Independent Investigation

into the

Care and Treatment Provided to Mr. X

by the

Sussex Partnership NHS Foundation Trust

Commissioned by
NHS South of England
Strategic Health Authority

Investigation Conducted by: HASCAS Health and Social Care Advisory Service
Report Authored by: Dr. Len Rowland

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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. X was commissioned by NHS South of England Strategic Health Authority pursuant to *HSG (94)27*.[1] This Investigation was asked to examine a set of circumstances associated with the death of Mr. A who was the victim of a homicide on 14 April 2011.

Mr. X received care and treatment for his mental health condition from the Sussex Partnership NHS Foundation Trust. It is the care and treatment that Mr. X received from this organisation that is the subject of this Investigation.

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has acted at all times in a professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos.

1 Health Service Guidance (94) 27

2. Condolences to the Family and Friends of Mr. A

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. A. At the time of writing this report the commissioners of this Investigation had not been able to make contact with them.

3. Incident Summary

Mr. X moved to Brighton in November 2010 and from February 2011 was treated by the Brighton and Hove Mental Health Homeless Team. He had a significant forensic history including numerous convictions for assault, criminal damage, burglary and anti-social behaviour. He had a diagnosis of *"possible Adult ADHD"*. Personality Disorder of either the Antisocial or Emotionally Unstable type and Mental and Behavioural Disorder due to the harmful effects of alcohol and multiple drug abuse were also identified and considered

On 19 April 2011 a serious incident form was completed by the Manager of the Mental Health Homeless Team. The form recorded that Mr. X had been arrested for the murder of a member of the public.[2] Mr. X was arrested and remanded in custody for the murder of a 48-year old man who had significant physical disabilities and was found dead on the 15 April 2011. The victim had died as a result of severe head wounds. Mr. X was known to the victim who had provided him with temporary accommodation at his home allowing him to sleep on his sofa.

On 23 January 2012 Mr. X was convicted of murder at Lewes Crown Court. Any mental health problems Mr. X might have had were not deemed to represent any mitigation for the killing of Mr. A. His Honour Judge Scott-Gall commented in his sentencing remarks:

> *"I have the benefit of the letter written by [The SpR] to your then General Practitioner … which was our Exhibit 14 in the trial. As I observed…, it is a snapshot providing details of your then condition at the time of this consultation two months or so before the commission of this offence. In my judgment, the contents do not meet the requirements envisaged in Schedule 21 paragraph 11(b) as a mitigating factor; although I do take into account the submissions made based on Dr. … reports".*
>
> *"In my judgment, the aggravating factors that I have set out justify the court departing from the suggested starting point of 15 years. The least term you must serve before you are eligible to be considered for parole is 18 years imprisonment. That represents, under our present sentencing regimen, a determinate sentence of 36 years".*[3]

2 Clinical notes pp 21-22
3 Sentencing Remarks of his Honour Judge Scott- Gall

4. Background and Context to the Investigation (Purpose of Report)

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South of England (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *HSG(94)27, LASSL(94) 4*, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:
"*…in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

The purpose of an Independent Investigation is to review thoroughly the care and treatment received by the service user in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of health services in the future, incorporating what can be learnt from a robust analysis of the individual case. The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident. The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and Independent Investigation Team.

5. Terms of Reference

The Terms of Reference for this Independent Investigation are as follows:

"The Independent Investigation is commissioned by NHS South of England. It is commissioned in accordance with guidance published by the Department of Health in HSG (94)27 The Discharge of Mentally Disordered People and their Continuing Care in the Community and the updated paragraphs 33 – 36 issued in June 2005.

Terms of reference

1 *To examine the care and treatment of Mr. X, in particular:*

- *The history and extent of Mr. X's involvement with health and social care services.*
- *The suitability of Mr. X's treatment, care and supervision in respect of:*
  - *his clinical diagnosis;*
  - *his assessed health and social care needs;*
  - *his assessed risk of potential harm to himself and others;*
  - *any previous psychiatric history;*
  - *any previous forensic history.*
- *The assessment of the needs of carers and Mr. X's family.*
- *The extent to which Mr. X complied with his prescribed care plans.*
- *The extent to which Mr. X's care and treatment corresponded to statutory obligations, the Mental Health Act (1983 and 2007), and other relevant guidance from the Department of Health.*
- *The quality of Mr. X's treatment, care and supervision, in particular the extent to which his prescribed care plans were:*
  - *appropriate;*
  - *effectively delivered;*
  - *monitored by the relevant agency.*
- *The adequacy of the framework of operational policies and procedures applicable to the care and treatment of Mr. X and whether staff complied with them.*
- *The competencies of staff involved in the care and treatment of Mr. X and the adequacy of the supervision provided for them.*
- *The internal investigation completed by Sussex Partnership NHS Foundation Trust and the actions that arose from this.*
- *The Trust clinical governance and assurance systems as they relate to care and treatment provided to Mr. X, this in particular regard to:*
  - *audit;*
  - *clinical supervision;*
  - *clinical leadership.*
- *Any other matters that the investigation team considers arise out of, or are connected with, the matters above.*

2 *To examine the adequacy of the collaboration and communication between all the agencies involved in the care and treatment of Mr. X, or in the provision of services to Mr. X, including Sussex Partnership NHS Foundation Trust and relevant agencies and GP services.*

3 *To prepare a written report that includes recommendations to the strategic health authority so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.*

Approach

The Investigation Team will conduct its work in private and be expected to take as its starting point the Trust's internal investigation supplemented, as necessary, by access to source documents and interviews, as determined by the Team. The Team is encouraged to engage relatives of the victim, Mr. X and his family and any relevant staff in the inquiry process.

The Team will follow good practice in the conduct of interviews by, for example, offering the opportunity for interviewees to be accompanied and giving them the opportunity to comment on the factual accuracy of their interview transcript.

Timetable

The precise timetable will be dependent on a number of factors including the availability of Mr. X's clinical records, the Investigation Team's own assessment of the need for information and the number of interviews necessary. The Team is asked to have completed the inquiry, or a substantial part of it, within six months of starting its work. Monthly reports on progress should be provided to NHS South of England.

Publication

The outcome of the investigation will be made public. The nature and form of publication will be determined by the NHS South of England. The decision on publication will take account of the views of the relatives and other interested parties."

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who work independently of Sussex Partnership NHS Foundation Trust Mental Health Services. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Investigation Team Leader and Chair

Dr. Len Rowland	Director of Research HASCAS Health and Social Care Advisory Service and Clinical Psychologist Member of the Team.

Investigation Team Members

Dr. Androulla Johnstone	Chief Executive HASCAS Health and Social Care Advisory Service and Nurse Member of the Team.
Dr. David Somekh	HASCAS Health and Social Care Advisory Service Associate and Consultant Psychiatrist Member of the Team

Support to the Investigation Team

Mr. Greg Britton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Mrs. Fiona Shipley	Transcription Services

Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

7. Investigation Methodology

In February 2012 NHS South of England (the Strategic Health Authority) commissioned the HASCAS Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section four of this report. The investigation methodology is set out below. It was the decision of the Strategic Health Authority (SHA) that full anonymity be given to Mr. X and all witnesses to this Investigation.

Consent and Communications with Mr. X

Mr. X was written to by the Strategic Health Authority (SHA) requesting his consent to access clinical records. There was a significant delay between the commissioning of this Investigation and communication with Mr. X due to his whereabouts being uncertain. In November 2013 the prison where he was detained was located and a letter sent to him. On the 4 November 2012 Mr. X signed a consent form to allow the Independent Investigation Team access to his clinical records.

Communications with the Victim's Family

The commissioner of this Investigation was not able to make contact with the victim's family.

Communications with the Family of Mr. X

The commissioner of this Investigation was not able to make contact with the family of Mr. X.

Communications with the Sussex Partnership NHS Foundation Trust

The SHA made contact with the Sussex Partnership NHS Foundation Trust in August 2012. This communication served to notify the Trust that an Independent Investigation under the auspices of *HSG (94) 27* had been commissioned to examine the care and treatment of Mr. X.

The Independent Investigation Team worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished;
- that a workshop for witnesses to the Independent Investigation was held on 22 January 2013. The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible;
- that interviews on 4, 5 and 6 February 2013 were held at the Trust Headquarters in Worthing, West Sussex. The Investigation Team were afforded the opportunity to interview witnesses and meet with the Senior Managers of the Trust.

Factual accuracy and headline findings communications were held between the Independent Investigation Team and the Sussex Partnership NHS Foundation Trust in accordance with Scott and Salmon compliant best practice.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon processes. The witnesses who attended for interviews are set out below in table one.

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
4 February 2013	▪ Executive Director of Nursing & Quality, Sussex Partnership NHS Foundation Trust ▪ Director of Governance, Sussex Partnership NHS Foundation Trust	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
5 February 2103	▪ Service Director, Sussex Partnership NHS Foundation Trust	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
6 February 2013	▪ Clinical Director, Adult Mental Health Services & Consultant Psychiatrist, Sussex Partnership NHS Foundation Trust	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
6 February 2013	▪ Community Psychiatric Nurse, Court Diversion Service ▪ Social Worker, Mental Health Homeless Team ▪ Manager, Mental Health Homeless Team ▪ Service Director	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
6 February 2013	▪ Specialist Registrar Mental Health Homeless Team	Investigation Team Chair; Investigation Team Psychiatrist; Investigation Team Nurse; Investigation Team Social Worker. In attendance: Stenographer

Salmon and Scott Compliant Procedures

The Independent Investigation Team adopted Salmon compliant procedures during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be given the opportunity to review clinical records prior to and during the interview.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual' manner and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, the Trust's Internal Investigation report and the Investigation Terms of Reference. Each Team Member identified potential clinical witnesses and general questions that needed to be asked. Each witness was made aware in advance of their interview of the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

First Team Meeting 15 January 2013

The Team examined and discussed the Chronological Timeline which had been produced following the receipt of the full clinical records. The Team decided which staff they wished to interview and agreed questions they would ask. The list of documents required was made; this consisted of various Trust Policies and Operational Policies together with information about the Trust.

