned to improve the position and mitigate the negative effects in the meantime. We believe that the challenge presented by the staffing issues (both in terms of numbers and morale) is sufficient to require an independent external review of progress, probably at between six and twelve months post-transaction.
  - GMW needs to understand more, prior to the Transaction, about the risk profile of the current MHSC services. There is evidence that the risk management processes at MHSC are not sufficiently rigorous or well linked to operations, meaning that the existing records may not provide a reliable view of risks in MHSC.
  - Other issues identified included MHSC mortality review processes, management of action plans, incidents and quality impact assessment processes.

### **Work underway in the last 12 months**

- 7.17 On the 1 January 2018 the new Trust will have completed its first 12 months in operation and will start to formally assess the success of the transaction both through regulation (CQC, NHSI Well-led Governance Review and the Single Oversight Framework) and through other triangulation such as the national staff and patient surveys.
- 7.18 In the last 12 months GMMH has been engaged in a busy schedule of activities to not only ensure that the key actions described in the PTIP were implemented, but also to ensure that there has been continuation of action implementation from the legacy MHSC, through for example, the CQC action plan and also ongoing actions with serious incident investigations. This has meant, however, some complex transitioning of actions, to ensure that they are reflective of the way that new services are delivered. Some of the actions identified in the legacy MHSC may not necessarily have been identified as deficits at GMW and so staff at GMMH have spent time providing the investigation team with assurance that systems and processes are in place to address to concerns raised in the internal investigation report into L.

7.19 Risks which were identified as requiring focus for the newly enlarged organisation at the post-transaction phase which are material to ensuring effective governance in the newly enlarged trust included:

- The portfolio of GMW's Director of Nursing and Operations is large and will be larger post-transaction.
- The remit of GMW's Quality Governance Committee is large and will be larger post-transaction.
- There is a major task for the Trust in standardising the clinical and quality governance policies and procedures to be used post-transaction.
- The mortality review process at MHSC has been previously criticised by HM Coroner as lacking rigour, which means potentially a lack of learning.
- There are significant staffing issues at MHSC, relating to both staff numbers and staff morale.
- The extension of GMW's risk management arrangements across the enlarged Trust is itself a significant risk because of the comparative lack of rigour in MHSC's risk management arrangements

7.20 The Board at GMMH have led an extensive programme to ensure that 'safe-landing' in for the legacy MHSC occurred and also to ensure that any service changes undertaken since then, have been well-planned, engaged and executed.

7.21 GMMH have ensured a number of resources are available to ensure that learning from outcomes occur across the organisation, some of these include:

- A substantive nursing and medical structure now sits underneath the Director of Nursing and the Medical Director which consists of staff from both of the previous legacy trusts as well as new appointments. These have promoted clear reporting lines which have been communicated to teams although it is accepted that the recognition of new posts and structures will take a while to be fully embedded.
- There is also a new Director level post sitting within the new structure and this is 'Director of Manchester Services'.
- Directorates in the Trust lead on the operational application of the business, governance, quality and performance elements. Directorates meet monthly and cover quality reporting including the work of multi-disciplinary teams.
- GMW had an established post-incident review (PIR) panel and from the 1 January 2017 included Manchester services to ensure trust-wide learning and development is captured and shared.
- There will be a period where both Datix systems and incident processes will run in parallel, with their ultimate integration being a priority programme post-Transaction.
- GMW has an Incident, Accident and Near Miss Policy and Procedure which was written and managed in line with the NHS Incident Framework (2015) and the Duty of Candour Principles (2014).
- Continuation of the weekly Serious Untoward Incident Group which reports to the PIR Panel and to the Quality Governance Committee to the Board.

- Dashboard data on quality (including incidents) is scrutinised at ward, department, directorate, subcommittee and Board level.
- Use of the CARE-hub which brings together all service user and carer feedback, themes from complaints and compliments and steps the trust is taking to identify and share learning.
- Also, the Positive and Safe Group which is a forum for learning from incidents of aggression and violence.
- The Trust facilitates proactive staff and patients' group meetings as part of the Safer wards model, engaging patients in decision-making about the clinical environment and their own care, supporting the writing of discharge messages whereby patients who are being discharged leave positive messages for current and future patients about their care and time spent on the ward.

