# An independent investigation into the care and treatment of a mental health service user, Mr CD, in Southern Health Foundation NHS Trust and Solent NHS Trust

January 2019 Final report

An independent investigation into the care and treatment of a mental health service user Mr CD in Southern Health Foundation NHS Trust and Solent NHS Trust

Authors: Mr Tony Thompson, Lead Investigator

Ms Pam White, Lay Member

Dr Martin Lawlor, Consultant Psychiatrist

Ms Maggie Clifton, Investigations Manager

First published: January 2020

Version: Final, January 2019

Caring Solutions (UK) Ltd is a professional consultancy for mental health and learning disability services.

Web: Caring Solutions UK Ltd

# Acknowledgements

At the outset of this independent investigation the panel were aware of the grief, suffered by Mr Beattie's family. We extend our condolences to his family.

The independent investigation team wish to thank all those who contributed to this investigation.

We are particularly grateful to family members of the victim, Mr Nick Beattie. We met his sister and two brothers to receive their comments on the final draft of this report and much appreciated their time and openness in talking about their brother: their comments have improved this report.

Members of staff agreed to be interviewed and were open and honest with their views and reflections on the care and treatment of Mr CD.

Staff from the Quality and Governance department of Southern Health NHS Foundation Trust worked hard to help us arrange the interviews, provided the documents we requested and welcomed us into their offices. Staff from the Legal and Compliance department of Solent NHS Trust equally enabled the interviews to take place and provided the documentation we requested.

We are grateful to those from both Trusts who helped us to understand the complexities of service provision and commissioning and the changes that had taken place during the period Mr CD was in contact with services and since.

We are grateful to the internal review teams from Southern Health NHS Foundation Trust and Solent NHS Trust who compiled the report which provided the springboard for the review.

The National Probation Service in Hampshire provided helpful information about Mr CD's contacts with them and with the Hampshire and Isle of Wight Community Rehabilitation Company.

We wish to thank staff from Southampton City Clinical Commissioning Group, supported by West Hampshire Clinical Commissioning Group for providing the information we requested and helping us to understand the structure and processes of their incident review systems.

All parties provided invaluable information and insights which form the basis of this report.

## Family impact statement

Our younger brother Nick did not have the best start to life, in fact an extremely unlucky one.

As a baby Nick has an accident where he dropped to the ground. The circumstances around this are difficult to be clear on but this resulted in a permanent disability to Nick's left hand and partial deafness, for which he required hearing aids.

As a family we can confidently say Nick did not have great parenting or treatment as a child, as we all experienced similar but Nick, somewhat worse. As a child if you cannot hear or do not have full use of your body you are going to behave differently to those that can, especially if you are not getting the help and support that you need early on. Nick was viewed as having "behavioural problems'. For years Nick would be taken to one specialist and another, receiving a diagnosis of ADHD aged 12. Of course Ritalin made no difference. Why? Because the problem was not medical or psychological.

As a baby Nick was looked after a lot by Sharon, his older sister. As with all older siblings they move out, but Sharon holds an incredible sense of guilt leaving Nick with such a difficult home life. This feeling is also shared by his brothers Peter, Andrew and Marc who over the years have tried so many ways to reach out to Nick and had been witness to all the physical and emotional abuse that Nick endured during childhood. Physical and emotional harm is not acceptable under any circumstance, and it always leaves the worse scars in life.

Nick spent time in and out of foster care and Glendalyn Children's home as a teenager, which probably were his safest times in life. He would also have respite/time out with a lovely positive male role model called Tom. Tom was a great influence on Nick and would give him the much-needed time out that Nick needed. We still have pictures of Nick looking so happy and having a great time with another young boy, James, who also had a difficult home situation.

The biggest blow came for Nick aged 14 when our Mum, Janice died of a heart condition. Understandably this was the most painful experience you can imagine. Our family situation was such that Nick needed more support than we as a family could give him. Nick went back into foster care. Unfortunately, Nick felt an innate sense of rejection from his family, us his siblings. A feeling Nick had actually voiced experiencing most of his life.

Nick was placed with a foster family in Bransgore, Hampshire. Lesley and Harry were his foster parents and would sometimes invite us as a family over for a gathering or BBQ. As lovely as this family were, Nick remained with that sense of rejection and for reasons of escape he became easily led and got involved with illegal substances. This resulted in Nick needing to leave the foster home.

Nick was then placed in his own flat, but unfortunately Nick would make the wrong friends, would be taken advantage of and continue to be misled further into this world of drugs.

A positive turning point for Nick was when the society of St James in Southampton

were able to offer Nick supported living accommodation. Whilst being under the care of Society of St James Nick had far more direct support and guidance. He would access support from 'The Bridge', a local drug and alcohol service. Nick would utilise this service on and off at the times he felt he had the strength to work on his addiction.

Nick felt incredibly guilty and ashamed for his problems, and so would shut out his family, because he didn't want to cause us any problems. In fact due to Nick trying to shut us, his family out we had no idea to the extent his drug dependency has developed too. Only a few of us were able to make contact with Nick and track him down from time to time to catch up and have a meal together, attempting to offer the little support that Nick would accept.

The staff at Nick's hostels were similarly deeply saddened at Nick's passing as they felt he was so close to his recovery and this is something he so desperately wanted to achieve so he could come back to us, his family and make us proud.

Nick's passing in such a tragic and horrible way has turned our lives upside down. The grief, loss and trauma is immeasurable. It has reopened childhood traumas for all of us, and our lives will never be the same again.

Nick may have had issues with addiction that he was working on, but he did not deserve to be so terribly physically hurt in the way he was. If Nick was not harmed in these awful ways he would still be here today, and have achieved his recovery. Whatever happened on that day Nick did not deserve to lose his life.

We as a family will never forget Nick. He had a kind, polite, caring, cheeky and harmless nature. We miss him dearly.

## Contents


Acknowledgements ..... 3

Family impact statement ..... 4

1 Executive summary ..... 10

Introduction ..... 10

Terms of reference ..... 10

Purpose of investigation ..... 11

Brief history ..... 11

Arising issues, comment and analysis ..... 14

Analysis, conclusions and recommendations ..... 16

Good practice ..... 16

Care and service delivery problems ..... 17

Contributory factors ..... 17

Root cause ..... 17

Recommendations ..... 18

2 Offence ..... 20

3 Independent investigation ..... 21

Approach to the investigation ..... 21

Purpose and scope of the investigation ..... 22

Investigation Team ..... 22

Methodology ..... 22

Structure of the report ..... 25

Involvement of Mr CD, members of his family and members of the victim's family (ToR 5) ..... 26

4 The care and treatment of Mr CD ..... 26

Childhood and family background ..... 26

Education and employment ..... 27

Relationships ..... 27
Contact with criminal justice system ..... 31
5 Arising issues, comment and analysis ..... 33
Care pathways and information sharing (ToR1) ..... 33
The services and professionals involved in the care of Mr CD ..... 33
The roles, functions and commissioning of Services ..... 37
Procedures, policies and standards ..... 38
Information sharing ..... 39
Substance misuse and offending behaviour ..... 40
Commissioning aspects ..... 43
Criminal justice system ..... 44
Homelessness ..... 46
Care planning, clinical risk assessment and transfer of care (ToR2) ..... 50
Events post-discharge from Melbury Lodge, 1 August 2014 ..... 52
Risk assessment and risk management (ToR3). ..... 58
To evaluate and comment on Mr CD's mental health care and treatment (ToR4). ..... 62
Community Mental Health Services and Homeless Health Care Team ..... 63
Mental health support whilst in police custody ..... 63
Inpatient admission ..... 64
Admission assessment and care plans ..... 65
OT and psychology input ..... 66
Time spent on the unit ..... 66
Medication ..... 67
Discharge ..... 67
The information infrastructure across the local healthcare system (ToR8). ..... 69
Duty of Candour and involvement with families of the victim and perpetrator (ToR7 and ToR13) ..... 69
Lessons and/or recommendations that have implications for all social and healthcare providers (ToR12). ..... 71
Consider if this incident was either predictable or preventable (ToR14) ..... 71

6 Review of the Trusts' joint internal investigation report and action plan (ToR6). ..... 73
Review of the internal report ..... 73
The investigation process ..... 74
Review of Mr CD's care and treatment ..... 75
Analysis in the report ..... 78
Accountability ..... 78
The report ..... 78
Positive practice ..... 79
Lessons learnt ..... 79
Care and service delivery problems/lessons learned ..... 79
Progress made on the delivery of action plans (ToR10) ..... 80
Compliance with policies and procedures for managing serious incidents ..... 85
SHFT policies and procedures ..... 85
Solent policies and procedures ..... 86
Conclusions ..... 87
Review of processes to embed learning and of internal governance systems (ToR6) ..... 87
SHFT Area level – Southampton ..... 87
SHFT Board level ..... 88
Solent – service level ..... 89
Solent – Board level ..... 90
Conclusions ..... 90
7 Monitoring the Trusts' action plans by the commissioning CCGs (ToR11) ..... 91
8 Overall analysis and recommendations: (ToR9) ..... 93
Good practice ..... 93
Care and Service Delivery problems ..... 93
Contributory factors ..... 94
Root cause ..... 94
Recommendations ..... 94

Appendix A: Fishbone diagram ..... 97
Appendix B: Terms of reference ..... 98
Appendix C: Chronology - February 2011 to March 2015 ..... 101
Appendix D: Members of the investigation team ..... 120
Appendix E: Services used by Mr CD ..... 122
1. Homeless Health Care Team (HHCT) ..... 122
2. The Mentally Disordered Offenders Service (MENDOS) ..... 122
3. Substance Misuse Services (SMS) ..... 123
3. Homelessness Services provided by Southampton City Council ..... 124
4. Criminal Justice System ..... 124
Sentencing practice ..... 124
The Offender Rehabilitation Act 2014 (ORA) ..... 125
Licence conditions ..... 125
National Standards for the Management of Offenders 2011 ..... 126
Appendix F: Conclusions of QNI research on homelessness ..... 128
Appendix G: List of abbreviations ..... 130
Appendix H: Anonymisation Index ..... 132
Appendix I: References ..... 134

# 1 Executive summary

## Introduction

1.1 On 8 March 2016, Mr CD was convicted of the murder of Mr Nick Beattie on 20 March 2015. Mr CD had received mental health and substance misuse services from Southern Health NHS Foundation Trust (SHFT) on several occasions between 2011 and September 2014. He also received substance misuse services from Solent NHS Trust (on two occasions between his release from prison on 13 March 2015 and the day of the homicide).

1.2 This independent review was commissioned by NHS England (South). We have submitted this report in response to the Terms of reference (ToR) set by NHS England (South).

## Terms of reference

1. Review the care pathways and information sharing processes between the range of teams identified in the joint internal investigation (i.e. Homeless Health Care Team, Antelope House (Acute Care Unit, Southampton), the Prison Mental Health team HMP Winchester, Integrated Offender Management Team, GP, Substance Misuse service, Melbury Lodge, Mentally Disordered Offenders Service, Solent NHS Trust Substance Misuse, Assessment, Review and Monitoring service, Crime Reduction Initiative and the Structured Intervention Team against existing provider policy and national best practice.
2. Review the application of both Trusts' care planning, clinical risk assessment and transfer of care policy and procedures in relation to Mr CD's treatment.
3. To establish if the risk assessment and risk management of Mr CD was sufficient in relation to his needs including the risk of harming himself or others.
4. To evaluate and comment on the mental health care and treatment Mr CD received at each stage of his treatment.
5. Establish appropriate contacts and communications with families/carers to ensure appropriate engagement with the independent investigation process.
6. Review the both Trusts' internal investigation and assess the adequacy of its findings, recommendations and action plan to:
   - Identify if the internal investigation satisfied its own terms of reference.
   - Identify if all key issues and lessons have been identified and shared.
   - Identify whether recommendations are appropriate and comprehensive and flow from the lessons learnt.
   - Review and comment on progress made against the action plans.
   - Review processes and comment on in place to embed any lessons learnt.

- Review and comment on the efficiency of monitoring of the action plans by the trust internal governance structures.

7. Review and comment on any communication and involvement with families of the victim and perpetrator before and after the incident.

8. To establish if the information infrastructure across the local healthcare system supports the delivery of effective clinical care and multiagency working.

9. To identify key issues, lessons learnt, recommendations and subsequent actions for local healthcare providers and commissioners.

10. To independently assess and provide assurance on the progress made on the delivery of action plans following the internal Trusts' investigations.

11. To independently assess and provide assurance that the monitoring of the relevant Trust's action plans by the commissioning CCGs is adequate.

12. To identify any lessons and/or recommendations that have implications for all social and healthcare providers both locally and nationally.

13. Review and comment on the trust(s) recording of its undertaking of its Duty of Candour.

14. Consider if this incident was either predictable or preventable.

1.3 Throughout the main body of the report, we have identified which section relates to which of the terms of reference by adding 'ToR' followed by the number and the full wording immediately following the heading.

## Purpose of investigation

1. To identify whether there were any gaps, deficiencies or omissions in the care and treatment that Mr CD received, which could have predicted or prevented the incident on 20 March 2015.

2. The investigation will identify any areas of best practice, opportunities for learning and areas where improvements to services are required in order to prevent similar incidents from occurring.

3. The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and/or the provider's formal Board sub-committees.

## Brief history

1.4 Mr CD was born in 1977 and was recorded as having a disordered childhood and adolescence, including being excluded from school for violent behaviour on occasions. His father and step-father are dead. He had occasional contact with his mother, including in 2014 and 2015.

1.5 He left school at 15 years of age without qualifications. He last worked as a bricklayer in 2012. Since then he has either been in prison, probation service accommodation or homeless (staying with friends or occasionally with his mother). He has a history of poly-drug abuse, commencing when he was 15 years old.

1.6 Self-reported information in the clinical records is inconsistent. There is reference to his violence against an ex-partner; and there is reference to a daughter but he was not in contact with her. There is nothing in the records to suggest he was in a relationship at the time of the homicide[1].

1.7 Mr CD was in contact with mental health services provided by SHFT. These were the mentally disordered offenders service (MENDOS) and community mental health nurses (CMHNs) attached to the Homeless Healthcare Team (HHCT). He received substance misuse services (SMS) from SHFT and Solent (SMS were provided by SHFT up to 30 November 2014 and by Solent from 1 December 2014). His first contact with services was in February 2011 and his final contact was on 23 March 2015 when he was in police custody following the homicide.

1.8 He was in contact with a range of services provided by the NHS, charities and the probation service. (Details of his contacts with these services are contained in Appendix C, and there is more information about the services themselves in Appendix E.) His contacts were erratic, due to several prison admissions and him not engaging with services.

1.9 He was seen and assessed by a consultant psychiatrist in the prison in-reach mental health service in February 2011. The consultant concluded:

- diagnosis - anti-social personality disorder (ASPD);
- alcohol dependence;
- harmful use of heroin and crack cocaine;
- possible Post Traumatic Stress Disorder;
- victim of two serious assaults (December 2010 and January 2011), reporting panic attacks, anxiety and palpitations when outside.

1.10 His next contact with services was on 9 July 2014, when he presented to the SHFT SMS on release from prison. He was prescribed methadone and a morphine-based pain killer for pain caused by nerve damage resulting from an assault.

1.11 On 19 July 2014 Mr CD presented to Antelope House (an acute unit in Southampton), requesting help because he stated he felt suicidal. He was assessed as a high risk of harm to himself and low to medium risk to others. He agreed to an informal hospital admission for further assessment and treatment. He was admitted to Melbury Lodge in Winchester as there were no beds in Antelope House.

1.12 Between 19 July and 1 August 2014, Mr CD was an inpatient at Melbury Lodge, where his mental health and risks were assessed, and his behaviour

[1] Homicide is the killing of one person by another.

was observed on the ward. He was prescribed methadone, diazepam, and zopiclone[2], and was assessed by a senior psychologist who concluded that no specific psychological work was appropriate at that time. He completed a 'recovery plan' with a member of the ward staff. During this time nursing staff reported that he was calm, cooperative and his stay was without incident. He had been given unescorted leave on 11 occasions, again with no reported incidents.

1.13 Mr CD was seen by Dr ST, his consultant psychiatrist, on 30 July 2014 when he was assessed as not having a mental illness but addiction to methadone and diazepam dependence. His presentation was consistent with Anti-social personality disorder (ASPD). He had no intention to stop using these drugs or engage in therapeutic work so Dr ST decided to discharge him on 1 August 2014. Follow-up was arranged with the ARM service, the HHCT and help was offered to find him somewhere to live. He was prescribed methadone and provided with diazepam for 5 days. There were difficulties in finding him suitable accommodation as he was known in both local hostels and by private landlords for his tendency to violent behaviour.

1.14 The faxed discharge summary had not arrived with the Dr DE, the HHCT GP, when Mr CD saw her on 6 August 2014 (SHFT have since ceased sending faxes on discharge, using electronic communications instead). He demanded a prescription for diazepam which she was reluctant to provide without any information as to his treatment plan as it was not clinically appropriate for her to prescribe diazepam[3].

1.15 Mr CD was annoyed. Dr DE did provide a prescription with the intention that this would be a rapidly reducing dose.

1.16 Between 4 August and 2 September 2014, he was under the care of the HHCT. Ms UV, his CMHN, saw him on 4 August and attempted to contact him on several occasions thereafter. Both SMS and the SHPT (Street Homeless Prevention Team) described him as being anxious and low in mood.

1.17 On 3 September he was in police custody. He was convicted and sentenced to prison for 14 months.

1.18 On 13 March 2015 he was released from prison. He was seen by the ARM worker and referred to the Structured Intervention Team (SIT) where he was assessed and provided with a methadone prescription.

1.19 In late afternoon on 20 March 2015, Mr CD attended the needle exchange service. He told Ms HI, the manager, that he was going to kill someone and then himself. Her manager, MS SW came and talked to Mr CD whilst Ms HI rang the police and ambulance service. Mr CD walked out about an hour later

[2] Diazepam is a benzodiazepine, a group of drugs prescribed to reduce anxiety which also have addictive qualities; and zopiclone is a sleeping tablet, used to treat insomnia.

[3] The Homeless Health Care Team do very limited prescribing of diazepam because of its addictive properties and potential to be abused.

and before the police arrived. This was after the incident during which Mr Beattie died.

1.20 On 23 March 2015 Ms PQ, the MENDOS worker, saw Mr CD who reported feeling suicidal. Ms PQ informed the custody sergeant and asked him to refer Mr CD to the drug arrest worker.

1.21 The following March he was convicted of murder and given a sentence of life imprisonment. He was to serve a minimum of 13 years before he could be considered for parole.

1.22 Mr CD had an extensive history of violence and other criminal offences and had been on probation whilst at Melbury Lodge in July 2014. He was known to have had several prison sentences, the longest being from 2004 to 2009.

1.23 Mr CD was as difficult to engage with probation services as he was with mental health services, including non-compliance with a 'Drug Rehabilitation Order' in 2011.

## Arising issues, comment and analysis

1.24 We have described in detail the range of services Mr CD used. Services were multiple and reflected Mr CD's multiple and complex needs. In summary, the issues for Mr CD appeared to be:

- social – including dysfunctional social networks and difficulty in obtaining stable accommodation;
- substance dependency - physical and psychological dependency;
- mental health and personality disorder and the issue of accessing services; and,
- criminality – as evidenced by his frequent periods in custody for numerous offences including drug offences (in 2004 to 2009), the possession of offensive weapon, going equipped for burglary and assault.

1.25 He received services from:

- MENDOS;
- SMS – including ARM (third sector) and SIT (NHS);
- Community, inpatient and prison mental health services;
- GP surgery – homeless healthcare team;
- Integrated Offender Management, prison and probation services; and,
- Homelessness services.

1.26 Issues identified included:

- information sharing about Mr CD and his needs (variable – MENDOS consistently passed information to the correct professionals; the ARM service reported that it was usual for the prison service not to provide information about risk assessment);
- the complexity of service arrangements, and changes in providers of services, including the probation service; and,
- aspects of the dual diagnosis policy and provision at the time – the interface between mental health and substance misuse services;

- transfer of services from one provider to another, leading to problems with incompatible IT systems, gaps in service provision;
- homelessness, and all the health (physical and mental) related difficulties that homeless people experience. We referred to the Queen's Nursing Institute research (2008) which highlighted poor communications, inappropriate/unsafe discharge, NHS systems not being designed for mobile populations, poor joint working, lack of supported housing, lack of awareness of homelessness services by hospital staff, lack of skills for working with homeless people.

1.27 In relation to risk assessment we were concerned primarily at the reliance on self-reporting process, and in one case, a worker relying on her memory of Mr CD as she had worked with him some years previously. We considered that more could have been done to use more structured and standardised risk assessment tools.

1.28 The events following his discharge from Melbury Lodge raised concerns about the discharge information not reaching the HHCT, in particular the GP, in a timely fashion. Mr CD saw Dr DE on the Wednesday following the Friday when he was discharged, but she had not received any discharge information from Melbury Lodge and she was unable to contact any medical staff on the day. This put her in a difficult position in relation to Mr CD's demands for diazepam. The changeover of junior doctors on 1 August meant that they were all at induction and the consultant was on leave.

1.29 Mr CD had limited contact with mental health services – this included support from the MENDOS workers on two occasions; two weeks of inpatient treatment (although he did spend a lot of time on leave away from the ward); and support from Ms UV, the CMHN based with the HHCT. This support was limited, partly because of the short time between imprisonments, and his unwillingness to engage with the service.

1.30 There was no contact with the families of either Mr Beattie or Mr CD either before or after the incident.

1.31 Mr CD's mother was in contact with him, but both Trusts seemed unaware of this, even though the internal report contains reference to her visiting her son in police custody following the homicide. It was recorded that, on one occasion, he left the ward at Melbury Lodge to spend time with his mother, but there is no record that she visited him on the ward or that staff would have had any opportunity to meet her.

1.32 We think it was reasonable that the Solent SMS did not involve Mr CD's family as he was only in contact with them on two occasions.

1.33 We reviewed the internal investigation report of the 'Root Cause Analysis' (RCA) review of the care and treatment provided to Mr CD. There were originally two, individual Trust reports. The Southampton City CCG (lead commissioner for reviewing the incident) requested that a joint report be produced.

1.34 We concluded that the report had appropriately identified several issues and had produced action plans based on the recommendations arising from their review. We found the report to be more descriptive of what had happened, with less analysis of 'why'.

1.35 We did at times find it difficult to 'follow the story', but attributed this to the complexities of service provision, Mr CD's multiple and complex needs and the fact that two reports had been brought together.

1.36 Several care and service delivery problems and 'lessons learnt' were identified and these were reflected in the 14 recommendations made.

1.37 We reviewed the action plans developed for each Trust and assessed their implementation. We also considered the extent to which the Trusts complied with their serious incident policies.

1.38 We reviewed the Trusts' arrangements for embedding learning and changing practice, and their arrangements for ensuring that the services are accountable for making improvements and managing change.

1.39 The information provided by SHFT, in conjunction with a review of published Board papers, suggests major efforts have been made to adopt a more rigorous and systematic approach to learning lessons and implementing actions arising from SIRIs (Serious Incidents Requiring Investigation) in general and homicides in particular. There is evidence that external homicide reviews are discussed at Board sub-committees; there are processes for learning lessons and taking action; and that assurance is sought and received that actions are implemented.

1.40 For Solent, there are similar governance structures and processes in place to share learning and plans are being developed to monitor action plans. Some changes to the governance structure have been discussed and ratified. This Trust appears to be at an earlier stage of developing robust processes.

1.41 We also reviewed the methods used by the CCGs for monitoring the implementation of action plans. The SC CCG has acknowledged that mistakes were made in following their processes to their conclusion and have taken steps to rectify this.

## Analysis, conclusions and recommendations

1.42 This section includes a summary of our analysis, conclusions and recommendations. All the recommendations are brought together to bring this report to an end. We have tried to avoid replicating recommendations already in the internal report but have built on these where appropriate.

### Good practice

1.43 The HHCT liaised with and updated the SMS during September 2014.

1.44 We commend the efforts made by Ms UV to establish and maintain contact with Mr CD, despite his limited engagement with her. This showed

professional diligence and extra effort which helped in creating a barrier to prevent further loss of contact.

1.45 We acknowledge the efforts of staff at the needle exchange service who remained at work on a Friday evening to try to engage Mr CD whilst waiting for the police to arrive.

## Care and service delivery problems

1.46 We identified a number of care and service delivery problems. These included:

- The late transfer of discharge information to the HHCT, when the GP was left to make decisions about medication without discharge information.
- The failure to complete the box on a form to trigger the referral process.
- Changes in health and substance misuse service providers, different commissioners, different commissioning criteria.
- Confidentiality - the internal investigation report noted that ARM does not share information with GP or family as the service is confidential.
- Inter-agency complexity – communication with the criminal justice system (prison, National Probation Service, Community Rehabilitation Company) as well weaknesses in the operation of the dual diagnosis policy between Solent and SHFT.
- Changes in the structure of the probation service.
- The handover to new junior doctors at Melbury Lodge, and the lack of medical availability after his discharge when Dr DE sought information about his medication.
- IT issues, including the inability of different organisation's IT systems ability to 'talk to each other'.
- Risk assessments relied on self-reporting and the memory of an ARM worker who had previous knowledge of him. Staff had to work without information from the prison service.

## Contributory factors

1.47 We did not identify any factors which contributed to this incident, apart from patient factors. These include:

- Mr CD's personality disorder and possible PTSD;
- his poly-substance misuse and involvement in a drug culture;
- impulsive behaviour/lack of anger control;
- his difficult childhood and upbringing;
- homelessness, locally transient, staying with friends, occasionally with family, at probation service 'approved premises';
- his violence and criminal history – a number of prison sentences which disrupted any attempt by community services to provide continuity and consistency of care; and,
- he only engaged with services when he required practical help, mainly on his own terms.

## Root cause

1.48 We did not identify any root cause(s) for this incident relating to the care and treatment provided to Mr CD. In this we agree with the finding of the joint internal report.

## Recommendations

1.49 We wish to stress that we found no contributory factors in the provision of care and treatment to Mr CD. The recommendations we are proposing are derived from issues arising from our review, and where we consider that improvements to service might be made. These recommendations do not imply in any way that the services to which they relate contributed to the homicide.

1.50 We identified a number of issues where lessons learnt were nationally relevant. We have therefore included recommendations which have national significance (numbers 2, 3, 4, 5, 8, 12) as well as those which focus on local services only (numbers 1, 6, 7, 9, 10, 11).

### Recommendation 1

Solent and SHFT should develop a written service specification to set out clearly the relationship between the homeless health care service and the secondary mental health component, to be reflected in specific job descriptions as part of defining the role and functions. This should be completed by 6 months following the publication of this report and the implementation audited within the following 12 months

### Recommendation 2

Commissioners of specialist services should develop formal service specifications which include protocols for liaison, communication and sharing information with other agencies, including non-health or NHS commissioned agencies, within 12months of publication of this report. Commissioners should ensure that contracts are monitored and evaluated for effective implementation by audit within 12 months of implementation.

### Recommendation 3

When commissioning services, commissioners should begin with client needs analysis and evidence-based pathways: if there are gaps in the services to be commissioned ensure that there are explicitly described, risks are assessed and mitigated. The effectiveness of implementation should form part of the contract monitoring cycle (within circa one year).

### Recommendation 4

Health and Justice specialist commissioners (NHS England and the Ministry of Justice) and commissioners of local services should promote greater collaboration between prison-based mental health and substance misuse services on the one hand and NHS mental health and local substance misuse services on the other. A progress report should be completed and made available to stakeholders at 12 months following the publication of this report

### Recommendation 5

Health and justice specialist commissioners and commissioners of local services should promote opportunities to enable prison officers and prison healthcare workers, (including mental and physical health care) to undertake mental health

screening aimed at making appropriate referrals prior to impending discharge.[4] A progress report reflecting current best practice should be circulated to stakeholders within 12 months following the publication of this report.

Recommendation 6

When any practitioner in SFHT, mental health court liaison services and associated services (e.g. ARM) consider risk history, extra caution needs to be taken in order to avoid over-reliance on self-reporting by the subject of the assessment. Risk information from other sources should be completed and if this is not possible a reason should be given. The Trust(s) and any other agencies should audit risk histories on an annual basis to ensure compliance, and follow up any non-compliance in supervision.

Recommendation 7

SHFT should continue to ensure that discharge summaries are sent electronically and should consider the option of reintroducing a Part A initial discharge summary to help ensure General Practitioners receive information about medication promptly. This should be completed within 6 months of publication of this report and Implementation should be audited no later than 6 months later.

Recommendation 8

SHFT should seek to ensure that all healthcare staff (but especially medical staff, who in many cases are at the centre of ongoing treatment planning for a service user) fully document, on RiO, leave/discharge plans including those plans most central to the continued treatment and coordination of care of the service user - for example, the medication regime. The Trust should audit the completion of leave/discharge plans on RiO by medical and other healthcare staff at 12 months after publication of this report.

Recommendation 9

When commissioning and re-commissioning services, local commissioners should ensure that contracts consider the potential impact of non-compatible IT systems, carry out a gap analysis and risk assessment and mitigate any risks identified. Assessment and mitigation of any risks arising from new contracts entered into by local commissioners which involve incompatible IT systems should be monitored prior to implementation.

Recommendation 10

Solent and SHFT must ensure that the Duty of Candour policy and procedures are followed in cases where a service user commits a homicide, and that actions taken under this duty are accurately recorded. Compliance should be audited within 3 weeks of any homicide being identified and reported to the Trust.

---

[4] See also a similar recommendation from another homicide investigation: "The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services." 'An independent investigation into the care and treatment of P in the West Midlands', NICHE, June 2017 Recommendation 15, p.24

Recommendation 11
Solent NHS Trust and CGL to work together to monitor the effectiveness of the screening element within the mental health assessment and space for an account of mental health service involvement. A report on progress towards this monitoring to be shared with stakeholders 6 months following the publication of this report.

Recommendation 12
The Trusts should jointly carry out an audit of the Dual Diagnosis policy within 12 months from the publication of this report, to evaluate its effectiveness in addressing the issues raised in this report and the internal investigation report.

Recommendation 13
We recommend that, where a service user who is involved in a homicide (or other SIRI) is receiving services from more than one NHS Trust, that a joint investigation should be carried out by those Trusts. NHS Improvement should include guidance to this effect in their review of the Serious Incident Framework. A progress report should be published within 6 months of the publication of this report.

# 2 Offence[5]

2.1 On 20 March 2015, Mr CD killed Mr Nick Beattie during a struggle over drugs. Mr CD was aged 38 years at the time of the offence. Mr Beattie had won money from betting in the morning and had met Mr CD later. Mr CD believed that Mr Beattie had not given him his fair share of the drugs they had purchased. This struggle took place in a flat lived in by a third drug user. A fourth drug user was also present. During this struggle, Mr CD punched, kneed and elbowed Mr Beattie. Possibly with the help of others, Mr CD dragged or carried Mr Beattie into the street, left him there and then left the scene. An ambulance was called and Mr Beattie was certified dead.