Second Team Meeting 5 February 2013

There was opportunity during the interview schedule which allowed the Investigation Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the organisation and systems of the various teams which had contact with Mr. X and also management and governance issues.

Following the witness interviews the Team received the transcriptions and were able to add to the chronological timeline to reflect upon the additional information. There were also additional policies and procedures sent from the Trust which were examined. The Investigation Team was able to work in a virtual manner in order to complete the Root Cause Analysis methodology and develop the report findings and conclusions.

Other Meetings and Communications
The Independent Investigation Team communicated with the SHA throughout the course of the Investigation and provided the SHA with regular information on the progress of the Investigation.

Root Cause Analysis
The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed throughout this process.

2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established. From this, causal factors or critical issues can be identified.

3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the Decision Tree and the Fish Bone.

4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

Information and Evidence Gathered (Documents)

The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. X's clinical records.
2. Letter and assessment reports provided by Mr. X's foster mother.
3. Sussex Partnership NHS Foundation Trust Clinical Polices.
4. Sussex Partnership NHS Foundation Trust internal investigation archive and report.
5. Clinical Witness/Witness transcriptions.
6. Healthcare Commission/Care Quality Commission Reports for the Sussex Partnership NHS Foundation Trust services.
7. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive (2006).
8. Guidelines for the NHS: National Patient Safety Agency, Safer Practice Notice 10, *Being Open When Patients are Harmed* (September 2005).
9. NICE clinical guidelines.
10. ICD 10 and DSM IV TR diagnostic guidelines and criteria.

8. Profile of the Sussex Partnership NHS Foundation Trust

The Sussex Partnership NHS Trust was formed in 2006 and became a Foundation Trust in August 2008; it has a turnover of £240 million. The Trust currently serves a population of 1.5 million people, employs 5,000 staff and provides services from 120 sites in Hampshire, Kent, London, Surrey, East Sussex and West Sussex. During 2012/2013 the Trust made 100,000 clinical contacts with service users.

The Trust Vision

1. *"Our vision is to ensure that the people who use our services, their carers and staff have the best possible experience of receiving help or working within our services*

2. *We are one of the largest mental health, learning disability and substance misuse trusts in the country*

3. *Our 5,000 staff provide treatment at home, in clinics, centres and hospitals across Sussex and beyond"*

The Five Strategic Aims

1. *"High quality clinical care for all people using Sussex Partnership services*

2. *Employer of enabled, engaged, well trained and motivated staff*

3. *A leading teaching and research mental health trust*

4. *A well-governed sustainable organisation*

5. *A growing organisation that invests in improving services"*

Services Provided

1. *"Primary mental health and wellbeing services including partnerships with GPs*

2. *Adult community mental health services for all adults over 18 (no upper age limit)*

3. *Specialist mental health services including eating disorders, personality disorders, and recovery services*

4. *Adult crisis and inpatient services*

5. *Dementia and later life services*

6. *Children and young people's services*

7. *Secure and forensic services*

8. *Substance misuse services*

9. *Prison healthcare services to HMP Lewes and HMP Ford"*

Mental Health Homeless Team

The Brighton and Hove Mental Health Homeless Team is a multi-disciplinary team that works with patients who are experiencing street homelessness, or living in temporary or hostel accommodation across the city. The team consists of Registered Mental Nurses (RMNs), an Approved Mental Health Professional and a Community Support Worker employed by a community and voluntary sector organisation in the city with expertise in homelessness. Medical input is provided by the Consultant Psychiatrist responsible for the Assertive Outreach Team. The team works closely with a range of agencies across the city including the Council's Housing Department, Substance Misuse Services, community and voluntary sector organisations including Brighton Housing Trust and the Crime Reduction Initiative Rough Sleepers and Street Services Team.

Identifying homelessness and accommodation status is a key element of the assessment process at all points in the care pathway throughout acute care, urgent care and in the Assessment and Treatment Services. Formulation of risk assessment and risk management plans are an essential part of assessment and care planning and risk assessment tools include accommodation status allowing for this to be included in a summary of risk.

In Brighton and Hove the Trust provides integrated mental health and social care services jointly with Brighton and Hove City Council. This allows for closer partnership working with the City Council's Housing Department in the identification of homelessness and resolution of the problem. The Trust has a member of staff seconded to the Council's Temporary Accommodation and Allocations Team with identified nomination rights into a variety of hostel and supported accommodation options provided by the Council, the Trust and community and voluntary sector organisations. Acute Services have a Discharge Coordinator role; one of the key elements of this role is to identify at an early stage in the patient's admission any issues relating to accommodation and make the appropriate referrals to the Council's Housing Options Team. Acute services have introduced a discharge checklist as a mandatory activity which also identifies a patient's accommodation status.

The Council's Housing Options service have a clear and well-established referral route into adult mental health and substance misuse services if there is a need for an assessment to establish whether the Trust has a duty to provide accommodation for a person using services. Both adult mental health services and substance misuse services in Brighton and Hove have access to the Council's Temporary Accommodation via a Service Level Agreement depending on eligibility and risk.

Brighton and Hove Clinical Commissioning Group has identified that homelessness is an on-going issue in the city and has formed a working party to submit an expression of interest to the Department of Health to become a Pioneer Site to address homelessness. This is a multi-agency approach to homelessness and has been supported by the city's Health and Well Being Board. It has been concluded that if the bid is unsuccessful all partner agencies will

implement plans to take a multi- agency approach to homelessness regardless. The Trust is a key stake holder in this work for both adult mental health and substance misuse services. The first action is to complete a full process mapping exercise of all homelessness services across the City with a view to forming a multi-agency 'hub' operating out of one location.

The Trust has been successful in accessing Department of Health money to support 'street triage' in Sussex. The Trust is also a key stakeholder in the city's 'safeguarding hub'. This is a multi-agency group of both statutory and non-statutory partners who work closely with the street community in the City and they meet to share information, identify vulnerable individuals and formulate plans to minimise risk and maximise opportunities to safeguard. This is attended by colleagues from the Trust's Mental Health Homeless Team and substance misuse services.

Dual Diagnosis

There is a Trust-wide dual diagnosis strategy with local implementation groups across the three core divisions. The implementation of the strategy is supported by the Nurse Consultant for Dual Diagnosis. The implementation group in Brighton and Hove is led by the Clinical Commissioning Group and attended by both statutory and community and voluntary sector partners engaged in the delivery of adult mental health and substance misuse services in the City. Recent developments have included the development of a specific dual diagnosis care plan which is being trialled in Brighton and Hove. The evaluation of this project includes patient, carers and staff focus groups. If successful it is envisaged that this care plan will be expanded across the whole of Sussex.

Substance Misuse Services in Brighton and Hove are commissioned by the Council's Public Health Directorate since this has transferred from the Primary Care Trust in April 2013. Substance Misuse services in the City are currently delivered jointly between the Trust and the Crime Reduction Initiative. This service is due to be tendered in the financial year 2014/2015. Prior to this mental health commissioners have created a short-life working group to evaluate whether far greater integration between adult mental health and substance misuse services would be of benefit to patients and carers. The Trust is a key stakeholder in this evaluation. It is proposed that staff from substance misuse services are co-located with adult mental health staff specifically to meet the dual diagnosis agenda and improve both assessment and treatment outcomes for patients.

9. Chronology of Events

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. X and on his care and treatment from mental health services.

Chronology

Mr. X was born in **1978**. He was placed in foster care with his long-term foster parents in November 1980 at the age of twenty-six months.[4]

Mr. X was excluded from primary school at the age of eight after throwing a stone at another boy. At the age of 10 he was excluded from his local junior school following several periods of suspension. At the age of 11 Mr. X was placed in a residential school for children with Emotional and Behavioural Difficulties (EBD). During his time at this school he frequently absconded and was eventually excluded when he was 15-years old. This was the end of his formal education.[5]

In **1989** Mr. X's intellectual abilities were assessed by an Educational Psychologist. His abilities were reported to be in the average range.[6]

Mr. X was assessed again in **1991** by an Educational Psychologist and again his intellectual abilities were recorded as being in the average range. This report concluded *"…Many aspects of [Mr. X's] behaviour (inattention, impulsivity, over activity, a predisposition to seek immediate satisfaction and an impaired ability to moderate arousal and inhibit responding) together with his WISC profile……are consistent with attentional deficit syndrome".*[7]

In **June 1995** Mr. X was assessed by a Senior Registrar in Forensic Psychiatry at the request of the Aldershot Youth Court. This report noted that in 1994 Mr. X had been one of a group of youths who had attacked a 14-year old boy; in 1995 he had broken a chair and threatened staff at the childrens' home where he had been placed for respite care and *"[Mr. X] is currently charged with more than 30 thefts, mainly from motor vehicles. He has breached bail and curfew on a number of occasions".*[8]

The diagnosis reached at this time was that Mr. X was suffering from a Conduct Disorder which was characterised by *"repetitive and persistent patterns of dissocial, aggressive or deviant conduct".*[9]

In **1996** Mr. X was referred for assessment by his GP who was concerned that Mr. X might be suffering with Attention Deficit Hyperactivity Disorder (ADHD). It was noted that by this time Mr. X had experienced a number of accommodation placements: in a childrens' home in

4 Clinical notes p 65
5 Clinical notes p 87
6 Clinical notes p 88
7 Clinical notes p 88
8 Clinical notes p 89
9 Clinical notes p 89

Aldershot, in a secure unit in Southampton, in a hostel in Aldershot, in a bed-sit in Aldershot, in a remand centre in Reading, and in a hostel in Portsmouth, in addition to spending intermittent period of time with his foster parents.