### **Commissioner oversight following serious incidents**

- 7.22 From April 2016 NHS Salford CCG ceased direct commissioning from GMW and commissioned a 'Local Care Organisation' lead by Salford Royal Foundation Trust, who now contract their mental health provision from GMW. NHS Salford CCG had been previous lead commissioner on the multi-lateral contract between Salford, Trafford and Bolton CCG's with GMW, but this transferred to Bolton CCG in April 2016. GMMH also has a contract with Manchester CCG, and also provides services to other CCG's in the Northwest e.g. drug and alcohol services in Cumbria.
- 7.23 NHS Manchester CCG and NHS Bolton CCG are responsible for incident management on the multilateral contract, Salford CCG manage serious incidents relating to Salford patients but themes and trends are shared across Salford, Manchester, Bolton and Trafford. The Serious Incident Review Group provides clinical insights, questions and signs off recommendations. NHS Manchester CCG now provides the administration of the Serious Incidents for Manchester Bolton and Trafford, with NHS Salford CCG managing their own.
- 7.24 Every two months there is a clinically- led quality and performance meeting, with GP, Salford CCG, Trafford CCG and Bolton CCG representatives present.
- 7.25 NHS Bolton CCG has a Serious Incident Group, that is partially resourced by NHS Manchester CCG (provision of administration resource), whereas NHS Bolton CCG provides clinical input to the report and evaluation etc. The Serious Incident Review Group provides clinical insights, questions and signs off recommendations.
- 7.26 NHS Bolton CCG host and Chair the bi-monthly Quality and Performance meeting with GMMH for the multilateral contract, attended also by Trafford and Salford. In the future Manchester CCG's will join that contract and may then become the lead commissioner. Bolton CCG's GP Incident Reporting System also acts as an Early Warning System of deteriorating services.

**Summary:**

- The legacy MHSC Trust was, for several years, experiencing financial, operational and strategic challenges which precipitated the decision to merge into GMW on the 1 January 2017, forming the new Trust GMMH.
- The legacy MHSC had a number of sustained challenges around staffing levels, staff morale and sustainability. They had received an adverse inspection report from the CQC around some fundamental aspects of delivering safe MH care.
- Significant enquiry was undertaken through a process of due diligence prior to the acquisition of MHSC services by GMW and some key risks were noted around staffing levels and the overall management of risk at the legacy Trust.
- GMMH has spent the last 12 months implementing the urgent actions agreed in the post-transaction implementation plan as well as taking forward the actions identified in the independent report. Some of the latter described actions, however, will require large scale transformational change and this work is ongoing. In the meantime, GMMH can demonstrate that they have enhanced process for learning from outcomes and will continue to make ongoing improvements in this area.