2.2 Both Mr CD and Mr Beattie were addicted to drugs and both had taken heroin and crack cocaine before the fight. They had both been homeless and used the same services (day centre and accommodation) for homeless people. They had been in the same place a couple of times before 20 March 2015 but had not spoken before that day. Mr Beattie was aged 32 years had mild learning disabilities, a disability in one arm and hearing loss. He had made attempts to come off the illegal drugs but this had not been successful by the time of the incident. He was described as a vulnerable and engaging young man.

2.3 Mr CD was similarly addicted to heroin and crack cocaine, had spells of being homeless and a long history of violence offences and imprisonment. He was known to become violent when taking drugs and had been moved from one prison to another because of his difficult to manage behaviour. He had been released from prison on 13 March 2015 and had spent the night before the

[5] Information taken from the Judge's summing up and sentencing remarks.

homicide[6] staying at his mother's house. He travelled to Southampton to seek help in finding accommodation.

2.4 The prosecution accepted that Mr CD did not intend to kill Mr Beattie. However, his assault on Mr Beattie on 20 March 2015 led to fractures to his ribs which punctured one lung. This alone was unlikely to have been sufficient to kill Mr Beattie but did so in conjunction with the amount of heroin in his system[7].

2.5 Mr CD was convicted of murder by a unanimous jury verdict on 8 March 2016. He was sentenced to life imprisonment and to serve a minimum of 13 years before he could be considered for parole.

# 3 Independent investigation

## Approach to the investigation

3.1 NHS England (London) commissioned Caring Solutions (UK) Ltd to carry out this independent investigation, in line with the Serious Incident Framework[8]. The Framework aims to facilitate learning by promoting a fair, open and just culture that does not use blame as a tool. It promotes the belief that an incident should not simply be linked to the actions of individual staff involved but rather to the system in which the individuals were working.

3.2 The independent investigation follows the Department of Health guidance HSG (94) 27, on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The guidance for commissioning an independent investigation is:

> "When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach, or is under the care of specialised mental health services, in the 6 months prior to the event."

3.3 The main purpose of an independent investigation is to discover whether there were any aspects of the care, which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

3.4 The terms of reference for this investigation are given in full in Appendix B.

---

[6] Homicide is the killing of one human being by another.

[7] In normal circumstances, the human body may be able to compensate for a punctured lung by breathing more rapidly. However, heroin depresses the body's systems and therefore for Mr Beattie this compensation did not happen.

[8] NHS England (2015) Serious incident Framework: Learning lessons to prevent recurrence

## Purpose and scope of the investigation

3.5 The purpose of this investigation is to examine the care and treatment of Mr CD and to identify whether there were any gaps or deficiencies in the care and service provided. The investigation will identify if the incident could have been predicted or prevented and will identify if there are any areas of best practice, opportunities for learning and areas where improvement to services could help prevent similar incidents from occurring.

3.6 The overall objective is to identify risks and possible opportunities to improve patient safety with the Trust; and, where appropriate, to make further recommendations about organisational and system learning. Any recommendations are implemented through effective action planning and monitoring by providers and commissioners.

3.7 We also concluded whether we considered the homicide to be either predicable or preventable[9].

## Investigation Team

3.8 The investigation was carried out by suitably qualified and experienced investigators appointed from Caring Solutions (UK) Ltd. The team consisted of:

- Mr Tony Thompson (Panel Chair and Lead Investigator);
- Dr Martin Lawlor (Independent Consultant Psychiatrist) for Caring Solutions (UK) Ltd;
- Ms Pam White, Lay Member; and
- Ms Maggie Clifton (Investigations Manager).

3.9 Brief details of the investigation team are included in Appendix D. The investigation team will be referred to in the first person in the report.

3.10 Dr Colin Dale, Chief Executive, Caring Solutions (UK) Ltd quality assured the process of carrying out the investigation and the report.

## Methodology

3.11 The investigation was carried out in accordance with the NHS England Serious Incident Framework (2015) and the National Patient Safety Agency (NPSA) guidance[10].

3.12 Root cause analysis (RCA) methodology has been used to examine the information supplied for the investigation. This approach is chosen because it aims to look at the role of the systems in place in care and service delivery,

[9] Definitions can be found in Section 6.

[10] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services.

rather than looking solely at the role and functions of individuals. The panel recognise the limitations of this approach and the RCA process is considered later in this report. Whilst it is likely that no single root cause for such an event can be identified, the procedure assists in identifying a range of contributory factors which may have increased risks. One of these may be accountability for professional actions or lack of them.

Panel consideration

Given the complexity of the nature of Mr CD's mental health problems and the degree to which they were manifest at specific times in his life, the context of professional help and interventions differed considerably. We are aware that it is unlikely that a single root cause based on RCA procedure would be identified. Whilst the process of RCA is useful in our examination, we are mindful of weaknesses in the method based on published work[11]. This work describes the modification of the 'Human Factors Analysis Classification System' based on James Reason's theory of causation for use in healthcare. This was helpful in our analysis as it resolves some difficulties of RCA, including:

- The use of RCA is neither standardised nor reliable between organisations.
- The emphasis tends to be on 'who' did 'what' rather than 'why' errors occurred.
- The identifiable causes are often nonspecific to develop actionable plans for correction.
- Standardised nomenclature does not exist which would allow accurate analysis of recurring errors across the organisation.

3.13 We used the RCA process to collect information and reconstruct the particular events through asking questions during interviews. We were able to identify any latent features within the services which may have adversely affected risk management.

3.14 Where appropriate we have referred to national and local policies and standard guidelines, to Department of Health (DH)[12] best practice guidelines and National Institute for Health and Social Care Excellence (NICE) guidelines.

3.15 We were aware of the need to reduce hindsight bias. The information we relied upon was in the main available to the service at the time. However, where outcome or hindsight assisted us in forming an opinion this has been recognised[13].

[11] Diller, T Helmrich G and others, (2015) 'The Human Factors Analysis Classification System (HFACS)

[12] DH (March 2008) Refocussing the Care Programme Approach: Policy and Positive Practice; and Code of Practice Mental Health Act 1983 (revised 2009).

[13] Hindsight bias is when actions that should have been taken at the time leading to the incident seem obvious because the facts have become clear after the event (NPSA, 2008)

3.16 We interviewed the following people:

- Ms EF, (Manager, Hampshire Liaison and Diversion Service, SHFT).
- Ms KL, (Crisis Pathway Manager, Adult Mental Health Services, SHFT).
- Professor GH (Interim Clinical Director, Southampton Adult Mental Health Service, SHFT).
- Ms IJ (Area Manager, Southampton Adult Mental Health Services, SHFT).
- Mr MN (Acute Transition Facilitator, SHFT).
- Mr OP (Bed Manager, SHFT).
- Ms QR (Ward Manager, SHFT).
- Dr ST (Consultant Psychiatrist, SHFT).
- Ms UV (CMHN and care coordinator).
- Ms WX (Nurse consultant/HHCT, Solent).
- Ms YZ (Business Manager (HHCT), Solent).
- Mr BC (Operations Manager, Mental Health and Substance Misuse Services, Solent).
- Dr DE (GP, HHCT, Solent).

3.17 We would have liked to talk to the following people, but they were not available to invite to interview.

- Dr FG - prescribing doctor, Structured Intervention Team (SIT) – retired.
- Ms HI - needle exchange service manager – left the Trust.
- Ms JK - SMS manager – retired.
- Ms LM - Solent report author – left the Trust.
- Dr NO - SHFT report author – on sick leave.
- Ms PQ - MENDOS worker – left the Trust.

However, despite this lack of opportunity to obtain their views, we did not consider this to have led to any material gaps in this overall review – relevant information was provided by other individuals.

3.18 We exchanged communications with Ms RS, Associate Director of Quality for Southampton City CCG, regarding the system and processes for reviewing the incident and monitoring implementation of the action plan. She and her colleagues provided relevant documentation and commented on a draft of the section about their incident review process.

3.19 We approached two external organisations for assistance with this investigation:

- The Hampshire and Isle of Wight Community Rehabilitation Company who supervised Mr CD in the community. We received valuable written information about his contacts with the probation service and their management of him.

- ‘Change, Grow, Live’ a third sector organisation which provides the ‘Assessment Review and Monitoring’ element of the Substance Misuse Service. This service was provided to Mr CD by ‘Crime Reduction Initiative’ (CRI) which has since changed its name to ‘Change, Grow, Live’. This organisation did not respond to our requests. Information from this organisation might have contributed to a more rounded review. We did not consider that their failure to respond resulted in any material gaps in our review and conclusions as we were provided with information by other agencies.

3.20 We reviewed the following paperwork:

- Mr CD’s clinical records (electronic and paper copy records, from both Trusts);
- Solent policies and procedures:
  - Serious Incidents Requiring Investigation (SIRI) policy, 2013 and 2016;
  - Reporting adverse events policy, 2016;
  - Clinical risk assessment and management, adult mental health services, 2016;
  - Risk management strategy, 2015; and,
  - Policy for investigation, analysis and learning from complaints, incidents and claims, 2013.
- SHFT policies and procedures:
  - Clinical engagement/did not attend (in place at the time of the incident and updated version);
  - Incidents management policy (in place at the time of the incident and updated version);
  - Procedure for the management of serious incidents requiring investigation, version 1, 2014 and version 2, 2016;
  - Clinical risk assessment and management policy (in place at the time of the incident and updated version);
  - Admissions, transfers and discharges policy;
  - MENDOS operational policy (in place at the time of the incident – this service no longer exists);
  - Hampshire and Isle of Wight Liaison and Diversion policy (this service did not exist at the time of the incident: this is the current policy for this service);
  - Dealing with the suspected possession of illegal substances by inpatients (in place at the time of the incident and updated version);
  - Physical assessment and monitoring procedure for mental health and learning disabilities (in place at the time of the incident and updated version);
  - Dual Diagnosis policy - mental health problems and substance misuse (in place at the time of the incident and updated version).
- Southampton City CCG Serious Incident Policy: Supporting learning to prevent recurrence (2015).
- We also reviewed current research, national guidance and examples of good practice.

## Structure of the report

3.21 Section 4 sets out the details of the care and treatment provided to Mr CD. We have included a full chronology of his care at Appendix C in order to provide the context in which he was known to services in Southampton and Portsmouth.

3.22 Section 5 examines the issues arising from the care and treatment provided to Mr CD and includes comment and analysis. This section is linked to the terms of reference which NHS England set for the investigation.

3.23 Section 6 provides a review of the trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

3.24 Section 7 reviews the monitoring by the relevant CCGs of the Trusts' implementation of their action plans.

3.25 Section 8 sets out our overall analysis and recommendations.

## Involvement of Mr CD, members of his family and members of the victim's family (ToR 5)

Establish appropriate contacts and communications with families/carers to ensure appropriate engagement with the independent investigation process.

3.26 Despite the best endeavours of NHS England, neither Mr CD nor members of his family responded to their invitation to them to participate in this investigation.

3.27 NHS England did speak to Mr Beattie's sister and sent her information about the investigation and its terms of reference, but she later informed us that she did not recall the telephone conversation and had not received the written information. After the investigation had concluded, a representative of a 'hundred families'[14] found contact details for a brother, passed these on to NHS England who made contact and arranged for us to meet them and for them to comment on the report. We met with Mr Beattie's sister and two brothers who did wish to meet us and would have responded positively if they had received the invitation to do so. We have made revisions to this report in light of their feedback.

# 4 The care and treatment of Mr CD

## Childhood and family background

4.1 In July 2014 a detailed history was taken at Melbury Lodge, including his family and social circumstances.

[14] A 'Hundred Families' was set up by its founder following the murder of his father by a man with a history of mental illness. It is a registered charity which provides practical information for families affected by mental health homicides in Britain, provides training for healthcare professionals and carries out research. They also provide a service to relatives of victims which is commissioned by Victims Support. Further information can be found at Hundred Families

4.2 Mr CD was born in 1977, and was recorded as having a disordered childhood and adolescence. He reported that his biological father was substance dependent, and had died of an overdose in about 2000. Mr CD had little contact with his father.

4.3 His step-father had abused him 'physically and mentally' between the ages of five and 16 years (when he left home). He reported a history of suicide in his family. Mr CD reported that this left him with ongoing anxiety.

4.4 While these events are recorded, there is no corroborating evidence for this information.

4.5 He continued to have occasional contact with his mother, including during his hospital admission in July 2014 and after his release from prison in March 2015.

## Education and employment

4.6 Mr CD left school at 15 years of age, without qualifications. He was excluded for violent behaviour on occasions.

4.7 An assessment in 2014 notes that his last employment was as a bricklayer in 2012. Since then he had been either in prison or homeless (staying with friends, occasionally with his mother and in hostels).

## Relationships

4.8 The clinical records include reference to a former partner, but no further information is available. Mr CD was discussed at a Multi-Agency Risk Assessment Conference (MARAC)[15], regarding violence towards a partner, but no further information was available and no action was taken. The violence was recorded as 'mutual' in a risk summary completed in July 2014.

4.9 There is nothing in the record to suggest that Mr CD was in a relationship at the time of the incident.

4.10 Self-reported information in the clinical records is inconsistent. On one occasion Mr CD reported he had a daughter, but did not know her name or age. He was not in contact with her or her mother. On another occasion the record does include her name and age.

## Psychiatric and substance misuse history

4.11 This section contains a summary of Mr CD's contacts with mental health services (provided by SHFT) and substance misuse services (provided by SHFT prior to 1 December 2014; and provided by Solent from 1 December

[15] MARAC is a regular local meeting to discuss how to help victims at high risk of domestic violence or abuse. These meetings include relevant agencies such as domestic abuse specialists, children's services, health, housing, and police. The focus is on sharing information to create an action plan for each victim.

2014). Details of these services are provided in Appendix E. Full details of Mr CD's contacts with these services are provided in the chronology in Appendix C.

4.12 Mr CD was in contact with a range of services between the first recorded contact on 9 February 2011 and 23 March 2015, immediately following the incident on 20 March 2015. His contacts were erratic, due to him not engaging with services and having a number of admissions to prison.

4.13 He was seen by staff from the mentally disordered offenders service (MENDOS) whilst in police custody on 9 February 2011. The outcome was a referral to the prison mental health team, where he was assessed by Dr AF who concluded:

- diagnosis - Anti-social personality disorder (ASPD);
- alcohol dependence;
- harmful use of heroin and crack cocaine;
- possible Post Traumatic Stress Disorder;
- victim of two serious assaults (December 2010 and January 2011), reporting panic attacks, anxiety and palpitations when outside.

4.14 Further contacts with MENDOS workers resulted in referrals to the prison mental health service and to the custody and prison drug services.

4.15 The next recorded contact was in January 2012 when Mr CD was living in a probation service hostel. Staff were concerned about his mental health and his GP referred him for an urgent mental health assessment. Mr CD did not attend the appointment – the mental health team ascertained that he was back in custody. They discharged him from their caseload and faxed the GP referral letter to the prison mental health team.

4.16 On 27 August 2013, there was a record that Mr CD had been discussed at a MARAC. Limited information was available and the conference had concluded that no further action was required.

4.17 In December 2013 he was known to be in police custody. There are no entries in the mental health clinical record between 20 December 2013 and 19 July 2014.

4.18 However, on 9 July 2014, it was recorded that Mr CD presented to the substance misuse service (then provided by SHFT) on release from prison. A non-medical prescriber completed a detailed medical assessment. A drug screen was positive for cocaine, methadone[16] and morphine. He was also prescribed a morphine based pain killer for pain resulting from an assault when he was subject to a knife attack which caused nerve damage to his back. He had a history of poly-drug misuse beginning when he was 15 years of age.

[16] Methadone is an opiate substitute, which can be prescribed to help people stop taking drugs such as heroin. It can help to reduce or prevent unpleasant withdrawal symptoms, if users wish to stop taking heroin.

4.19 On 19 July Mr CD presented to the reception of Antelope House[17] where he was assessed by members of the Access and Assessment Team (AAT). He stated he had been in prison for possession of a bladed article and had left prison seven days previously and was feeling suicidal. He was assessed as being a high risk to himself and a low to medium risk to others. He agreed to an informal admission for further assessment and treatment. A bed was found at Melbury Lodge[18] as there were no vacancies at Antelope House.

4.20 Between 19 July and 1 August 2014 Mr CD was an inpatient in Melbury Lodge, where his mental health and risks were assessed and his behaviour was observed on the ward. He was prescribed methadone, diazepam, and zopiclone[19], and was assessed by a senior psychologist who concluded that no specific psychological work was appropriate at that time. He completed a 'recovery plan' with a member of the ward staff. During this time nursing staff reported that he was calm, cooperative and his stay was without incident. He had been given unescorted leave on 11 occasions, again with no reported incidents.

4.21 Mr MN, the 'Acute Transition Facilitator', spent some time on the telephone prior to Mr CD's discharge trying to sort out accommodation, support from the substance misuse service and from the HHCT in Southampton. The homelessness service (provided by the City Council) offered to (and did) provide money to Mr CD for a deposit on a privately rented flat. Information about his discharge and medication was faxed by Mr MN to the needle exchange service (this fax did arrive) and the HHCT GP (this fax did not arrive with the GP prior to her seeing him on 6 August 2017) on the day he was discharged. He was to be provided with medication (diazepam and zopiclone) for 5 days following discharge.

4.22 His consultant, Dr ST, saw him on 30 July 2014, when he assessed Mr CD as not having a mental illness, but addiction to methadone and diazepam. He had no intention to stop using these drugs or engage in therapeutic work so Dr ST concluded that there was no reason to continue his hospital stay and discharged him on 1 August 2014.

4.23 Mr CD was discharged as agreed, and the planned services were put in place. He stayed with friends over the week-end before going to the Street Homeless Prevention Team (SHPT) to seek private rented accommodation. Medication was provided or prescribed to meet his needs until he could see the SMS on the Monday and a GP during the week. He met Ms UV (CMHN) at the HHCT for mental health follow up, assessment and any required support.

4.24 Between 4 August and 2 September 2014 Mr CD was under the care of the HHCT where he was seen by Ms UV and Dr DE (GP). He saw Dr DE on 6

[17] Antelope House provides acute inpatient services and is in Southampton

[18] Melbury Lodge provides acute inpatient services and is in Winchester.

[19] Diazepam is a benzodiazepine, a group of drugs prescribed to reduce anxiety which also have addictive qualities; and zopiclone is a sleeping tablet, used to treat insomnia.

August. Mr MN's discharge fax had not arrived with Dr DE so when Mr CD demanded diazepam because the hospital had said that his medication 'would not be messed with' she had no information as to whether this was to be a maintenance or reducing dose. Mr MN's fax contained basic information about his medication (drugs and dosage), but no plan for managing this into the future. We were unable to identify why this fax did not arrive with the GP. Dr DE rang Mr MN for further information about his medication regime, particularly around the continued use of diazepam. No medical staff who knew the details of the medication were available and Mr MN could find no information on the RiO notes as to whether this should be a reducing or maintenance dose. Consequently, Mr MN was unable to help Dr DE regarding the plan for the diazepam prescription.

4.25 Mr CD was annoyed and Dr DE was compromised: Dr DE prescribed some diazepam with the expressed intention of rapidly reducing the dose. In fact, the discharge summary, completed by a junior doctor and faxed to the HHCT on 5 August 2014 stated clearly that the GP was not to continue to prescribe diazepam and that any further supply of diazepam was to be managed by the 'Community Treatment Team'. (Mr CD had been discharged from hospital with 5 day's supply of diazepam.) This summary should have arrived with the GP within 24 hours but was delayed, because of the handover between junior doctors on 1 August 2014. The summary also records the risk both to self and to others as 'none currently' although historical risks of both were recorded.

4.26 Information from both the SMS and SHPT reported to Ms UV indicated that he was anxious and feeling low. Between 6 August and 3 September 2014, Ms UV tried to telephone Mr CD on seven occasions but his telephone was switched off. One appointment was made for him to see the CMHN but he did not attend.

4.27 On 3 September 2014 Mr CD was in police custody and was later sentenced to 14 months imprisonment, with further criminal charges pending. Whilst in prison information about his history and medication was exchanged between the offender management team and Ms UV.

4.28 On 13 March 2015 Mr CD was released from prison and seen by a worker from the ARM service (Ms EP). She referred him to the Structured Intervention Team for methadone prescription and he was to be seen by Dr FG. Ms EP noted that Mr CD was interested in residential detoxification and rehabilitation. Ms EP was to prepare the paperwork. Ms EP arranged a further appointment with Mr CD on 24 March 2015, by which time he was in custody in relation to the death of Mr Beattie.

4.29 On the same day, Mr CD was seen by Dr FG from the SMS who completed a detailed medical assessment. She recorded a diagnosis of personality disorder and opiate dependency and prescribed a reducing dose of methadone to be changed to subutex[20].

[20] Another drug to treat heroin dependence – it works by reducing the severity of withdrawal symptoms.

4.30 On 20 March 2015 in the late afternoon, Mr CD attended the needle exchange service to collect injecting equipment. He told Ms HI, needle exchange manager that he was planning to kill himself, he was homeless, some family members were or had been addicted to drugs or alcohol and he had been abused all his life. Ms HI rang her manager who came to talk to Mr CD whilst Ms HI contacted the police and an ambulance. After about an hour, Mr CD left the building.

4.31 On 23 March 2015 Ms PQ from MENDOS, on a routine visit to the police station, was informed that Mr CD had been arrested in relation to murder and other offences on 20 March 2015. Having seen Mr CD, she advised the custody sergeant to contact the drug arrest worker and informed him that Mr CD had reported feeling suicidal. After Mr CD was charged and remanded in prison, Ms PQ informed the prison CMHT of his high suicide risk and substance misuse issues.

4.32 On 23 March 2015 the SMS clinical team meeting noted that Mr CD was in custody in connection with a death and was receiving his methadone in custody. On 24 March 2015, Ms ED noted that Mr CD was in custody for alleged involvement in a death. His case was closed due to the severity of the offence.

## Contact with criminal justice system

4.33 Mr CD had an extensive history of violence offences and had been sentenced to imprisonment on a number of occasions, commencing in 1996. His violence continued when he was in prison, he claimed he was 'provoked' by prison staff.

4.34 There is some information about his criminal behaviour in the clinical records, although we do not have a full forensic history. Additional information was provided by the National Probation Service (NPS).

4.35 It was recorded (SMS medical assessment, 9 July 2014) that he had previous convictions for:

- property offences;
- assault;
- supplying drugs.

4.36 2004 to 2009: Mr CD served a prison sentence, having been convicted of several offences, where he completed a RAPt[21] course. This was the longest period when he was abstinent from drugs.

[21] RAPt is a charity committed to preventing crime and destructive behaviour, and helping people reach their potential. As well as other services, RAPt provides intensive abstinence-based drug and alcohol rehabilitation programmes. They provide high-quality drug and alcohol services to over 15,000 people every year within the criminal justice system, including prison, and in the community. Further information is available at the RAPt website.

4.37 9 February 2011: Mr CD was arrested for possession of an imitation weapon with intent to endanger life. He was remanded in custody and a Crown Court hearing was set for 5 April 2011.

4.38 9 February 2011: Ms PQ noted that Mr CD was subject to a Drug Rehabilitation Requirement[22] (DRR) and was being supervised by a probation officer (PO). There is no information about the sentence that this requirement was part of, nor the specific offence, nor the length of the sentence/DRR, nor when it commenced.

4.39 There is nothing further in the records to indicate when he was released.

4.40 6 February 2012: a prison mental health inreach team requested information from the Osborn Centre (Adult Mental Health CMHT).

4.41 He was known to be in custody on 27 August 2013 but there is no information as to why, where or for how long.

4.42 He was released from custody on 20 November 2013.

4.43 On 9 December 2013: Mr CD was in police custody for the alleged offence of possessing an offensive weapon and going equipped for burglary, at magistrates' court. He was remanded in custody to the Crown Court with a hearing scheduled for 7 January 2014.

4.44 On 9 July 2014 Mr CD was released from prison, having served 7 months. He was managed by the Hampshire and Isle of Wight Community Rehabilitation Company (CRC)[23] on release.

4.45 On 20 July 2014, Mr CD was admitted to Melbury Lodge in Winchester. At his request, staff at Melbury Lodge informed his Probation Officer (PO) that Mr CD was in inpatient there.

4.46 Prior to Mr CD's discharge, Mr MN informed the PO of the date of his discharge and of a 'working diagnosis 'of personality disorder. Following his discharge from Melbury Lodge, Mr CD did not attend probation at the required frequency. This led to the warning process – he only attended on three occasions before being recalled for a further offence.

4.47 Mr CD was moved to the management of the NPS because of the increase in level of assessed risk.

4.48 On 4 September 2014 Mr CD was sentenced for assault to 14 months' imprisonment, giving an earliest date of release of 15 February 2015.

---

[22] Drug Rehabilitation Requirements were introduced for offences committed after 4/04/2005. DRRs could be part of a Community Order or a Suspended Sentence Order. The DRR requires an offender to comply with an agreed drug treatment regime.

[23] In 2014 responsibility for supporting and monitoring offenders assessed as 'low' to 'medium' risk was transferred from the (public sector) Probation Trusts to private sector companies. Offenders classed as 'high' risk are supervised by the National Probation Service which remains part of the public sector.

However, there was a further case pending against him and that date was extended by a further month.

4.49 The probation service assessment of his history was that he would be high risk of committing further harm, based on 'an extensive pattern of violent offending involving weapons and the serious use of violence to partners, the public, known drug using associates'.

4.50 13 March 2015 Mr CD was released from prison.

4.51 20 March 2015 Mr CD was arrested in connection with the death of Mr Beattie.

# 5 Arising issues, comment and analysis

5.1 We addressed the following issues – these are as set out in the terms of reference. To aid the reader, we have identified which of the Terms of reference (ToR) each section relates to, and included the full requirement under the heading.

## Care pathways and information sharing (ToR1)

Review the care pathways and information sharing processes between the range of teams identified in the joint internal investigation (i.e. Homeless Health Care Team, Antelope House (Acute Care Unit, Southampton), the Prison Mental Health team HMP Winchester, Integrated Offender Management Team, GP, Substance Misuse service, Melbury Lodge, Mentally Disordered Offenders Service, Solent NHS Trust Substance Misuse, Assessment, Review and Monitoring service, Crime Reduction Initiative and the Structured Intervention Team against existing) provider policy and national best practice.

5.2 This section details a review of the care pathways between February 2011 and March 2015 in relation to the care and treatment of Mr CD. It is apparent that Mr CD had contact with numerous and different agencies and professionals during this time. Additionally, these came from various sectors of public services, mental health, housing, primary care and criminal justice services. The key themes from this review are examined.

### The services and professionals involved in the care of Mr CD

5.3 In order to understand the pathways and the treatment provided to Mr CD during this time period, it is necessary to appreciate the numerous agencies and professionals who had some level of contact and involvement with Mr CD and the following services have been identified as engaging with Mr CD.

5.4 In summary, the issues for Mr CD appeared to be:

- Social – including dysfunctional social networks and problems obtaining stable accommodation;
- Dual Diagnosis;
- Substance dependency - physical and psychological dependency;

- Mental Health and Personality Disorder and the issue of accessing services;
- Criminality – as evidenced by his frequent periods in custody for numerous offences including drug offences (in 2004 to 2009), the possession of offensive weapon, going equipped for burglary and assault.

5.5 His multiple issues and problems translated into his dependency on different services in response to specific need at various times, such as housing or medication.

5.6 These services and a summary of their input with Mr CD are described below.

| Service | Organisation | Involvement with Mr CD |
|---|---|---|
| Mentally Disordered Offender Service (MENDOS) | SHFT | MENDOS workers were in contact with Mr CD on two occasions, when he was in police custody |
| Prison CMHT | SHFT | Mr CD was referred to this service but the team did not work with him as he was assessed as not suffering from mental health issues |
| Integrated Offender Management Team | Hampshire Probation Service | This included provision of hostel accommodation in 2013 |
| Adult CMHT (Osborn centre) | SHFT | Accepted an urgent referral from the GP but did not see Mr CD who was in custody |
| Primary care – GP | Independent GP | The GP referred Mr CD to adult mental health services in 2012 |
| Southampton Homeless Healthcare Team, including GP services and CMHNs | Solent/SHFT | GP involvement re medication<br>Attempted assessment of mental health state in 2014 and prior to the offence |
| Integrated Offender Management | Hampshire Probation Trust; NPS/CRC from 2014). | Limited information is available, but contacts included accommodation and supervision, including a DRR. |
| Acute inpatient services including the AAT, Antelope House and Melbury Lodge | SHFT | 19 July to 1 August 2014 |
| Southampton Drug and Alcohol Recovery Service (included ARM, SIT, needle exchange) | Services provided by SHFT, Solent and CRI which were commissioned by Southampton City Council | Involvement with Mr CD, included access to the needle exchange service; assessment at the ARMS service following release from prison; prescription of methadone |

| | | |
|---|---|---|
| Prison Drug Team | SHFT | Specific interventions with Mr CD including group work. No details available. |
| Needle exchange service | SHFT/Solent | Attended on day of offence and documentation would suggest that he had had previous contact with the service |
| Housing services including street homeless prevention team. | Southampton City Council | In addition to helping with bonds for privately rented accommodation, the services had intermittent involvement with Mr CD and at times when he came out of prison |
| Two Saints Day Centre | A not for profit organisation which provides practical help such as food, clothing showers, and support. | The HHCT is situated in the same building |

5.7 It is evident that numerous services had knowledge of and engagement with Mr CD from 2011 until his arrest for the offence in 2015. These services had varying and often inconsistent involvement with Mr CD. There was no process for establishing an 'overall' professional lead in terms of either ensuring his treatment was 'co-ordinated' nor that one organisation was in a position to be the lead service in this respect. The complexity of the system of multiple agencies for managing such individuals as Mr CD with his equally complex and multiple needs is a significant factor in understanding the context of any care provision.

5.8 Attempts were made to contact and engage with Mr CD but these were not sustained, mainly due to the actions of Mr CD and his involvement with the criminal justice system. Given the chaotic lifestyle and his communication with services, it would be beneficial to examine how information is shared, who decides the process and what information is detailed. Information sharing is addressed in paragraphs 5.21 to 5.29. The role of probation has been described below and in Appendix E. Whilst we did not have information directly from the ARM service, Solent staff we did speak to confirmed the information in the internal report, that 'the ARM service was not sent any current or historic risk information from the prison'. Staff reported that this is always the case and that they also had not asked for further risk information. We concluded this was a problem for service delivery as it may contribute to weakening effective inter agency working.

## The roles, functions and commissioning of Services

5.9 Multiple organisations operated with different processes and procedures including information on risk assessments and interventions, contact and referrals to other services. Consequently, multiple professionals were involved, each overseeing a specific aspect of care or intervention.

5.10 There are specific issues around the separation of functions and providers between services e.g. drug service and the governance of services. Of particular note is the separate systems and structures including contracts and different commissioners for these services. For example, CRI (now CGL) runs the ARM service which Southampton City Council – Public Health commission. Southampton City Council – Public Health also commission services from Solent. ARM and Solent SMS have different contracts and different roles and responsibilities.