The conclusion of the assessment was that *"Mr. X is a young man who experiences both Attention Deficit Hyperactivity Disorder [ADHD] as well as Conduct Disorder"*.[10]

The report also noted: *"Disinhibition and lack of impulse control is further demonstrated by [Mr. X] having acquired 'more that his fair share of fractures', and significantly, having suffered the consequences of a serious road accident in 1988, when he ran across the road in a rage and was struck by a car. This latter incident resulted in a 6-week hospital stay, which included a period of unconsciousness, the onset of pancreatitis, and two abdominal operations…*

… [Mr. X's] Conduct Disorder behaviours have now led him towards legal difficulties. A picture emerges where [Mr. X] lacks personal responsibility, and where we observe an increasingly established, repetitive and persistent pattern of antisocial behaviour.

[Mr. X] has little empathy and little concern for the feelings and well-being of his foster parents.

His self-esteem is extremely low, even though he attempts to project an image of toughness".[11]

In **July 1997** a Child Psychiatrist, who had recently taken responsibility for Mr. X's care and treatment, wrote to the Aldershot Probation Service concerning Mr. X. This report confirmed that Mr. X had a diagnosis of ADHD. It was noted that following Mr. X being diagnosed as suffering from ADHD he had been prescribed Ritalin (methylphenidate). The report said that *"When Mr. X takes the medication there is a marked noticeable improvement in both his behaviour and attitude to others. He becomes much more rational, much more able to plan ahead and at those times he becomes quite insightful into the difficulties he is having and expressed a desire to change things for the better"*. The Child Psychiatrist noted however that *"Over that past year [Mr. X] has been off his medication for a number of reasons. It is during that time that once again he has got into trouble"*. The report went on to state *"Over the past week since he had been in the Bail hostel…he has been back on Ritalin and once again there is an improvement in his functioning. Clearly it is important therefore that he continues on his medication since without it he is almost certainly going to revert back to the troublesome behaviour"*.[12]

This report also mentioned that in addition to medication it would be important for Mr. X to be placed in a structured and calm environment *"with clear expectation in which the individual is assisted to develop the skills that he has failed to learn over the years…These*

10 Clinical notes p 91
11 Clinical notes pp 91-92
12 Clinical notes p 96

skills include the essential life skills…He has never gained those kind of skills and therefore cannot be expected to demonstrate them at present unless he is first trained in them".[13]

The report went on to state that a prison sentence at this time would be counterproductive.

A Psychiatric Court Report was prepared in **October 1997** when Mr. X was in Dorchester Prison. Mr. X had been seen on **13 October 1997** by the Community Forensic Team from the Dorset Healthcare Trust but had been unwilling to co-operate with them, however he was willing to be interviewed by the Psychiatrist on **21 October 1997**. The report stated that Mr. X had been diagnosed as suffering from ADHD *"a condition about which the medical profession is divided".* However it continued *"Whatever its pathology, it describes a condition in children of very high tension levels in which they are unable to concentrate and learn, have short fuses and act out, have difficulty in learning, probably because the high tension levels impair their concentration and learning process, and who appear to mature psychologically at a slower rate than their peer group. And it is certainly true that [Mr. X] presents with these characteristics and it has impaired interpersonal relationships and psychological growth and development and he has underperformed intellectually, and he shows signs of an immature, impulsive irritable personality. In the past he has abused drugs….He appears to still abuse alcohol".*[14] *"He clearly has an anxious worrying personality with paranoid traits that other people are against him".*[15]

The report made two recommendations: that Mr. X be held responsible for his behaviour; and that the Community Forensic Service should offer Mr. X *"a treatment service which would include cognitive behavioural therapy, encourage him to develop the skills in social interaction and preparation for acquiring work skills, and such medication as is thought appropriate".*[16]

The author of the report commented that he believed that a hospital admission would be counter-productive. He went on to note that *"One has to remember that this is a life-long dysfunction and will not easily be resolved and the prognosis is not necessarily good in spite of best efforts".*[17]

On **13 November 2008** a Psychiatrist at the Surrey Borders Partnership NHS Foundation Trust wrote to Mr. X's GP following an assessment on 12 November 2008. Mr. X had missed three previous appointments. At this time Mr. X had been in a relationship for five years and was described as having two step children. However he had recently broken up with his girlfriend and was sleeping rough. He reported that he had been using illicit drugs since the age of 14 and *"had taken everything".* Mr. X reported that he had also abused alcohol and tended to use a combination of spirits and beer *"until he is knocked out".*

13 Clinical notes p 97
14 Clinical notes p 100
15 Clinical notes p 102
16 Clinical notes p 104
17 Clinical notes p 104

It was noted that Mr. X had a long forensic history including convictions for assault, criminal damage, burglary and anti-social behaviour.

Mr. X was described as subjectively low in mood and that objectively had some symptoms of mild to moderate depression. There was no evidence of any psychotic symptoms though Mr. X reported that he sometimes felt paranoid, this appeared to be in the context of his drug misuse. The diagnosis recorded was *"Mental and behavioural Disorder due to the harmful effects of alcohol and multiple drug use; ? Anti-Social Behavioural Disorder"*.

The plan was to continue to prescribe Mirtazapine (30mg *nocte*); to commence prescribing Quetiapine (100mg *nocte*); to refer Mr. X to the substance misuse services; to help him to secure accommodation; to discuss Mr. X with the Consultant Psychiatrist and the Community Mental Health Team to identify which services could be provided and to review him in a month's time.[18]

Mr. X was reviewed by the same Psychiatrist on **18 December 2008**. He reported that his mood was a little improved since he had started the medication and he was calmer although he was still irritable at times and his mood fluctuated. He denied any thoughts of self-harm or of harming others. Mr. X reported that he had not used any illicit drugs for four to six weeks. His diagnosis remained unchanged. Mr. X's Mirtazapine prescription remained unchanged but his Quetiapine was increased to 300mg (*nocte*). The plan was to review Mr. X again on 12 February 2009.[19]

On **23 April 2009** Mr. X's GP wrote to the Consultant Psychiatrist. The GP reported that he had spoken to Mr. X's foster parents. They were concerned that Mr. X had not been given the opportunity to *"try a treatment for ADHD"*. His foster parents were concerned that his behaviour was deteriorating, that he might become violent and that he might have assaulted his girlfriend. He was drinking alcohol excessively and was homeless. Mr. X was not taking his medication and his foster parents were hoping that he could be assessed as a residential patient. The GP had indicated to Mr. X's foster parents that he did not believe that this option was available.

Mr. X had not attended this appointment with his GP. The GP believed that the Community Mental Health Team had telephoned Mr. X but was unsure whether he had made contact or attended an appointment with the team.[20]

On **8 May 2009** Mr. X's GP wrote to the Consultant Psychiatrist. He thanked the Consultant Psychiatrist for seeing Mr. X urgently and reported that Mr. X had described a *"complex situation"* whereby there was a *"contract out for him to be killed. This was worth £3,000"*. This was making Mr. X *"very agitated"*. Mr. X had reported that he should have been living in a shelter in Winchester but there was no bed for him and in consequence he was sleeping rough. Because of Mr. X's agitation and because he reported that *"the drug he has been on*

18 Clinical notes p 77
19 Clinical notes p 78
20 Clinical notes p 79

before 'does his head in'" the GP had changed Mr. X's prescription to Trifluoperazine 1mg-2mg twice a day.

Mr. X's foster parents considered him to be a suicide risk and Mr. X reported that he would *"do himself in"* rather than kill someone else.[21]

On **12 May 2009** the Psychiatrist who had previously reviewed Mr. X wrote to his GP. Mr. X had reported that he was sleeping rough as there was no place for him at the night shelter. He reported that he was stressed and distressed because of his social circumstances and because he was waiting for a Court case to be heard. He reported that he had stopped using illicit drugs but was still drinking excessive amounts of alcohol. The possibility of Mr. X suffering from adult ADHD had been discussed with Mr. X and the Consultant had recommended that Mr. X should be referred for assessment.

Mr. X reported that he had stopped taking his Mirtazapine as he had run out of that medication. He was advised to restart this and continue to take the Trifluoperazine (Stelazine) 1mg daily which the GP had prescribed.

The diagnoses recorded were *"Mental and Behavioural Disorder due to the harmful effects of alcohol and multiple drug abuse;? Antisocial Behaviour Disorder;? Adult ADHD"*.