## 8. Overall analysis and recommendations

- 8.1 This was a complex investigation with a significant amount of documentary evidence to be reviewed and a wide range of staff interviewed.
- 8.2 We have tried as much as possible to focus on the changes the new organisation will bring to mental health services in Manchester, not simply to identify where things went wrong.
- 8.3 We believe that although the Trust internal investigation did identify missed opportunities in the care provided to L, it was not an adequate or robust investigation, and did not adequately identify the significant contributory factors that need to be addressed in order to transform mental health services in Manchester.
- 8.4 We have heard of the systemic stress that clinicians and practitioners from both in-patients and community mental health services have come to accept as part of their daily routine.
- 8.5 We have heard how this was manifested in high caseloads and a shortage of beds. Central West CMHT reported that L did not stand out in terms of acuity or complexity, since many of the patients on the case load have similar issues. There are two Bail Hostels and UCR supported accommodation in the team's catchment area, which lead to a local population with a much higher than would be expected complexity and morbidity.
- 8.6 We have heard how consultant psychiatrists can be working with caseloads of 500 – 600 out-patients, as well as 30 or more patients on a CTO, and an additional 10 to 15 patients needing close working with the Ministry of Justice because of their complexity.
- 8.7 We heard how the processes of the then Trust added to the workload of community mental health staff, with more duty assessments to support the social care aspect of the Trust.
- 8.8 Alongside that we believe that staff had become inured to the risk and complexity of challenging and complex patients like L. We heard from interviews that previous attempts to escalate concerns about safety due to high caseloads and lack of beds had gone unheard. This led to a culture where staff were resigned to the circumstances and felt helpless to change things.
- 8.9 We therefore believe that the internal investigation conclusion, that there is no root cause for the death of Will, is flawed. Although we accept that L had made rapid progress since transfer to Edenfield, this had to be measured against the complexity and significance of his previous forensic history. We believe that the root cause of this tragic incident lay with the decision to remove L from his section instead of accepting the consultant psychiatrist's recommendation and using a CTO to ensure a more managed transition into the community.
- 8.10 However, L's risks were well known and documented. Care plans identified the signs of relapse.

- 8.11 Attempts to re-titrate his clozapine were not made assertively enough or over sufficient time to allow them to make a difference.
- 8.12 Despite the strenuous efforts of his care coordinator, once the professionals started to question the diagnosis of paranoid schizophrenia and failed to recognise L's symptoms of relapse it became harder for L to receive the right treatment.
- 8.13 Confirmation bias took over, and this led to a perception that because L had some mental capacity, his behaviour was a result of rational choices he had made and not as a consequence of a complex and relapsing psychosis.
- 8.14 Alongside this, because of the demands placed on a stressed mental health system, some professionals lost sight of the degree of mental illness that L was suffering with, instead considering only the apparent risk. Since L was often able to say what he thought people wanted to hear, and hide his true thoughts and feelings, he was often taken at his word. So for example, he was repeatedly admitted informally, as he said he would stay in hospital, despite the fact he had absconded several times before, and on each occasion had either become involved with the police, or taken an overdose, leading back to a further admission.
- 8.15 When he was found by the police after he had absconded, and they undertook a welfare check, excessive emphasis was placed on their assurance that he seemed well, when a more formal mental health assessment and preferably a forensic opinion was required.
- 8.16 This then was compounded by a stressed and stretched mental health system, which had become inured to risk, with an increasing focus on managing 'flow' not clinical need.

### **Predictability and preventability**

- 8.17 We are asked to provide a view in such investigations on whether the incident that led to the death of Will was predictable or preventable.
- 8.18 In its document on risk, the Royal College of Psychiatrists scoping group observed that:

'Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour.'<sup>43</sup>

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<sup>43</sup> Royal College of Psychiatrists (2008) Rethinking risk to others in mental health services. Final report of a scoping group. p23. <http://www.rcpsych.ac.uk/pdf/CR150%20rethinking%20risk.pdf>

8.19 The National Confidential Enquiry Annual report of 2017 reports that there was an average of 32 homicides by people with schizophrenia in England each year between 2005 and 2015. The report draws attention to the following points:

“65 (32%) patients with schizophrenia were non-adherent with drug treatment in the month before the homicide, an average of 6 per year. There had been no fall since 2008. 75 (39%) patients with schizophrenia missed their final service contact before the homicide, an average of 7 per year, and again there had been no fall since 2008. In total 116 (59%) were either non-adherent or missed their final contact with services”.<sup>44</sup>

8.20 Predictability is ‘the quality of being regarded as likely to happen, as behaviour or an event’.<sup>45</sup> An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.<sup>46</sup>

8.21 Prevention<sup>47</sup> means to ‘stop or hinder something from happening, especially by advance planning or action’ and implies ‘anticipatory counteraction’; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

8.22 In considering these we have asked two key questions:

- Was it reasonable to have expected those caring for L to have taken more proactive steps to manage the risks presented by him?
- Did they take reasonable steps to manage these known risks?