5.11 The commissioning landscape has become more complex as a result of organisational and system changes, including the divisions between public health (part of the local authority since 2013) and their role as commissioners of, for example, drug and alcohol services; and the establishment of Clinical Commissioning Groups (CCGs) and NHS England in commissioning specialist services. Further changes continue as highlighted by the move towards more integrated social and health provision and new ways of working. The commissioning of and the criteria for accessing these services has relevance for the extent which they were or could be involved with Mr CD.

5.12 Other organisations such as the probation service have also been subject to change and reorganization during this period (detail in Appendix E). This included creation of the National Probation Service (NPS), working with 'high risk' offenders, and Community Rehabilitation Companies (CRCs), working with 'low' and 'medium risk offenders.

5.13 The evidence examined indicates that Mr CD was assigned probation support that would provide an overview of his engagement and compliance with any requirements (such as drug testing). Mr CD was subject to various prison sentences, with varying lengths of detention which would determine the support and supervision provided by the probation service as indicated above. It is useful to examine how the interface between the systems collaborate in assessing and managing the risks posed by Mr CD. Consideration, therefore, is required in terms of how this provision links in and provides further coherence in managing the factors and issues facing Mr CD upon release from his prison terms. There does not appear, however, that there was a systematic and formal approach at the time of Mr CD's release in co-ordinating a response to the issues presented. This seems to be more a system issue rather than specific professional communication and liaison issues.

5.14 The above overview puts in context the system pressures evident in health, social and voluntary sector in addition to criminal justice, during the period that Mr CD was involved with services. This would also incur significant changes in personnel and operating procedures. The difficulty of engaging and working with such individuals as Mr CD cannot be underestimated; however, it is best practice that there are systems and processes in place to

ensure that all relevant professionals are aware of and work with a consistent approach.

5.15 We examined a key area around the roles and responsibilities along this pathway and the identification of who was responsible for what part or action, including clarity around the term 'care coordinators' and what in practice this meant in the care of Mr CD.

5.16 The professionals involved in providing the services have been identified as:

- CMHNs, practice nurses including care coordinator in the HHCT;
- GP in HHCT;
- Southampton Access and Assessment Team Worker;
- Acute Care Transfer Facilitator;
- Acute inpatients staff – consultant psychiatrist/junior doctors/nurses/psychologist/OT;
- Housing co-ordinator Integrated Offender Management worker
- Integrated drug team worker (prison);
- Mentally disordered offender service practitioner (custody);
- Street Homelessness Prevention service worker;
- Needle exchange service manager;
- Assessment, Review and Monitoring – ARM assessor (CRI);
- Structured Intervention Team (Solent), Prescribing Doctor. No key worker at this service was identified.

5.17 Although the term is the same, Mr CD did not have a 'care coordinator' as described in the CPA[24]. We recognise that, given the nature of his lifestyle and intermittent involvement with health and voluntary services, to adopt a cross-service and multi-disciplinary co-ordinated management plan would have been difficult to formulate and implement.

## Procedures, policies and standards

5.18 The policies and procedures to assist the staff in managing the care pathways were specific to each organisation. Reference was made to a Dual Diagnosis pathway which at the time of the incident did not appear to be fully integrated or implemented in practice (as acknowledged in the internal investigation report). Additionally, it is unclear what formal arrangements were in place at the time to manage those individuals who cross organisational boundaries.

5.19 We reviewed all policies provided and scrutinised the following in detail, as being the most relevant to our investigation**:**

- Dual Diagnosis Policy (SHFT);
- Incident Management policies (SHFT and Solent);
- Serious Incident Management policy (Southampton City CCG).

[24] Within the HHCT Ms UV was described as a 'care coordinator'. However, we note that Mr CD was not subject to the CPA. .

5.20 The policies were clear in instructions and outline actions to be taken by professionals involved in the services. It is not clear how organisational policies were shared with other related services, or how the individual services ensured that practices and information are shared. Again, this refers to the commissioning and the contract management of these services, often under the remit of different commissioners and commissioning bodies (Service Delivery Problem). We consider that this aspect may contribute to a weakening of effective communication and continuity of service delivery.

## Information sharing

5.21 In order to ensure a consistent approach when providing interventions and engaging with any service user, it is important that the services and professionals involved have some mechanism by which to share key and relevant information.

5.22 In reviewing the documentation, it is clear that there was a reliance on the self-reporting by Mr CD as to issues, involvement with other services and interventions made. For example, the risk assessment on admission to Melbury Lodge was mainly, if not solely, the account provided to the staff by Mr CD, including no reference to substance dependency and his links with the drug service.

5.23 One issue was the lack of a systematic documentation of risk factors, triggers and plans. Professionals were aware of Mr CD's key risks (such as outlined in the GP referral to Adult MH services in 2012) but there did not appear to be a system wide process for ensuring that this information was shared. Additionally, there were references to services being notified, such as when he was released from prison, but it is also unclear how that would impact on how Mr CD accessed services or how treatment would have been changed as a result of any notification.

5.24 There is a reliance on individual relationships between professionals to share specific information about clients on an informal basis. Whilst this forms a key role in the delivery of services, its effectiveness is dependent on the strength and sustainability of those relationships. There were examples provided, showing that professionals across the service communicated key issues about Mr CD, his current status and when he was due to re-enter the community following the completion of a prison sentence.

5.25 We note that the HHCT used mostly effective but informal ways of working and communicating with other agencies, such as acute mental health services and prisons. We were informed that very strong working relationships existed between local services and the communication and information sharing worked well; but that working with more geographically dispersed and distant services could be less effective.

5.26 While such communication is valuable, it is no substitute for more structured means of sharing information which is then transmitted across the team(s). We concluded that the arrangements at the time were a potential source of weakness.

5.27 As previously stated, the services involved with Mr CD went across health, voluntary and criminal justice systems. In such cases as this, it is crucial that a structured and systematic system is in place to ensure that all relevant

knowledge and information is shared across systems and professionals within each area. We note that HHCT are in discussions with commissioners regarding a service specification.

Recommendation 1

Solent and SHFT should develop a written service specification to set out clearly the relationship between the homeless health care service and the secondary mental health component, to be reflected in specific job descriptions as part of defining the role and functions. This should be completed by 6 months following the publication of this report and the implementation audited within the following 12 months

Recommendation 2

Commissioners of specialist services should develop formal service specifications which include protocols for liaison, communication and sharing information with other agencies, including non-health or NHS commissioned agencies, within 12months of publication of this report. Commissioners should ensure that contracts are monitored and evaluated for effective implementation by audit within 12 months of implementation.

5.28 The services outlined operate within a climate of Information Governance awareness. Legislation regarding the sharing and protection of personal information surround the administration and operation of every day procedures. This includes the Human Rights Act 1998, the Data Protection Act 1998, the Freedom of Information Act 2000 and the Access to Records Act 1990. These are further supported by the Caldicott Guidelines for the protection and management of service user information. The revised guidelines, issued in 2013, recognise the importance of sharing information pertinent to the care and treatment of individuals[25].

5.29 How this translates in practice may vary across professionals and services. The need to 'protect' confidentiality may sometimes result in a cautious response to sharing information. We realise that this is a familiar service delivery problem which is raised in similar reports of investigations of Serious Incidents (SIs). In response, organisations establish information sharing agreements and processes to maintain a consistent approach in the delivery of services. A positive example of where the need to help someone overrode confidentiality is when the needle exchange worker, Ms HI, contacted the police when Mr CD left her service saying he was going to kill himself.

## Substance misuse and offending behaviour

5.30 The demographics of the population served by SHFT and Solent concerned with providing services to Mr CD at various times, has led to specialist provision being developed to meet the increasing challenges presented by service users presenting with complex needs including substance misuse and offending behaviour. We have noted elsewhere (paragraphs 4.33 to 4.51) how Mr CD repeatedly offended. This can be seen as an example of the established association between substance misuse and crime. When we identified the agencies involved in his care, the necessity for commissioners

[25] The Caldicott Committee (December 1997). "The Caldicott Report". DH; The Information Governance Review: "To Share or Not to Share" (March 2012) DH

of services to understand the nature of the link in supporting appropriate and effective interventions for offenders with the presentation of Mr CD was clearly apparent.

Panel consideration

A difficulty for individual professionals and for agencies is that when recidivists drink alcohol to excess or misuse substances, an assumption may be made that such actions are invariably the cause of criminal behaviour. If this occurs offenders are consequently directed down a pathway of intervention programmes aimed at reducing the addiction. While such interventions may have been of some benefit in improving Mr CD's wellbeing, in common with similar offenders it is not necessarily true that a reduction in the likelihood of offending will follow. Simply put, models of substance use and crime that propose a direct causal relationship can be over simplified. In turn, they are weak when attempting to explain the association between these two aspects of Mr CD's presentation[26].

5.31 The chronology of Mr CD's contacts identifies the times that the major agencies needed to take such information into account, when they endeavoured to engage him in appropriate assessment, intervention and management of his behaviour.

5.32 One of the hurdles that risk and care planning assessors had to overcome was that data was typically collected through client self-report. There is guarded scepticism by professionals about the validity of self-report in the treatment of addictions. It is likely that the reliability of Mr CD's self-reporting would have been influenced by his perception of what the information being sought could be used for. Such a view is typical if he believed that his accounts of substance use could influence important decisions such as those relating to further criminal charges, sentencing directions, and increased access to methadone. We felt these features to be important to record because when anti-social personality disordered offenders are asked if they are using substances at the time of an offence and if this was related to their offending they may be more comfortable blaming alcohol or drugs for an anti-social act rather than accept responsibility for the behaviour (McMurran. 1996)[27].

5.33 The nature of Mr CD's presentation at various times and in a variety of places highlighted some of the key areas of concern faced by the services involved. These included mental health, homelessness, substance misuse, criminal justice, primary and secondary care and these services have historically struggled with service delivery. A significant issue when considering the history of Mr CD was the differing thresholds for intervention between agencies and professionals. Those service users that have mental health needs superimposed on a drug habit are particularly challenging, regardless of any personality disorder, as services may face uncertainty over the law and the fact that the way they present is unlikely to fit into provider agencies

[26] Blackburn, R. Criminal behaviour, personality disorder and mental illness: the origins of confusion. Criminal Behaviour and mental Health, 2 66-77, 1992, Whur Publishers Ltd.

[27] McMurran, M. Alcohol, Drugs, and criminal behaviour. In Working with offenders, Psychological Practice in Offender Rehabilitation, Edited C. R. Hollins 1996, John Wiley& Sons Ltd.

workflow, due to the time needed to build professional relationships capable of successful interventions.

5.34 The above issues were further complicated when services had to consider the impact of Mr CD's life style on other people, particularly when it was clearly anti-social and put both him and others at risk. This is a dilemma for assessors when considering self-reporting as part of risk management. On some occasions we noted that risk decisions were made based on Mr CD's self-reported willingness to comply, or assumptions about his current capacity to choose how and where he lived. When this occurred such as at prison release, Mr CD's personal circumstance appears to have been viewed as a lifestyle choice and insufficient attention was then paid to the threat his behaviours posed to others, particularly his history of carrying weapons. For any service to be effective, it had to be able to challenge and work assertively with the level of risk aimed at a collaborative approach including Mr CD himself. In fact, the risk assessment was based on self-reporting and the memory of a worker and was completed without a structured and standardised risk assessment tool. We concluded that this was a weakness in the care and treatment of Mr CD in the period leading up to the incident.

5.35 We felt that key people we interviewed thoroughly understood these points. Since the incident, Professor GH and Ms EF, manager of the Liaison and Diversion service were making a significant impact on establishing and increasing relationships with offender management. SHFT, working with Solent, have implemented improvements in the dual diagnosis service and in the Hampshire L&D service.

5.36 Professor GH steered implementation of the revised policy on dual diagnosis; and Ms EF ensured that probation services and associated agencies know the appropriate source of competent mental health assessment, including a diverse range of treatment options. These initiatives are essential for those who commission services as they are more likely to consider the more holistic needs of the offender (housing, employment training and drug rehabilitation). Had these areas been more advanced in 2014 there may have been the opportunity for Mr CD to have benefitted from a mental health treatment requirement combined with the support of other care provider agencies.

5.37 We have quoted the work being undertaken by Professor GH in the production of the Dual Diagnosis policy (2016) as it reflects a lot of the guidance necessary to ensure more accurate commissioning of the type of service people such as Mr CD could benefit from. The policy does not impose more demands or organisational stresses on any one service working in drug treatment or mental health, rather it assists commissioners, drug partnerships and service providers to meet their professional commitments by highlighting best evidence based practice. To that end it also compliments the contemporary guidance on commissioning for recovery, drug treatment, reintegration and recovery in the community and prisons (NTA, 2010)[28].

[28] National Treatment Agency for Substance Misuse (2010) Commissioning for recovery, drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships. National Treatment Agency

5.38 We examined the latest draft of the Dual Diagnosis policy authored by Professor GH. We felt that implementation of the policy would serve to address several elements of improvements to the quality of care plans and treatments to meet the needs of the diverse range of drug misusers. The need for local drug partnerships to be supported by effective commissioning processes was recognised by the professional practitioners and specialists we interviewed. We saw evidence (including bulletins, factsheets and digital information) that the demographic of the commissioning area has enabled drug services to become well established but most professionals acknowledged the continuing need to ensure the commissioning aims of prompt access to help, penetration into the prison system and successful discharge from secondary care are met by local procedures. We conclude that these developments represent good practice.

## Commissioning aspects

5.39 Commissioners need to ensure that the local systems are balanced and that they can provide a range of effective interventions, including harm reduction, abstinence focussed treatment and accurate and timely substitute prescribing where appropriate. Whist these features of commissioning are a necessary condition they are not sufficient. They require improved provision of local systems of support and reintegration for misusers and families aimed at preventing risk and promoting life style change. We have emphasised elsewhere how Mr CD and the victim in this case challenged the local services, as they represent the proportion of drug users with associated mental health issues who relapse, fail to complete programmes or stay in treatment too long before making personal effort to improve their life style. Service users who fall into this category often have poor social and personal resources on which to modify their life which are further complicated by mental health issues.

5.40 The NTA (2010) guidance also contains several 'commissioning competency checklists' which we commend.

5.41 The interface between SMS and mental health services was identified in the internal investigation as causing concern; and a previous serious incident had raised this matter.

5.42 The action plan has reinforced the need for local treatment systems to be more responsive to individual needs. The Solent action plan captured the concerns and these reflect the problems of work at the interface with drug addiction and mental health. The current organisational efforts on policy and practice are addressing the findings of this and related reports of serious incidents, these being:

1) "The outcomes of referrals to SHFT Adult Mental Health Services may not always meet the requirements of the service user related to their Dual Diagnosis needs identified by the Substance Misuse Teams.

2) The fact that the CMHT criteria for inclusion in their service do not match what their dual diagnosis policy says or their joint working protocol with the Solent SMS teams.

3) There is a gap in the provision of services for people who are a high risk of suicide or have moderate depression with suicidal ideation and who do not meet the criteria for working with the CMHT."

5.43 It was also noted that these interface difficulties had occurred between Solent mental health and substance misuse services.

5.44 Up to 30 November 2014, the NHS SMS was provided by SHFT. On 1 December 2014 the service was transferred to Solent, who won the contract when all drug services were recommissioned by Southampton City Council. Details of the current organisation of services are included in Appendix E. Key changes which have been made since March 2015 are clarification of roles and responsibilities through the Dual Diagnosis policy; and resolutions of the IT difficulties.

5.45 From 1 December 2014, Solent started running the SIT service and CRI (now CGL) started running the ARM service. Prior to this, the services were provided by SHFT and SSJ (a third sector organisation) under a completely different commissioned model[29]. So, the contracts with Solent had only been running for about 3 months when Mr CD was referred from prison. There were difficulties in understanding the respective roles and responsibilities of the three providers. When each had tendered for one service out of three, they made assumptions about what the other two bidders were going to be providing. In this case, Solent assumed that the other bidders (CRI/CGL and No Limits) and their care coordinators would provide ongoing 1:1 contact with clients; CRI/CGL and No Limits assumed that Solent would build in ongoing 1:1 time with their clients. In fact, no-one had built in 1:1 time with clients. They found this out during the 10-week lead-in time and had to find a resolution. We acknowledge that, if providers are ensure about how an element of services which they feel should be there will be provided, it would be helpful if they sought clarity from commissioners.

5.46 We concluded that the process of re-commissioning could have been improved.

Recommendation 3
When commissioning services, commissioners should begin with client needs analysis and evidence-based pathways: if there are gaps in the services to be commissioned ensure that there are explicitly described, risks are assessed and mitigated. The effectiveness of implementation should form part of the contract monitoring cycle (within circa one year).

## Criminal justice system

5.47 From the age of about 19, Mr CD was detained in prison on numerous occasions, the longest period being for 5 years from 2004 to 2009.

5.48 He was detained at HMP Winchester from February 2012 then transferred to HMP Coldingley. The joint internal report is critical of the lack of risk information made available by prison services to the CRI ARM: and staff we interviewed reported that this was not unusual. The report identifies this

[29] Full details in Appendix E.

inadequate communication as a 'care and service delivery problem'; and recommends that communication should be improved – with which we agree.

5.49 The clinical records report that Mr CD underwent a Rehabilitation for Addicted Prisoners Trust (RAPt) programme during this sentence (also relates to ToR1). The issues faced by Mr CD relating to his addictions and recidivism have been researched in depth by RAPt.

Panel consideration

The data held by them and the analyses were particularly useful to us when we considered these elements of our ToR. Their data base holds information about 6,000 drug or alcohol dependent offenders who have engaged with accredited programmes. RAPt reinforces the Bradley (2009) report[30] and its recognition of the need for step changes in mental health service provision. This is particularly so regarding the insufficient links to substance misuse services in prisons.

Except for the five-year sentence noted above, up to the point of the homicide, Mr CD's offending history was typical of those serving short (less than twelve months) in prison. The reoffending rates remain stubbornly high at 57 % (MoJ 2014)[31].

The data also describe prisoners with a drug and/or alcohol problem as having even higher rates of mental health problems than the rest of the prison population. The most prevalent of these are either a history of trauma or symptoms which indicate PTSD. Some 42% of RAPt programme participants had ASPD.

Symptoms of depression were found in over two thirds of the service users with higher rates of offending[32] (Breedvelt, 2014).

In his 2014 follow up report Lord Bradley[33] found that his initial criticisms were unchanged. Only a minority of inmates with acute mental health received treatment during their sentence. The majority must cope with their problems in a hostile prison environment without dedicated specialist support. Prison health care services do not generally undertake proper and competent screening for mental health problems and are likely to be unaware of unmet need.

5.50 Contemporary commentators including RAPt urge much greater integration of mental health and substance misuse services. When we examined the somewhat convoluted care pathway of Mr CD we acknowledged the importance of the Bradley recommendation of: "the adoption of a more psychosocial oriented model of care to recognise the multiple and complex

[30] The Bradley Report (2009). Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: Department of Health.

[31] Ministry of Justice (2014). Statistical Notice - further breakdown of a proven reoffending of adult offenders in England and Wales released from custodial or sentences of less than 12 months by region.

[32] Breedvelt, J.J.F, Dean LV., Jones, G.Y., Cole, C. and Mayes, H.C. A. (2014). Predicting recidivism for offenders in UK substance dependence treatment: do mental health symptoms matter? Journal of Criminal Psychology. Vol 4. Issue2.pp 102-115.

[33] Durcan, G. Saunders, A. Gadsby, **B** & Hazard, A. (2014) The Bradley Report five years on: an independent review of progress to date and priorities for further development. Centre for Mental Health, London.

nature of need" in the design and delivery of services between prison and health.

5.51 The records of Mr CD illustrate that his periods of detention may have provided him with an opportunity to receive specialist help and treatment to improve both his mental health and his quality of life. We are aware that there are committed and skilled substance misuse and mental health practitioners in the prison service. These practitioners find it difficult to deliver the integrated service needed in the face of both resource and regime restrictions.

5.52 We conclude that there is clearly scope for improvement in the collaboration between the prison-based services available to Mr CD and the NHS/third sector services.

Recommendation 4

Health and Justice specialist commissioners (NHS England and the Ministry of Justice) and commissioners of local services should promote greater collaboration between prison-based mental health and substance misuse services on the one hand and NHS mental health and local substance misuse services on the other. A progress report should be completed and made available to stakeholders at 12 months following the publication of this report

Recommendation 5

Health and justice specialist commissioners and commissioners of local services should promote opportunities to enable prison officers and prison healthcare workers, (including mental and physical health care) to undertake mental health screening aimed at making appropriate referrals prior to impending discharge.[34] A progress report reflecting current best practice should be circulated to stakeholders within 12 months following the publication of this report.

5.53 There are only two references to Mr CD accessing probation services. He was recorded as subject to a DRR and being supervised by a probation officer (CRC) in February 2011; and as 'on probation' (CRC) following his release from prison in June 2014 and his arrest in September 2014. We have been informed that he did not comply with requirements to engage with his probation officers – this is consistent with his behaviour in respect of NHS mental health and substance misuse services. Details of the general conditions of these requirements are contained in Appendix E.

Homelessness

5.54 The demographic profile served by Solent NHS Trust and SHFT has resulted in several different agencies representing the public, private and voluntary sectors being responsible for contributing to the delivery of care for homeless people. The difficulties faced by these agencies are particularly apparent

[34] See also a similar recommendation from another homicide investigation: "The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services." 'An independent investigation into the care and treatment of P in the West Midlands', NICHE, June 2017 Recommendation 15, p.24

when examining the nature of the contact Mr CD had with them. The specialist HHCT was an instrumental part of the support available to Mr CD and indeed the victim of the index offence, both of whom lived in the most challenging circumstances.

5.55 Following his discharge from hospital (Melbury Lodge) on 1 August 2014 Mr CD was offered a 7 day follow-up by the HHCT. The internal review recognised that there had been issues around communication between Melbury Lodge and the homeless team. The team report that they did not receive accurate and comprehensive discharge paperwork in a timely fashion. (See paras. 4.21 to 4.25 for details). One result of the delay was that, when Mr CD presented for his planned review, the homeless service was unclear as to the regime of care and particularly the medication prescribed in Melbury Lodge. Mr CD's reaction to this was aggressive and it caused difficulty for Dr DE and other workers, as he was insisting that he had been informed by the ward that he was to continue on the Diazepam when discharged. Dr DE attempted to clarify the situation but was unable to contact an appropriate medical professional. She subsequently wrote to express concern to the ward consultant.

5.56 The events which followed this process typified the pattern shown by homeless men and those described by the investigations by Solent and SHFT are reflected in wider evidence based examples we refer to later in our report (paragraphs 5.67 to 5.74).

5.57 When Mr CD was discharged from the Melbury Lodge, homelessness services faced a problem in finding him suitable accommodation. This was due to his past behaviour and negative reputation being known to established housing associations and private landlords. At the same time, Mr CD was expressing his disenchantment at his number of appointments with the various teams. These included the SMS, probation service, primary and secondary care services.

5.58 Despite attempts by the team to engage with Mr CD these proved to be unsuccessful. He either did not attend planned appointments or on one occasion left the building whilst the practitioner was trying to locate a suitable room to converse. The mobile phone he possessed was regularly switched off and was an unreliable means of the services communicating with him. On the occasions he did attend he was likely to present in an agitated and aggressive state. This was made worse when he was refused medication for which he felt he needed and which he claimed he had been promised. The efforts aimed at engagement and appropriate support continued throughout September 2014. The good practice of the homeless team liaising and updating the Substance Misuse Service was maintained during that time.

5.59 The HHCT were notified by HMP Winchester that Mr CD had been sentenced on 4 September 2014 to serve a 14 months' prison sentence. This resulted in the team closing his case and it was suggested that the prison mental health team should contact them if they had concerns about Mr CD's mental health needs on future release.

5.60 Approximately six months later the HHCT were contacted by the Winchester Integrated Offender Management (IOM) Team notifying them of Mr CD's impending release. The request was for help with locating suitable

accommodation for him and to inform the team that he had deteriorated during his sentence, had mood problems and presented with anxiety and aggression. There was no formal referral for further examination of mental health issues but the Integrated Drug Treatment Service had seen him during his sentence.

5.61 It was possible for Mr CD to attend the homeless team premises on his release as he remained registered with Dr DE, the GP based in the team. As this was not considered as a formal request for referral no specific appointments were made for Mr CD but it was proposed that after being seen by Dr DE he could be linked back in with the wider team if this was thought to be required.

5.62 On 13 March 2015 Mr CD did attend the HHCT and was reviewed by a CMHN. He was requesting medication (Mirtazapine and Gabapentin)[35]. This was denied as there was no evidence found that he had ever been prescribed these for any condition. Mr CD became threatening and abusive, stating that it would be the team's fault if he ended up returning to hospital. Subsequently he did not attend his GP appointments on 17 March or 23 March 2015. Attendance at this last appointment was precluded as he was arrested on suspicion of murder on 20 March 2015.The team was not formally notified of the fact that Mr CD was in custody by the MENDOS hence they had continued to pursue him to see Dr DE.

5.63 While the roles and functions of the services aimed at assisting the homeless people were made available to Mr CD, the challenges faced by the services showed that there is scope for further development within the local partnerships. This should include health, social services, adult education and the third sector. In practical terms this might involve building on current relationships, for example developing an inter-disciplinary forum. This would share ideas and best practice at a local level. This would be facilitated using shared resources in order to incorporate them into any lessons learned from SIs, practice development and staff training initiatives.

Panel consideration

There is good evidence that homeless people and men in particular will lead unhealthy and risk prone lives, this manifested in both perpetrator and victim in this case. They are more likely to drink alcohol to destructive excess, be disengaged from any employment, be non-compliant with prescribed care and treatment, less likely to eat healthily and unlikely to engage with health promotion programmes. These issues are a major challenge to services because there is a known correlation between poor physical health and mental illness. The erratic engagement demonstrated by Mr CD reinforced this evidence.

Numerous local and national programmes promote healthier lifestyles with the objective of improving population health. Very few of these programmes target homeless people and in any case the emphasis is on physical health. Contemporary evidence of meeting these challenges is reflected in the report

[35] Mirtazapine is an atypical anti-depressant for major depressive illness. Gabapentin an analgesic and anti-epileptic.

"Making every adult matter"[36]. This coalition is made up of MIND, Drugscape, Homeless Link and Clinks. This has managed pilot projects aimed at better coordination of services across mental health, addiction, homelessness and criminal justice.

5.64 The arrangements around supported living for Mr CD continually broke down and were worsened by his periods in custody. This culminated in 2014 in a reluctance of housing agencies to consider him as a viable tenant. This was attributed to drug and alcohol violence related behaviour. Mr CD frequently had no fixed abode, sometimes "sofa surfing" and he was locked into the typical cycle of a vulnerable homeless person with a history of peripheral contacts with mental health services.

5.65 The unhealthy and risk prone behaviours of Mr CD, particularly when homeless were accurately recorded in the notes of the contributing agencies. These included;

- risk caused by issues of medication/ services/treatment;
- risk caused by emotional/physical abuse;
- risk of financial abuse;
- risk of physical harm;
- violence/aggression to services and the general public;
- use of weapons.

5.66 All the above associated risks and the consequences of homelessness contributed to the facts we have been able to examine within our terms of reference. This includes the requirement to improve core discharge planning from the secondary care facility (Melbury Lodge) and any transition to the homeless health services. It is further reinforced by the need to improve the communications between the prison service and the NHS teams available to assist transitions between the two services. This was depicted in the homeless health care team not being notified by MENDOS that Mr CD was in custody, which resulted in the team making repeated attempts to contact him.

5.67 The main features of the problems associated with the various transitions of care of patients who are homeless have been reported by the Queen's Nursing Institute (QNI)[37]. This organisation surveyed over 180 nurses who work on the frontline with homeless people in order to get their views of typical problems associated with discharge arrangements.

5.68 The most effective transition of care management for this group of service users is best evidenced when robust joint protocols and systems of effective sharing of confidential information exist between hospital and community staff, social care, housing services and voluntary organisations.

5.69 We found the main conclusions of the QNI report (also relates to ToR1) raised several commonalities with the profile of Mr CD. Amongst the pertinent themes reflecting various events in the care and treatment of Mr CD between

[36] Bacley J. (2016) Making Every Adult Matter (MEAM), changing systems, changing lives: a brief review of the MEAM Coalition, MEAM; and website Making Every Adult Matter accessed 15 September 2016.

[37] Queen's Nursing Institute (2008) 'Homeless health initiative, service user consultation', QNI.

his first contact with MENDOS in February 2011 and the index offence, the following highlight the specific relevance[38].

5.70 Poor communications.

1. Discharge planning is poorly communicated, little forward planning resulting in the patient subsequently being discharged to no fixed abode.
2. A lack of joined up working e.g. having to chase up where people are and track discharge summaries and current prescribed medications.
3. Poor knowledge of discharged patients and not being provided with an accurate mental health and risk summary.

5.71 Inappropriate/unsafe discharge.

4. Patients discharged to the streets or hostels that are so full that they sleep on the floor.
5. Patients discharged inappropriately with no realistic care management plans, especially if alcohol predominates.
6. Being discharged back into chaotic hostels or temporary bed and breakfast accommodation where there is lack of supervision and support to meet complex health and social care needs.

5.72 NHS systems not designed for transient populations.

7. Homeless people frequently move between urban locations and care can become fragmented.
8. NHS ICT systems and the rapid transfer of health notes are not designed with such a mobile population in mind.

5.73 Reasons for these challenges.

9. Poor joint working between organisations.
10. Lack of local supported housing.

5.74 Clearly, some of the problems faced by the services for homeless people may be attributed to weaknesses in systems or in functions of organisations. However, the aspects of the behaviour of Mr CD when he was offered specialised support also highlighted 'patient factors' as contributory to the incident as a consequence of his addiction to illegal substances.

## Care planning, clinical risk assessment and transfer of care (ToR2)

Review the application of both Trust's care planning, clinical risk assessment and transfer of care policy and procedures in relation to Mr CD's treatment.

5.75 The way in which substance misuse services are planned and coordinated is most relevant to the responsibilities associated with the assessment and management of risks. The then CRI ARM service administered a risk

[38] The full list of their main conclusions are set out in Appendix F, as being of relevance to meeting the needs of homeless people with mental health problems in general.

assessment using the criteria contained in the Substance-DICE[39] risk assessment. The assessment is based on self-reporting by the service user. This process, which we considered to be unreliable, complied with CRI policy. The internal investigation recorded that the ARM service confirmed that they do not attempt to gain information to support risk history from either the GP or the family as the service is confidential. Only if the service user raised any safeguarding concerns would the ARM service then act on them and inform the social services. We were unable to speak to anyone from the ARM service so could not confirm this.

5.76 We concluded that this process was problematic for several reasons but primarily as the internal investigation report indicated, the ARM service provided care coordinators for Mr CD. ARM would only refer Mr CD into Solent's Structured Intervention Team (SIT) if he required a prescription, specific group work or counselling. If that had occurred then the SIT would have provided a keyworker and when any episode was completed they would have returned Mr CD back to the ARM service. If, during that process, the contact with a service user by the Structured Intervention Team raised issues around risk to self or others due to mental state they would then refer into Southern Health crisis service. The fact that this process did not occur correctly when Mr CD presented at the needle exchange service stating he felt suicidal was an error in implementing the system. In the internal report, the reason given was that, because the worker dealing with Mr CD was aware that the police had been alerted, the manager did not follow protocol and alert the crisis team as well. The internal report also notes that the manager did acknowledge that, if Mr CD had presented to another service which had then contacted the crisis team, that team would not have had information which would have helped them meet his needs. In this instance, however, it would not have made any difference to the outcome.