The plan was for Mr. X to contact the local drug and alcohol services regarding his alcohol problem; he was to be referred for an assessment for ADHD; he was to be referred to Forensic Services because of his forensic history and he was to be reviewed in two months' time.[22]

On **25 January 2010** a GP in Odiham, Hampshire referred Mr. X to the Mental Health Team in Tadley Hampshire. The GP reported that Mr. X had recently moved to the area and had a long history of depression and anxiety. Mr. X had reported that he had suffered from ADHD as a child and felt that this continued to cause him problems. He had been prescribed Ritalin but this had been stopped in 1998. He had also reported that he had been under the care of the Mental Health Team in Cove and had been prescribed Mirtazapine and Quetiapine for a number of years, though he felt that these did not really help. At the time Mr. X was seen by the GP he was reporting that his mood was *"not too bad"* and he was not expressing any suicidal intent. Mr. X was awaiting surgery to repair a scaphoid fracture. He had been taking Co-dydramol but the GP had changed this to Tramadol. Mr. X denied any current illicit drug use. The GP requested advice on the management of Mr. X, particularly with the regards to the use of Quetiapine.[23]

On **1 June 2010** a Consultant Psychiatrist at the Hampshire Partnership NHS Trust wrote to Mr. X's GP in Odiham, Hampshire thanking him for the referral and informing him that he had reviewed Mr. X on **12 May 2010**.

21 Clinical notes p 80
22 Clinical notes p 84
23 Clinical notes p 85

Mr. X had presented with poor concentration, low mood and difficulties in managing his anger. He reported that although he was at times agitated he did not lose his temper as often as he had in the past. Mr. X reported that he head butted the wall when he got angry. He reported that his sleep was disturbed and his appetite poor. Mr. X reported that he had no current thoughts or intentions of harming himself. His symptoms had not changed in nature or intensity in recent times.

Mr. X reported that in 1997 he had taken an overdose of Ritalin and in 2003 an overdose of Carbamazepine. He had been given a diagnosis of Personality Disorder in 2003, possibly while he was in prison, and had been diagnosed with depression in 2007. Mr. X had stopped taking his Mirtazapine about a month before the review appointment. He reported that he had been prescribed Quetiapine however he had taken this only a couple of times as it had made him drowsy.

Mr. X reported that he had made contact with his biological mother when he was 17. He got on well with her and she had been living with him until two weeks earlier. Mr. X had a history of offences including: burglary, theft, actual bodily harm, assaulting police officers, grievous bodily harm and aggravated burglary. He had first gone to prison at the age of 17 and had spent a total of eight and a half years in prison. His longest sentence was between 2003 and 2008 for grievous bodily harm. He had recently been in prison for three weeks for breaching his bail conditions when he had sent a threatening text message to his ex-girlfriend. He had nine outstanding charges of common assault, affray, threatening and abusive behaviour and assaulting a police officer. Mr. X was due to appear in Court on 17 June 2010.

Mr. X said that he had not drunk alcohol for two months and that his last use of recreational drugs had been two years earlier. The Psychiatrist rated Mr. X risk of self-harm as low and his risk of harming others as low to moderate, however he recorded that there was a significant risk of harm to others when Mr. X was under the influence of alcohol. He also concluded that Mr. X's risk level was possibly related to personality traits.

The Consultant Psychiatrist concluded that *"[Mr. X] is a 31-year old man with a past history of ADHD and polysubstance abuse. He also has a long standing history of alcohol abuse which is ongoing and contributing to his mental state, He also possibly has some emotional unstable and antisocial personality traits which contribute to his symptoms"*. He did not recommend that Mr. X be prescribed any medication.

The plan was that if Mr. X's mood or other symptoms deteriorated a trial of an antidepressant might be of benefit. As the Psychiatrist was unclear whether Mr. X met the criteria for a diagnosis of Adult ADHD he suggested that Mr. X might be referred to a specialist unit such as the Maudsley Hospital for assessment. He recommended that Mr. X should seek help from the local services for his alcohol problem. Mr. X was to be offered one follow-up appointment.[24]

24 Clinical notes pp 81-83

By **December 2010** Mr. X had moved to Brighton and on **1 December 2010** having been released from Winchester Prison he approached the Local Authority for accommodation. He informed the Local Authority that he had come to Brighton to be near his sister. Due to the severe weather conditions and because he had a septic foot, for which he had been treated at the Royal Sussex County Hospital, the Council exercised its discretion and provided emergency accommodation for Mr. X.[25]

On **4 January 2011** a GP in Brighton wrote to the Central Access Team of the Secondary Mental Health Services. This referral letter appears to have been received on 14 January 2011. The GP reported that Mr. X had registered with the surgery the previous November 2010. He had been under the care of a Community Mental Health Team in Basingstoke, but had moved to Brighton to be near his family. His foster father had died recently and Mr. X was possibly suffering a grief reaction. He felt irritable and frustrated. Mr. X had told the GP that he had been prescribed Mirtazapine and Quetiapine which had been commenced in 2007 following an admission to hospital under the Mental Health Act (1983). In the summer of 2010, as he was coming out of prison, he had discussed with his Psychiatrist the possibility of coming off all his medication. Mr. X said he had a previous diagnosis of ADHD and he had been prescribed Ritalin, Depixol and Carbamazepine in the past. Mr. X had been keen to restart Mirtazapine and the GP had prescribed this. He had also provided Mr. X with a small supply of Hydroxyzine. The GP referred Mr. X to Secondary Mental Health Services with the request that that he could be reviewed by a Psychiatrist with a view to recommencing Quetiapine.[26]

On **12 January 2011** a Homeless Person's Officer wrote to Mr. X regarding his application for accommodation as homeless person. It was noted that Mr. X was homeless following his release from Winchester Prison and that he had been provided with temporary accommodation in December because of the severe weather conditions at that time. Mr. X had reported that he had a history of depression and that he been prescribed antidepressant medication in the past, though not for some months.

Mr. X's application had been discussed with his GP who reported that he had met Mr. X only once and had referred him to a Community Mental Health Team (CMHT) as he had been known to a CMHT in Basingstoke in the past. The Homeless Persons' Officer had been provided with a copy of report sent by the Psychiatrist at the Basingstoke CMHT to Mr. X's GP at that time, on 25 May 2010. This letter appears to contain the same information as the letter written to the GP in Odiham on 1 June 2010.

The letter from the Homeless Persons' Officer noted *"Although it is accepted that you are eligible for assistance and homeless, the law states that it is also necessary for a homeless person to be in 'priority need' before there is a duty to provide accommodation on a long term basis"*.[27]

25 Clinical notes p 39
26 Clinical notes p 5
27 Clinical notes p 38

The letter went on to say *"The law states that a person is likely to be in priority need if they or a member their household:*

- *is pregnant;*
- *has dependent children;*
- *is vulnerable as a result of old age, mental illness or physical disability or other special reason (for example: domestic violence, having been in the armed forces or in prison);*
- *is aged 16 or 17;*
- *is a care leaver (with some exceptions);*
- *is homeless as a result of an emergency such as flood, fire or other disaster".*[28]

The letter also noted *"On 7 January 2011….[you] advised that you had a partner…who had just come out of HMP Bronzegrove and was currently pregnant with your unborn baby.*

Investigations into this claim have found that [Ms X] had presented to the Authority a couple of days earlier and was seen and interviewed by Housing Options staff. At no point did she mention that she was pregnant or that she had a partner. The council is therefore satisfied that she is not someone who would reasonably be expected to reside with you and is not in Priority Need through pregnancy".

The Local Authority conclusion of this assessment was that "*the council is satisfied that you [Mr. X] are not in Priority Need as per the Act"* and in consequence had no duty to provide accommodation.[29]

A *"Single Point of Access Recording Sheet"* recorded that a referral had been received from Mr. X's GP in Brighton on **14 January 2011**. The Recording Sheet noted that Mr. X's case had been allocated to a *"Medic*" on **17 January 2011**. It was also noted that the Basingstoke CMHT had been contacted for Mr. X's clinical notes and had been advised that a consent form from Mr. X was required. The plan was to obtain Mr. X's consent to access his Basingstoke records and fax this to the Basingstoke CMHT. [30]

On **17 January 2011** it was recorded on the electronic record *"Returned from triage requesting old notes from Basingstoke CMHT*"; and that the case had been "*allocated to Medics".*[31]

Mr. X's temporary emergency accommodation came to an end on **18 January 2011**.[32]

On **28 January 2011** a second GP at the Practice Mr. X was attending referred Mr. X to the Mental Health Team for Homeless People in Brighton. The letter stated that Mr. X had recently moved to Brighton from Basingstoke where he had been under the care of a local CMHT. He had remained in contact with his foster mother who had been sending him money

28 Clinical notes p 39
29 Clinical notes p 41
30 Clinical notes p 11
31 Clinical notes p 44
32 Clinical notes p 41

but appeared to be "*under severe stress with all this, particularly since her husband died in December"*.

Mr. X and his foster mother had reported that Mr. X had severe ADHD as a child and that as an adult he had misused illicit substances and been involved with the Police. Mr. X *"was adamant"* that he was not taking any drugs at that time though he did admit to drinking alcohol. Since moving to Brighton Mr. X had attended his GP surgery *"regularly"* and had also attended the local Accident and Emergency Department on several occasions but, the GP believed, had not been seen by the Mental Health Team there. Mr. X was complaining of a difficulty in concentrating and of feeling angry and irritable.

Mr. X had recently been in trouble for biting someone on the cheek and he had damaged some bones in his hand as a consequence of a *"punch injury"*. Most recently Mr. X had nearly been run over by a car, whilst running across a road to the aid of his girlfriend who had been punched in the face and had her nose broken.

The GP reported that it was difficult to get a coherent history from Mr. X. He was crying and saying that he could not cope. The GP had sent him in a taxi to the Accident and Emergency Department but the GP was unclear whether he had been seen by the Mental Health Liaison Team there. The GP was requesting an assessment of Mr. X's mental health.