### **Was the death of Will predictable?**

8.23 We have reviewed the care provided to L. We believe, given his significant forensic history, and the risks clearly identified and known, that once L started to relapse and disengage from mental health services a violent offence was extremely likely.

8.24 However, it wasn’t predictable that he would kill Will two months after he was last seen by mental health services.

### **Was the death of Will preventable?**

8.25 We have tried to avoid the bias of hindsight<sup>48</sup> in considering whether the degree of harm was avoidable.

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<sup>44</sup> National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2017

<http://documents.manchester.ac.uk/display.aspx?DocID=37560>

<sup>45</sup> <http://dictionary.reference.com/browse/predictability>

<sup>46</sup> Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120

<sup>47</sup> <http://www.thefreedictionary.com/prevent>

<sup>48</sup> Hindsight bias is the inclination, after an event has occurred, to see the event as having been predictable, despite there having been little or no objective basis for predicting it Roese, N. J.; Vohs, K. D. (2012). "Hindsight bias". Perspectives on Psychological Science. 7: 411–426. doi:10.1177/1745691612454303

8.26 We have considered the following points:

- L had a diagnosis of paranoid schizophrenia with additional components of personality disorder and a degree of psychopathy.
- The symptoms of his psychosis were known to include violent thoughts of harming people, and his withdrawal from services and starting to abuse drugs.

8.27 Actions taken which should have lessened the risk of harm and relapse include:

- Maintain L on a Community Treatment Order.
- Ensure L was moved more slowly through a structured step down process.
- Ensure L remained on clozapine, and when starting to disengage act assertively and promptly to restart it.
- Not discharging L in his absence and ensuring he stayed in hospital.

8.28 Because of these issues, we believe that the death of Will was preventable. Had any of these steps been taken, it is much more likely that L would not have relapsed.

## Root Cause Analysis Investigation tools

### Contributory Factors Classification Framework

Patient Factors	Components
Clinical condition	<input type="checkbox"/> Dual diagnosis <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Significant forensic history
Physical Factors	<input type="checkbox"/> Poor general physical state <input type="checkbox"/> Obese/metabolic syndrome <input type="checkbox"/> Poor sleep pattern
Social Factors	<input type="checkbox"/> Lifestyle (smoking/ drinking/ drugs/diet) <input type="checkbox"/> Rootless and homeless <input type="checkbox"/> Lack of support networks / (social protective factors - Mental Health Services) <input type="checkbox"/> Engaging in high risk activity <input type="checkbox"/> Easily influenced <input type="checkbox"/> Dispersed relationships <input type="checkbox"/> Excessive alcohol use <input type="checkbox"/> Use of illicit substance
Mental/ Psychological Factors	<input type="checkbox"/> Motivation issue <input type="checkbox"/> Stress / Trauma <input type="checkbox"/> Existing mental health disorder <input type="checkbox"/> Some learning difficulties <input type="checkbox"/> Non-compliance with medication <input type="checkbox"/> Refusal to engage with inpatient or community services
Interpersonal relationships	<input type="checkbox"/> Staff to patient and patient to staff <input type="checkbox"/> Elusive about feelings <input type="checkbox"/> Poor coping strategies <input type="checkbox"/> Family to patient or patient to family