5.77 Our main conclusion, however, regards the self-reporting process and we have commented on this elsewhere (paragraphs 5.32 to 5.34, 5.75). It is important to note that there were particular problems arising at the time as the SIT and the ARM service was under considerable stress due to the transfer of the SIT to Solent NHS Trust and alongside new protocols having to be implemented, they also had complex information technology problems (paragraphs 5.149 to 5.151).

Recommendation 6

When any practitioner in SFHT, mental health court liaison services and associated services (e.g. ARM) consider risk history, extra caution needs to be taken in order to avoid over-reliance on self-reporting by the subject of the assessment. Risk information from other sources should be completed and if this is not possible a reason should be given. The Trust(s) and any other agencies should audit risk histories on an annual basis to ensure compliance, and follow up any non-compliance in supervision.

[39] Substance-DICE™ Association of Psychological Therapies (A.P.T.). A.P.T. publish a number of risk assessment tools, which may only be used by people registered at A.P.T. as having attended the DICES™ courses.

## Events post-discharge from Melbury Lodge, 1 August 2014

5.78 We felt it to be appropriate to examine and describe the process of events as they affected Mr CD in the period following his discharge from hospital as an informal patient in Melbury Lodge. This period was one where Mr CD expressed his disenchantment with having to consider a variety of appointments with multiple services. It also gave rise to a letter from Dr DE to Dr ST (the consultant at Melbury Lodge) expressing her dissatisfaction with the discharge arrangements. The GP's concerns revolved around lack of transferred information at the point of discharge. She felt that the lack of information placed both her and other members of the HHCT in a difficult position with regards to Mr CD's medication and associated risks. This is a view we shared when we considered the possible reactions from an addicted person with the risk history of Mr CD.

5.79 Although Mr CD had been admitted to Melbury Lodge on 19 July 2014, the team leader at the HHCT was not notified until 30 July 2014 and this was via the Bed User Group (BUG) meeting the same day. Mr CD was subsequently allocated a care coordinator, Ms UV, a CMHN in the HHCT. This was the same day Dr ST at Melbury Lodge undertook a medical review of Mr CD and confirmed the previous diagnosis of ASPD. Two days later Mr CD was discharged. He did not have any accommodation to return to and dialogue took place between Mr MN (Acute Transfer Facilitator) from Melbury Lodge and the team manager at the Southampton HHCT. Mr MN had managed to secure a deposit for a flat via the Street Homeless Prevention Team but this was not ready for occupation until three days later. The probation service did offer Mr CD the opportunity of approved premises but he declined this as he believed that it would be a detrimental environment for him, taking him back into contact with a drug-using community.

5.80 The internal investigation traced the subsequent events from the Southern Health Care records and we felt that these revealed at least some of the reason for the frustration expressed as anger by Mr CD when he attempted act on the advice from Mr MN regarding which service and who to contact on his discharge from hospital. Mr MN had confirmed that Mr CD was open to the Drug Intervention Project (DIP), and also who Mr CD was supposed to liaise with in relation to his ongoing care. The plan for Mr CD was for him to attend the Substance Misuse Service at 09.30 hrs. each day for Methadone over the weekend via the pharmacy (he was discharged on a Friday). Although Mr CD had been prescribed Diazepam during his stay in Melbury Lodge, there were concerns about issuing him with a week's supply owing to the high dosage[40]. It was agreed that the manager of the HHCT would arrange a GP appointment with the intention of seeking a new prescription, together with a completion of a seven day follow up by the HHCT CMHN in order to review the need for any mental health input.

[40] Diazepam may be prescribed to treat anxiety disorder or to prevent withdrawal seizures. We concluded that 30 mg is a little on the high side for treating anxiety, the reason Mr CD gave for requesting this medication, although it is difficult to comment on the dose of Diazepam in the absence of a clear clinical rationale. The risk of aggression or self-harm as a result of the disinhibiting effect of benzodiazepines also must be borne in mind in the context of a history of impulsive aggression.

5.81 It transpired that no GP appointments could be booked for the Monday or the Tuesday following Mr CD's Friday discharge. It was agreed with Melbury Lodge that Mr CD would still attend the GP surgery at 09.30 hrs. on the Monday after he had collected his Methadone that morning. Mr CD was advised to ask for Ms UV, his care coordinator, who would review him as part of the seven day follow up and arrange the appropriate appointments. The follow up was completed that day (4 August 2014). Mr CD reported that he was anxious and stressed due to being given various appointments the same morning to different places. He still had not seen a GP regarding the need for a prescription to maintain his medication, but he had not informed the receptionist of this need when he had arrived earlier at the surgery. He was assisted to make the appointment by Ms UV. He could not take the appointment that was offered as he was due to attend another appointment at the Drug Intervention Programme. An alternative appointment with a GP was made for two days later at ten o clock in the morning.

5.82 We considered it important to emphasise the confusion that appears to have occurred during this phase of care and treatment as it was recorded during the internal investigation report. The cause of the confusion was the result of the Homeless Health Care Team not receiving a faxed copy of the prescription on the 1 August 2014 date from Melbury Lodge. The discharge summary, which would have included the list of medications on discharge and the rationale for this, was not sent until 5 August 2014 and did not arrive with the GP until after she had seen Me CD on 6 August 2014. The explanation for this was recorded during the internal investigation and it transpired that although Mr MN recorded in the file that a fax had been sent, it only contained basic information about the medication but with no specific plan around it, for example, whether it was to be a reducing dose of Diazepam. As the intended recipient did not receive either fax the ensuing confusion and "mixed messages" escalated the anxiety for Mr CD and placed the GP in a difficult position as to suggesting a reducing dose of diazepam, based on the consultant's view that no mental health issues were apparent. We were surprised that such important faxed messages relating to discharge did not at least have an instruction to tell the intended recipient to confirm receipt. We have since been informed by SHFT that discharge summaries are now sent electronically.

5.83 At the time of Mr CD's discharge, the summaries were sent in two parts. Part A was the initial summary containing key information including diagnosis, discharge date and medication and which was to be sent within 24 hours. Part B was a more detailed summary of the admission and discharge. We were informed that these have since been combined so that a single discharge summary is to be sent within 24 hours. This becomes a lengthy document and increases the risk of delays in the GP receiving it.

Recommendation 7

SHFT should continue to ensure that discharge summaries are sent electronically and should consider the option of reintroducing a Part A initial discharge summary to help ensure General Practitioners receive information about medication promptly. This should be completed within 6 months of publication of this report and Implementation should be audited no later than 6 months later.

5.84 In addition, we note that there was no information on the RiO notes about the plans for any continued prescription for diazepam following discharge. This meant that Mr MN was unable to respond to Dr DE's request for information, leaving both clinicians in a difficult situation. A record of the medication plans on RiO would have enabled transfer of relevant information even though medical staff with this knowledge were unavailable.

Recommendation 8

SHFT should seek to ensure that all healthcare staff (but especially medical staff, who in many cases are at the centre of ongoing treatment planning for a service user) fully document, on RiO, leave/discharge plans including those plans most central to the continued treatment and coordination of care of the service user - for example, the medication regime. The Trust should audit the completion of leave/discharge plans on RiO by medical and other healthcare staff at 12 months after publication of this report.

5.85 From 6 August 2014 Ms UV attempted to make several telephone calls to Mr CD, but his telephone was switched off. She was trying to offer another appointment to assess his mental health and social care needs. Ms UV liaised with the SHPT who had seen Mr CD. This team informed her that they felt Mr CD was very anxious and kept looking over his shoulder. A window had been smashed at his property, he claimed by an ex-girlfriend. Mr CD asked for more support from the SHPT, which was agreed, and he was informed staff would visit in pairs due to his forensic history. Mr CD reported having his mobile phone switched off for the week and that this was now switched on.

5.86 On 15 August Ms UV contacted Mr CD by telephone. He reported that he was not happy with the GP surgery at the day centre and had been told by Dr ST that nothing would be changed when he was discharged with regards to his medication. Mr CD was aware he would have mental health follow up and appeared to believe he was not receiving this via Homeless Healthcare. Ms UV attempted to explain that she had been trying to arrange to see him but Mr CD had left before his appointment and had not responded to attempts to contact him. Mr CD stated he was experiencing anxiety around other people so had to leave. Mr CD was noted to become more agitated during the call. He reported having instructed a solicitor to help him as felt his aftercare package had not been followed through. Ms UV arranged a joint appointment with Dr DE.

5.87 Mr CD did not attend the appointment to collect a sick note on 18 August 2014 so a message was left for him. He continued to be difficult to reach by telephone and did not arrive to collect his sick note so Ms UV attempted further contact on 20 August 2014.

5.88 On 21 August 2014 Mr CD did see Dr DE and met Ms UV on his way out of the building. He advised Ms UV that his Diazepam had been stopped but did not appear angry about this. Ms UV asked if they could meet up to discuss his mental health needs and an appointment was arranged for 27 August 2014. However, Mr CD did not attend this appointment.

5.89 We commend the efforts made by Ms UV to establish and maintain contact with Mr CD, despite his limited engagement with her. This showed professional diligence and extra effort which helped in creating a barrier to prevent further loss of contact.

5.90 We examined the arrangement of the appointment of the care coordinator for Mr CD following the initial ARM input, the service which provided care coordinators to clients. It should be noted that the service response to Mr CD's prison discharge was organised by ARM which was a component of the substance misuse service. In turn, this was managed by CRI, and CRI held a separate provider contract with commissioners (The Southampton City Council). Therefore, the city council was responsible for the governance of the service. The ARM service was limited to assessing, reviewing and monitoring as its name implied but any required structured interventions would have to be undertaken by a team contracted to Solent NHS Trust.

5.91 Subsequently, the mental health nurse in the HHCT (Ms UV) was also described as the care coordinator. Ms UV had limited information about the risk history of Mr CD as the discharge communication from prison was typically poor and, as recorded in the Internal investigation, information sharing was found to be lacking. Ms UV was dealing with someone who was not considered to be suffering from a mental illness based on previous diagnosis from doctors in the Melbury Lodge and later by the SIT prescribing doctor, Dr FG. Despite the limitation of not knowing a comprehensive history, we do not consider Ms UV was disadvantaged, as while some people with mental health problems do act violently due to mental state, more often a violent act is independent of any mental health problem, including personality disorder and substance misuse.

5.92 Ms UV did attempt to engage Mr CD in order to assess any mental health needs and plan appropriate care. However, the chaotic nature of Mr CD's lifestyle and the fact that he did not engage with her attempts meant that a main function of designing care plans in line with risk assessment and long term needs was challenging. In addition, Mr CD's recidivism had historically precluded consistency of support and treatment. Ms UV's involvement with Mr CD ended on 15 September 2014, when he was discharged from her caseload. The rationale for this was his non-engagement and the medical view that no significant mental health issues and risk history were considered to be present. There was no planned follow up on his future release from prison as he had been sentenced to 14 months with a pending court case. Mr CD could be re-referred on discharge if this was felt appropriate.

5.93 We considered contemporary policy guidance which related to both the features of the mental health care pathways and to the criminal justice aspects of Mr CD's relationship with services. It was possible to compare and contrast the guidance available now to assist agencies, including the probation services, when they seek to support someone with an anti-social personality disorder that was not available from 1996 when Mr CD first entered those systems. We felt this to be necessary because, during the time span of his recidivism, fundamental organisation and policy changes occurred across the public sector.

5.94 A specific piece of guidance, the Mental Health Treatment Requirement (MHTR): Guidance on Supporting Integrated Delivery from the National

Offender Management Service (NOMS)[41] was helpful in identifying best practice, as it included those people with personality disorder. Although non-statutory, it seeks to provide support to service commissioning and provider agencies so that appropriate mental health services and inter-agency partnerships enable a treatment requirement to be delivered locally in an effective way. The complexities of inter-agency roles, contributions, responsibilities and relationships necessary to deliver the MHTR effectively are addressed and clarified. The guidance also reflects the changes to responsibility for probation services from 2014 resulting from the Government's Transforming Rehabilitation reforms and the Offender Rehabilitation Act 2014. It aims to support practical mental health service delivery to offenders in the community.

Panel consideration

Mr CD presented at the Acute Care Unit, Southampton in July 2014. In the previous month, the Probation Trusts in England and Wales were replaced by the National Probation Service (NPS) and 21 Community Rehabilitation Companies(CRC). The NPS was made responsible for all court work, risk assessments and supervising high risk offenders and public protection cases. The CRCs were made responsible for the management of low to medium risk offenders including planning and provision of "through the gate" services for all offenders serving more than one day in prison (Service Delivery Problem - further detail in Appendix E).

The MHTR was introduced as a sentencing option in 2005 and in 2012 the Legal Aid, Sentencing and Punishment of Offenders Act made it easier for the courts when dealing with cases such as Mr CD to use the MHTR. It did this by removing the requirement that evidence of an offender's need for mental health treatment be given by a Section 12 registered medical practitioner.

It was within this framework of policy that the MENDOS practitioner was unable to review Mr CD in December 2013, when he had been arrested for possession of an offensive weapon and going equipped for burglary and held at Southampton police station. He had already been taken to court when the MENDOS practitioner was made aware so there was no further involvement.

5.95 It can be seen from our previous considerations of the application of care planning and processes around assessments of risks from multiple agencies, that commissioners of services play a vital role in ensuring that offender treatment services are effective. In common with the rest of England, the health services serving the geographic area where both Mr CD and Mr Beattie lived underwent organisational changes. The responsibility for commissioning mental health services for the general population (including for offenders in the community) transferred on 1 April 2013 from Primary Care Trusts to Clinical Commissioning Groups (CCGs).

5.96 Mental health services which support the treatment elements of MHTRs are not specifically commissioned for offenders. Instead offenders such as Mr CD

[41] Mental Health Treatment Requirement - A Guide to Integrated Delivery.pdf National Offender Management Service.

are expected to access the same mental health treatment services commissioned for the general population. How easy it is for them to do so depends as much on interagency collaboration as it does the individual's ability to navigate the system. The collaborative element was reinforced in the NHS Mandate[42]. This implored the 'NHS and its public sector partners to work together to assist one another to achieve their objectives'. It went on to specifically identify prisons, the police and criminal justice agencies as key partners.

5.97 We concluded that, overall, the services appropriate to Mr CD were available and the level of communication and cooperation necessary for efficient delivery however was variable. The weaknesses were particularly noticeable during prison discharge procedures and liaison with the health services. We note that following the internal investigation report that the CRI manager was taking action to improve risk sharing information between the prison and themselves. We felt this to be of particular importance as the nature of the risks was complicated and included the impact on other people of Mr CD's self-neglect and illegal drug dependence. In these circumstances health and social care staff need to be able to challenge and work assertively with the known types of risks and to what level they are likely to manifest. This process places demands on the local CCGs when they seek to ensure that appropriate community based mental health services are accessible to their area population including offenders. The health commissioners should therefore seek to encourage accurate and increased communication with the prison service, so that they are able to ensure that this aspect of care provision is explicitly detailed in contracts.

Panel consideration

We believe that some of the weaknesses in communication and that of risk management within and between the various agencies, revolved around a need for the prison service and the probation service to seek to ensure that changes in health and justice service delivery are understood by local partners. We felt it to be essential that there should be a strengthening of the efforts of the National Probation Service and the prison service, when they seek to influence the availability and accessibility of suitable treatment to meet offender need through their contributions to local commissioning plans and processes aimed at effective service delivery. Additionally, the local probation providers have a key role in promoting the treatment needs of offenders like Mr CD to local commissioners. This should include outlining the importance of the availability of suitable mainstream mental health treatments and specialised drug rehabilitation on prison discharge.

[42] The Mandate: A mandate from the Government to the NHS Commissioning Board. The Mandate The Mandate is published annually and sets out the overall objectives for NHS Commissioners (now NHS England) to achieve in that year.

The central government policies and guidance which applied to the services being commissioned for service users such as Mr CD were those contained in the NHS National Treatment Agency (2010)[43].

We could evidence that within services the aims of the policy were largely being pursued but the organisational arrangements and various service structures added to the complexity of users like Mr CD of reintegrating and recovery in the community and in the prison system. The policy promotes outcome based commissioning in drug partnership areas for problem drug users. This is based on the desired goal of attaining reductions in drug use and ultimately abstinence in those who can achieve this, reduced offending behaviour, an improvement in general health and reintegration with education, training, employment, housing and other services. In order to deliver this challenging agenda, the contributing agencies need to pay a lot of attention to how service users exit treatments in one service and access the services of another. Hence, our concern that the action taken as part of the lessons learned in this case relating to the quality of prison release information needs to be closely monitored.

## Risk assessment and risk management (ToR3).

To establish if the risk assessment and risk management of Mr CD was sufficient in relation to his needs including the risk of harming himself or others.

5.98 The risk history of Mr CD had most of the characteristics of the diagnosis given by the consultant forensic psychiatrist Dr AF, when Mr CD was detained at HMP Winchester. The assessment took place on 10 February 2012 and the process identified:

- Anti-social Personality Disorder (ASPD);
- alcohol dependence and substance misuse including crack cocaine and heroin;
- methadone medication;
- possible Post Traumatic Stress Disorder (PTSD).

5.99 A violent criminal history was also noted in addition to childhood and adolescent difficulties.

5.100 Following this assessment, 19 days later on 29 February 2012, he was transferred to HMP Coldingley. This is a Category C training prison. This profile is somewhat typical of people in the criminal justice system, and has been described in Lord Bradley's report on inmates with mental health problems. Those prisoners have significantly higher rates of mental health problems than the general population. Indeed, Bradley describes over 90% of prisoners as having one or more of the five main psychiatric disorders (psychosis, neurosis, and personality disorder hazardous drinking and drug dependence). Personality disorder specifically was found in 66% of prisoners compared with 5.3% in the general population.

[43] National Treatment Agency (2010) Commissioning for Recovery: Drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships.

Panel consideration

The systems for dealing with offenders such as Mr CD and the mentally disordered are inter-dependent, and the de-institutionalisation of complex patients intended to facilitate their care within the community is increasingly believed to be leading to more of them being processed within the criminal justice system. This belief is not new and in the early part of the last century it was proposed that changes in the population of one institutional system, force an inverse change in the other.

5.101 Two of the characteristics of the risk issues when Mr CD presented to various services and agencies, personality disorder and drug use which is common among prisoners would not usually be sufficient to identify him as mentally disordered. Clinically then, formally designated mentally disordered offenders tend to be an arbitrarily defined group.

5.102 It is frequently argued that such offenders should have increased access to health care services. The view is taken with regard to community treatment that it is more humane to treat those who are "ill" than to subject them to periods of imprisonment. This contemporary policy underlies recent moves to divert more mentally disordered offenders to community facilities. However, legal recognition of mental disorder is not predicated solely on what is humane and the reasons why those with anti-social, deviance or dangerous personality disorder continue to be debated in the medico-legal system and have been for a long time (Radden,1985)[44].

5.103 It can be readily observed from the chronology of events that Mr CD challenged both individual practitioners and systems when they attempted to intervene in order to help him and to reduce his offending behaviour. Any treatment aimed at specific aspects of personality disorder tends to be "psychological "in nature, and this was considered during his admission to Kingsley Unit at Melbury Lodge. Mr CD stayed on this unit as an informal patient between 19 July 2014 and the 1 August 2014. Psychological based treatments revolve around, individual counselling, cognitive behavioural therapy, psychotherapy or case work. During this twelve day admission Mr CD was formally assessed by a clinical psychologist. This took place two days before he was discharged. The outcome included a statement that Mr CD was more aware of "external conditions and factors", and less so regarding his own reactions and behaviours. The subsequent recommendation was that no specific psychological work was indicated at that time. The view was that Mr CD would be unlikely to sign up or work on psychological treatment. The psychologist did offer to see him again the following week, by which time he had been discharged.

5.104 We do not consider this outcome as a pessimistic view as historically, based on investigation of 555 studies of recidivism, Martinson (1979)[45], found that

[44] Radden, J. (1985) Madness and Reason. London: Allen and Unwin. For further information on anti-social personality disorder, see: Anti-social personality disorder; and Anti-social personality disorder NICE guideline

[45] Martinson, R. (1979). "New Findings, New Views: A Note of Caution Regarding Sentencing Reform". Hofstra Law Review. 7 (2) Winter.

treatments were impotent under certain conditions, beneficial under others and detrimental under still others.

5.105 The period of hospitalisation which offered an opportunity for a time for increased observation and clinical assessment, did not reveal any clear sign of mental illness. The prior diagnosis of anti-social personality disorder was thought to be consistent with his presentation. Based on the clinical records and discussion with Dr ST, we agree with this conclusion.

Panel consideration

When we reviewed the nature and degree of risks presented by Mr CD whilst he was in contact with the various services, it was clear that the criminal justice concepts of personality disorder appear to have limited correlation with those held by health and social care practitioners. This was reflected in problems in assessing the treatability of an identifiable personality disorder. It also obscures the heterogeneity of personality disorder among the antisocial person. Any risk management processes would therefore require accurate specification of evidence based treatment targets.

5.106 Blackburn (1992)[46] described a useful construct of personality disorder and those elements were reflected in the risk history and various presentations of Mr CD. This is described as inflexible inter personal styles supported by expectations of others which are self-fulfilling prophecies and that these cut across the medico-legal categories of mental illness and psychopathic disorder.

5.107 Simply put, Mr CD circulated around various agencies including homeless health care, probation service, general health care, mental health services and prisons. Despite the objectives of these services, he typically confounded the nature of the interventions offered to him which were aimed at attaining the targets of the agencies. The course of his contact with the services presented as a person predisposed to violate moral rules about concern for others, obligations to professionals, friends and the wider community. These traits are held to exemplify the anti-social type of a disordered personality.

5.108 One of the difficulties experienced by the various agencies when they had to consider issues of risk with the intention of attempting to predict future risks, rather than just record previously known risks, was that of Mr CD's socially deviant behaviour. This was likely because while socially deviant behaviour may sometimes occur as a consequence of personality disorder or even mental illness, ant-social behaviour in itself cannot be logically be used to define a disorder of personality.

5.109 Since personality disorder and mental illness are not mutually exclusive, Mr CD may also have been expected to show some symptoms of mental illness. On occasion assessors had to consider self-reported statements that he had

[46] Blackburn, R. (1992) Criminal behaviour, personality disorder and mental illness: the origins of confusion. Criminal Behaviour and mental Health, 2 66-77, Whur Publishers Ltd.

overdosed due to being depressed and that he had been hearing voices which he claimed he suppressed by drinking alcohol to excess.

Panel consideration

We felt it understandable how the personality traits shown by Mr CD, together with the occasions when he consistently behaved in a manner which society found unacceptable, led to him being diagnosed as having an antisocial personality disorder. In 1980, this controversial diagnostic category was introduced into psychiatry. Since that time, the concept has been widely debated by clinicians, researchers and the media. The debates have raised important issues surrounding where the boundaries of psychiatry should lie.

The way in which the various services tried to engage with Mr CD and the management of the consequences of his actions reinforced the central problems associated with assessing and classifying abnormal personality. This was more so when services needed to focus on offending behaviour, early risk factors, possible associated mental health conditions and antisocial personality disorder.

The checklists which are used to help determine personality disorders are bedevilled by lack of reliability and uncertain validity of specific disorders within the general category. Practitioners within services of the type delivered to Mr CD are usually aware that the possible "signs" of future dangerous behaviour are value judgements rather than observations. When they rely on risk assessment that is self-reported it may produce as many traps for the unwary as the consequences of the behaviour which may result of not having done so. It is the latter that becomes the focus of any interventions.

The classification of a severe and enduring mental illness and the subsequent pathways for treatment can be confusing for service users and their families. This may be particularly so when someone presents to services with a disordered personality and which such a classification precludes them from receiving certain psychiatric services.

In mental health services, the judgements of clinicians and the choices of service recipients tend to be based on some underlying premise. These may be unique and idiosyncratic to the individual. They are likely to reflect such diverse elements as social values, psychological perspectives and neuro-pharmacology.

Unfortunately, it appears that the concept of personality disorder does not have a clear paradigm that establishes logical, conceptual and ethical continuity between its various elements.

5.110 Two risk assessments were completed in relation to his admission to Melbury Lodge. The first was part of the assessment carried out at Antelope House, on 19 July 2014; this was followed by a medical interview when he was admitted to Melbury Lodge, also on 19 July 2014. A risk summary was completed in the early hours of 20 July 2014. The risk assessment and summary are generic in presentation, areas covered and limited regarding the presence and risk of substance abuse. This area, however, had been highlighted by the Antelope House assessment although there was limited opportunity to raise these issues in the Melbury Lodge review and summary. It should be noted

that the assessments are reliant on self-report as no additional information was provided by way of supporting documentation available to the staff at the time.

5.111 The risk assessment and formulation completed at Antelope House on 19 July 2014 stated that he was deemed a high risk to self and a low to medium risk to others, although it was noted that 'with his current presentation nothing could be guaranteed with certainty'. It was concluded that a hospital admission would be beneficial.

5.112 In the risk summary completed on 20 July 2014 the risk of harm to self was rated as medium. This risk assessment describes the circumstances for his attending Antelope House on 19 July and specifically his thoughts of jumping off a bridge. At this point Mr CD stated that he had no plan to harm himself.

5.113 In the same summary, risk of harm from others was identified as very low, with risk of physical harm 'ticked'. The risk formulation stated that Mr CD disclosed physical and mental abuse by his stepfather from the ages of 5 to 16 where he then left home. These incidents were not disclosed and no police investigation took place. There was no reference to any current risk of harm from others.

5.114 Risk of harm to others was rated as medium, with reference to his violence/aggression/abuse to family and the use of weapons. These were the only two factors highlighted. It was noted that he moved prisons frequently due to his behaviour – 'aggressive outbursts', which the formulation comments led to prison staff 'wearing helmets and restricting him'. Mr CD denied aggression towards others. Regarding the risk to family, it is noted that he disclosed past (mutual) domestic violence (with ex-partner). He also stated that he had no contact with his daughter nor the mother of his daughter.

5.115 The only other risk factor identified incidents with the police and repeated the formulation as outlined above. An overall risk rating of medium was specified with little further detail added.

5.116 Therefore the main issues, given his presentation prior to and immediately following admission, concerned the incidence of self-harm. The risk summary did not highlight any areas where substance use (other than the use of medication) could be assessed and a formulation completed.

5.117 We have concluded that, whilst the risk assessments and management were sufficient in relation to his perceived needs as presented and identified at the time, more could have been done to make use of more structured and standardised risk assessment tools.

## To evaluate and comment on Mr CD's mental health care and treatment (ToR4).

To evaluate and comment on the mental health care and treatment Mr CD received at each stage of his treatment.

5.118 Mr CD had limited involvement with mental health services, in comparison with his engagement with other agencies as outlined previously. The rationale for this involves numerous aspects including but not restricted to the following:

- custody and imprisonment following the commission of offences (on four occasions from 2011 till 2015, with varying sentences imposed);
- the non-attendance at appointments including those at the HHCT and with the Adult CMHT;
- that he was not diagnosed as having a mental illness, other than personality disorder and dependence on illicit substances.

## Community Mental Health Services and Homeless Health Care Team

5.119 His referral to Community Mental Health Services (Adult) in January 2012 centred on a specific referral made from his GP at that time and his concern over his presentation. However, Mr CD did not attend the given appointment (he was in custody) so there was no engagement or treatment provided.

5.120 Of note during this specific time period is the work of the HHCT in their work with Mr CD and their efforts in engaging with him. Their role centred on providing primary care services (specifically GP input) and designated work concerning the mental health of individuals in contact with the service. In the case of Mr CD, it is evident that he used this service when discharged from hospital in August 2014 and when released from prison in March 2015, with particular reference to the prescribing of medication.

5.121 The documented history of his involvement with this service is one marked by consistent attempts to engage with Mr CD and his inconsistent contact with the CMHN assigned as his link with the service. Given the features of his presentation and lifestyle, it is not surprising that he did not nor could not engage fully with the service. Attempts were made to undertake a mental health state assessment by the CMHN but this could not be completed. On his discharge from his inpatient admission in August 2014, he was offered a seven day follow up with the service. As noted previously, the HHCT did not receive the discharge paperwork. It was unclear what medication he had received while admitted or what was recommended on discharge. It was also recognised that there were difficulties in engaging Mr CD with the service and the team.

## Mental health support whilst in police custody

5.122 From 2011, Mr CD was occasionally in contact with MENDOS workers when he was detained in police custody. He had self-reported, on one occasion to the service and to the police, that he had schizophrenia. Mr CD also disclosed that he was 'getting deeper and deeper into the drug scene' in Southampton (reported in 2011).

5.123 On the occasions where Mr CD had contact with the MENDOS team, he disclosed various issues and concerns such as his dependency on alcohol and feelings of depression and anxiety. What appeared to be consistent are the various assessments that state that Mr CD did not exhibit mental health

symptoms. The team made appropriate referrals to both services within the prison system and also in the community – such as HHCT.

## Inpatient admission

5.124 On 19 July 2014, Mr CD was admitted to the inpatient facility of Southern Health in Winchester. This was following his self-presentation stating his suicidal ideation. He stated that he had been released from prison 'about a week' previously (recorded elsewhere as 9 July 2017)[47]. He was admitted later that day to Melbury Lodge (Kingsley Unit) and underwent various assessments during the initial admission period.

5.125 Mr CD's admission to the inpatient facility does not raise particular issues in terms of the risks presented and his compliance with the care plans and the medication regime in place. No incidents or concerns appear to have been noted nor any areas where further interventions were required. He was noted as being 'pleasant'.

5.126 Mr CD was an informal patient under the Mental Health Act 1983 (amended 2007), having voluntarily been admitted to the ward. This means that he was not subject to any conditions or requirements (such as prescribed section 17 leave) during his admission at this time. Mr CD could therefore leave the unit as and when he wished, with consent required for any suggested courses of treatment.

5.127 His admission is typified as one of compliance and engagement with fellow residents and staff, albeit on a superficial level. The Unit in question adopted a recovery approach, engaging with the individual in outlining circumstances where they have faced difficulties and identifying actions to address such issues.

Panel consideration

The recovery model (including the incorporation of such tools as the 'Outcome Star') aims to address the main areas of an individual's life, including their social network, addictive behaviour, relationships, living skills and issues of trust and hope. It involves a self-assessment by the individual, in conjunction with an assessment by the professional involved in the process, and a level of self-awareness as to the issues to be addressed. The nature of the approach requires a level of engagement and compliance to ensure that the aims identified are realistic and achievable. Given the time spent as an inpatient and the opportunity to explore the issues highlighted, it is difficult to assess the value of such an approach with Mr CD.