The GP explained that Mr. X's presence at the surgery had been chaotic. He had been prescribed Mirtazapine 30mg *nocte* and Hydroxyzine 25mg twice daily at his request.[33]

On **31 January 2011** a Mental Health Homeless Team referral from was completed. The form recorded that Mr. X had recently bitten someone on the cheek and that he had several broken fingers from punching a wall. The reasons for referral were recorded as:

- current mental health concerns, including risk to self;
- evidence of anger and irritability;
- poor coping skills.

Mr. X was noted as having a history of ADHD and having been under the care of the CMHT in Basingstoke.

It was noted that Mr. X had been referred by two GPs in the Practice he attended. There was also a handwritten note that Mr. X had been seen by the Criminal Justice Team in February in relation to acquisitive offences. Presumably this information was added at some later date.[34]

On **1 February 2011** it was recorded in the electronic record that a *"new"* referral had been received from Mr. X's GP and as he was homeless and after discussion with the Central Access Team Secretary the Mental Health Homeless Team were to take the original referral and the GP was to be advised of this. The referral was to be discussed at the team meeting the next day.[35]

33 Clinical notes pp 7-8
34 Clinical notes pp 2-3
35 Clinical notes p 44

On **1 February 2011** the administrator of the Mental Health Homeless Team wrote to Mr. X's GP informing him that the referral he had made on 4 January 2011 had been passed to the Mental Health Homeless Team because Mr. X was in emergency accommodation provided by the Council. The team planned to inform the GP surgery of the outcome of the referral.[36]

On the same day the Forensic Community Psychiatric Nurse (CPN) with the Criminal Justice Liaison Team wrote a letter, it is not clear to whom, stating that Mr. X had been in the Magistrates' Court that morning on a charge of theft to the value of £11.94 from a supermarket. The CPN had identified that Mr. X had been referred to Mental Health Services on 4 January 2011 by his GP and was awaiting a medical review. He also noted that Mr. X had been known to a CMHT in Basingstoke.

The letter noted that Mr. X was on crutches following having been hit by a car the previous week when he had fractured the tibia in his right leg. Mr. X informed the CPN that he was unhappy with the treatment he had received for his injury and was thinking of suing. The letter recorded that Mr. X had smelt of alcohol and he was irritable and somewhat agitated but the CPN had been able to establish a rapport with him.

Mr. X did not want the CPN to prepare a Court report but asked if the CPN could speed up his appointment with a Psychiatrist to discuss his medication as, Mr. X reported, he was not taking any medication at that time. There was no evidence of psychotic symptoms or concerns that suggested that an urgent assessment was needed. It was noted that Mr. X had 28 convictions from 99 offenses mostly of an acquisitive kind. The CPN offered to remain involved.[37]

On **2 February 2011** Mr. X's referral was discussed at the Mental Health Homeless Team meeting and it was agreed that an appointment would be made for him to see the Specialist Registrar (SpR) and Social Worker on the 7 February 2011. Mr. X was telephoned and given the details of the appointment. It was noted that he sounded calm and engaged well in conversation.[38]

On **3 February 2011** the Mental Health Homeless Team wrote to the GPs who had referred Mr. X thanking them for the referral and informing them that the Mental Health Homeless Team had contacted Mr. X by telephone and offered him an appointment with the SpR and Social Worker on 7 February 2011.[39]

Mr. X failed to attend his appointment on **7 February 2011.** The SpR and Social Worker waited 30 minutes after which the Social Worker telephoned him. Mr. X said that he was aware that he had an appointment but he *"couldn't make it and didn't have any credit on his phone to let us know"*. Mr. X was informed that a new appointment had been made for him on 28 February 2011.[40]

36 Clinical notes p 4
37 Clinical notes p 36
38 Clinical notes p 44
39 Clinical notes p 35
40 Clinical notes p 44

Mr. X was written to on the **8 February 2011** offering him a further appointment on 28 February 2011**.**[41]

On **28 February 2011** Mr. X called the Social Worker asking for directions to the CMHT. He said that he was going to bring his *"missus*" with him to the appointment as he wanted her to be involved in the initial assessment. Prior to meeting Mr. X the Social Worker telephoned Mr. X's foster mother to find out which of the two CMHTs in Basingstoke had been caring for him. The Social Worker recorded that Mr. X's foster mother was not sure but she was relieved that to hear that Mr. X was attending his appointment. She then, unprompted, provided some background to Mr. X's lifelong behavioural problems. She said that Mr. X had always acted on impulse and that he had an inability to learn from past experiences. She felt that he was vulnerable to exploitation by others because of his impulsive nature. She wondered whether his behavioural problems, particularly his relationship problems, were because his disorder belonged in the autistic spectrum. She also provided a brief summary of the treatment Mr. X had had for ADHD. Mr. X's foster mother said that he was artistic, musical and had been a good dancer as a child.[42]

On **28 February 2011,** following her appointment with Mr. X, the SpR wrote to his GP. Mr. X had reported that his main problem was that he could not control his temper which resulted in him responding violently to minimal provocation. He had spent 13 of the previous 15 years in prison and had 28 separate convictions for offences such as assault, GBH, assaulting a police officer and carrying weapons. At the time of the assessment Mr. X was awaiting sentencing for possession of a knife, threatening a police officer, aggravated assault and breaking conditional discharge conditions. The sentencing Hearing was due to be held on 23 March 2011.

Mr. X and his partner reported that he was constantly *"on edge",* he could not relax and his thoughts seemed to be racing. Mr. X reported that he was impulsive and did not learn from his mistakes and had had problems functioning in society throughout his life because of this. Mr. X reported that he had also been a heavy user of alcohol, heroin and cocaine although he denied using illicit substances or drinking heavily at that time, saying that he had stopped eight years previously. It was noted that his foster father had died the previous December and his partner had had a miscarriage of twins at three months in January 2011.

A full psychiatric history was given based on what Mr. X was able to recall. He had been fostered from the age of two years and had been placed with a supportive and loving family. From the age of 11 Mr. X had been sent to a special school because of his uncontrollable behaviour. He had been diagnosed at the age of 16 with ADHD and was prescribed Ritalin for two years which made a difference to his behaviour; he was calmer and others noticed a positive change in his personality. Mr. X reported that he had seen several psychiatrists over the previous ten years *"in an effort to be re-assessed/diagnosed with ADHD but this had not happened"*. Mr. X had been prescribed antipsychotic medication including Zuclopenthixol, Stelazine and Quetiapine. He had also been prescribed mood stabilisers. Mr. X thought that

41 Clinical notes p 34
42 Clinical notes p 44

his medication had not helped him but had possibly made him worse. Mr. X had been on Mirtazapine for three years which he thought to be of help. Mr. X said that he had never been admitted to a psychiatric hospital.

The SpR described Mr. X as *"unkempt and pale with a number of scars, cuts and bruises on his face. There was some body odour and signs of poor personal hygiene"*. He tended to dominate the conversation; he spoke loudly and was difficult to interrupt. He seemed pleased that the SpR was willing to consider a diagnosis of ADHD. There were no delusional thoughts and Mr. X was well orientated. He was angry, irritable and frustrated, low in mood and at times paranoid.

The SpR recorded her impression that Mr. X was a 33-year old man who had been diagnosed with ADHD as a teenager. He had an extensive forensic history and a conduct disorder as a child. Mr. X had misused drugs and alcohol in the past, but not at the time of the assessment Mr. X had been prescribed antipsychotic medication which had not helped him. Antidepressants had appeared to improve his mood a little. At the time of the assessment he was irritable and made angry easily. He was anxious and could not settle; this presented as low grade paranoia.

The diagnosis was recorded as possible Adult ADHD. The risk identified was *"Risk of physical aggression when provoked"*.

The plan was to:

- *"Get copies of old reports from Basingstoke;*
- *Speak to foster mother, with [Mr. X's] permission, for more collateral history;*
- *Investigate local ADHD specialist services for help with diagnosis. Refer if possible;*
- *At request of [Mr. X] and GP start low dose of Quetiapine (50mg, to be increased to 100mg if tolerated) for anxiety/ paranoia/ low mood;*
- *Continue Mirtazapine 30mg nocte;*
- *See again in 4-6 weeks once above is done".*[43]

On **8 March 2011** a Level 1 Risk Assessment form was completed by the Social Worker. This was based on the information that Mr. X, his partner and his foster mother had provided on 28 February 2011.

Risk to self: It was recorded that in the past Mr. X had misused illicit drugs, that he believed that he had no control over his life and that he was unemployed, however he had not made an attempt on his life and did not express feelings of hopelessness. At the time of the assessment he reported that he was not misusing illicit drugs but that he had experienced significant life events. It was noted that he had not been diagnosed with a major psychiatric illness.

It was recorded that Mr. X and his partner had reported that he had been low in mood for a few months, his appetite and sleep were poor and he had lost interest in things. Mr. X said he had stopped misusing drugs and alcohol eight years previously. His foster mother had reported that Mr. X acted impulsively and did not appear to learn from his mistakes.

43 Clinical notes pp 25-27

Neglect: No indicators of previous neglect were identified. However it was noted that at the time of the assessment Mr. X was not eating properly, he was having difficulty managing his physical health, he was living in inadequate accommodation, he had difficulty in maintaining his physical hygiene and he had financial difficulties. It was noted that his foster mother had reported that Mr. X had been asking her for money.