<b>Staff Factors</b>	<b>Components</b>
Physical issues	<input type="checkbox"/> Fatigue
Psychological Issues	<input type="checkbox"/> Stress (e.g. distraction / preoccupation)
Cognitive factors	<input type="checkbox"/> Preoccupation / narrowed focus (Situational awareness problems) <input type="checkbox"/> Perception/viewpoint affected by info. or mindset (Confirmation bias) <input type="checkbox"/> Inadequate decision/action caused by Group influence <input type="checkbox"/> Overload
<b>Task Factors</b>	<b>Components</b>
Guidelines, Policies and Procedures	<input type="checkbox"/> Unclear/not useable (Ambiguous; complex; irrelevant, incorrect) <input type="checkbox"/> Not adhered to / not followed (AWOL/CPA/Risk Assessment policy) <input type="checkbox"/> Not monitored / reviewed (clozapine titration)
Procedural or Task Design	<input type="checkbox"/> Too many tasks to perform at the same time <input type="checkbox"/> Contradicting tasks (patient flow versus clinical priorities ) <input type="checkbox"/> Staff do not agree with the 'task/procedure design' (flow & capacity/caseload) <input type="checkbox"/> Inadequate Audit, Quality control, Quality Assurance built into the task design (patient flow process/bed management ) <input type="checkbox"/> Insufficient opportunity to influence task/outcome where necessary
<b>Communication</b>	<b>Components</b>
Verbal communication	<input type="checkbox"/> Ambiguous verbal commands / directions (MHA assessments not carried out) <input type="checkbox"/> Incorrect use of language
Written communication	<input type="checkbox"/> Lack of effective attention paid to written communication by staff of risks (Alerts systems etc)
Communication Management	<input type="checkbox"/> Information from patient/carer disregarded <input type="checkbox"/> Ineffective communication flow to staff up, down and across <input type="checkbox"/> Ineffective interface for communicating with other agencies (partnership working) <input type="checkbox"/> Lack of measures for monitoring communication
<b>Work Environment</b>	<b>Components</b>
Administrative factors	<input type="checkbox"/> Unreliable or ineffective general administrative systems (Please specify e.g.: Bookings, Patient identification, ordering, requests, referrals, appointments) <input type="checkbox"/> Unreliable or ineffective admin infrastructure (e.g. Phones, bleep systems etc) <input type="checkbox"/> Unreliable or ineffective administrative support
Staffing	<input type="checkbox"/> Inappropriate skill mix (e.g. Lack of senior staff; Trained staff; Approp. trained staff) <input type="checkbox"/> Low staff to patient ratio <input type="checkbox"/> No / inaccurate workload / dependency assessment <input type="checkbox"/> Use of temporary staff <input type="checkbox"/> High staff turnover
Work load and hours of work	<input type="checkbox"/> Shift related fatigue <input type="checkbox"/> Excessive of extraneous tasks
<b>Organisational</b>	<b>Components</b>
Organisational structure	<input type="checkbox"/> Hierarchical structure/Governance structure not conducive to discussion, problem sharing, etc. <input type="checkbox"/> Professional isolation <input type="checkbox"/> Clinical versus the managerial model

	<ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of robust Service level agreements/contractual arrangements</li> </ul>
Priorities	<ul style="list-style-type: none"> <li><input type="checkbox"/> Not safety driven</li> <li><input type="checkbox"/> External assessment driven e.g. Annual Health checks (focus on merger/FT status)</li> <li><input type="checkbox"/> Financial balance focused</li> </ul>
Externally imported risks	<ul style="list-style-type: none"> <li><input type="checkbox"/> Locum / Agency policy and usage</li> <li><input type="checkbox"/> Lack of service provision</li> <li><input type="checkbox"/> Bed Occupancy levels (Unplanned bed opening/closures)</li> </ul>
Safety culture	<ul style="list-style-type: none"> <li><input type="checkbox"/> Inappropriate safety / efficiency balance</li> <li><input type="checkbox"/> Poor rule compliance</li> <li><input type="checkbox"/> Lack of risk management plans</li> <li><input type="checkbox"/> Inadequate leadership example (e.g. visible evidence of commitment to safety)</li> <li><input type="checkbox"/> Inadequately open culture to allow appropriate communication</li> <li><input type="checkbox"/> Inadequate learning from past incidents</li> <li><input type="checkbox"/> Incentives for 'at risk'/risk taking' behaviors (flow &amp; capacity)</li> <li><input type="checkbox"/> Acceptance/toleration of inadequate adherence to current practice</li> <li><input type="checkbox"/> Ignorance/poor awareness of inadequate adherence to current practice</li> <li><input type="checkbox"/> Disempowerment of staff to escalate issues or take action</li> </ul>
<b>Education and Training</b>	<b>Components</b>
Competence	<ul style="list-style-type: none"> <li><input type="checkbox"/> Inappropriate experience or lack of quality experience (access to forensic expertise)</li> </ul>
Supervision	<ul style="list-style-type: none"> <li><input type="checkbox"/> Inadequate supervision</li> <li><input type="checkbox"/> Lack of / inadequate mentorship</li> <li><input type="checkbox"/> Training results not monitored/acted upon</li> </ul>
Availability / accessibility	<ul style="list-style-type: none"> <li><input type="checkbox"/> Training needs analysis not conducted/acted upon</li> <li><input type="checkbox"/> Team training unavailable or inaccessible (forensic complex pts)</li> </ul>
<b>Team Factors</b>	<b>Components</b>
Role Congruence	<ul style="list-style-type: none"> <li><input type="checkbox"/> Role + responsibility definitions misunderstood/not clearly defined (continuity in inpatients, medical role in CMHT)</li> </ul>
Leadership	<ul style="list-style-type: none"> <li><input type="checkbox"/> Ineffective leadership – clinically (especially medical)</li> <li><input type="checkbox"/> Ineffective leadership – managerially</li> <li><input type="checkbox"/> Lack of decision making</li> <li><input type="checkbox"/> Inappropriate decision making</li> </ul>
Support and cultural factors	<ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of support networks for staff</li> <li><input type="checkbox"/> Inappropriate level of assertiveness (flow &amp; capacity/management)</li> <li><input type="checkbox"/> Inadequate inter-professional challenge</li> </ul>