5.128 In his recovery narrative, he stated how he was settling in, the circumstances prior to admission, the areas of 'things to focus on' including strengths and resources, and his safety plan and goals. Mr CD stated that he had been

[47] There is some discrepancy in the records: the SHFT methadone clinic records state that he left prison on 9 July 2014, which is consistent with his self-report at Antelope House on 19 July 2014, that he had been released about a week previously and that he had spent seven months in prison. The Melbury Lodge records on 20 July 2014 state first, that he had been released seven months previously, which is 'corrected' to seven weeks.

depressed and low. He additionally stated that he wanted to be referred to the Southampton Drugs Team.

5.129 No specific treatment interventions such as psychology or occupational therapy (OT) were initiated; however, given his short length of stay, status as an informal patient and time spent out of the unit, this is not surprising nor any inferences suggested as to any limited access to such interventions.

## Admission assessment and care plans

5.130 From and during his admission, Mr CD was subject to various assessments. In addition to risk assessments, these included:

- assessment prior to admission (triage assessment);
- doctor assessment on admission on 21st July;
- care plans and medication review.

5.131 The triage assessment noted that he presented with psychotic symptoms, being also low in mood and hearing voices, which were telling him to do 'bad things'. Alcohol and drugs had been used following his release from prison, according to Mr CD himself.

5.132 The ward review on 21 July 2014 noted his current presentation as polite and cooperative. Mr CD described himself as 'subjectively depressed'. The plan following this review stated as a need to confirm Mr CD's dose of methadone, the potential use of olanzapine, to complete a review of the past risk and forensic assessments and to initiate a potential joint review with psychologist.

5.133 The care plans which were implemented were generic but comprehensive. They included an emphasis on the recovery approach. The outline of care plans and their outcomes are described in detail in the timeline. Key points are:

- 72 hour care plans were described in detail.
- Safety care plans were also recorded (to the effect that Mr CD was not displaying risk behaviours and therefore remained on general observations).
- The goal for the care plans was that Mr CD should feel 'safe and listened to'.
- Care plans were not agreed with Mr CD.

5.134 The plan on admission is generic rather than specific to Mr CD's particular needs. In particular, there is no reference to his substance misuse as a 'care need', despite him being prescribed methadone. There was no screening for drugs in Mr CD's system during the two weeks he was an inpatient of Melbury Lodge.

5.135 Appropriate referrals were made to other departments as per best practice and the initial concerns regarding a new admission were addressed. No specific plans with regard to the issues faced by Mr CD were recorded. However, given this was the first engagement with mental health services by Mr CD (other than limited contact with MENDOS when in police custody) the limited availability of supporting documentation from other agencies and the reliance of staff on the symptoms as presented by Mr CD at the time of his admission, this is not unusual.

## OT and psychology input

5.136 Referrals were made to both OT and psychology during Mr CD's admission on Kingsley ward. The OT assessment took place following admission and noted that 'occupational therapy may be indicated', but stated that further screening would be discussed with the Multi-disciplinary Team (MDT). No further intervention was noted nor actions taken.

5.137 The psychology assessment of the 30 July noted that he presented as 'nervous' but he stated that this was due to him not being aware of what to expect. The assessment stated that Mr CD was more aware of 'external conditions and factors' and less so regarding his own reactions and behaviour. The recommendation was that no specific psychological work was indicated at the time of the assessment. The psychologist stated that it was unlikely that Mr CD would 'sign up to' or 'actively work on' psychological treatment. This assessment however took place close after discharge was being considered (on 28 July) and it is unclear whether this assessment was shared with professionals outside the inpatient facility. The psychologist did record that she would see him the following week, but he was discharged.

## Time spent on the unit

5.138 As a voluntary patient, Mr CD could leave the unit when he wished. This depended on his presentation on the day and any concerns the staff may have had concerning any risk to himself and others. What appears clear that, in examining the evidence, there were significant periods where Mr CD was away from Kingsley Unit on leave. These are summarised as below.

- He was absent from the ward on 13 occasions (including twice a day on four days).
- He was absent from the ward for more than 35 hours (the record does not always include the time Mr CD returned to the ward).
- On 22 July 2014 (the second full day after he was admitted), Mr CD was absent for 8 hours.
- Reasons for leave varied – they included spending time with his mother, going to local shops/the local area, and once to Southampton.

5.139 When a service user is informal during their admission as an inpatient, it is expected that, in line with any risk assessment at the time, that they are free to leave the ward when they so wish. In this respect, the leave used by Mr CD is not unusual and would be seen as consistent with ensuring that the patient engages in their local community and maintains their existing social and supportive networks. What raises potential issues, however, in this instance, is that there was limited knowledge of Mr CD (given the reliance on self-report) and limited consideration of significant risk factors such as his dependence regarding substance use. The amount of leave during a two-week stay is significant.

5.140 There is no evidence that the circumstances surrounding his periods of leave from the Unit were considered and discussed. There is no reference to the implications of the frequency and extent of his absences from the ward environment for their treatment approach, specifically medication and therapeutic work with nursing and other staff.

## Medication

5.141 The medication prescribed to Mr CD was the subject of review as part of his inpatient admission. This occurred on admission and during the time of his admission. On admission, it was noted that his medication was prescribed as methadone, zopiclone and paracetamol. There were issues in obtaining information as to which GP Mr CD was registered with. His previous GP had not seen him in 12 months. He had recently registered, which was confirmed, with the Homeless Healthcare Team.

5.142 The review on 30 July 2014 stated that his medication included diazepam (20mg in the morning and 10mg in the evening).

5.143 It would be beneficial to further appreciate the clinical rationale for the use of and also the increase in the use of diazepam.

## Discharge

5.144 It was decided to discharge Mr CD following a review where it was stated that he did not appear to suffer from a mental illness. The review of the 30 July 2014 outlined the following key points:

- Mr CD did not demonstrate 'any clear signs of mental illness' and that the previous diagnosis of anti-social personality disorder was consistent with his presentation. At this review a discharge date of 1 August was agreed
- Medication was noted as diazepam (20mg in the morning and 10mg in the evening). The MAR chart (regular scheduled medication) of 30 July 2014 confirms that the medication prescribed was:
  - methadone – 35mg;
  - diazepam – 20mg (morning);
  - diazepam- 10 mg (evening).

5.145 It was further noted that Mr CD did not appear distressed or agitated, having no thoughts of self-harm. Mr CD stated that he wanted to continue with diazepam as it alleviated his anxiety.

5.146 The plans in place following agreement to discharge Mr CD were comprehensive and extensive. It recognised the need for him to engage with the various services central to his care and treatment. He was not subject to Section 117 aftercare (as under the Mental Health Act 1983 (amended 2007) nor a CPA which would have initiated a more systematic and structured process. One observation noted, however, was the number of appointments made for the same day following his discharge. Mr MN made contact and appointments with the following services for Mr CD:

- telephone contact to the Southampton (New Road) Drug and Alcohol team;
- telephone contact with the HHCT;
- telephone contact to the Accommodation Officer, Acute Care Support Team.

5.147 Whilst it was important that these appointments were scheduled at the earliest opportunity to ensure that the issues pertinent to Mr CD were addressed, there is some comment regarding the particularities of these for someone as

chaotic as Mr CD. Of equal relevance, and in line with previous observations regarding the system-wide approach, is the co-ordination of care for Mr CD.

Panel consideration

The situation regarding his discharge can be summarised as one which aimed to provide him with access to the relevant services but was reliant on his ability to self- manage and co-ordinate his involvement with services. That he appeared to attend all necessary appointments is to be noted. The issue remains, however, regarding what was in place to ensure his continued involvement and engagement and the systems in place to manage his risk behaviours.

5.148 Overall, in relation to Mr CD's mental health care, we have concluded that:

- the efforts made by the CMHN to engage Mr CD were commendable;
- there were specific problems in July 2014 regarding the transfer of discharge information to the HHCT which placed the GP in a difficult position and hindered the smooth transfer of responsibility for Mr CD's care;
- the support offered by the MENDOS was appropriate, particularly in light of their limited resources at the time;
- Mr CD's behaviour in relation to his admission, whilst compliant and acceptable, again demonstrated his limited interest in engaging with care and treatment by spending significant amounts of time off the ward;
- staff do not appear to have questioned the time he spent off the ward, or attempted to deter him from at least some of these outings, thereby limiting the opportunities for addressing any mental health needs;
- ward staff carried out appropriate assessment and monitoring of risk, care planning and attempts to engage Mr CD;
- the ward used the 'Recovery' model of care, with which Mr CD did participate, but given his complex needs it is questionable as to how useful this model could be - the nature of his personality disorder would have made sustained engagement extremely difficulty.
- he was seen for initial assessment by both the OT service and the psychology service, but was discharged before any further interventions could be agreed or delivered.
- the Acute Transition Facilitator did excellent work in making appointments and arrangements to meet his various needs on discharge, although the success of these arrangements were dependent on Mr CD's ability to manage these – which he was able to do
- in several services, practitioners relied heavily on Mr CD's reporting of risk – these included Melbury Lodge, the SIT and ARM service and the MENDOS service.

## The information infrastructure across the local healthcare system (ToR8).

To establish if the information infrastructure across the local healthcare system supports the delivery of effective clinical care and multiagency working.

5.149 There were difficulties with IT, in setting up an IT system that would allow Solent and CGL to access and share information and electronic patient records (Service Delivery Problem). The SIT was co-located with CGL, but in different parts of the same building. It was agreed that they would use the existing Solent system that was in place as Solent then provided the Hampshire SMS service and wanted to use the same system as Hampshire because the transient nature of the population and the boundary being a couple of miles from Southampton.

5.150 But the CGL system did not allow the use of the Solent system. This made building a 'seamless service' difficult and protracted. The IT issue was resolved, firstly in that Solent provided CGL with the hardware that would allow them to access the Solent system, and allow them to share information through a network. However, since September 2016, Solent have adopted the CGL IT system. The Hampshire SMS was re-commissioned to a different provider so the rationale for using the Solent system has gone. A bespoke system was developed and has been in use since Sept./Oct. 2016. This is now working well.

5.151 We concluded that these events do highlight the, perhaps unexpected, consequences of re-commissioning services. Along with the number of organisations involved in providing the various components of the substance misuse service, the implications for sharing information necessary for effective clinical care between agencies become apparent. The picture can be further complicated if a service user is diagnosed with both mental illness/personality disorder and substance misuse. We acknowledge that such issues may not be identified until after the tender has been awarded.

### Recommendation 9

When commissioning and re-commissioning services, local commissioners should ensure that contracts consider the potential impact of non-compatible IT systems, carry out a gap analysis and risk assessment and mitigate any risks identified. Assessment and mitigation of any risks arising from new contracts entered into by local commissioners which involve incompatible IT systems should be monitored prior to implementation.

## Duty of Candour and involvement with families of the victim and perpetrator (ToR7 and ToR13)

Review and comment on any communication and involvement with families of the victim and perpetrator before and after the incident.

Review and comment on the trust(s) recording of its undertaking of its Duty of Candour.

5.152 We note that the general Duty of Candour, to act in an open and transparent way, applies in these circumstances, but that the additional steps required by the statutory Duty of Candour do not apply.

5.153 The final version of the combined internal report of the investigations carried out by SHFT and Solent makes no specific reference to the Duty of Candour[48]. An earlier version does refer to the Duty of Candour in relation to one of the services – the SHFT individual report does not include reference to the Duty of Candour; the Solent individual report does.

5.154 The final version of the combined report notes that there was no contact with Mr CD about the investigation, after the incident. The report erroneously states that his family were not involved with Mr CD. In fact, Ms PQ, the MENDOS worker, when she saw him in police custody after the incident recorded that his mother was bringing clothes into him; and when he was in Melbury Lodge he spent leave with his mother. If SHFT had taken note of this contact, it would have been appropriate for them to attempt contact with his mother following the incident.

5.155 The family of the victim was not contacted because the police investigation was ongoing at the time the reports were written. This is the correct action in the circumstances.

5.156 The Solent report states that the service will be able to engage with the families as part of the formal homicide review process should they (the families) be amenable to this.

5.157 Neither action plan makes any reference to the Duty of Candour.

5.158 There is no record of any involvement with any family member of Mr CD prior to the incident. We would not expect this of Solent SMS since he was only in contact with the service provided by them on two occasions. There is no reference in the records that his family featured in the thinking of any healthcare professionals who saw him in the SMS or CMHNs provided by SHFT or by members of the HHCT provided by Solent. Again, this might be reasonable, given his lifestyle and resistance to engage with professionals except when requesting help with specific needs and wants.

5.159 There is reference in the SHFT records to him spending leave from Melbury Lodge with his mother on one occasion. There is no record that she visited him on the ward. Again, given the limited contact with this service (two weeks' admission, with the equivalent of one working week out on leave), it is perhaps understandable that the service did not pursue contact with his mother. However, if they had contacted his mother, she might have been able to provide information to assist them in developing a more accurate risk assessment and more appropriate care plan. We do appreciate that this is speculative.

5.160 We conclude that there may have been a missed opportunity to engage Mr CD's mother in the internal investigation and that the lack of reference to the

[48] The legal requirement to inform families and carers when things go wrong in the care and treatment of a patient/service user which is provided by or funded by the NHS.

Duty of Candour in the joint report is concerning. The non-involvement of Mr Beattie's family was appropriate in the circumstances.

Recommendation 10
Solent and SHFT must ensure that the Duty of Candour policy and procedures are followed in cases where a service user commits a homicide, and that actions taken under this duty are accurately recorded. Compliance should be audited within 3 weeks of any homicide being identified and reported to the Trust.

## Lessons and/or recommendations that have implications for all social and healthcare providers (ToR12).

To identify any lessons and/or recommendations that have implications for all social and healthcare providers both locally and nationally.

5.161 We considered that the work completed by Prof. GH on the Dual Diagnosis policy (paragraphs 5.35 to 5.38) could be the basis of lessons learnt and be useful in the wider locality and nationally, since it addresses significant issues we have examined in similar cases associated with service users who challenge multiple organisations.

5.162 Mr CD underwent a RAPt programme (paragraphs 5.49, 5.50) We considered that similar services which are not already using RAPT should consider its potential value and that it would be useful to disseminate this more widely.

5.163 We have noted our concerns about the reliance on self-reporting in the care and treatment of Mr CD (paragraphs 5.32 to 5.34, 5.75, 5.77, 5.109 to 5.110 and 5.139). This is another lesson learnt that has ramifications more widely as again it is a recurrent theme in similar cases we have reviewed[49].

5.164 We have also noted concerns about the, no doubt unintended, consequences that can occur following re-commissioning of services – there is a responsibility on commissioners and potential providers to ensure that assumptions are not made in the process or specifications about 'who will provide what' (paragraphs 5.39 to 5.46), and the need to take into account any risks to information sharing and compatible record-keeping arising from changes to the IT systems in use (paragraphs 5.149 to 5.151).

## Consider if this incident was either predictable or preventable (ToR14)

Consider if this incident was either predictable or preventable.

5.165 The members of Mr Beattie's family who contributed to this report noted that the Winchester Prison Integrated Offender Management Team had reported that Mr CD's mental health had deteriorated during his sentence: the family informed us that, during the court case, Mr CD's 'increased aggression, agitation, violence, anxiety and mood problems were clearly articulated'.

5.166 However, Mr CD did not receive a mental health assessment either immediately prior to his release from prison or shortly afterwards. Family

[49] For example, in our review of the care and treatment of Mr RS we identified reliance on self-reporting constituted part of the 'root cause' in this case. Details in: Report into the care and treatment of Mr RS

members concluded that a full assessment and associated care and treatment should have been carried out and that their brother's murder was 'clearly predictable and preventable'. They noted that there were 'numerous faults on all levels of professionals involved'.

5.167 Mr Beattie's family were very clear that a full mental health assessment of people exhibiting mental health problems in prison prior to or shortly after release will lead to improved services or follow up/monitoring for those people, with access to appropriate mental health care to meet their needs. Mr Beattie's family members therefore firmly believe it was preventable and predictable. Mr Beattie's family members would recommend a policy being in place around offenders presenting as Mr CD did, receiving a full mental health assessment and appropriate decisions taken around level of risk. Mr Beattie's family believe that appropriate interventions, follow up and monitoring could then be put into place to prevent such tragic circumstances occurring in the future.

5.168 The family also recommend and request that Mr CD has thorough monitoring and treatment whilst in prison, and the above mentioned recommendations are in place when Mr CD is released from prison. The family believe that a person as high risk as Mr CD needs an extremely high level of monitoring when released so as not to commit murder a second time.

5.169 Whilst we readily acknowledge the family's right to their opinion and are happy to incorporate it into this report, our professional judgement remains that this homicide was neither predictable nor preventable.

5.170 We regard 'predictability' as 'the quality of being thought likely to happen, as behaviour or an event'[50]. Our examination of risk assessments acknowledges that these assessments involve someone estimating a probability. If a homicide is thought to have been predictable it means that, at the time of the event, 'the probability was high enough to expect intervention or action by professional practitioners to attempt to avoid it'[51].

5.171 We regard 'prevention' as meaning to stop or hinder something from happening especially by advance planning or action. This involves reviewing the process of care delivery to identify any missed opportunities which, if action had been taken, might have resulted in a different outcome. Therefore, for a homicide to be considered preventable, there would have to have been the knowledge, legal means and the opportunity to stop the event from happening[52].

5.172 On the basis of these definitions and for the reasons sent out in paragraphs 5.172 and 173, we have concluded that this specific incident was neither predictable nor preventable by either mental health services (SHFT) or substance misuse services (SHFT/Solent).

---

[50] Definition of predictability

[51] Munroe E. and Rumgay J. (2000) 'Role of risk assessment in reducing homicides by people with mental illness' The British Journal of Psychiatry, 176 pp 116-120.

[52] Munroe E, Rumgay J. (2000) as above.

5.173 We fully agree with the family that past violence may predict future violence – but we are equally clear that past violence does not predict murder of a particular individual at a specific time and place. Similarly, whilst we agree that it would have been best practice for Mr CD to have received an assessment of his mental health prior to discharge, there is no guarantee that this would have led to care and treatment that would have prevented the homicide. There is no evidence that he suffered from a mental disorder of a nature or degree sufficient to warrant detention under the Mental Health Act 1983, amended in 2007, which would have provided the legal means to stop the homicide from taking place.

5.174 We also note that the Judge identified mitigating factors in his sentencing remarks. These mitigating factors were that:

- Mr CD did not intend to kill Mr Beattie; and
- the 'level of heroin in Mr Beattie's blood contributed to the death'.

5.175 Whilst respecting the absolute right of Mr Beattie's family to come to their conclusion as set out above, our professional conclusion remains that the murder of Nick Beattie on 20 March 2015 could neither have been predicted or prevented.

# 6 Review of the Trusts' joint internal investigation report and action plan (ToR6).

Review the both Trusts' internal investigation and assess the adequacy of its findings, recommendations and action plan to:

- Identify if the internal investigation satisfied its own terms of reference (paragraphs 6.3 to 6.45);
- Identify if all key issues and lessons have been identified and shared (paragraphs 6.3 to 6.45);
- Whether recommendations are appropriate and comprehensive and flow from the lessons learnt (paragraphs 6.3 to 6.45);
- Review and comment on progress made against the action plans (paragraphs 6.47 to 6.52);
- Review processes and comment on those in place to embed any lessons learnt (paragraphs 6.66 to 6.96);
- Review and comment on the efficiency of monitoring of the action plans by the trust internal governance structures (paragraphs 6.66 to 6.96).

## Review of the internal report

6.1 We reviewed the combined report of the investigations carried out by SHFT and Solent, using the audit tool described in the methodology section. Each Trust had independently completed a serious incident review into their care and treatment of Mr CD, and these had later been combined into one report. Solent carried out a Level 1 concise investigation as Mr CD was under their care at the time of the homicide; the SHFT incident review was amalgamated with the Solent report.

6.2 We were unable to interview the authors of the report as one had left the Trust and the other was on leave. Interviewing the authors might have provided us with additional insights, but we do not consider that this

materially affected our ability to review and comment on the internal review and report. We did interview representatives of each Trust about the action plans and were able to review the extent to which the Trusts had implemented them.

## The investigation process

6.3 The only two individuals identified in the report were the authors – a senior psychologist (SHFT) and a 'manager' (Solent). There was no reference to other members of the team or input from other disciplines. Broader professional perspectives on Mr CD's care and treatment would have enhanced the report.

6.4 Limited information about the homicide was available to the authors at the time of the investigations. Although some of the details are incorrect (date and time of arrest) brief information about the homicide is reported. The circumstances of the incident and cause of death were not known.

6.5 Ms PQ was the first clinician to learn about Mr CD's arrest when she made a routine visit to the police station where he was held. She saw Mr CD and made appropriate referrals based on her interview with him.

6.6 The date when the review commenced was not included. The independent SHFT report was completed within 45 days (within the timescale required); the date the Solent report was completed has not been made available to us.

6.7 Separate Terms of Reference were provided for each Trust's investigation. We considered these to be clear and appropriate.

6.8 Both Trusts reviewed appropriate supporting information, including clinical records from both Trusts and relevant policies and procedures.

6.9 Each Trust interviewed a range of staff to enable the authors to understand the care and treatment provided to Mr CD and the Trust responses to the incident. This included Mr CD's GP at the time of the incident (Dr DE working with the HHCT) and as well as professionals from the substance misuse service, from MENDOS, from ARM and from the CMHN service attached to the HHCT.

6.10 There was no opportunity to interview someone from the IOM at Winchester prison. The CRC was considering whether or not to hold their own internal review and asked SHFT to defer contact. Mental health services reported that communications from the IOM were 'timely and responsive' so did not pursue the matter.

6.11 Relatives of the victim were not approached as the case was still under police investigation; Mr CD's relatives were not approached by SHFT 'due to no current involvement with Mr CD'. This was not in fact correct – according to Ms PQ's record of her interview with him in police custody on 23 March 2015, his mother was going to be bringing some clothes into him. There was therefore no family input into their review. We feel that some attempt should have been made to contact Mr CD's mother once these records had identified her current contact with her son.

6.12 The individual Solent report states that Mr CD was in custody and that the service had had no contact with him. There is an expectation that the family will be offered involvement in the 'formal homicide review process'. There is a

statement to the effect that there had been no contact with the family as the family were not involved with the case or with Mr CD. There is no evidence that they made any attempt to ascertain if Mr CD had been in any contact with his family. Once the two reports had been combined and his contact with his mother known, it would not have been unreasonable for Solent to have approached Mr CD's mother with SHFT.

6.13 Overall, the process was transparent and open. In particular, arrangements for sharing learning within and between the two Trusts are listed, including review by governance and incident review panels. The report was shared with both Trusts, Southampton CCG and NHS England.

6.14 The report is described as a 'Root Cause Analysis'. The only specifically RCA technique used was a detailed timeline of Mr CD's contacts with both Trusts. A 'Fishbone' diagram sets out 'contributory factors' derived from James Reason's work on patient safety.

6.15 We note that the internal reports identify contributory factors which relate to the patient and the environment, and identified several care and service delivery problems. We agree with the issues identified as aspects of care and service delivery which could be improved. We agree that these did not contribute to Mr CD committing the homicide. We also agree with their conclusion that the homicide was neither predictable nor preventable.

## Review of Mr CD's care and treatment

6.16 There is a detailed chronology of the care and treatment provided to Mr CD by the two Trusts.

6.17 There is reference to Mr CD's previous violent behaviour and violence offences, provided at different points through the clinical records. There is no detailed overview of his criminal history, although there are references to individual offences and sentences – one of these was definitely a community sentence; and there are references to him being seen in police custody and receiving a prison sentence; and to him being released from prison. Half of his 10 episodes of care with the substance misuse service ended when he was sentenced to imprisonment. There also a reference to domestic violence and his 'abusive and threatening' behaviour when told by Dr DE that she would only prescribe a reducing dose of diazepam.

6.18 There is a section on the 'roles and responsibilities for risk management'. This section discusses risk assessment and management by the various services involved with Mr CD. The report notes that the ARM service uses the 'DICES' risk assessment model, which relies entirely on self-reported risk. The authors of the report note their concerns about this. Although the report states that a DICES assessment was carried out when he was released from prison (in March 2015) there is no evidence of or reference to this assessment tool in the clinical records we were given. The report also records that the person completing the assessment relied on her memory of his history from contact in 2007 (Service Delivery Problem).

6.19 The report notes that Mr CD had a risk management plan which included his risk of violence, including several convictions for violence, and risks to himself with history of self-harm and overdoses, family history of suicide and diagnosis of ASPD.

6.20 The authors concluded that staff understood the nature of risk and their responsibility to assessment and management of risk, and where to refer service users if they considered there was a risk to self or others due to the individual's mental state.

6.21 The report comments that, when Mr CD left the needle exchange service when he was talking about committing suicide, the staff did report this to the police. The manager agreed, with hindsight, that they should have also informed the SHFT crisis service in case he came to their attention via another route.

6.22 There is a detailed review of the care and treatment of Mr CD by both SHFT and Solent services, and several issues are identified, including:

- Delay in forwarding discharge information from Melbury Lodge on 1 August 2014 (five days before the discharge information was received by the HHCT) related to the rotation of junior doctors, with new staff being on induction programmes, and the consultant being on annual leave. New arrangements have been put in place to respond to requests for information at this time in this area.
- Communication between services, particularly with the transfer of SMS from SHFT to Solent on 1 December 2014; and following release from prison on 13 March 2015. The report noted that work to improve the interface was being addressed through development of a Dual Diagnosis policy.
- SHFT SMS records prior to December 2014 were paper records and had to be requested by the new Solent service; a summary of information about each service user, including care plans/risk assessment and management/prescription details, were uploaded to the electronic record, but the quality was variable.
- Communication between the prison referral for him to be assessed for residential drug rehabilitation was reviewed, although the reports are inconsistent. At one point the report confirms that a referral was made and that there was a discussion but no record was made. Elsewhere, the report indicates that no referral was made.
- IT issues – the Solent Structured Intervention Team had difficulties accessing the ARM reports and therefore were generally having difficulty identifying service users who had been referred to them. In the case of Mr CD, however, the 'referral' box (Service Delivery Problem) had not been completed, in error.
- Mr CD's difficulties in engaging with services, including not attending for appointments and not responding to telephone calls.

6.23 There is no discussion of any vulnerable child or adult issues. There is reference to Mr CD having a daughter, but that he had no contact with her; there is reference to domestic violence in relation to a previous relationship but no evidence that he was in a relationship during his contacts with the Trusts. There is reference to Mr CD's mother but no information about the nature of their relationship, so we cannot assess if she might have been a vulnerable adult in this context.

6.24 There is no reference to a care needs assessment as such. Various diagnoses are mentioned - benzodiazepine and methadone addiction,

reported low mood and suicidal ideation, PTSD, ASPD and DPD. The report notes that he was assessed on several occasions as not having a mental illness. There is also a description of his housing difficulties and attempts that were made to resolve these.

6.25 There is a description of why he was not referred to mental health services prior to discharge from prison in March 2015, noting that he was assessed as not having a mental illness, other than his substance misuse. This was recorded by the prescribing doctor on 13 March 2015 and that he did not require involvement of the mental health service.

6.26 However, a worker from the Integrated Offender Team at Winchester Prison had described that she felt his mental health had deteriorated, being quite anxious and aggressive, with his mood out of control'. He had not been seen as a priority by the prison mental health team as he was being seen by the drug treatment service, and was not referred for mental health care on release. The report did not investigate this decision, given the reported deterioration in his mental health. The IOM worker was informed that he could attend the HHCT service on release, which he did.

6.27 The report does review compliance with relevant local policies and procedures, as follows:

- joint management of dual diagnosis clients;
- lack of understanding of the serious incidents policy;
- compliance with Solent's procedure for managing drug and alcohol screening;
- non-adherence with the Medicines Control, Administration and Prescribing Policy;
- lack of protocols between the new providers of the ARM service and Solent SMS on joint working;
- staff not always making best use of the Clinical Engagement/DNA policy.

6.28 This last point seems inconsistent with comments elsewhere that the HHCT CMHN were to be commended for the efforts they made to keep in contact with Mr CD.

6.29 The report identified issues in relation to IT systems which made sharing access to Solent's SMS records difficult (after they had taken SMS services over from SHFT in December 2014) and that these were ongoing at the time of the internal reviews. When this service was transferred to Solent, the paper records from the SHFT SMS were archived and, according to this report, Solent staff could not access them. In fact, we were told at interview that these records could be accessed, but staff did not know how to do this.

6.30 There is a detailed discussion of the relationship between the different services Mr CD was in contact with, particularly between Solent SMS and SHFT mental health services. It would have been helpful to external reviewers if there had been a clear description of the relationship between the primary care part of the HHCT and the CMHNs who provided mental health input.

6.31 There is a review of issues arising from the transfer of Mr CD's care from Melbury Lodge to the HHCT, particularly the non-receipt of a fax sent from

Melbury Lodge to HHCT. The report went on to review his 7-day follow-up appointment and the difficulties for staff in engaging Mr CD with care and treatment.

6.32 No issues in relation to police liaison were identified and none were apparent from our review of the records. We initially felt that there did not seem to be a system for the police to proactively refer people in custody to MENDOS except during routine visits. It was not until the interviews that we discovered that the MENDOS service consisted of only two people who did not have the capacity to respond to referrals in any way other than routine visits.

6.33 The lack of a bed at Antelope House (Southampton) when Mr CD presented with thoughts of suicide and was admitted to Melbury Lodge (Winchester) was not identified as a resources issue.

6.34 The only issue regarding staff training that was identified concerned the failure of the MENDOS worker to refer the incident to the area service manager in accordance with the policy for managing serious incidents. A recommendation was made to rectify this.

## Analysis in the report

6.35 From the perspective of the individual authors, the logical connections between facts are drawn out. Any weakness in logical connections may be attributed to the amalgamation of the separate service perceptions of roles and functions. There is a small number of examples of inconsistent or contradictory accounts of events.

6.36 Whilst gaps between what did happen and what should have happened are described, there is limited analysis as to why these gaps occurred.

6.37 Conclusions are based on the evidence provided and relate back to the Terms of Reference. The investigation did satisfy the Terms of Reference set by each Trust. Recommendations for action are appropriate and comprehensive and flow from the lessons learnt to improve services and are clearly linked to the conclusions drawn.

6.38 There are two explicit action plans – one for each Trust. In line with best practice, these include timescales for completion of each action and an identified person responsible for implementing these actions. Developments in services and actions taken since the incident are identified.

## Accountability

6.39 In these reports, several systems weaknesses were identified but no individual's performance in Mr CD's care and treatment was identified as deficient. Clear recommendations were made to address the system failings which were identified.

## The report

6.40 Given the complexities of the services involved, the amalgamation of two separate reports and Mr CD's unstable lifestyle, it is at times difficult for an external reader to 'follow the story'.

6.41 As noted previously there are occasional examples where there are inconsistences in the description of some events. It is possible that this arises from the fact that the individual reports were amalgamated.

6.42 The report avoids emotive language and presents an objective account of Mr CD's care and treatment.

## Positive practice

6.43 The SHFT report did not identify any positive practice in the care they provided to Mr CD. For Solent, the report concluded that staff efforts to maintain a safe service whilst 'working with unclear processes and IT issues' when the structured intervention service transferred from SHFT to Solent on 1 December 2014 were commendable.