Aggression/Violence: It was recorded that previously Mr. X had been involved in incidents of violence, he had used weapons, he had misused drugs and alcohol, there were no known personal triggers associated with his violence and that he had engaged in dangerous impulsive acts. However he had not experienced paranoid delusions about others, or command hallucinations.

His current risk indicators were deemed to be the same as the historical ones recorded except that Mr. X was no longer misusing drugs and alcohol, he was now recorded as experiencing paranoid delusions about others and that he had been held previously in a low secure unit.

Mr. X reported that he had spent 13 of the past 15 years in prison for assault and carrying weapons. At the time of the assessment Mr. X was awaiting sentencing for possession of a knife, threatening a police officer, aggravated assault and breaking conditional discharge conditions. He described feeling paranoid, anxious and unsafe much of the time but could not explain why. Mr. X recognised that he often misinterpreted the actions of others as being hostile and consequently got into fights.

Other: No other risks were identified.

It was decided that a more detailed risk assessment was not required at this time.

The formulation of risk was:

- *"Low mood at present, no current risk of suicide.*
- *Some evidence of self neglect, insecurely housed, living at friend's who is currently in hospital.*
- *History and current reports of aggression and violence to wards others".*

The management plan was much as that recorded in the SpR's letter to Mr. X's GP on 28 February 2011:

1. *"get copies of old reports from CMHT in Basingstoke*
2. *contact foster mother for copies of old reports*
3. *get list of previous convictions*
4. *started on low dose of Quetiapine for anxiety/paranoia/low mood*
5. *Continue Mirtazapine".*[44]

On **8 March 2011** the Social Worker sent an e-mail to the Sussex ADHD website asking about ADHD services in the Brighton area. On **14 March 2011** he received a reply providing him with the contact details of the Neurobehavioural Clinic in Brighton where, he was

44 Clinical notes pp 14-15

informed, there were specialists in ADD and ADHD. He was advised that this was where he should refer his client. The Social Worker forwarded this e-mail to the SpR.[45]

On **12 March 2011** Mr. X's foster mother wrote to the Social worker. With this letter she enclosed *"a selection of our letters to various authorities throughout the years in our efforts to obtain help for [Mr. X], as well as some relevant professional reports"*. Mr. X's foster mother began her letter by informing the Social Worker that Mr. X's *"present problems go back a long way – all his life in fact – and are very deep seated. Nevertheless I believe that he could well be helped very considerably with the right treatment, which he desperately needs"*.[46]

On **15 March 2011** the SpR referred Mr. X to the Neurobehavioral Clinic for an assessment for possible ADHD. She enclosed her assessment letter of the 28 February 2011 with the referral and provided a brief history identifying that Mr. X had an extensive forensic history having spent the majority of the previous 15 years in prison; that he had been dependent on alcohol and opiates but reported that he was not using these at that time; that he was reporting that his mood was low due to his current social circumstances. It was also stated that he was homeless and out of work. The SpR noted that Mr. X struggled to function outside prison though he said that he was determined not to return there.

The SpR reported that Mr. X had been given a diagnosis of ADHD in the past and believed that he continued to suffer with this. He had been treated with Ritalin as a child but this had been stopped when he took an overdose of this medication in 2003 when his son was stillborn.

The SpR recorded his symptoms as:

Impulsivity: Mr. X had difficulty controlling his temper; had a low tolerance of frustration; got into trouble because he responded in a hostile and violent manner to minor provocations; was frustrated that he could not learn from his mistakes nor control his temper; easily became angry and head butted the wall because of this.

Restlessness: Mr. X's partner reported that Mr. X was unable to sit down or to concentrate; he paced around and was always *"jittery and anxious"*: he described feeling mildly paranoid and as if he were under threat from others although he could not explain these feelings as they did not seem to be based in reality.

Inattention: Mr. X's foster mother had reported that although Mr. X was a talented artist and musician he had never been able to make anything of these talents because of his inability to concentrate and follow things through.

The letter also noted that Mr. X talked a lot and it was difficult to interrupt him; his thoughts appeared to be rapid and he had to try to explain them all at once.

45 Clinical notes p 45
46 Clinical notes p 55

The SpR reported that Mr. X had been assessed by psychiatric services on a number of occasions in recent years and had been identified as having borderline personality traits and alcohol dependency. *"The assessors have often mentioned the possibility of adult ADHD and talked about referral for further expert assessment but this has never actually happened"*.

The SpR concluded that she believed that Mr. X satisfied the diagnostic criteria for ADHD. She reported that she had spoken to a colleague who was more expert than herself in the area and this colleague had recommended a trial of Concerta XL which she was about to initiate.[47]

On the same day, **15 March 2011**, the Social Worker spoke to Mr. X's Probation Officer about his previous convictions and his forthcoming Court appearance. He provided the Probation Officer with information on Mr. X's mental health history and at the meeting he and the SpR had had with Mr. X on 28 February. The Probation Officer said that he was considering referring Mr. X to the mental health team within the Probation Service. He was of the view that a further custodial sentence would be of no value and that treatment options needed to be considered by the Court. It was agreed that these two professionals, the Social Worker and the Probation Officer, would continue to liaise by e-mail.[48]

The Probation Officer sent an e-mail to the Social Worker later that day confirming that he would inform him, the Social Worker of the outcome of his interview with Mr. X and his recommendations to the Court on 23 March 2011.[49]

On **18 March 2011** Mr D's Probation Officer sent an e-mail to the Social Worker informing him that Mr. X had failed to attend his appointment and that consequently he had provided the Court with a *"non-report"* outlining the Mental Health Homeless Team's involvement with Mr. X and asking for a further adjournment. The Probation Officer wrote that he would not be providing any future reports however he had put the Mental Health Homeless Team's contact details on file for the Offender Manager who would be providing future reports to the Court.[50]

The Social Worker responded to this e-mail on the same day, attaching the referral letter the SpR had sent to the Neurobehavioural Unit and informing the Probation Officer that the Neurobehavioural Unit had an eight month waiting list and so the SpR would treat Mr. X with specialist advice in the interim.[51]

On **21 March 2011** the Social Worker telephoned Mr. X's foster mother to thank her for sending the reports on Mr. X. He informed Mr. X's foster mother that Mr. X had been referred to the *"neurobehavioral specialist on ADHD in Brighton"* and that the reports she had provided had been included as part of the referral.

Mr. X's foster mother informed the Social Worker that Mr. X had become homeless again and she was sending him money to stay in a local hotel. She estimated that she had sent him

47 Clinical notes pp 23-24
48 Clinical notes p 45
49 Clinical notes p 45
50 Clinical notes p 31
51 Clinical notes p 31

around £2,000 already that year. Mr. X had told his foster mother that he was using heroin again and had split up with his partner. The Social Worker urged Mr. X's foster mother not to give Mr. X any more money. He told her that there were support services in Brighton to help Mr. X and her continued financial support could be counter productive as *"she is aware he is vulnerable to exploitation"*.

The Social Worker informed Mr. X's foster mother that Mr. X had missed his last two appointments with the Probation Service, and asked her to advise Mr. X to contact his Probation Officer. He also gave her the telephone number of the night shelter to pass on to Mr. X.[52]

Later that day the Social Worker returned another telephone call to Mr. X's foster mother. She informed the Social Worker that she had spoken to Mr. X but he refused to go to the night shelter because, he said, there were people there who were *"out to get him"*. She had sent him a further £50.00 because, he had told her, he was sleeping rough and had no money for food. She had given him this money on condition that he contacted his Probation Officer.

Mr. X's foster mother provided the Social worker with Mr. X's new mobile telephone number. The Social Worker then telephoned Mr. X and gave him the telephone number of the Rough Sleepers' Team who could help him access temporary accommodation. He urged Mr. X to contact his Probation Officer and informed him of the contents of the Probation Officer's e-mail.[53]

On **25 March 2011** Mr. X's foster mother telephoned to speak to the Social Worker. He was not available and she left a message to say that she was very concerned about Mr. X's lack of accommodation and that he needed to be housed before the weekend. He was sleeping rough, had limited mobility as he was on crutches, and he was begging on the streets. She was not able to continue sending him money to stay in private Bed and Breakfast accommodation. A worker from the Mental Health Homeless Team returned Mr. X's foster mother's call. She reiterated her concerns about Mr. X being homeless and vulnerable. It was agreed that the Social Worker would contact her when he was back in the Office on 28 March 2011.[54]

When the Social Worker returned to the office on **28 March 2011** there was a message asking him to contact Mr. X. He telephoned Mr. X as requested but it was not clear why Mr. X had asked that the Social Worker contact him urgently. He told the Social Worker that he had started using heroin again. He said this was because of his recent bereavements, the most recent being his partner miscarrying twins in January. He said that he felt upset that his foster mother did not fully appreciate the effects that the bereavements had had on him. He said that he did not tell his foster mother everything because he did not want to *"stress her too much"*. The Social Worker informed Mr. X that in his conversations with Mr. X's foster mother he had found her stressed by his current circumstances.

52 Clinical notes p 46
53 Clinical notes p 46
54 Clinical notes p 47

Mr. X informed the Social Worker that his Court case had been adjourned until the 13 May 2011 pending probation reports. Mr. X said he had telephoned because he wanted to talk about accommodation and that *"the council owe me"*. It was agreed that Mr. X would meet the Social Worker the next day, 29 March 2011, at a local café. Mr. X said that his partner would accompany him.[55]

On **29 March 2011** the Social Worker wrote to Mr. X offering him an appointment on 11 April 2011 with himself and the SpR.[56]

Later the same day the Social Worker spoke to Mr. X's foster mother. She was very concerned about Mr. X's welfare and she had drafted a letter to the Social Worker asking how she could co-ordinate support for Mr. X. She told the Social Worker that she was sending him £25.00 a day so that he could eat.