## Appendix A – Terms of reference

### Terms of Reference for Independent Investigations under the NHS England Serious Incident Framework

The Terms of Reference for independent investigation 2016/3780 are set by NHS England, North, and Greater Manchester and Health and Social Care Enterprise.

These terms of reference are to be developed further in consultation with all stakeholders including the successful offeror of the independent investigation and family members.

#### Terms of Reference:

1. All affected families will be offered a detailed explanation of the independent investigation process detailing how it will be conducted and have the opportunity to be appropriately involved in the investigation process.
2. The Investigator will seek to meet with the perpetrator, alongside NHS colleagues to inform and explain the investigation process and seek their input to inform the investigation process.
3. Review the trust's internal and independent investigation and assess the adequacy of its findings, recommendations and associated action plan.
4. Review the progress that the trust has made in implementing the associated action plan.
5. The investigators to conduct a proportionate review of the care, treatment and services provided by the NHS, the local authority and other relevant agencies to the perpetrator from first contact with services to the time of their offence. Including:
  - a comprehensive chronology of events leading up to the homicide;
  - compliance against local policies, national guidance and relevant statutory obligations, including safeguarding and section 117 aftercare;
  - the adequacy of risk assessments and risk management, including specifically the risk of the perpetrator harming themselves or others;
  - the appropriateness of the treatment of the perpetrator in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern;
  - the effectiveness of the perpetrators care plan and the involvement of the service user and if appropriate their family in its development;
  - if affected families were engaged with appropriately within the internal investigation processes.
6. Review the effectiveness of Trusts internal governance processes with reference as to how they support the sharing and embedding of learning from serious incidents and identify any areas for improvement.

7. Based on overall investigative findings, constructively review any gaps in inter-agency working and identify potential opportunities for improvement.
8. Review the wider commissioning issues highlighted within the independent internal report, including any impact of recent service change.
9. Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement.
10. Support providers and commissioners to develop a robust, outcome focussed action plan.
11. The lead investigator to assist the Trust to develop an internal learning event
12. Provide a written report to NHS England, North with outcome focussed recommendations and a supplemental briefing report highlighting the key issues and outcomes to enable wider learning across NHS organisations.
13. Undertake an assurance follow up review within 12 months of the reports completion, to gain assurance on the implementation of the report's recommendations and provide a brief written report on progress to NHS England North and produce a short report that may be made public.
14. Assist NHS England, North in undertaking a brief post investigation evaluation

## Appendix B – Profile of the Trusts

- **Manchester Mental Health and Social Care NHS Trust (Legacy)**

Ceased in the provision of healthcare on the 1<sup>st</sup> January 2017 following a merger with Greater Manchester West Mental Health NHS Foundation Trust.