## Lessons learnt

6.44 Following the incident the SMS discussed follow-up and monitoring service users who had been released from prison who were commencing opiate substitute treatment. Mr CD had asked to collect his prescription for methadone from the pharmacy rather than going to the clinic to get his prescription and take the methadone there. Because of the fact that Mr CD later reported that he had been taking methadone and heroin, the service now requires people to be followed up by them at least once a week. This was implemented prior to the completion of the RCA report.

## Care and service delivery problems/lessons learned

6.45 A number of these were identified and are reflected in the 14 recommendations which are summarised below:

- adherence to medication policy, including clarification of a preferred surname if service users have more than one (SHFT);
- discharge and risk information to be available to GP within the agreed time frame to ensure good continuity of care across services (SHFT);
- consultant medical cover to be available during period of junior doctor rotation to ensure good transition management within and between services (SHFT);
- Hampshire Liaison and Diversion Service to notify relevant staff/services when a service user is in custody (SHFT);
- staff to be reissued with guidelines on procedure for onward reporting deaths to Area Management team (SHFT);
- staff to be aware of Clinical Engagement/ Did Not Attend Policy for service users who are difficult to engage (SHFT);
- acute care pathway team to ensure the GP is aware of prescribed medications at the point of discharge (SHFT);
- full risk information to be shared with the ARM service and the SIT prior to any prison release (Solent);
- Solent to work with the ARM service to implement a basic mental health screening tool to provide guidance of pathways and treatment (Solent);
- Solent to work with CRI to work together to develop clear protocols for partnership working in place around roles, responsibilities, procedures and quality assurance (Solent);

- Solent to ensure that the onward referral field is completed in the electronic form appropriately and for each intended referral from ARM to the SIT (Solent);
- the IT infrastructure issues to be resolved to the benefit of all users of the service (Solent/SHFT);
- senior management to request a review of the Hampshire Commissioning Strategy and Southern Health Dual Diagnosis Policy relating to the Joint Working Protocols between CMHTs and SMS with Southern Health and the Council Commissioners. This will provide services with clear guidance regarding roles and responsibilities for those with a dual diagnosis (SHFT/Solent);
- interagency Dual Diagnosis Meetings to be re-established to review the management of service users with dual diagnosis to ensure good cross service working (SHFT/Solent).

6.46 Overall, we came to the following conclusions:

- The internal investigation satisfied its own terms of reference, which were appropriate, although we considered that report would have been improved if a broader range of mental health professionals had been involved, to reflect the range of services Mr CD made use of.
- Appropriate key issues and lessons were learnt, and there were appropriate mechanisms for sharing the learning.
- Recommendations were appropriate and derived from the conclusions: we agreed with the care and service delivery problems that they identified and with their conclusion that the incident was neither predictable nor preventable.
- Efforts should have been made to involve Mr CD's mother in the investigation but it was appropriate that they did not attempt to involve Mr Beattie's family whilst the criminal justice process was not complete. The failure to mention the Duty of Candour is a notable omission.
- The fact that this report was an amalgamation of two separate reports may account for some inconsistencies in the joint report. This, in conjunction with the complexity of the services Mr CD accessed and changes in the providers of these services contribute to the lack of narrative flow at times,

## Progress made on the delivery of action plans (ToR10)

To independently assess and provide assurance on the progress made on the delivery of action plans following the internal Trusts' investigations.

6.47 We reviewed the action plans for each Trust and discussed their implementation with senior managers responsible for the services involved.

6.48 We asked the Trust to provide documentary evidence of implementation of action plans. We reviewed this evidence and evaluated implementation of the plans using an adaptation of the NHS Litigation[53] Authority model. This uses

[53] NHSLA (2013) Risk Management Standards 2013-14 for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care. NHS Litigation Authority.

three levels of assessment of risk and the principles applied to each level were applied to the implementation of action plans. These are:

- Level 1 - Policy: evidence has been described and documented.
- Level 2 - Practice: evidence has been described and documented and is in use.
- Level 3 - Performance: evidence has been described, documented and is working across the whole organisation.

6.49 The table below sets out the recommendations/actions identified by each Trust, the evidence produced and our assessment as to the current level of implementation.

| SHFT | | |
|---|---|---|
| Action | Evidence | Level of implementation |
| Service user name to be confirmed at point of admission (where known by more than one surname) and at time of medication dispensing to ensure accurate medication concordance. | The Trust has confirmed that the Action has been "Completed and ongoing", but has not provided any supporting evidence. | Unable to ascertain without supporting evidence. |
| Discharge and risk information to be available to GP within the agreed time frame (24 hours) to ensure good continuity of care across services. | Lead administrator monitors this daily – any problems are drawn to the attention of the consultant. And additional support is provided for junior doctors if necessary.<br>HHCT reported this has improved. | Level 3 |
| A more systematic approach to medical cover at the point of Junior Doctor induction. | The system now is that there is always consultant cover when there is a changeover of junior doctors. This applies across the Division, not just at Melbury Lodge. | Level 2 |
| Re-establishment of Interagency Dual Diagnosis meetings across Southampton to facilitate management of service users with substance misuse issues. | These meetings are now happening (agenda and minutes seen); community mental health teams in the area all have a dual diagnosis lead, they attend | Level 3 |

| | | |
|---|---|---|
| | the meetings and take any concerns from their team to the meeting; and feed information from the meeting back to their team. Communication is two-way. | |
| Hampshire Liaison and Diversion Services to notify relevant staff when service user is in custody. | This service is now managed by one person, who also manages the crisis team and A&E team; they are now part of the crisis pathway and are part of the system.<br>There is now a 'notification tracker' to monitor this. This refers to the weekly HLDS team meeting "Tracker" which ensures appropriate action is taken for all patients seen. | Level 3 |
| Staff to be reissued with the guidelines for incident reporting to ensure all serious incidents are reported to the Area Management team at time of detection. | The process has been revised since the incident and new guidance has been issued. | Level 1 |
| Embed Clinical Engagement/ Did Not Attend Policy SHCP97 | A revised policy has been launched at the area learning network. | Level 1 |

| Solent | | |
|---|---|---|
| Recommendation/Actions | Evidence | Level of implementation |
| Recommendation:<br>Full risk information to be is shared with the ARM service and the structured intervention team prior to any prison release.<br>Actions:<br>SIRI report to be shared with CRI – completed;<br>Contact details to CRI for PHE lead – completed. | Implementation can be patchy, depending on the prison. The relationship with local prisons has improved. | Level 1 |

| | | |
|---|---|---|
| Within the comprehensive assessment there is no specific mental health assessment tool to support the identification of mental health needs.<br>Actions:<br>Share SIRI report with CRI to raise the issue – completed;<br>Solent NHS Trust to work with the ARM service to implement a basic mental health screening tool. | The ARM service has now been commissioned from CGL and both the Solent SMS and CGL use the same electronic patient record system. This IT system includes a screening element within the mental health assessment and space for an account of mental health service involvement. | Level 1 |
| There is a need to develop robust pathways for all client's accessing the Service.<br>Action:<br>Clear protocols for partnership working to be developed and implemented within CRI and Solent around roles, responsibilities, procedures and quality assurance. | All post holders have job descriptions which have been reviewed; roles and responsibilities reviewed as part of the 10-week transition period after SMS and CRI was commissioned to provide the SIT and ARM services respectively. Patient pathways were mapped.<br>Solent and CGL have introduced a 'pod' system – every two care coordinators link with one or two nurses from the Solent SIT and they have a team approach for a specific number of people.<br>The relevant KPIs have been met or exceeded in the last six months. | Level 3 |
| The IT infrastructure across the partnership requires continued, consistent attention until all issues are resolved to the benefit of all users of the service.<br>Actions:<br>To work with the IT providers to rectify IT issues to support medical practice. | These issues were finally resolved when CGL and Solent SMS agreed to use the CGL IT system for electronic patient records and for sharing information. | Level 3 |

| | | |
|---|---|---|
| Senior management to request a review of the Hampshire Commissioning Strategy and Southern Health Dual Diagnosis Policy relating to the Joint Working Protocols between CMHTs and SMS with Southern Health and the Council Commissioners.<br><br>Solent Medical Director to send a letter to Medical Director (Quality) of SHFT.<br><br>To provide provider services with clear guidance regarding roles and responsibilities for those with a dual diagnosis. | Solent Medical Director wrote to the SHFT Medical Director (quality) to raise this issue.<br><br>A new Dual Diagnosis policy has been developed by Professor GH (SHFT) in conjunction with staff from Solent and approved in 2016. This policy comprehensively addresses the concerns raised; quarterly dual diagnosis meetings are in place for the city, and a consultant psychiatrist represents Solent SMS. | Level 1 |
| Ensure that the onward referral field is completed within Nebula appropriately and for each intended referral from ARM to the Structured Intervention Team | This action has been superseded by the new IT system – it is no longer necessary to complete the onward referral field in this way.<br><br>Relevant KPIs have improved. | Not applicable |

6.50 We discussed in interviews changes in the organisations commissioned to provide substance misuse services and the changes to the criminal justice system. We were advised that the changes had led to improvements although the pace of change and change across multiple agencies could make it more difficult to achieve consistency in standards for joint working arrangements and sharing communications.

6.51 In conclusion, the Trusts provided supporting evidence for all actions (except SHFT action 1): we have independently assessed this evidence and can provided assurance that the Trusts' have made progress in implementing these action plans (with the exception of SHFT action 1).

6.52 As a result of our review of the action plans and their implementation we are proposing the following recommendations.

Recommendation 11
Solent NHS Trust and CGL to work together to monitor the effectiveness of the screening element within the mental health assessment and space for an account of mental health service involvement. A report on progress towards this monitoring to be shared with stakeholders 6 months following the publication of this report.

Recommendation 12

The Trusts should jointly carry out an audit of the Dual Diagnosis policy within 12 months from the publication of this report, to evaluate its effectiveness in addressing the issues raised in this report and the internal investigation report.

## Compliance with policies and procedures for managing serious incidents

6.53 We reviewed policies and procedures from each Trust which set out the requirements for reporting and managing serious incidents which include homicide committed by a current service user of a mental health Trust (or within 12 months of the last contact - 2013 Serious Incident Framework; 6 months – 2015 Serious Incident Framework, although this is guidance).

### SHFT policies and procedures

6.54 Ms PQ, the MENDOS worker who saw Mr CD in police custody, was the first member of staff from either Trust to become aware of the homicide. However, she did not realise that the SHFT policy required her to report the incident. This was because Mr CD had been in contact with mental health services within the previous 12 months, even though he was not a SHFT service user at the time of the incident. This was identified in the internal report and a recommendation made to rectify this omission in future. We note however that the timescale included in the 2016 version of the procedure reduces the timescale to 'normally within 6 months of discharge from care'[54]. If the current policy had been in place at the time of the homicide, the incident may not have triggered an internal investigation, as it occurred just outside the six month timescale.

6.55 The SHFT's procedure for internal investigation in place at the time of the incident states that an internal investigation should be completed within 45 days following the incident. Their individual report was completed within that timescale, on 4 May 2015.

6.56 The same procedure does make provision for, but does not require, the use of clinical or non-clinical experts to provide specialist advice. We note that, in this incident, expert advice on homelessness, forensic psychiatry or dual diagnosis would have enriched the report. Given the multiple practitioners, including specialists and agencies providing services to Mr CD, a wider range of contributors to the internal investigation would have offered the opportunity to drill deeper into the specific areas around the knowledge and experience of practice issues.[55]

6.57 This procedure also refers to situations, such as this, where a service user receives care from SHFT and another provider. In this case, 'a lead organisation should be agreed to coordinate the local investigations and

[54] SHFT: Procedure for the management of serious incidents that require investigation, version 2, March 2016, paragraph 3.3. This timeframe is guidance only so there may be situations where there is a longer gap after discharge.

[55] The independent panel did include members with experience and expertise in forensic services, dual diagnosis, and homelessness, details are in Appendix D.

amalgamate findings or alternatively oversee a joint investigation'[56]. We consider that, in the case of Mr CD, a joint investigation, or at the very least, a coordinated investigation would have provided a more readable and more focussed report. We note that the 2016 version of the procedure uses different phrasing, referring to a 'multi-agency Serious Incident'. If Mr CD's situation was being investigated under this policy, the following would apply:

> "collaborative working between partner agencies is essential, and ideally, only one investigation should be undertaken. Commissioners should be included in deciding which organisation takes the lead in any investigation." (Appendix Seven)

6.58 Whilst the Duty of Candour is referenced within the 2014 procedure, there is no reference at all to this principle in the combined internal report. Whilst the authors do provide reasons why they did not involve relatives in the report, reference to the Duty of Candour would have established an explicit connection with the requirements of the procedure. The more recent procedure includes new requirements to involve relatives more fully in internal investigations – including offering the opportunity to contribute to setting the terms of reference.

## Solent policies and procedures

6.59 Solent provided us with their 'Serious Incidents Requiring Investigation (SIRI) Policy' dated 2013; and their 'Serious Incidents Requiring Investigation (SIRI) Policy (including Mortality review)' dated June 2016.

6.60 The Solent 2013 policy (in place at the time of the incident) required this investigation report to be completed within 45 working days. It is not stated as to when the investigation was commissioned but it was completed on 22 May 2015, which was 45 days after the incident.

6.61 This policy also sets out that a Strategy Meeting will provide a 'commissioning brief for the investigation detailing any specific questions that need to be answered'. The Solent report does not include the commissioning brief, making it difficult to review the extent to which the individual report fulfilled the requirements of the Strategy Meeting.

6.62 As well as appointing an Investigating Officer, there is also reference in the policy to a Specialist Officer. As we have previously said (paragraph 6.3, 6.56), we consider that the investigation might have been improved in terms of breadth of understanding if there had been additional input from specialist health care professionals, as indicated by this policy.

6.63 The policy does refer to the Duty of Candour requirements, and the individual report does address this. Again, the author erroneously concludes that there was no family involvement with Mr CD. This is quite reasonable, as there were only two contacts with Solent services and there was no opportunity to work with him to the extent of finding out about and involving his family in his care. The Trust would not be expected to approach Mr Beattie's family as the court proceedings were still ongoing.

---

[56] SHFT: Procedure for the management of serious incidents that require investigation, version 1, March 2014, paragraph 6.5.

6.64 However, there is an expectation in the individual report (also replicated in the joint report) that 'the service will be able to engage with the family as part of the formal homicide review process should they (the families) be amenable to this'. Whilst it is not clear from this report what is meant by 'formal homicide review process', communication with the SC CCG suggests that this may refer to the independent review process. If this is the case (and we were unable to confer with the report author), then we wish to clarify that we would not involve services in our discussions with family of either perpetrator or victim. If they had been willing to contribute to the investigation then the results of that contribution would have been referenced within the report and available to services.

### Conclusions

6.65 There is no reference within either Trust's policies to homicides as serious incidents and the additional requirements for reporting and involvement of NHS England's homicide team and the possibility or probability that a report may be read and used as a 'springboard' for an independent investigation. Such reference might support authors of similar investigations to write for an external audience and include a description of services involved; who commissions and provides these services; and an explanation of any complexities such as transfer of services from one provider to another or changes to commissioning arrangements. In contradiction to the SHFT policy, a joint investigation was not undertaken, although the two reports from each organisation were consolidated into a single report.

### Recommendation 13

We recommend that, where a service user who is involved in a homicide (or other SIRI) is receiving services from more than one NHS Trust, that a joint investigation should be carried out by those Trusts. NHS Improvement should include guidance to this effect in their review of the Serious Incident Framework. A progress report should be published within 6 months of the publication of this report.

## Review of processes to embed learning and of internal governance systems (ToR6)[57]

6.66 We discussed with Mr BC (Solent) and Ms IJ (SHFT) how each Trust learned lessons from Serious Incident reviews and how each Trust assured itself that actions had been embedded. In addition, we reviewed public Board papers to assess how these processes might work in practice.

### SHFT Area level – Southampton

6.67 Currently, we were informed in interview that, once a serious incident report has been 'signed off', it goes to the local governance meeting and they discuss learning points from it. They discuss incidents which have happened in the previous month, and four key areas of learning.

[57] ToR6 is set out in full on p.69.

6.68 Ms IJ, area manager, produces a monthly learning hot spot. Any new learning would go in the learning hot spot. The report itself will go to any relevant team that were involved in the incident, for them to discuss at their team meeting, in more detail.

6.69 Every other month, they have a learning network meeting in the area. This was described as an interactive learning process around a theme that's come up quite a lot. Examples of themes are care planning, disengagement and working with families. They discuss: 'what do we get right, what don't we get right?' 'How can we change and improve?' In the broader Trust, the area provides evidence of improvement, so they report back on a number of SIRIs and the learning and the action they've taken.

6.70 Ms IJ has one area tracker for all actions in the area from SIRIs. Ms IJ reported that this goes to each team manager every month and that she goes through any actions that are red or due to become so. She told us that any learning gets aggregated up to a division level. The division has 'learning hot spots' and identify themes across the whole division. They will send out alerts when there's something quite specific and urgent that has come out of a SIRI across the division.

6.71 The division is working to be able to identify themes and trends more widely, so learning is not just about the individual SIRI.

6.72 At the time of the incident, the overall management of action was a very cumbersome task, which did not flow very easily. There was a backlog of overdue SIRIs. There was a delay in terms of the learning, and it could be some time before staff received the final version of the SIRI. They did not have the learning networks or learning hot spot. It was more about sharing the report and the individual actions.

6.73 Reports on learning go to Board level, and will be reviewed by executive and non-executive directors.

## SHFT Board level

6.74 A review of published Board papers for a meeting in January 2017 showed that SHFT was carrying out an ongoing review of family experience of engagement in SIRs, supported by external consultants.

6.75 The 'Serious Incident Oversight & Assurance Committee' reports to the Board. This Committee was created in response to the Mazar report, and is to be incorporated into the Quality and Safety Committee, one of the key committees which reports to the Board of Directors. Membership of the Quality and Safety Committee includes Non-executive Directors, the Chief Executive, the Executive Director of Nursing and the Medical Director.

6.76 SHFT has created the role of a Family Liaison Officer, to provide support and training to the Investigation Officers on family engagement. A patient engagement strategy is being developed to build on the findings of the external review of family engagement in investigations. The external consultants have begun a phase 2 review of embedding outcomes of the serious incident improvement plan.

6.77 The report on progress against the business plan included a section on investigations, including SIRIs.

6.78 The plan is for effective investigation and learning processes. All SIRIs have been closed on StEIS within the 60 day target, and only one was overdue internally.

6.79 Update on progress against the business plan, this section includes SIRIs.

6.80 Clinical divisions are using techniques such as 'hotspots' and 'learning matters' and are 100% compliant. Learning meetings take place in the mental health divisions and case studies are use in the Divisional Quality and Safety meetings.

6.81 The external report stressed that SHFT should work with families and service users to respond to its recommendations, to ensure that their needs and experience were at the heart of the Trust processes, ways of working and ensuring best use of resources. Wide engagement with voluntary sector groups, service user groups, families and carers groups has led to a number of people who have said that they want to work with SHFT to help them to improve things. The policy for investigations into serious incidents is also being reviewed by the Trust, including a review and feedback by some 'Experts by Experience'.

6.82 SHFT has also begun to develop staff training in the Duty of Candour with experts by experience. The role descriptions of the Investigating Officer and Commissioning Manager within the investigation process have been reviewed and updated and now include clear expectations ofpatient and family involvement.

6.83 The January Board papers included minutes of the Quality and Safety Committee, which provide evidence that the Committee does receive reports including the findings of independent homicide review commissioned by NHS England. The Committee 'took assurance' from the actions completed and planned in response. There will be a follow-up paper to the Committee in April, with an 'Evidence of Improvement Panel'. The aim is to provide assurance as to the evidence seen by the Panel on completion of actions and to address any remaining gaps.

6.84 The minutes of this Committee also report that there was progress toward meeting the national target of submitting Serious Incident Investigation Reports via StEIS within 60 days. They received a report which provided assurance of the reporting and investigation management processes for serious incidents.

6.85 Monthly 'Evidence of Improvement panels' are held within SHFT. As an example, the Committee received a report informing them of the findings of an independent homicide review commissioned by NHS England, and took assurance from the actions completed and planned in response. An Evidence of Improvement Panel and a follow-up paper to the Quality & Safety Committee were scheduled for April 2017 to provide assurance as to the evidence seen by the Panel on completion of actions and to address any outstanding gaps.

Solent – service level

6.86 The Quality and Standards Lead manages incident reporting and lessons learned. If a SIRI is commissioned and completed it goes through a variety of governance processes and groups. Within Mental Health Services there is the Governance of Essential Standards Group. The operational manager and quality and safety lead attend, and SIRI reports and action plans will go through there. That then leads on to a divisional mental health governance group, which also includes services such as pharmacy. The report and actions plans will then go to the assurance committee. This is a Board level meeting, which all Trust services feed into. That is the overarching governance group.

6.87 There is also a SIRI Panel that meets at least every month. This is chaired by the Chief Nurse and the Medical Director, where SIRIs would be signed off and that process enables them to get shared back with commissioners.

6.88 There are processes for learning lessons at two levels. We were informed that summaries are written quarterly of what they have learnt from complaints, incidents, SIRIs and mortality reviews. This learning goes out to all services, summarising some of the key things that they have identified in any of those matters in the previous quarter. The SIRI Panel also have a 'lessons learnt' log which goes out to services.

6.89 At the time of this incident (March 2015) the Substance Misuse Service had its own separate governance structure. It was very similar but it wasn't quite the same.

6.90 We were informed that Solent do monitor that lessons have been learned and that practices or systems have changed as a result, although it was something they felt could be improved. The next stage in the governance processes is that they go back and just check that actions do get done.

6.91 The pace of change can present difficulties. There can be turnover of staff, changes to local processes and to the national agenda. Nothing ever really stays still too long and it does impact upon the service's ability to maintain a consistent standard of approach, even though changes is generally for the better.

## Solent – Board level

6.92 We reviewed the November 2016 and January 2017 public Board papers.

6.93 There is an Assurance Committee which reports to the Board. The Committee's role includes seeking assurance on all aspects of quality. The Board receives reports from the SIRI panel and of any actions being taken.

6.94 The November Board meeting received the minutes of the Assurance Committee, which included reference to reports received from the SIRI Panel. The Committee focussed on the reporting and sharing processes and received assurances that key learning messages were shared. The last meeting of this Committee had received a report from Solent's Chief Nurse on plans to track actions raised from incident reviews – the Committee suggested that using the clinical audit process might strengthen the tracking.

## Conclusions

6.95 The information provided by SHFT, in conjunction with a review of published Board papers, suggests major efforts have been made to adopt a more rigorous and systematic approach to learning lessons and implementing actions arising from SIRIs in general and homicides in particular. There is evidence that external homicide reviews are discussed at Board sub-committees; there are processes for learning lessons and taking action; and that assurance is sought and received that actions are implemented.

6.96 For Solent, there are similar governance structures and processes in place to share learning and plans are being developed to monitor action plans. Some changes to the governance structure have been discussed and ratified.

# 7 Monitoring the Trusts' action plans by the commissioning CCGs (ToR11)

To independently assess and provide assurance that the monitoring of the relevant Trust's action plans by the commissioning CCGs is adequate.

7.1 We reviewed Southampton City CCG's (SC CCG) Serious Incident policy – this was revised in July 2015 to reflect changes to NHS England's Serious Incident Framework when the March 2015 version was published. The policy addresses the key areas we would expect – scope and definitions, management of serious incidents including reporting and monitoring), roles and responsibilities, training, equality analysis, success criteria/monitoring the effectiveness of the policy and review of the policy. Appendices include a 'closure checklist' and a table of commissioner responsibilities for the people of Southampton – this latter well illustrates the complexities of commissioning arrangements. The policy clearly says that a homicide committed by a person in receipt of mental health services may meet the criteria for a serious incident[58].

7.2 In the case of this homicide, the commissioning CCG was SC CCG as this is the CCG with which Mr CD was registered. SC CCG functions as an integrated commissioning unit with Southampton City Council. The CCG managed the process of reviewing the investigation report and monitoring the action plan.

7.3 Both Solent and SHFT reported the incident and the decision taken to manage the case by SC CCG through Solent. At the time of the incident, West Hampshire CCG (WH CCG) led the mental health contract with SHFT, with SC CCG as an associate to the contract. Now, SC CCG has a separate contact with SHFT for mental health services.

7.4 The decision to manage the case through Solent meant that the contractual responsibility sat with SC CCG rather than WH CCG. Both CCGs work closely together on the mental health contracts with SHFT bringing the processes into line as much as possible. This meant that a representative from WH CCG was invited to participate in the SC CCG panel reviewing this case.

[58] If the homicide is committed when the person is a current user of specialist mental health services or has been within the six months prior to the homicide. The six months is a guide and each case should be considered individually.

7.5 Initially, Solent provided an individual investigation report which was reviewed by the CCG serious incident panel meeting on 22 October 2015. As a result of this review, a joint investigation with SHFT was requested and a combined report was provided on 20 November 2015.

7.6 This combined report was shared with the homicide team on of NHS England (South) on the same day, and this was forwarded to us for our review.

7.7 A Serious Incident Panel meeting was held on 8 March 2016, with WH CCG in attendance, and which representatives of both Trusts attended. A representative from Southampton City Council sent apologies.

7.8 The combined report was reviewed in detail at the meeting on 8 March 2016. The panel raised several areas where clarification and further information were required. They concluded that the report needed significant re-working. This was undertaken by SHFT and a revised report was submitted to the homicide team on 6 April 2016. This was also passed on to us – we consider this to be a much improved report.

7.9 Because of an oversight in the process, a panel meeting was not convened to review the revised report. Further updates on implementation of the action plan have been requested and provided. SHFT provided an update on 17 May 2016 and confirmed that they will be monitoring compliance with the actions. Solent incorporated their update into the report – revised information on implementation of actions is dated 14 July 2016.

7.10 SC CCG is planning to hold a further panel meeting to review progress on the action plans. We would support this course of action, to improve the rigour of the CCG's review and monitoring.

7.11 We are informed that SC CCG is putting a plan in place to ensure that panel meetings are held as appropriate and to avoid steps in the process being omitted. We also support this course of action, again to improve the robustness of their processes.

7.12 We reviewed the process undertaken following the homicide committed by Mr CD against the processes set out in the Serious Incident Policy[59], and come to the following conclusions:

- The inclusion of the two CCGs was in accordance with the policy.
- Membership of the panel was in accordance with the policy.
- The Solent report was reviewed and feedback was given – that a joint report was required; and the additional information should be provided.

7.13 We did consider that the feedback on the initial joint report could have been more detailed, more in depth and more critical (in the sense of 'critical review', not in the sense of being negative).

7.14 The policy states that, where the panel does not agree the closure of an incident, they should give feedback to the provider (which was done) and review the further information in order to close the incident.

[59] This policy was accepted three months after the homicide, but much of the CCG process continued after the policy's implementation.

7.15 In this case, there were further requests for the progress reports from both Trusts on the implementation of their action plans. However, there has not been further formal review of the incident and the incident has not been 'closed'. This is not compliant with the policy, but we are advised this was the result of an error and is to be rectified.

7.16 Consequently, we conclude that the CCG did not adequately monitor implementation of the Trusts' action plans, but that they have recognised this and are taking steps to rectify this in the future. However, the CCG did take appropriate steps to ask the Trusts to improve their internal reports and to create a joint report.

# 8 Overall analysis and recommendations: (ToR9)

To identify key issues, lessons learnt, recommendations and subsequent actions for local healthcare providers and commissioners.

8.1 This section includes our summary and conclusions. All the recommendations are brought together to bring the main report to an end. We have tried to avoid replicating recommendations already in the internal report, but have built on these where appropriate.

## Good practice

8.2 The homeless health care team liaised with and updated the Substance Misuse Service during September 2014.

8.3 We commend the efforts made by Ms UV to establish and maintain contact with Mr CD, despite his limited engagement with her. This showed professional diligence and extra effort which helped in creating a barrier to prevent further loss of contact.

8.4 We acknowledge the efforts of staff at the needle exchange service who remained at work on a Friday evening to try to engage Mr CD whilst waiting for the police to arrive.

## Care and Service Delivery problems

8.5 We identified a number of care and service delivery problems. These included:

- The late transfer of discharge information to the HHCT, when the GP was left to make decisions about medication without discharge information.
- The failure to complete the box on a form to trigger the referral process;
- Changes in health and substance misuse service providers, different commissioners, different commissioning criteria.
- Confidentiality (in substance misuse services).
- Inter-agency complexity – communication with the criminal justice system (prison, NPS, CRC) as well weaknesses in the operation of the dual diagnosis policy between Solent and SHFT.
- Changes in the structure of the probation service.

- The handover to new junior doctors at Melbury Lodge, the lack of medical availability after his discharge, and the lack of discharge information on RiO when Dr DE sought information about his medication.
- IT issues, including the inability of different organisation's IT systems ability to 'talk to each other'.
- Risk assessments relied on self-reporting and the memory of an ARM worker who had previous knowledge of him. Staff had to work without information from the prison service.

## Contributory factors

8.6 We did not identify any factors which contributed to this incident, apart from patient factors. These include:

- Mr CD's personality disorder and possible PSTD;
- his poly-substance misuse and involvement in a drug culture;
- impulsive behaviour/lack of anger control;
- his difficult childhood and upbringing;
- homelessness, locally transient, staying with friends, occasionally with family, at probation service 'approved premises';
- his violence and criminal history – a number of prison sentences which disrupted any attempt by community services to provide continuity and consistency of care;
- he only engaged with services when he required practical help, mainly on his own terms.

## Root cause

8.7 We did not identify any root cause(s) for this incident relating to the care and treatment provided to Mr CD. In this we agree with the finding of the joint internal report.

## Recommendations

8.8 We wish to stress that we found no contributory factors in the provision of care and treatment to Mr CD. The recommendations we are proposing are derived from issues arising from our review, and where we consider that improvements to service might made. These recommendations do not imply in any way that the services to which they relate contributed to the homicide.

8.9 We identified a number of issues where lessons learnt were nationally relevant. We have therefore included recommendations which have national significance (numbers 2, 3, 4, 5, 8, 12) as well as those which focus on local services only (numbers 1, 6, 7, 9, 10, 11).

### Recommendation 1

Solent and SHFT should develop a written service specification to set out clearly the relationship between the homeless health care service and the secondary mental health component, to be reflected in specific job descriptions as part of defining the role and functions. This should be completed by 6 months following the publication of this report and the implementation audited within the following 12 months

### Recommendation 2

Commissioners of specialist services should develop formal service specifications which include protocols for liaison, communication and sharing information with other agencies, including non-health or NHS commissioned agencies, within 12months of publication of this report. Commissioners should ensure that contracts are monitored and evaluated for effective implementation by audit within 12 months of implementation.

Recommendation 3

When commissioning services, commissioners should begin with client needs analysis and evidence-based pathways: if there are gaps in the services to be commissioned ensure that there are explicitly described, risks are assessed and mitigated. The effectiveness of implementation should form part of the contract monitoring cycle (within circa one year).