Mr. X's foster mother said that she was feeling stressed because of Mr. X's situation and concerns of her own. The Social Worker observed that Mr. X's foster mother tended to believe whatever Mr. X told her and gave as an example the fact that Mr. X had told her that he was not in receipt of benefits when the Social Worker had discussed Mr. X's benefits with him and informed his Foster Mother of this. Similarly he told his foster mother that he needed crutches in order to be mobile whereas the Social Worker reported that he was walking unaided in February.

Mr. X's foster mother believed that nothing was being done to help Mr. X and that he was being left homeless and with no money. The Social Worker observed *"Even when clarifying the situation for [Mr. X's foster mother] she will still be vulnerable to emotional blackmail from [Mr. X], leading her to continue to send him money. [Mr. X] may not be the main instigator of exploiting his foster mother; it may be others are aware of [Mr. X's] vulnerability and his foster mother's financial support"*.

The Social Worker was of the opinion that contact with Mr. X's foster mother should be time limited and an identified worker should be allocated to speak to her.[57]

Later the same day the Social Worker met Mr. X and his partner as planned. Mr. X appeared well, he had shaved his head and he was well dressed. His speech was slurred and he reported that he had stopped taking heroin two days previously. He was taking prescribed medication to overcome the effects of withdrawal.

Mr. X and his partner reported that they were *"sofa surfing"*. They were trying to get accommodation together, but had acquired a young dog which was complicating matters. They were exploring the possibility of Mr. X's partner claiming carer's allowance as they believed that this would improve their chances of being housed as a couple. The Social Worker said that he would provide them with the contact details of the Welfare Rights Advice Team and MACS Welfare Benefits Advice lines to help them with their application.

55 Clinical notes p 47
56 Clinical notes pp 30, 47
57 Clinical notes p 48

The Social Worker noted that Mr. X's main topic of conversation was himself and his circumstances interspersed with stating his love and affection for his partner, their interdependence and their need to be housed as couple.

Mr. X said he did not want to *"stress out"* his foster mother, though Mr. X often made his situation sound worse than it was in order to persuade his foster mother to send him money. The Social Worker informed Mr. X that in future when his foster mother called to enquire about his circumstances he would advise her to speak directly to Mr. X. It was inappropriate for him, the Social Worker, to act as an intermediary between them.

Mr. X was given a letter confirming his appointment on 11 April 2011 and the Social Worker urged him to attend the appointment because the SpR was in consultation with the ADHD specialist regarding the appropriate medication regimen for him. Mr. X reported that he had an appointment with his Probation Officer regarding his Court appearance on the 13 May 2011.[58]

On **5 April 2011** Mr. X telephoned the Social Worker to say that his foster mother had told him that she had been advised by the Social Worker to have nothing more to do with Mr. X. He was unhappy about this. The Social Worker informed Mr. X that neither he nor any member of the team had or would have given such advice. The Social Worker noted that Mr. X gradually began to appreciate that his foster mother was very stressed as a result of what Mr. X had been telling her. The Social Worker had been trying, in his conversations with Mr. X's foster mother, to get her to consider her own needs.

Mr. X reported that he had been in touch with the Rough Sleepers' Team who had put him in touch with Sandlewood Lodge. However Mr. X was hopeful that his foster mother would help him access private rented accommodation. At this point the credit on Mr. X's mobile telephone ran out and the call was ended.

Later in the day Mr. X's foster mother telephoned the Social Worker. She said that Mr. X had misinterpreted what she had said to him. She remained concerned that someone needed to co-ordinate the care that Mr. X required. The Social Worker observed that all anyone would know about Mr. X's circumstances was what he chose to tell them. Currently the Mental Health Homeless Team was addressing his mental health needs and the Rough Sleepers' Team was helping with Mr. X's accommodation. These were Mr. X's two biggest problems and they were being addressed. The Social Worker promised to contact the Rough Sleepers' Team to liaise with them about the contact they had had with Mr. X.

Mr. X's foster mother informed the Social Worker that she had been in contact with the Rough Sleepers' Team and that she was currently sending Mr. X £350.00 a week in instalments.

58 Clinical notes p 49

The Social Worker then contacted the Rough Sleepers' Team and left a message for them to contact him about Mr. X.[59]

On **8 April 2011** the Neurobehavioral Unit acknowledged receipt of the referral for Mr. X. The letter noted that there was a waiting time of at least six months from the date of referral.[60]

On **11 April 2011** Mr. X attended his appointment with the SpR and the Social Worker. He was accompanied by his partner. Mr. X was commenced on a steadily increasing dose of Concerta XL. As the next available appointment was not until 30 May 2011 it was agreed that the Social Worker would maintain contact with Mr. X and meet him occasionally *"to assess his medication and address any issues and concerns"*. Mr. X's partner expressed the hope that the medication would moderate Mr. X's being *"snappy"* towards her.

Mr. X reported that he was due to be in Court on the 13 April 2011 but he expected the Hearing to be adjourned so the psychiatric reports could be prepared. The SpR said she was willing to write a report if requested to do so.[61]

On **19 April 2011** a serious incident form was completed by the Manager of the Mental Health Homeless Team. The form recorded that Mr. X had been arrested for the murder of a member of the public.[62]

On **23 January 2012** Mr. X was convicted of murder at Lewes Crown Court. His Honour Judge Scott-Gall commented in his sentencing remarks:

> *"I have the benefit of the letter written by [The SpR] to your then General Practitioner … which was our Exhibit 14 in the trial. As I observed…, it is a snapshot providing details of your then condition at the time of this consultation two months or so before the commission of this offence. In my judgment, the contents do not meet the requirements envisaged in Schedule 21 paragraph 11(b) as a mitigating factor; although I do take into account the submissions made based on Dr. … reports".*
>
> *"In my judgment, the aggravating factors that I have set out justify the court departing from the suggested starting point of 15 years. The least term you must serve before you are eligible to be considered for parole is 18 years imprisonment. That represents, under our present sentencing regimen, a determinate sentence of 36 years".*[63]

59 Clinical notes p 50
60 Clinical notes p 43
61 Clinical notes p 50
62 Clinical notes pp 21-22
63 Sentencing Remarks of his Honour Judge Scott- Gall

10. Exploration and Identification of Contributory Factors and Service Issues

In its simplest of terms Root Cause Analysis (RCA) seeks to understand why an incident occurred. An example from acute care utilising the 'five whys' could look like this:

- Serious incident reported = serious injury to limb
- Immediate cause = wrong limb operated upon (ask why?)
- Wrong limb marked (ask why?)
- Notes had an error in them (ask why?)
- Clinical notes were temporary and incomplete (ask why?)
- Original notes had been mislaid (ask why?)
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root Cause Analysis does not always lend itself so well to serious untoward incidents in mental health contexts.

A root cause is an initiating cause of a causal chain which leads to an outcome, in this case the death of Mr. A. In order for causality to be attributed to a service it has to be shown that the service had control over the outcome of the events in question. The purpose of using root cause analysis is to seek out lessons that can be learned from the examination of a single case to try to establish how incidents of this kind can be prevented from occurring in the future. No Investigation Team should endeavour to make connections where they cannot reasonably be made.

This Investigation has developed a detailed narrative which chronicles the events that occurred during the time Mr. X was under the care of the Sussex Partnership NHS Foundation Trust. It has assessed whether services worked in accordance with extant national and local best practice guidance and detailed where interventions could have been improved.

RCA Third Stage

This section of the report examines the evidence collected by the Independent Investigation Team. This process will identify the following:

1. Areas of practice that fell short of both national and local policy expectation.
2. Key contributory and service issue factors.

In the interests of clarity each thematic issue is set out with the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined in context. This method will also avoid the need for the reader to be repeatedly redirected to reference material elsewhere in the report.

The terms 'causal' and 'contributory' factors, and 'service issues' are used in this section of the report. They are explained below.

Causal Factor. In the realm of mental health service provision it is never a straightforward task to categorically identify a causal relationship between the quality of the care and treatment that a service user received and a subsequent homicide perpetrated by them. The term 'causal factor' is used to describe an act or omission that it is concluded had a direct causal bearing upon the failure to manage a service user effectively and that this as a consequence impacted directly upon an incident occurring.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown of Mr. X's mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Service and the act of homicide perpetrated by a third party.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Mr. A need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

Findings

The findings set out in this Section analyse the care and treatment given to Mr. X by the Sussex Partnership NHS Foundation Trust between January and April 2011.

10.1. Diagnosis

10.1.1. Context

In medicine, diagnosis is the process of identifying an illness or disease process which is, normally, recognised by a set of signs, symptoms or changes in structure or functioning. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, mental state examination, observation and standardised devices.

There is an on-going debate in the academic literature about the reliability and utility of categorical diagnostic schemas and what is sometimes, imprecisely, referred to as the medical model. What is not in debate, however, is that if an individual is to receive effective and

efficient treatment then there has to be a clear formulation of his/her difficulties, which informs a plan determining how the individual might be helped to achieve identified goals.

The categorical diagnostic schema employed in the United Kingdom is the International Statistical Classification of Diseases and Related Health Problems (ICD 10, 1992). This is also the schema employed by the World Health Organisation. In the United States of America the *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (2000*) (DSM IV-TR*) is employed.