- **Greater Manchester West Mental Health NHS Foundation Trust**

Changed to the new name of Greater Manchester Mental Health NHS Foundation Trust (below) on the 1<sup>st</sup> January 2017.

- **Greater Manchester Mental Health NHS Foundation Trust**

Provides inpatient and community-based mental health care and treatment for adults and older people living within the North West. The Trust also provides a wide range of more specialised, or tertiary, services across Greater Manchester, the North West of England and beyond. These include substance misuse services (inpatient and community-based), forensic mental health services for adults and adolescents, child and adolescent mental health services, mental health and deafness services, health and justice services and community psychological therapies.

- **Pennine Care NHS Foundation Trust**

Provides community and mental health services in Greater Manchester.

Bury, Oldham and Rochdale – community services and mental health for children and adults

Tameside and Glossop – children’s and adults mental health, health improvement and intermediate care

Stockport – children’s and adults mental health

Trafford – community services and child adolescent mental health services (CAMHS)

Mental health services provide care and treatment for people with mild to moderate conditions such as depression, anxiety or dementia, or more serious mental health illnesses such as schizophrenia, bi-polar disorder and more.

Community services, including district nursing, health visiting, audiology, podiatry, health improvement and intermediate care.

## **Appendix C – Documents reviewed**

- GP Notes
- Clinical Notes from Pennine Care and MHSC
- Medical Reports Pennine Care and MHSC
- Police Records and Report
- Internal Investigation Reports and Action Plans
- Psychiatric Assessment Report (Ashworth)
- Discharge Report from Edenfield
- Heathfield Report
- CPA Mental Health Review from Pennine Care

### Policies:

#### **Pennine Care:**

- Integrated Care Pathway (ICP) for the Management of clozapine (approved November 2012)
- Care Programme Approach Policy (version 10)
- MHA section 117 – After-care (Version 3)
- Clinical Risk Assessment & Management Policy (Version 7)

#### **MHSC/GMMH**

- Admission, Transfer and Discharge Policy (March 2016)
- Adults of working age inpatient service description and standard operating procedure (October 2015)
- Absent Without Leave (AWOL) Policy (including procedure for missing persons) (May 2016)
- Being Open and Duty of Candour Policy (November 2016)

- Clinical Risk Management and Assessment: Policy and Procedures (August 2016)
- Service description and standard operating procedures for the Adult Community Mental Health Area Teams (December 2015)
- Recovery Focused Care Programme Approach (CPA) and Non CPA 2016 (November 2016)
- Prescribing Antipsychotic Drugs in Schizophrenia Guidelines for use [compatible with NICE guidance] (August 2002)
- Incident and Serious Incidents Requiring Investigation (SIRI) – Procedure and Practice Guidance including Data Incidents (March 2016)
- Clozapine Guideline – Community (September 2011, reviewed November 2014)
- Section 17 (Leave of Absence) (October 2015)
- Shared Care Protocol for Atypical Antipsychotics (May 2013)
- Urgent Care Services Service Description & Standard Operating Procedures for Individual Service Components under Urgent Care Services (May 2015)
- “Independent Review of a Serious Incident” Kate Glenholmes, 25 October 2016

Other documents:

- NICE Guidance: Psychosis and schizophrenia in adults: prevention and management (February 2014)

## Appendix D – Professionals interviewed in this investigation

### **Pennine Care NHS Foundation Trust:**

- Rehabilitation consultant psychiatrist CP1
- Care Coordinator and Social Worker CCO1
- Patient Safety Lead PS
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### **Greater Manchester Mental Health NHS Foundation Trust**