Recommendation 4

Health and Justice specialist commissioners (NHS England and the Ministry of Justice) and commissioners of local services should promote greater collaboration between prison-based mental health and substance misuse services on the one hand and NHS mental health and local substance misuse services on the other. A progress report should be completed and made available to stakeholders 12 months following the publication of this report

Recommendation 5

Health and justice specialist commissioners and commissioners of local services should promote opportunities to enable prison officers and prison healthcare workers, (including mental and physical health care) to undertake mental health screening aimed at making appropriate referrals prior to impending discharge. [60] A progress report reflecting current best practice should be circulated to stakeholders within 12 months following the publication of this report.

Recommendation 6

When any practitioner in SFHT, mental health court liaison services and associated services (e.g. ARM) consider risk history, extra caution needs to be taken in order to avoid over-reliance on self-reporting by the subject of the assessment. Risk information from other sources should be completed and if this is not possible a reason should be given. The Trust(s) and any other agencies should audit risk histories on an annual basis to ensure compliance and follow up any non-compliance in supervision.

Recommendation 7

SHFT should continue to ensure that discharge summaries are sent electronically and should consider the option of reintroducing a Part A initial discharge summary to

[60] See also a similar recommendation from another homicide investigation: "The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services." 'An independent investigation into the care and treatment of P in the West Midlands', NICHE, June 2017 Recommendation 15, p.24

help ensure General Practitioners receive information about medication promptly. This should be completed within 6 months of publication of this report and Implementation should be audited no later than 6 months later.

Recommendation 8

SHFT should seek to ensure that all healthcare staff (but especially medical staff, who in many cases are at the centre of ongoing treatment planning for a service user) fully document, on RiO, leave/discharge plans including those plans most central to the continued treatment and coordination of care of the service user - for example, the medication regime. The Trust should audit the completion of leave/discharge plans on RiO by medical and other healthcare staff at 12 months after publication of this report.

Recommendation 9

When commissioning and re-commissioning services, local commissioners should ensure that contracts consider the potential impact of non-compatible IT systems, carry out a gap analysis and risk assessment and mitigate any risks identified. Assessment and mitigation of any risks arising from new contracts entered into by local commissioners which involve incompatible IT systems should be monitored prior to implementation.

Recommendation 10

Solent and SHFT must ensure that the Duty of Candour policy and procedures are followed in cases where a service user commits a homicide, and that actions taken under this duty are accurately recorded. Compliance should be audited within 3 weeks of any homicide being identified and reported to the Trust.

Recommendation 11

Solent NHS Trust and CGL to work together to monitor the effectiveness of the screening element within the mental health assessment and space for an account of mental health service involvement. A report on progress towards this monitoring to be shared with stakeholders 6 months following the publication of this report.

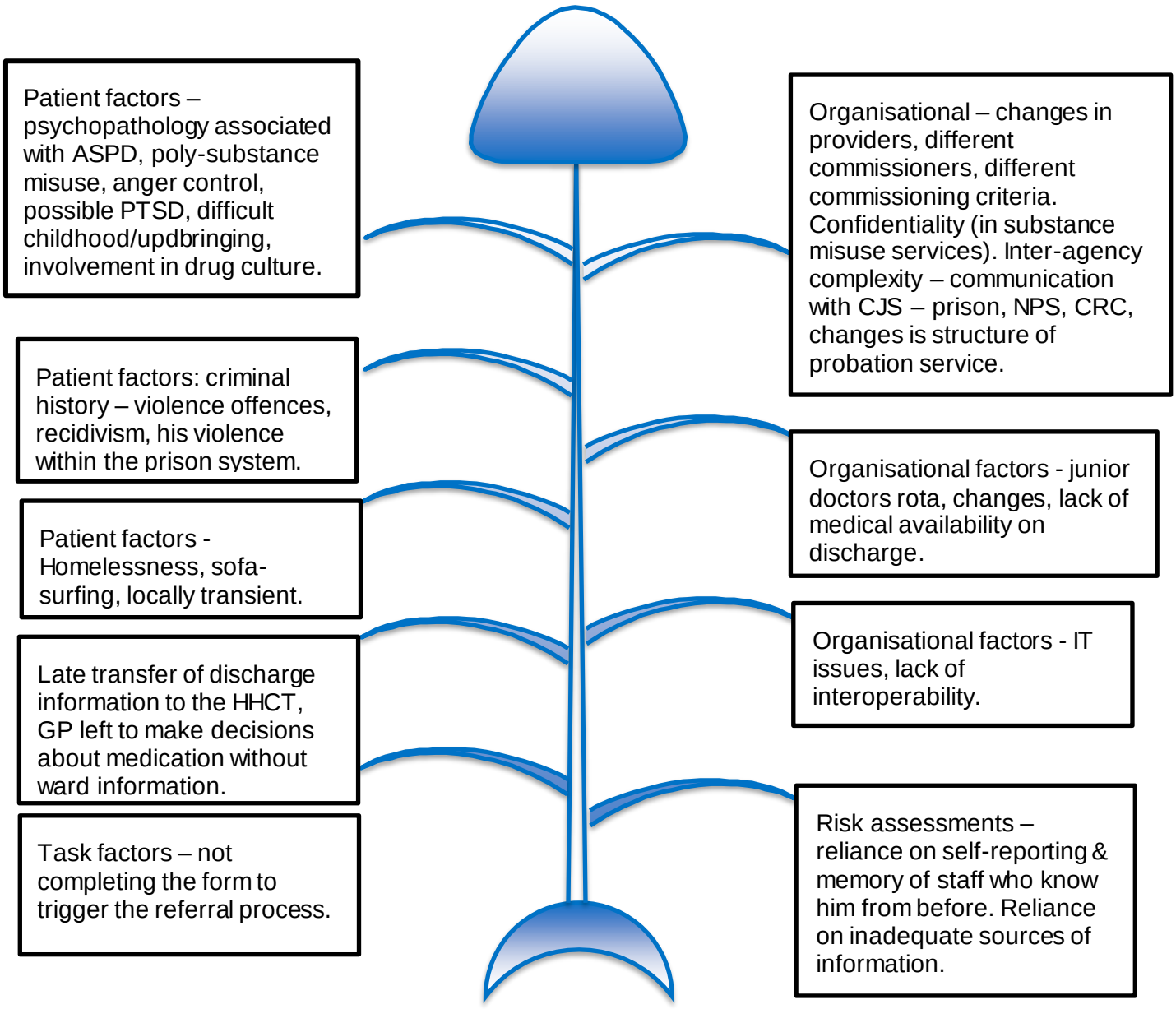
Recommendation 12

The Trusts should jointly carry out an audit of the Dual Diagnosis policy within 12 months from the publication of this report, to evaluate its effectiveness in addressing the issues raised in this report and the internal investigation report.

Recommendation 13

We recommend that, where a service user who is involved in a homicide (or other SIRI) is receiving services from more than one NHS Trust, that a joint investigation should be carried out by those Trusts. NHS Improvement should include guidance to this effect in their review of the Serious Incident Framework. A progress report should be published within 6 months of the publication of this report.

## Appendix A: Fishbone diagram



# Appendix B: Terms of reference

**Terms of Reference for Independent Investigations under HSG (94) 27**

**Purpose of Investigation**

To identify whether there were any gaps, deficiencies or omissions in the care and treatment that Mr CD received, which could have predicted or prevented the incident on .

The investigation will identify any areas of best practice, opportunities for learning and areas where improvements to services are required in order to prevent similar incidents from occurring.

The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and/or the provider's formal Board sub-committees.

**Main Objectives**

Review the assessment, treatment and care that Mr CD received from Southern Health NHS Foundation Trust and Solent NHS Trust from February 2011 up to the time of the incident.

The report will include a review of the communication between agencies, services, friends and family including the transfer of relevant information to inform clinical risk assessments and care planning.

Review the effectiveness of care pathways between a range of health care services and organisations

Identify any care or service delivery issues that may have contributed to the incident or affected its preventability/predictability

**Terms of Reference**

1. Review the care pathways and information sharing processes between the range of teams identified in the joint internal investigation (i.e. Homeless Health Care Team, Antelope House (Acute Care Unit, Southampton), the Prison Mental Health team HMP Winchester, Integrated Offender Management Team, GP, Substance Misuse service, Melbury Lodge, Mentally Disordered Offenders Service, Solent NHS Trust Substance Misuse Service (SMS), Assessment, Review and Monitoring (ARM - Crime Reduction Initiative) and the Structured Intervention Team (SIT) against existing provider policy and national best practice.

2. Review the application of both Trusts' care planning, clinical risk assessment and transfer of care policy and procedures in relation to Mr CD's treatment.

3. To establish if the risk assessment and risk management of Mr CD was sufficient in relation to his needs including the risk of Mr CD harming himself or others.

4. To evaluate and comment on the mental health care and treatment Mr CD received at each stage of his treatment.

5. Establish appropriate contacts and communications with families/carers to ensure appropriate engagement with the independent investigation process.

6. Review the both Trusts' internal investigation and assess the adequacy of the findings, recommendations and action plan and identify:
   - If the internal investigation satisfied its own terms of reference
   - If all key issues and lessons have been identified and shared.
   - Whether recommendations are appropriate and comprehensive and flow from the lessons learnt.
   - Review and comment on progress made against the action plans.
   - Review processes and comment on in place to embed any lessons learnt.
   - Review and comment on the efficiency of monitoring of the action plans by the trust internal governance structures.

7. Review and comment on any communication and involvement with families of the victim and perpetrator before and after the incident.

8. To establish if the information infrastructure across the local healthcare system supports the delivery of effective clinical care and multiagency working.

9. To identify key issues, lessons learnt, recommendations and subsequent actions for local healthcare providers and commissioners.

10. To independently assess and provide assurance on the progress made on the delivery of action plans following the internal Trust(s)investigations.

11. To independently assess and provide assurance that the monitoring of the relevant Trusts action plans by the commissioning CCGs is adequate.

12. To identify any lessons and/or recommendations that have implications for all social and healthcare providers both locally and nationally.

13. Review and comment on the trust(s) recording of its undertaking of its Duty of Candour.

14. Consider if this incident was either predictable or preventable.

**Level of investigation**

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

**Timescale**

It is envisaged that the investigation process should be completed within six months of receipt of all clinical and social care records up to the time of the incident.

**Initial steps and stages**

**NHS England will:**

1. Arrange an initiation meeting between the Trust(s) and commissioners.

2. Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved.

3. Seek full disclosure of the perpetrator's medical records to the investigation team and with a view that the report will be published in the public interest.

**Outputs**

1. A clear chronology of the events leading up to the incident.
2. A clear and up to date description of the incident and any Court outcomes (e.g. sentence given or Mental Health Act disposals).
3. A final report that is easy to read (and meets the NHS England accessible information standards) and follow with a set of measurable and meaningful recommendations, having been legally checked, proof read and shared and agreed with participating organisations and families.
4. Meetings with victim and perpetrator families and perpetrator to explain the findings of the investigation.
5. A concise and easy to follow presentation for families.
6. A final presentation of the investigation to NHS England or Clinical Commissioning Group as required.
7. We would encourage the investigators to include a lay/family member on the panel to bring an independent voice to the investigation.
8. An assurance visit follow up and review by the independent investigator, six months after the report has been published, to assess if the report's recommendations have been fully implemented and adequately monitored by the relevant CCG. Then produce a short report for NHS England, families and the commissioners which should be made public.

## Appendix C: Chronology - February 2011 to March 2015

| Date/time | Source | Event | Comment |
|---|---|---|---|
| 2011 | | | |
| 08/02/ 2011 | Clinical records | Arrested for possession of an imitation firearm (with intent to endanger life) and theft. | |
| 09/02/2011 | Clinical record; Internal report; | Ms PQ (MENDOS worker) saw Mr CD at police station, he told her he had taken an overdose of diazepam. Hostel staff also informed her that he had sustained a head injury.<br>Taken to A&E and prescribed medication. Returned to police cell.<br>Telephone conversation with hostel: information provided that Mr CD was also prescribed olanzapine by GP in January 2011. No previous involvement with the HHCT or mental health services.<br>Hostel staff were not aware of any mental health problems. He used several aliases. He could return to the hostel but was 'hardly ever there'.<br>Mr CD responded appropriately, no clear signs of psychosis. Probation service also involved (supervising a DRR).<br>Mr CD gave them permission to contact his probation officer. | |
| 10/02/2011 | Clinical record | Appeared at Southampton Magistrates' Court and remanded into custody.<br>Ms PQ referred Mr CD to prison mental health team, noting<br>overdose and attendance at A&E: Mr CD now said he had not taken an overdose.<br>Mr CD had self-reported that he had schizophrenia, that he had been hearing voices over the previous | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | month and managed this with the use of alcohol.<br>There were no observable signs of psychosis.<br>Mr CD said he had was not involved with mental health services in the past, this confirmed by Ms PQ.<br>He reported that:<br>• he was using alcohol more recently;<br>• he had not used heroin recently<br>• he was 'getting deeper and deeper into the drug scene' in Southampton; and,<br>• he had frequently turned up at the hostel with various physical injuries.<br>Prison mental health team were requested to 'keep an eye' on Mr CD and report any mental health issues to Ms PQ whilst he was on remand. | |
| 15/02/11 | Clinical records | Mr CD discussed at the prison CMHT MDT referral meeting, he did not have a serious mental illness so was advised to see the GP who could refer to CMHT if necessary. Letter sent to Mr CD and Ms PQ. | |
| 23/02/2011 | Clinical records | Prison CMHT referred Mr CD to prison GP.<br>Mr CD attended court. Trial date set for 5/04/2011. | |
| 11/2011 | Clinical records | GP referral letter to AMHT (dated 25/01/2012) noted that:<br>• Mr CD was released from prison in 11/2011 (precise date unknown);<br>• he was resident in a probation hostel; and<br>• he was 'on probation'. | |
| 2012 | | | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| 25/01/2012 | Clinical records | GP saw Mr CD then made urgent referral to Fareham CMHT: noted his violent history. Issues identified as:<br>• hostel had concerns about his behaviour and possible psychotic features;<br>• increased agitation, paranoia, and complaining of visual and auditory hallucinations;<br>• Mr CD reported experiencing vivid nightmares and often waking screaming;<br>• reported he had been the victim of two violent stabbings and that he panics whilst in public, disliking people being behind him;<br>• an ambulance had been called for a presumed panic attack.<br>Letter noted the lack of medical records. Mr CD self-reported several anti-psychotic medications he had been prescribed whilst in prison. He said that only medication which helped was nitrazepam. He had requested this from the GP at this appointment. | |
| 25/01/2012 | Clinical records | Appointment made for Mr CD with CMHT, he did not attend. | |
| 30/01/2012 | Clinical records | Mr CD was discharged back to GP. CMHT had rung the probation hostel, found that Mr CD was no longer resident there and had been 'picked up' by the police. | |
| 06/02/2012 | Clinical records | Prison CMHT requested copy of GP referral from Fareham CMHT. | |
| 10/02/2012 | Clinical records | Assessed by Prison consultant psychiatrist:<br>• diagnosis of anti-social personality disorder;<br>• alcohol dependence and substance use of (crack cocaine and heroin);<br>• methadone medication; | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | • possible PTSD noted.<br>Prescribed sertraline (50mg) - trial and review. | |
| 29/02/2012 | Clinical records | Mr CD transferred to HMP Coldingley. Coldingley CMHT informed and psychiatric assessment sent to them. | |
| 2013 | | | |
| 27/08/2013 | Clinical records | MARAC conference, regarding incident of domestic violence - no further information and no action taken. | |
| 20/11/2013 | Clinical records | Mr CD was released from prison.<br>He was resident in an IOM property and was not engaging with staff. | |
| 09/12/2013 | Clinical records | Arrested for possession of an offensive weapon and going equipped for burglary. Mr CD was remanded into custody (committed to Crown Court 07/01/2014).<br>Mr CD asked to be seen by MENDOS, who were unable to do as he was in court.<br>His solicitor noted that there had been no mental health issues or involvement. | |
| 20/12/2013 | Clinical records | Mr CD referred to prison CMHT; discussed at MDT; noted no serious mental health problem; care to remain with IDTS.<br>Letter sent to Mr CD, referrer and IDTS team. | |
| 2014 | | | |
| 09/07/2014 | Clinical records | Released from prison. Assessed by non-medical prescriber at SMS (Southampton), who noted:<br>• drug use, including use of cocaine previous day; previous drug use included morphine, cocaine, methadone; | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | • last employment in 2012 (bricklaying);<br>• Mr CD had not taken drugs when in prison for five years (2004-9) and had completed a RAPt course;<br>• forensic history noted including property offences, supply of drugs, assault;<br>• Mr CD had been seen by mental health services in prison in 2012 (PTSD and personality disorder);<br>• history of violence offences<br>• has been victim of violent attack (slashed in back with Stanley knife, leaving ongoing pain from nerve damage).<br>No risk of self-harm or suicidal ideation. | |
| 19/07/2014 | Clinical records | Mr CD presented at Antelope House (Southampton); admitted informally to Melbury Lodge (Winchester) - no male beds at Antelope House; noted that he:<br>• presented with psychotic symptoms;<br>• was low in mood;<br>• was hearing voices, telling him to do 'bad things';<br>• had used alcohol and drugs had been used following his release from prison.<br>Mr CD was assessed as being a 'high risk to self and a low to medium risk to others' although 'with his current presentation nothing could be guaranteed with certainty'.<br>Concluded that a hospital admission would be beneficial. | |
| 19/07/2014 | Clinical records | Junior doctor assessment of Mr CD noted Mr CD self-report of hallucinations and long standing anxiety issues.<br>Risks included: | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | • harm to self;<br>• harm to others.<br>Mr CD agreed to inform staff if he had thoughts to harm himself.<br>He had one daughter.<br>Plan to review medication.<br>Mr CD placed on general observations. | |
| 20/07/2014 | Clinical records | Risk assessment:<br>• harm to self – evidence found for suicidal ideation: medium risk;<br>• harm from others – very low, with risk of physical harm 'ticked';<br>• harm to others - violence, aggression, abuse to family and the use of weapons.<br>The risk formulation stated that he was released from prison 7 months previously (this was later changed in the RiO progress notes to 7 weeks, Mr CD stated it was 'about a week' and the methadone clinic record gives the date and 9/07/ 2014 - about 10 days).<br>He moved prisons frequently due to his behaviour – 'aggressive outbursts', leading to prison staff 'wearing helmets and restricting him'.<br>Mr CD denies hitting anyone.<br>Mr CD disclosed past domestic violence (with ex-partner). Said he has had no contact with his daughter or her mother<br>Identified incidents with the police. | |
| 20/07/2014 | Clinical records | 72 hour care plan.<br>To assess physical and mental health to inform subsequent care planning. | |
| 20//07/2014 | Clinical records | First 72 hours.<br>Plan to 'feel safe and listened to'.<br>Activities stated as: | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | • exploration as why in hospital;<br>• complete with staff the 'recovery narrative';<br>• referral to other members of the team, including OT and psychology;<br>• introductory pack to be given;<br>• speak with community team and arrange a CPA;<br>• allocation of member of staff each shift to 'develop therapeutic relationship';<br>• exploration of any specific worries or concerns;<br>• assessment of mood thought content physical state, food/fluid intake, sleep pattern, personal hygiene, motivational levels, concentration, speech content interactions both verbal and nonverbal;<br>• compliance with medication;<br>• contact with friends/family;<br>• levels of observations and review. | |
| 20/07/2014 | Clinical records | Safety care plan.<br>Address risks as identified during the 'recovery narrative safety plan' and other risk assessment. | |
| 20/07/2014 | Clinical records | Goal stated as 'safe and listened to'.<br>Activities stated as:<br>• outline of the level of observations and review;<br>• allocation of staff during each shift to discuss concerns and review recovery since admission;<br>• medication including the procedure for medication bought 'over the counter';<br>• process for leaving the unit (informing staff etc.). | |
| 21/07/2014 | Clinical records | OT assessment carried out. Concluded that OT might be appropriate for him, and to discuss | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | this at MDT. There is no record of a MDT being held prior to his discharge. | |
| 21/07/2014 | Clinical records | Recorded that Mr CD appeared calm in mood and no risk behaviours noted.<br>Mr CD had left ward for 3 hours, to go to town with his mother. | |
| 22/07/2014 | Clinical records | Left ward to go to town, off ward for 10.5 hours. | |
| 23/07/2014 | Clinical records | Care plan update:<br>• Mr CD concerned about missed appointment with PO;<br>• Mr CD encouraged to phone or to use time when on leave from ward;<br>• Mr CD left ward to go to bank; did not resolve issues with PO.<br>No increase in risk was observed.<br>2 periods of leave noted. | |
| 24/07/2014 | Clinical records | Incorrect medication was given (partly because Mr CD used two surnames). No ill effects for Mr CD; safeguarding alert raised to the HHCT. | |
| 24/07/2014 | Clinical records | 24 hour recovery narrative - Mr CD reported:<br>• how he was settling in;<br>• his circumstances prior to admission;<br>• 'things to focus on';<br>• his strengths and resources;<br>• a safety plan;<br>• his goals.<br>Mr CD stated that he had been depressed and low; and that he wanted to be referred to the Southampton Drugs Team.<br>Mr CD reported on group work he was involved with whilst in prison and the coping strategies/skills he developed. | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| 24/07/2014 | Clinical records | Tel. call to Southampton HHCT, regarding medication error on 23/07/2014. | |
| 24/07/2014 | Clinical records | Medication changed:<br>• diazepam increased;<br>• olanzapine increased. | |
| 25/07/2014 | Clinical records | Mr CD anxious about situation with his PO; contact made with probation service, informed of Mr CD's admission to hospital: Mr CD to contact PO on 28/07/2014.<br>Mr CD left ward to go to job centre.<br>(Notes refer to Section 17 leave, but this is incorrect, Mr CD was an informal patient and could take leave without the S 17 procedure). | |
| 25/07/2014 | Clinical records | Mr CD left ward to go to local area on two occasions. | |
| 26/07/2014 | Clinical records | Mr CD 'bright in mood', left ward and returned with female friend. | |
| 27/07/2014 | Clinical records | Mr CD left the ward on 2 occasions. | |
| 28/07/2014 | Clinical records | Mr MN (acute care transition facilitator) telephoned the following services:<br>• Southampton Drug and Alcohol Team – regarding Mr CD's methadone script: Mr CD would have a key worker;<br>• HHCT – unlikely Mr CD would have a key worker, but the HHCT would see him in the community 'at some point';<br>• Accommodation Officer, Acute Care Support Team who confirmed that Mr CD was banned from all hostels in the local area because of his violent past; the SHPT would be willing to provide a deposit; a private landlord was suggested. Mr MN to ask Mr CD if he could | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | stay with friends over the week-end. | |
| 28/07/2014 | Clinical records | Discharge being considered as Mr CD does not appear to have a mental illness.<br>Mr CD on leave from the ward from most of the day. | |
| 29/07/2014 | Clinical records | Mr CD left the ward twice during the day. | |
| 30/07/2014 | Clinical records | Psychology assessment, recommended that specific psychological work was not indicated, it was unlikely that Mr CD would actively work on psychological treatment. Psychologist would see Mr CD again the following week, if he was still on the ward (but he was discharged 2 days later). | |
| 30/07/2014 | Clinical records | Southampton HHCT – a care coordinator would be allocated to Mr CD, he would be discussed at a referral meeting. | |
| 30/07/2014 | Clinical records | Dr ST (Consultant psychiatrist) reviewed Mr CD, concluding:<br>• Mr CD did not show any clear signs of mental illness;<br>• the previous diagnosis of anti-social personality disorder was consistent with his presentation;<br>• discharge date of 01/08/2014 was agreed;<br>• medication was:<br>  ○ methadone – 35 ml<br>  ○ diazepam – 20 mg (morning)<br>  ○ diazepam – 10 mg (evening)<br>• Mr CD did not appear distressed or agitated;<br>• no thoughts of self-harm.<br>Mr CD wanted to continue with diazepam as it prevents his anxiety. | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| 30/07/2014 | Clinical records | Mr CD left the ward to the local area (records are inconsistent about the timing of the leave). | |
| 01/08/2014 | Clinical records | Mr CD concerned about lack of accommodation - he had been looking for somewhere to live with a friend the previous day.<br>Mr CD was pleasant on the ward. | |
| 01/08/2014 | Clinical records | HHCT Leader contacted Mr MN, was informed of pending discharge and that Mr CD would have accommodation on 04/08/2014. Mr CD had declined offer of probation accommodation, he wished to avoid that type of environment; methadone prescription to be obtained daily from drugs service; Mr CD prescribed 50 mg diazepam daily, in two doses.<br>Ward concerned about giving Mr CD medication to take away, but he was given diazepam for 5 days.<br>Plan – Mr MN to contact HHCT GP regarding new prescription and 7-day follow up. | |
| 01/08/2014 | Clinical records | Mr MN contacted GP surgery for appointment on 04/07/2014 – none available; Mr CD to attend the 'drop-in' surgery at 9.00am.<br>Appointment for 7 day follow-up made with CMHN for 4/08/2014. | |
| 01/08/2014 | Clinical records | Discharge plan documented, including access to methadone prescription over the week-end. The key worker from the drug service would contact Mr CD on 05/08/2014.<br>All appointments given to Mr CD on a card. | |
| 01/08/2014 | Clinical records | Dr ST reviewed Mr CD, confirmed previous assessment and discharge. | |
| 01/08/2014 | Clinical records | Discharged from Melbury Lodge to a friend's address. | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| 04 and 05/08/2014 | Clinical records | Discharge summary was faxed to HHCT but does not appear to have arrived. This meant that Dr DE was unable to check Mr CD's version of the plan for his medication with an official source. | Care delivery problem. |
| 04/08/2014 | Clinical records | 7 day follow up with CMHN in the Homeless Healthcare Team.<br>Mr CD unhappy that he had several appointments that day to attend different services/professionals. He was anxious and stressed due to this. He requested to see a GP regarding his medication.<br>Mr CD was in contact with a private landlord regarding accommodation, during his appointment with Ms UV. Deposit being supplied by SHPT. | |
| 04/08/2014 | Clinical records | Mr CD reviewed by the SMS (DIP), Probation Service, primary and secondary care services. | |
| 04/08/2014 | Clinical records | Discharge summary from Melbury Lodge (Part A):<br>Discharge medication:<br>• zopiclone 7.5mg (Not to be prescribed by GP)<br>• diazepam 10 mg am and 20 mg pm (Not to be prescribed by GP)<br>• methadone – supervision consumption by chemist.<br>Discharge plan: Follow up by CTT. Further supply of Diazepam to be managed by CTT. | |
| 05/08/2014 | Clinical records | Discharge summary from Melbury Lodge (Part B):<br>Reason for Admission:<br>• expressing thoughts of ending his life;<br>• would not contract to safety in the community;<br>• has spent 7 months in prison for burglary; | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | • uses methadone and is dependent on benzodiazepines;<br>• did not engage with psychological services or other interventions on the ward.<br><br>Dr ST assessed that Mr CD did not suffer from a mental illness.<br><br>No evidence of psychosis or thoughts of self-harm during his admission and at the point of discharge.<br><br>He was discharged subsequently. He has an extensive risk history. He is currently of no fixed abode.<br><br>Summary of risk assessment:<br><br>• Risk to self – none currently but expressed an intention to jump off a bridge;<br>• Risk to others – none currently. In the past, he has displayed aggression in prison and disclosed evidence of domestic violence towards to an ex-partner;<br>• Suicide – none currently;<br>• Vulnerability – low | |
| 05/08/2014 | Clinical records | DIP worker tel. call to Ms UV, reporting that Mr CD was usually 'quite stroppy' and 'aggressive' but that day appeared tearful and restless during the appointment. He had discussed his brother's suicide. | |
| 06/08/2014 | Clinical records | Appointment with Dr DE at 9.30am.<br><br>Mr CD not anxious during the appointment. Mr CD 'was determined on having' diazepam and was told by Dr DE that this would be a reducing dose. Mr CD unhappy, made 'veiled threats'. She rang Mr MN to be told there was nothing in the notes as to whether this should be a reducing or a maintenance dose. Mr CD said he had been told that this medication would not be altered. He also requested zopiclone. | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | Dr DE plan was to attempt to engage Mr CD to assess current mental health state. | |
| 06/08/2014 | Clinical records | Dr DE attempted to contact medical staff at Melbury Lodge, without success. | Care Delivery Problem. |
| 06/08/2014 | Clinical records | Ms UV saw Mr CD, but he left before she could find a room. Ms UV made 2 telephone calls to Mr CD but he did not answer. | |
| 06 to 12/08/2014 | Clinical records | Ms UV continued to try to contact Mr CD (four times) but his phone was switched off. | |
| 11/08/2014 | Clinical records | Letter from Dr DE to Dr ST, expressing her concern that no discharge information had been provided before Mr CD arrived in her surgery 5 days after discharge so she had no professional recommendation regarding the medication to be prescribed. | |
| 14/08/2014 | Clinical records | SHPT worker had visited Mr CD: telephone call to Ms UV – Mr CD was very anxious. A window had been smashed at his property. Mr CD needed to obtain a 'sick note' and was advised to see the HHCT. Mr CD had requested continued support from SHPT – agreed (SHPT see Mr CD in pairs, due to his forensic history). | |
| 15/08/2014 | Clinical records | Ms UV telephoned Mr CD. Mr CD requested sick note. Difficulty in making appointment, Mr CD had to see DIP worker.<br>Ms UV informed Mr CD about her role as a mental health nurse; and that she had been unable to contact him to arrange the mental health assessment. She noted that Mr CD became agitated.<br>Plan: Mr CD to see Dr DE with Ms UV for sick note. | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| 15/08/2014 | Clinical records | Dr DE would be on leave: Ms UV to give Mr CD the sick note.<br>Mr CD advised to attend on 18/08/2014. | |
| 18/08/2014 | Clinical records | Phone message left asking Mr CD when he was attending for his sick note. He did not attend. | |
| 20/08/2014 | Clinical records | Phone message left for Mr CD to attend on 21/08/2014 to collect sick note. | |
| 21/08/2014 | Clinical records | Ms UV saw Mr CD, his diazepam prescription had been stopped and he did not know why. Appointment made for him to see Ms UV on 27/08/2014 to discuss his mental health needs. | |
| 27/08/2014 | Clinical records | Mr CD did not attend appointment with Ms UV. Ms UV telephoned Mr CD, there was no reply, she left a message for him to call back. | |
| 29/08/2014 | Clinical records | Ms UV telephoned Mr CD, there was no reply, she left a message for him to call back. | Good practice – Ms UV made significant efforts to contact Mr CD during this time. |
| 03/09/2014 | Clinical records | On routine visit to police station, Ms LH (MENDOS worker) was informed Mr CD was in custody following arrest for alleged assault.<br>Mr CD had told the police that he was an alcoholic, on methadone and was experiencing anxiety and depression. He had attempted to overdose 3-4 weeks prior.<br>Ms LH noted that he presented with good eye contact and understood the situation.<br>Advised Mr CD TO see HHCT when released.<br>No concern with Mr CD's presentation and no urgent/immediate mental | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | health input required. Referral was closed. | |
| 04/09/2014 | Clinical records | Mr CD sentenced to 14 months' imprisonment. Release date of 05/02/2015, but further charge pending so release might be deferred. | |
| 04 and 09/09/2014 | Clinical records | Ms UV attempted to telephone Mr CD. | |
| 09/09/2014 | Clinical records | Ms UV left message for DIP worker to contact her. | |
| 11/09/2014 | Clinical records | Ms UV contacted DIP worker and was informed that Mr CD was in prison. | |
| 11/09/2014 | Clinical records | Ms UV contacted prison CMHT, she was told that there would be no mental health input, Mr CD's care would involve the prison drug service. | |
| 15/09/2014 | Clinical records | Prison CMHT contacted HHCT. | |
| 15/09/2014 | Clinical records | HHCT discussed Mr CD at MDT; Mr CD discharged from Ms UV's caseload; informed prison CMHT he could be referred to her on release. | |
| 15/09/2014 | Clinical records | Prison IOM contacted Mr MN (Melbury Lodge) requesting details of his care there, including diagnosis and community support. | |
| Undated, but prior to 1/12/2014 | Internal report | IOM saw Mr CD in prison, he requested referral to residential drug rehabilitation on release from prison. An assessment took place and referral form sent to SHFT funding panel. SHFT staff recalled a discussion, but no record could be found. The outcome of this referral is not known. | |
| 2015 | | | |
| 25/02/2015 | Clinical records | Prison IOM contacted Mr MN (Melbury Lodge) requesting details of | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | his care there, including diagnosis and community support. | |
| 09/03/2015 | Clinical records | Prison IOM contacted HHCT, Mr CD due for release. No formal referral to be made to CMHN as Mr CD was under the drugs team in prison, not CMHT. IOM reported Mr CD's mental health had deteriorated (anxiety and aggression) whilst he had been in prison.<br>Mr CD was still registered with HHCT, would be seen by GP on release and would be linked back into the team. | |
| 11/03/2015 | Internal report | P1 sent CRI a complaint as he had not received an answer for his detoxification and rehabilitation funding request. There had been a delay in processing the request as Southampton City Council had cancelled the ARM team's access to the electronic social care client record system. This has been rectified. The ARM care coordinator had also left the service.<br>If the application had been processed, it would have gone to the mental health panel for consideration. The preferred course of action would have been for Mr CD to be released from prison and then engage in drug treatment to develop an agreed recovery plan, which could have included detoxification and rehabilitation. | |
| 13/03/2015 | Client case notes<br>(SMS) | Ms EP (ARM worker) contacted West AMHT regarding previous admission to Melbury Lodge, and medication.<br>SMS informed of Mr CD's release from prison. | |
| 13/03/2015 | Client case notes | ARM worker noted that that Mr CD was interested in suboxone; paperwork to be completed for residential detoxification rehabilitation. | |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | Plan included referral to Access Group and a gym.<br>Mr CD to:<br>• see the SIT doctor for heroin substitute prescribing;<br>• go to HHCT to see a CMHN regarding mental health medication.<br>Next appointment made for 24/03/2015 at 2.00pm. | |
| 13/03/2015 | Client case notes | Dr FG, prescribing doctor with SIT completed assessment of Mr CD:<br>• Mr CD had been in prison for 7 months;<br>• his previous drug history and the amount spent on purchasing heroin and cocaine (approximately £1,700 per week) - he did not take these drugs whilst in prison;<br>• medication listed as pregabalin and nitrazepam;<br>• Mr CD was placed on a reducing script of methadone prior to being prescribed subutex;<br>• diagnosis of personality disorder and anti-social personality disorder documented. | |
| 18/03/2015 | Client case notes | Dr FG letter to Dr DE, outlining the methadone regime and requesting any information on relevant medical problems and medication. | |
| 20/03/2015 | Judge's summing up. | Mr CD assaulted Mr Beattie, Mr Beattie died as a result of his injuries. Mr Beattie was pronounced dead at 1.40pm. | |
| 20/03/2015<br>5pm | Client case notes | Mr CD attended SMS to collect injecting equipment.<br>Mr CD informed Ms HI, the needle exchange manager, that he was going to kill himself. Ms HI contacted her service manager, Ms JK. | Good practice – Staff remained at work on Friday evening to try to engage Mr CD whilst waiting for |

| Date/time | Source | Event | Comment |
|---|---|---|---|
| | | Mr CD was standing outside the building, observed as 'unsteady on his feet' and standing close to the kerb.<br>Ms HI called the ambulance and police services (via 999).<br>Ms JK went to speak to Mr CD and invited him in to the building.<br>Mr CD stated that he would end his life that day by buying heroin to inject and kill himself. | the police to arrive. |
| 23/03/2015 | Clinical records | Mr CD in custody at Southampton Police station, arrested for murder and other offences on 20/03/2015.<br>Mr CD reviewed by Ms PQ. Mr CD reported he had been 'struggling', hearing voices, and felt suicidal. Ms PQ will request a drug arrest worker to see him.<br>Ms PQ advised custody sergeant that Mr CD should be reviewed by drugs arrest worker; he was suicidal; and she will refer to the Prison Mental Health Team if Mr CD is charged. | |
| 24/03/2015 | Client case notes<br>Clinical records | Mr CD appeared in court, charged with murder. He was remanded in prison.<br>Ms PQ to inform prison he is suicide risk. | |
| 23 and 24/03/2014 | Client case notes | Mr CD discharged from SMS because he was on remand and on account of the seriousness of the offence. | |
| 08/03/2016 | Court transcript – the verdict | Mr CD found guilty of murder. | |
| 08/03/2016 | Judge's sentencing remarks | Mr CD was sentenced to life imprisonment, with a minimum period of 13 years before he could apply for parole. | |

# Appendix D: Members of the investigation team

Investigation Chairman and Lead Investigator Mr Anthony R Thompson.

Tony offers wide experience to the undertaking of sensitive and high profile SUI investigations. His career spans over 40 years working within public services. This includes H.M. Forces and regulatory /statutory body senior positions held at a national level. A mental health nurse background with subsequent director posts within mental health services, forensic services (high and low secure care), higher education, non-profit organisations and the independent health sector. Tony is an experienced and trained independent investigator he has undertaken numerous sensitive and high profile investigations of SUI within the NHS. He is commissioned as an expert by several legal firms. Post retirement from the NHS he currently holds the following roles;

- Senior Associate of Caring Solutions (UK) Ltd.
- Director Bridge UK R&D Ltd.
- Organisational consultant to Roefield and Debdale Specialist Care Ltd.
- Independent CAMHS services Nestlings Care Ltd ( R.I., Ofsted and CQC)

Tony is an author, editor and reviewer of standard professional textbooks and journals. He is an international conference speaker within the fields of mental health, learning disabilities and social policy.

Qualifications held include: F. Inst LM. MA. B.Ed (Hons). RMN. RNLD.DN. (Lond). Cert Ed.RNT.

His most recent international work is alongside his Bridge R&D Co Director Dr P. Mathias, on a European project concerning Mental Health and Substance Misuse (dual diagnosis).This is the Erasmus + programme entitled “InTICgration”. This five country programme is assisting agencies to develop the integration of ICT in the educational processes of persons with dual diagnosis. His particular emphasis is on treatment adherence and socialisation in marginalised groups, including homeless people.

Ms Maggie Clifton, MA, MCMI, Investigations Manager.

Maggie Clifton has managed and contributed to a number of Independent Investigation Panels and to the review and audit of internal and independent SUI investigation reports. She trained and worked as social scientist, specialising in qualitative research including interviewing, documentary and transcript analysis and report-writing, in health and social policy related areas. She is also a qualified general manager with extensive experience in the voluntary sector of managing services for homeless people and for people with long-term mental health problems. She is currently an independent research and management consultant, specialising in quality assurance, mental health service development, and training and development for managers. As an independent management consultant she has worked on projects for the Department of Health, Royal College of Nursing, Primary Care Trusts, Universities of Liverpool and Lancaster. She is currently a Senior Associate and Investigations Manager for Caring Solutions (UK) Ltd and Director of Quality Assurance for The Development Partnership and British School of Coaching.

She is trained in advanced investigation skills and in the use of the European Foundation for Quality Management Excellence Model.

Dr Martin Lawlor: Consultant Psychiatrist, Carraigmor Centre, Cork, Ireland.

Dr Lawlor's current role involves the management of complex patients with both Axis I and Axis II pathology in a 20 bed PICU setting along with providing a special interest in Forensic Psychiatry with a particular emphasis on effective risk assessment and management. He contributes to teaching, clinical audit, research, management and is registered with the Royal College of Psychiatrists for CPD. He was appointed regional CPD representative for the Irish College of Psychiatry in November 2009. In 2008, Dr Lawlor led a team to establish the Centre for Recovery and Social Inclusion (www.crsi-cork.com), Ireland, which is a charitable foundation aimed at promoting social inclusion in Mental Health Services.

Dr Lawlor has successfully worked with both in–patient and community multidisciplinary General Adult, Rehabilitation and Forensic psychiatry teams using a bio-social treatment model to manage the needs of complex clients. He is an experienced Consultant in Rehabilitation Psychiatry with a special interest in Forensic Rehabilitation who is committed to delivering excellent care to service users. He has worked in a number of sub-specialities including Learning Disability, Substance Misuse, and Academic Psychiatry. Dr Lawlor has Section 12 approval and Approved Clinician Status. In addition to his psychiatric experience, Dr Lawlor has extensive experience in management, with a MSc in Human Resource Development and he is currently undertaking a Doctorate in Business Administration.

Ms Pamela White – former carer and retired teacher.

Pam's interest in mental health provision began when her son became seriously ill with anxiety and depression. After his death in 2010, she began to seek out ways to put the family/carer perspective into policy and provision and she worked with a community involvement agency in a variety of ways to try to achieve this ambition. She took part in interview panels for psychiatrists and nursing staff for mental health wards, and in informal feedback sessions with mental health staff, sharing a carer's view of issues around confidentiality and provision of crisis services. She supported Mind's initiative for better Crisis Services nationally, both in their media campaign, and in their presentation to MPs in the House of Commons, and she has worked with the local mental health Trust on its plans to meet the Crisis Concordat's proposals. Until recently Pam was the carer representative on the Dual Diagnosis Steering Group, and continues to be an active member of the Carers and Families Steering Group, which exists partly to monitor the implementation of the local Trust's Carers' Charter, and acts in an advisory capacity for carers' interest for the mental health Trust.

# Appendix E: Services used by Mr CD

The following paragraphs describe the main services used by Mr CD between 2011 and the homicide in March 2015.

## 1. Homeless Health Care Team (HHCT)

The HHCT has been in place for 25 years and has been managed by 3 different organisations. It is currently provided by Solent NHS Trust. The team provides primary care services to homeless people. This includes the provision of GP sessions and patients register with the GP surgery. The HHCT is nurse led, with nurse independent prescribers. Access to the nursing and GP service can be on a drop-in basis; they also offer some pre-booked appointments. The team is made up of primary care nurses with two mental health nurses on long-term secondment from SHFT and they have access to GPs if necessary. A weekly multi-disciplinary team meeting is held at which referrals to the mental health team are discussed and decisions made as to whether to accept them and if so, who would be most appropriate to provide support to them. Discharge decisions might also be made at this meeting.

The CMHNs are managed by SHFT which also provides clinical supervision and continuing professional development: salaries and associated costs are paid by SHFT and reimbursed to them by Solent. A consultant psychiatrist attends the multi-disciplinary team meeting and is available to provide specialist medical advice to the HHCT. The CMHNs have offices in the same building as the GPs and nursing staff.

Their offices are attached to a day centre for homeless people where food, showers and other services are available. This is close to the Royal South Hants Hospital site, where there is also a psychiatric department and Antelope House, an inpatient unit provided by SHFT.

Three GPs are employed by Solent and are part of the HHCT. They provide a drop-in and appointments service to their patients: they also provide surgeries in two hostels.

## 2. The Mentally Disordered Offenders Service (MENDOS)

MENDOS existed until April 2015 when it was subsumed into the Hampshire Liaison and Diversion (L&D) service.

Mr CD saw workers from the MENDOS service on several occasions between 2011 and 2015. MENDOS consisted of two practitioners (one probation officer & one social worker). They provided a service 8.30am to 4.30pm 5 days a week to people in custody. They visited the police custody suites in Southampton. Police notified them if there was anyone they were concerned about and they would see them if available, and refer to other services where appropriate.

The L&D service is a pilot project, part of a national approach to services, in response to recommendations of the Bradley report. They provide an assessment team (including mental state examination but not 'fitness to plead' assessments), working with people in contact with the criminal justice service, from entry and through to sentencing/sometimes post sentence work, to engage them with a service identified prior to sentencing; and all age groups; anyone with a health vulnerability.

There are seven practitioners, with professional qualifications in learning disabilities, mental health and occupational therapy. There are a support and recovery posts. The service is available 24/7 in custody and staff are co-located in the Southampton custody suite 12 hours a day; staff are available in court five days a week and Saturday morning. The team has access to police records and can upload information. Much of their work is liaison and sharing information with other services/agencies (criminal justice, mental health, substance misuse, homeless healthcare). The role is about screening, assessing for unmet needs and risks

Standardised recording and reporting systems are from the scheme with their approval. The service will become substantive, commissioners are going to invite bids to provide the service in 2018.

SHFT and Southampton City Council provided the MENDOS service; the Hampshire L&D service is a joint venture between Solent and SHFT. The manager of the L&D service is employed by Solent and seconded to SHFT.

## 3. Substance Misuse Services (SMS)

Both when Mr CD was in contact with SMS and now, Solent NHS Trust provided the Structured Intervention Team component. There are now three contracts for substance misuse services, which are commissioned by Southampton City Council. One contract is for services to people aged under 25 years, provided by No Limits and undertakes the same functions as CGL for people under the age of 25. The remaining two, relevant to Mr CD, are with:

1. 'Change, Grow, Live' (CGL - a charitable organisation) which provides the Assessment Review and Monitoring service (ARM). ARM provide initial and comprehensive assessments, care coordination and brief interventions for clients over 25 years. Clients can be referred from other services (for example, the criminal justice system) or can self-refer. They also provide care coordination. If the person requires structured intervention they are referred to the Solent team.
2. Solent NHS Trust which provides:
    - prescription service (for example, methadone);
    - the Structured Intervention Team (SIT) provides psycho-social services (individual and group therapy, counselling) for the wider service;
    - after-care and recovery support, e.g. integration with community activities, until the service user no longer needs their support (also provided through SIT);
    - structured interventions for those aged 25 years and under;
    - Solent subcontracts to two other organisation to help them undertake this work (Society of St James and No Limits).

Once the service user no longer needs SIT services he/she is referred back to CGL or No Limits, who will, if appropriate, provide further support if required or discharge a service user back to 'ordinary' primary care or community support groups.

The ARM services can be described as equivalent to primary care or first access services, with the Solent service being equivalent to secondary care, for example specialist services to meet the needs of people who have presented to CGL or No Limits.

These services were recommissioned in 2014. Prior to 1 December 2014 the SIT service had been provided by SHFT; and the ARM service by the Crime Reduction Initiative. The services were provided within a different commissioned model – SHFT provided the majority of services, though drug users and alcohol users were supported by distinct separate teams. Society of St James provided a criminal justice service for drug users who were referred into treatment through the criminal justice team (knows as the DIP service).

The Solent NHS Trust started running the SIT service from 1 December 2014, as did CGL start providing the ARM service. There was a 10 week 'transition' period before the new providers took full responsibility. These new contracts had only been running for about three months when Mr CD was referred from prison. The challenges posed to providers by these changes included difficulties in understanding some of the roles and responsibilities; and in relation to the IT system used for patient records (further detail in paragraphs 5.46 and 5.146-5.148).

## 3. Homelessness Services provided by Southampton City Council

This support service offers a service for street homeless people and those at risk of imminent street homelessness within the Southampton area. They work mainly in the community via street outreach and in day centres. Referrals are accepted to hostels and housing projects, befriending, support around the risk of eviction, support for entrenched street homeless people. The street homeless prevention team also provide bonds (or deposits) to private landlords, to secure accommodation for homeless people or to prevent people from becoming homeless, it they meet the Council's eligibility criteria.

Further details of Southampton City Council's services for homeless people or people facing homelessness, can be found at Housing help and Homeless Prevention Strategy, 2013 - 2018

## 4. Criminal Justice System

The probation service has also been subject to change and reorganization during this period. This included the separation of services for offenders into two distinct organizations, though ensuring that there was inter service coordination, in 2014. The National Probation Service works predominantly with violent and serious sexual offenders and also those cases where the offender has received a sentence of 12 months or more, or as a detained mental health patient. The Community Rehabilitation Companies focus on those with sentences with less than 12 months in custody and services include involvement in the Integrated Offender Management Service, and the support processes required following release from prison. It is important, however, to recognise how these systems and process changes impact on the practice and implementation of procedures on those working within the services.

### Sentencing practice

A 'determinate' prison sentence is for a fixed length of time. This would be the type of sentences given to Mr CD. The sentence given will determine what or if supervision is available

For prison sentences of 12 months or more the person spends the first half of the sentence in prison and the second half in the community 'on licence'.

If they break any licence conditions – for example, if they commit another crime – they could go back to prison.

For prison sentences under 12 months, the person is normally released automatically halfway through.

## The Offender Rehabilitation Act 2014 (ORA)

ORA came into force for those who committed offences after 1 February 2015.

CRCs deal with those deemed low to medium risk and NPS those assessed as high. This assessment is carried out by the NPS. It does not appear to be a sentence duration route to services anymore due to the ORA. It is suggested that CRCs manage 70 percent of offenders compared with 30 percent managed by NPS.

Prior to February 2015, those under 12 months sentence did not receive any support after release. They were just subject to automatic release without a supervisor in the community from probation. Following the ORA 2014, those with sentences over one day are now released under a standard license and are subject to an additional period of supervision when the license comes to an end.

Licence conditions are outlined below (from 2015).

The conditions of a licence, and the requirements of a post-sentence supervision period, are set on behalf of the Secretary of State. All licences include a set of standard licence conditions, which are:

i) To keep in touch with your supervising officer in accordance with any instruction you may be given

ii) If required, to receive visits from your supervising officer at your home/place of residence (e.g. an Approved Premises)

iii) To permanently reside at an address approved by your supervising officer and obtain the prior permission of the supervising officer for any stay of one or more nights at a different address

iv) To undertake only such work (including voluntary work) approved by your supervising officer and notify him or her in advance of any proposed change

v) Not to travel outside the United Kingdom unless otherwise directed by your supervising officer (permission for which will be given in exceptional circumstances only) or for the purpose of complying with immigration/deportation

vi) To be well behaved, not to commit any offence and not to do anything which could undermine the purpose of your supervision, which is to protect the public, prevent you from re-offending and help you to re-settle successfully into the community

In addition, discretionary conditions or requirements can be imposed during the licence or post-sentence supervision period.

## National Standards for the Management of Offenders 2011

National Standards for the Management of Offenders (2011) provide a practice framework for practitioners and managers. They were published by the Secretary of State under the provisions of the Offender Management Act 2007 (Chapter 21: Part 1 paragraph 7). This sets out in (in very basic terms) the requirements for probation in the management of offenders.

The following may be of relevance regarding implementing sentences (both custodial and community)

| |
|---|
| Implement the sentence<br><br>Purposeful contact is maintained during a custodial element of the sentence<br><br>Purposeful contact is made with the offender promptly after order commencement/release on licence<br><br>The sentence plan is implemented<br><br>Engagement with community resources is promoted as an integral part of implementing the sentence plan<br><br>Transfer is administered to maintain effective management of the offender and the sentence<br><br>The sentence is enforced |

Interestingly, in these standards, no reference is made other than informing relevant parties of court decisions (sentencing etc.), and in the following standard 1 record keeping: "Records are kept up to date, stored securely, and are accessible to appropriate parties".

The National Standards which came into force in February 2015 included more detail and in particular reference to Standard 4 Planning, Standard 5 implementation and Standard 6 risk assessment (this latter was not in the standards in 2011): key points are in table below.

| |
|---|
| Standard 4 – Planning<br>a) A Plan includes:<br><br>• The identification of the current Risk of Serious Harm level of that offender.<br>• The proposed management and mitigation of the current Risk of Serious Harm level if that offender presents a medium or high Risk of Serious Harm.<br>• The needs of the offender in the context of the delivery of the sentence and the identification of the likelihood of that offender reoffending.<br>• The activity to be undertaken with the offender to deliver that part of the sentence of the court to be served in the community and to reduce the likelihood of reoffending.<br><br>Standard 5 - The plan is implemented |

- For offenders released subject to a licence or post sentence supervision period a face-to-face appointment with the offender is arranged to occur within one-working day of the offender's release from custody. Purposeful contact is established at the pre-release stage and maintained following release from custody.
- The Plan is implemented and updated as appropriate.
- Engagement with community resources is facilitated as an integral part of implementing the Plan.
- Transfer of offenders between probation providers is arranged to maintain continuity and effective management of the offender and delivery of the sentence.

Standard 6 - Risk Management

- The offender's risk of causing serious harm is managed, using a multi-agency approach where appropriate.
- For offenders initially assessed as low or medium level risk of serious harm where there are indications that the risk of serious harm level may have increased to high the case is referred to the National Probation Service.
- Immediate risk management action and activities are undertaken where the offender presents an immediate risk of causing serious harm to the public, known victims or other individuals.

A key point is that these standards were introduced in 2015 and may have been useful when Mr CD came out of prison in March 2015, but not when he had contact with probation service prior to that. There is no reference to information sharing (other than that included in 2011). There is reference is made to 'multi agency approach', highlighted in the risk management section, but no further details.

The Ministry of Justice has announced a new frontline service which will focus on reforming offenders and cutting crime (8 February 2017). This will launch in April 2017. The key points are:

- Her Majesty's Prison and Probation Service (HMPPS) has replaced National Offender Management Service (NOMS).
- The new service will be responsible for rolling out government's reform programme to reduce reoffending and protect the public.
- The service will launch a new leadership programme and new promotion opportunities for staff.
- Changes will be backed by additional £100 million to boost frontline services by an extra 2,500 staff.

## Appendix F: Conclusions of QNI research on homelessness.

The conclusions of this report which we consider to be specifically relevant to the circumstances of Mr CD are set out in paragraphs 5.67 – 5.70 above. We considered that it would be helpful to readers to set out the conclusions in full, providing the context for those relevant to Mr CD.

Poor communications.

1. Discharge planning is poorly communicated, little forward planning resulting in the patient subsequently being discharged to no fixed abode.

2. A lack of joined up working e.g. having to chase up where people are and track discharge summaries and current prescribed medications.

3. Hospital staff not getting in touch with community staff even when contact numbers have been left and vice versa.

4. Poor knowledge of discharged patients and not being provided with an accurate mental health and risk summary.

Inappropriate/unsafe discharge.

5. Patients discharged to the streets or hostels that are so full that they sleep on the floor.

6. Patients discharged inappropriately with no realistic care management plans, especially if alcohol predominates.

7. Underfunded housing resulting in staff who struggle to provide support with competence and knowledge.

8. Being discharged back into chaotic hostels or temporary bed and breakfast accommodation where there is lack of supervision and support to meet complex health and social care needs.

NHS systems not designed for transient populations.

9. Homeless people frequently move between urban locations and care can become fragmented.

10. NHS ICT systems and the rapid transfer of health notes are not designed with such a mobile population in mind.

Reasons for these challenges.

11. Poor joint working between organisations.

12. Lack of local supported housing.

13. Working in overstretched/under resourced mental health systems.

14. Lack of awareness of community homeless health care teams amongst hospital staff.

15. Staff from all sectors require support to improve skills in working with homeless people.

16. Homeless people receive poorer experience of general healthcare.

## Appendix G: List of abbreviations

| Abbreviation | Definition |
|---|---|
| AMHT | Adult Mental Health Team |
| ARM | Assessment, Review and Monitoring service (a component of the Substance Misuse Service provided by a third sector organisation) |
| ASPD | Anti-social Personality Disorder |
| CCG | Clinical Commissioning Group |
| CMHN | Community Mental Health Nurse |
| CMHT | Community Mental Health Team |
| CGL | 'Change, Grow, Live', which provided the ARM service from 1 December 2014 |
| CPA | Care Programme Approach |
| CRC | Community Rehabilitation Company |
| CRI | Crime Reduction Initiative, provided the ARM service until 30 November 2014 |
| DRR | Drug Rehabilitation Requirement |
| HHCT | Homeless Heatlhcare Team |
| HMP | Her Majesty's Prison |
| HMPPS | Her Majesty's Prison and Probation Service (from 1 April 2017) |
| IOM | Integrated Offender Management |
| L&D | Liaison and Diversion |
| MENDOS | Mentally Disordered Offenders' Service |
| MARAC | Multi-agency Risk Assessment Conference. |
| MDT | Multi-disciplinary Team |
| MHTR | Mental Health Treatment Requirement |
| NOMS | National Offender Management Service (until 30 March 2017) |

| | |
|---|---|
| NPS | National Probation Service |
| NTA | National Treatment Agency for Substance Misuse |
| OT | Occupational Therapy/Therapist |
| PTSD | Post-Traumatic Stress Disorder |
| PO | Probation Officer |
| QNI | Queen's Nursing Institute |
| RCA | Root Cause Analysis |
| SC CCG | Southampton City Council Clinical Commissioning Group |
| SI | Serious Incident |
| SIRI | Serious incident requiring investigation |
| SIT | Structured Intervention Team (a component of the Substance Misuse Service, provided by SHFT up to 30 November 2014; and by Solent from 1 December 2014) |
| SMS | Substance Misuse Service |
| ToR | Terms of Reference |
| WH CCG | West Hampshire Clinical Commissioning Group |

# Appendix H: Anonymisation Index

| Initials | Role |
|---|---|
| Mr Beattie | Victim |
| Mr CD | Perpetrator |
| Ms EF | Manager, Hampshire Liaison and Diversion Service, SHFT |
| Professor GH | Interim Clinical Director, Southampton Adult Mental Health Service, SHFT |
| Ms IJ | Area Manager, Southampton Adult Mental Health Services, SHFT |
| Ms KL | Manager, Adult Mental Health Services, including the CMHNs (Community Mental Health Nurses) seconded to the Homeless Health Care Team, SHFT |
| Mr MN | Acute Transition Facilitator, SHFT |
| Mr OP | Bed Manager, SHFT |
| Ms QR | Ward Manager, SHFT |
| Dr ST | Consultant Psychiatrist, SHFT |
| Ms UV | CMHN, SHFT, seconded to the HHCT |
| Ms WX | Nurse consultant/HHCT, Solent |
| Ms YZ | Business Manager, HHCT, Solent |
| Mr BC | Operations Manager, Mental Health and Substance Misuse Services, Solent |
| Dr DE | GP, HHCT |
| Dr FG | Prescribing doctor, Structured Intervention Team (SIT) |
| Ms HI | Needle exchange service manager |
| Ms JK | SMS manager |
| Ms LM | Solent report author |
| Dr NO | SHFT report author |
| Ms PQ | MENDOS worker |

| | |
|---|---|
| Ms RS | Associate Director of Quality for Southampton City CCG |

# Appendix I: References

References.


Southern Health NHS Foundation Trust policies and procedures.

Clinical engagement/did not attend (in place at the time of the incident and updated version).

Incidents management policy (in place at the time of the incident and updated version).

Procedure for the management of serious incidents requiring investigation, version 1, 2014 and version 2, 2016.

Clinical risk assessment and management policy (in place at the time of the incident and updated version).

Admissions, transfers and discharges policy.

MENDOS operational policy (in place at the time of the incident – this service no longer exists).

Hampshire and Isle of Wight Liaison and Diversion policy (this service did not exist at the time of the incident: this is the current policy for this service).

Dealing with the suspected possession of illegal substances by inpatients (in place at the time of the incident and updated version).

Physical assessment and monitoring procedure for mental health and learning disabilities (in place at the time of the incident and updated version).

Solent NHS Trust policies and procedures.

Reporting adverse events policy, 2016.

Clinical risk assessment and management, adult mental health services, 2016;

Risk management strategy, 2015.

Policy for investigation, analysis and learning from complaints, incidents and claims, 2013.

Southampton City CCG policies and procedures.

Serious Incident Policy: Supporting learning to prevent recurrence (2015).

Publications

Barcley, J. (2016) Making Every Adult Matter (MEAM), changing systems, changing lives: a brief review of the MEAM Coalition, MEAM; and website Making Every Adult Matter accessed 15 September 2016

The Bradley Report (2009) Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. Department of Health, London.

Blackburn, R. (1992) Criminal behaviour, personality disorder and mental illness: the origins of confusion. Criminal Behaviour and Mental Health, 2 66-77, Whur Publishers Ltd.

Breedvelt, J.J.F, Dean LV, Jones G.Y., Cole, C. and Mayes H.C. A. (2014). Predicting recidivism for offenders in UK substance dependence treatment: do

mental health symptoms matter? Journal of Criminal Psychology. Vol 4. Issue2. pp 102-115.

The Caldicott Committee (December 1997). "The Caldicott Report". Department of Health, London.

DH (March 23008) Refocussing the Care Programme Approach {Policy and Positive Practice; and Code of Practice Mental Health Act 2983 (revised 2009).

Diller, T Helmrich G and others, (2015) 'The Human Factors Analysis Classification System (HFACS).

Durcan, G., Saunders, A., Gadsby, B. and Hazard, A. (2014) The Bradley Report five years on: an independent review of progress to date and priorities for further development. Centre for Mental Health, London.

The Mandate: A mandate from the Government to the NHS Commissioning Board. The Mandate

The Information Governance Review: To Share or Not to Share" (March 2012) Department of Health.

Martinson, Robert (1979). "New Findings, New Views: A Note of Caution Regarding Sentencing Reform". Hofstra Law Review. 7 (2) Winter.

McMurran, M. (1996) Alcohol, Drugs and criminal behaviour. In Working with offenders, Psychological Practice in Offender Rehabilitation, Edited C, R. Hollins, John Wiley& Sons Ltd., Chichester.

Ministry of Justice (2014) Statistical Notice - further breakdown of a proven reoffending of adult offenders in England and Wales released from custodial or sentences of less than 12 months by region.

Munroe, E. and Rumgay, J. (2000) 'Role of risk assessment in reducing homicides by people with mental illness' The British Journal of Psychiatry, 176 pp 116-120.

NHS England (2015) Serious incident Framework: Learning lessons to prevent recurrence.

NICE (2009) Clinical Guidance: Anti-social personality disorder: prevention and management. NICE CG 77.

NHSLA (2013) Risk Management Standards 2013-14 for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care. NHS Litigation Authority.

National Offender Management Service Mental Health Treatment Requirement - A Guide to Integrated Delivery.pdf

National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services.

National Treatment Agency for Substance Misuse (2010) Commissioning for recovery, drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships. National Treatment Agency

National Treatment Agency (2010) Commissioning for Recovery: Drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships".

Patient Access: Dissocial Personality Disorder https://www.nice.org.uk/guidance/cg77 accessed 29 September 2017

Queen's Nursing Institute (2008) 'Homeless health initiative, service user consultation', QNI.

Radden, J. (1985) Madness and Reason. Allen and Unwin: London.