- Responsible clinician, consultant psychiatrist, Central West CMHT CP2
- Care Coordinator, and Social Worker, Central West CMHT CCO2
- Interim consultant psychiatrist ICP
- Area Team Manager, Central West CMHT ATM
- Assistant Area Team Manager, Central West CMHT AATM
- Ward Manager, Mulberry ward WM1
- Named Nurse, Mulberry ward NN
- Consultant Psychiatrist, SAFIRE CP3
- Consultant Psychiatrist Mulberry ward CP4

- Internal investigation report author
- Service Manager and member of internal investigation panel
- Specialist Registrar and member of internal investigation panel

- Deputy Director of Nursing
- Executive Director of Nursing
- Executive Medical Director
- Head of Patient Safety & Governance

### **Others:**

- L's GP
- Deputy Manager, Creative Support
- Interim Director of Nursing, MHSC
- Executive Nurse and Director of Safeguarding, Manchester Health & Care Commissioning
- Assistant Director of Quality, NHS Bolton CCG
- Senior Investigating Officer, Greater Manchester Police

## Appendix E – Questions raised by the family of Will

We believe that many of the questions asked by Will's family have been answered in the narrative of this report, and its main findings and conclusions. However, the following table lists in more detail where in our report those questions are more explicitly addressed. We have identified only those points in the main body of the report, and not the executive summary.

Questions	Paragraph
1. Assessment and management of the risks posed by L:	
a. What were the relevant policies and procedures for assessing L's risk and were they followed?	5.28 to 5.66.
b. Was L's forensic / criminal / violent history adequately considered?	Throughout the report, but in 8.10.
c. Was the impact of his illicit drug use adequately considered?	Throughout the report.
d. Was L's non-concordance with clozapine adequately considered?	5.71, 5.72 and 5.76.
e. Were L's episodes of self-harm adequately considered?	5.49 and 5.122.
f. Were L's obvious concerns about institutionalisation and moving on to independent accommodation (which appear to have led to his repeated absconding from hospital) adequately considered?	4.82, 5.67 to 5.126.
g. Was L's apparent functional homelessness in the weeks before W's murder adequately considered?	5.164.
h. Were L's disclosures about being fearful he would hurt someone (e.g. 25 April 2015) adequately considered?	5.28 to 5.66, but especially 5. 44.
2. Why wasn't the opinion of a forensic psychiatrist sought to assist with the management of L's care?	5.117 and 5.60
3. Why was no assessment of L for detention under the Mental Health Act 1983 undertaken prior to W's murder and in particular (i) in light of L's repeated absconding from the ward and use of illicit substances; and (ii) when this was recommended in May and July 2015?	7.8
4. Were adequate measures taken to ensure that L resumed clozapine?	4.97, 4.98, 4.101, 4.115, 4.132, 5.26, 5.103, 5.110, 8.11, and 8.29.

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|---|--|
| 5. Was it appropriate to discharge L from Mulberry ward in his absence on 8 October 2015? Were proper discharge planning and risk assessment procedures followed?     | 4.145, 5.118, and 5.126.                         |
| 6. Was there a lack of continuity of care in L's case and if so, what was its impact?   | 5.119  |
| 7. Should an alternative approach to L's care, such as Assertive Outreach, have been adopted?   | \perpetuating factors page 49-50.<br>Para 5.169. |
| 8. Were appropriate records kept documenting L's care?  | 5.47 to 5.48.                                    |
| 9. Why wasn't L allocated an interim Care Co-ordinator in January 2016 and what was the impact of this?   | 4.161.   |
| 10. Should further action have been taken by the Trust when L's mother advised them on 13 January 2016 that he was a medical inpatient at Manchester Royal Infirmary? | 4.162  |
| 11. Were the teams responsible for L's care adequately resourced and, if not, what was the impact of this?  | 5.167 to 5.169.                                  |
| 12. Was there any failure of multi-agency working in this case?   | 5.14, 5.159, 5.165 and 5.166.                    |
| 13. What was the impact of the fact that two authorities (Manchester and Stockport) in L's care?  | 5.14 and 5.161                                   |