Diagnosis is important for a number of reasons; amongst other things it provides a common language to facilitate communication, it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties and provides access to information and guidance on treatment and prognosis. Determining a diagnosis is only part of the process of understanding the individual's problems and how they might be best cared for and treated. The more comprehensive formulation must take appropriate account of the context in which the individual lives his/her life and his/her aspirations, as well as the difficulties s/he is experiencing and, for at least this reason, the service users must be at the centre of the process of diagnosis, formulation and the subsequent planning of care.

Attention Deficit Hyperactivity Disorder (ADHD)

The diagnostic label that was most frequently associated with Mr. X was Attention Deficit Hyperactivity Disorder (ADHD)

While Attention Deficit Hyperactivity Disorder has been a widely employed 'diagnostic' term in recent times and the National Institute of Health and Clinical Excellence (NICE) have produced a clinical guideline entitled: *The NICE Guideline on the Diagnosis and Management of ADHD in Children, Young People and Adults* (2008) ADHD is not an identified diagnostic category in the ICD 10 schema. It is, however, identified in DSM IV-TR. The DSM criteria for ADHD break down symptoms into two groups: inattentive and hyperactive-impulsive. The diagnostic criteria are listed below.

DSM-IV-TR criteria for ADHD:

A. Either 1or 2.

1. Inattention: six or more symptoms persisting for at least six months to a degree that is maladaptive and inconsistent with developmental level. They are as follows:

- often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities;
- often has difficulty sustaining attention in tasks or play activities;
- often does not seem to listen when spoken to directly;
- often does not follow through on instructions; fails to finish schoolwork, chores or workplace duties (not due to oppositional behaviour or failure to understand instructions);
- often has difficulty organising tasks and activities;
- often avoids, dislikes, or is reluctant to do tasks requiring sustained mental effort;

- often loses things necessary for tasks or activities;
- is often easily distracted by extraneous stimuli;
- is often forgetful in daily activities.

2. Six or more of the following symptoms of **hyperactivity-impulsivity** have persisted for at least six months to a degree that is maladaptive and inconsistent with the developmental level:

Hyperactivity

- often fidgets with hands or feet or squirms in seat;
- often leaves seat in classroom or in other situations in which remaining seated is expected;
- often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness);
- often has difficulty playing or engaging in leisure activities quietly;
- often talks excessively;
- is often 'on the go' or often acts as if 'driven by a motor'.

Impulsivity

- often has difficulty awaiting turn in games or group situations;
- often blurts out answers to questions before they have been completed;
- often interrupts or intrudes on others, e.g. butts into other children's games.

Some hyperactivity - impulsive or inattentive symptoms that cause impairment were present before the age of seven years.

Some impairment from the symptoms is present in more than two or more settings (for example at school or work or at home).

There must be clear evidence of clinically significant impairment in social, academic or occupational functioning.

The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder, and are not better accounted for by another mental disorder (for example Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Based on these criteria, three types of ADHD are identified:

1. ADHD, Combined Type: if both criteria 1A and 1B are met for the past six months.
2. ADHD, Predominantly Inattentive Type: if criterion 1A is met but criterion 1B is not met for the past six months.
3. ADHD, Predominantly Hyperactive-Impulsive Type: if Criterion 1B is met but Criterion 1A is not met for the past six months.

The ICD uses a different nomenclature; the same symptoms are described as part of a group of hyperkinetic disorders. Inattention, hyperactivity and impulsivity must all be present to meet the diagnostic criteria for this disorder.

ICD-10 criteria for hyperkinetic disorders

1. **Inattention:** at least six symptoms of attention have persisted for at least six months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

- often fails to give close attention to detail, or makes careless errors in school work, work or other activities;
- often fails to sustain attention in tasks or play activities;
- often appears not to listen to what is being said to him or her;
- often fails to follow through on instructions or to finish school, work, chores or duties in the workplace (not because of oppositional behaviour or failure to understand instructions);
- is often impaired in organising tasks and activities;
- often avoids or strongly dislikes tasks, such as homework, that require sustained mental effort;
- often loses things necessary for certain tasks and activities, such as school assignments, pencils, books, toys or tools;
- is often easily distracted by external stimuli;
- is often forgetful in the course of daily activities.

2. Hyperactivity: at least three symptoms of hyperactivity have persisted for at least six months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

- often fidgets with hands or feet or squirms on seat;
- often leaves seat in classroom or in other situations in which remaining seated is expected;
- often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, only feelings of restlessness may be present);
- is often unduly noisy in playing or has difficulty in engaging quietly in leisure activities;
- often exhibits a persistent pattern of excessive motor activity that is not substantially modified by social context or demands.

3. Impulsivity: at least one of the following symptoms of impulsivity has persisted for at least six months, to a degree that is maladaptive and inconsistent with the developmental level of the child:

- often blurts out answers before questions have been completed;
- often fails to wait in lines or await turns in games or group situations;
- often interrupts or intrudes on others (for example, butts into others' conversations or games);
- often talks excessively without appropriate response to social constraints.

4. Onset of the disorder is no later than the age of seven years.

5. Pervasiveness: the criteria should be met in more than a single situation, for example, the combination of inattention and hyperactivity should be present both at home and at school, or at both school and another setting where children are observed, such as a clinic. Evidence for cross-situationality will ordinarily require information from more than one source; parental reports about classroom behaviour, for instance, are unlikely to be sufficient.

6. The symptoms in 1 and 3 cause clinically significant distress or impairment in social, academic or occupational functioning.

Adult ADHD

The NICE Guidance on ADHD notes

> *"Prevalence of strictly applied operational definitions of ADHD decline with age. A recent review of longitudinal follow-up studies of individuals diagnosed with ADHD as children found that by age 25 only 15% retained the full ADHD diagnosis. However, a much larger proportion (65%) fulfilled criteria for either ADHD or ADHD in partial remission, indicating the persistence of some symptoms associated with clinical impairments in the majority of cases (Faraone et al., 2006). Applying these figures to the prevalence range commonly seen in children of 4–8%, one would expect to find 0.6–1.2% of adults retaining the full diagnosis by age 25 years and a larger percentage (2–4%) with ADHD in partial remission. This is consistent with population surveys in adult populations that estimate prevalence of ADHD in adults to be between 3 and 4% (Faraone & Biederman, 2005; Kessler et al., 2006)".*

The research literature then suggests that a significant proportion of the adult population suffers with at least some of the symptoms of ADHD and around 1 *per cent* of the adult population would be expected to meet the criteria for adult ADHD.

Validity of the Diagnosis of Adult ADHD

The Psychiatrist who assessed Mr. X in October 1997 observed that Mr. X had been diagnosed as suffering from ADHD *"a condition about which the medical profession is divided"*. However he continued by pointing out that whatever label was given to the condition from which Mr. X was suffering, he was manifesting the symptoms and behaviours associated with the diagnostic label of ADHD. The NICE Guidance on the management and treatment of ADHD addressed this issue of "divide opinion" and reached the following conclusion:

"5.12 POSITION STATEMENT ON THE VALIDITY OF ADHD

"On the basis of the evidence reviewed … the GDG drew the following conclusions:

- *Symptoms that define hyperactive, impulsive and inattentive behaviours are found to cluster together.*
- *Hyperactivity, inattention and impulsivity cluster together both in children and in adults and can be recognised as distinct from other symptom clusters, although they frequently coexist alongside other symptom clusters.*

- *Symptoms of ADHD appear to be on a continuum in the general population. ADHD is distinguished from the normal range by the number and severity of symptoms and their association with significant levels of impairment.*
- *The importance of evaluating impairment and the difficulty in establishing thresholds on the basis of symptom counts alone needs to be addressed. It is not possible to determine a specific number of symptoms at which impairment arises.*
- *There is evidence for psychological, social and educational impairments in both children and adults with ADHD.*
- *ADHD symptoms persist from childhood through to adulthood in the majority of cases. In a significant minority the diagnosis persists and in the majority, subclinical symptoms continue to be detectable and are associated with significant impairments.*
- *In adults the profile of symptoms may alter with a relative persistence of inattentive symptoms compared with hyperactive-impulsive symptoms.*
- *There is evidence of both genetic and environmental influences in the aetiology of ADHD. The extent to which there is diversity in the aetiology of the disorder is not known. Current evidence indicates the presence of multiple risk factors of minor effect.*
- *The complex interplay between genes and environment is not well understood. Environmental risks may interact with genetic factors, be correlated with genetic factors or have main effects. Similarly genetic factors may interact or correlate with environment or have main effects. There will be a different balance of factors in individual cases.*
- *There is evidence of genetic associations with specific genes, environmental risks and neurobiological changes in groups of children with ADHD. However, no neurobiological, genetic or environmental measure is sufficiently predictive to be used as a diagnostic test.*
- *The diagnosis remains a descriptive behavioural presentation and can only rarely be linked to specific neurobiological or environmental causes in individual cases.*
- *Hyperkinetic disorder (ICD-10) is a narrower and more severe subtype of DSM-IV-TR combined type ADHD. It defines a more pervasive and generally more impairing form of the disorder. Both concepts are useful (Santosh et al., 2005).*
- *There was limited evidence to support a different concept of ADHD in children and adults. Age-related changes in the presentation are recognised, however. Theses changes are not yet reflected in the current diagnostic criteria.*
- *All current assessment methods have their limitations. There is evidence of the need for flexibility and for a consideration of levels of impairment in assessments and when deriving appropriate diagnoses."* (p. 118) *"On the basis of this review, the GDG summarised the evidence for the diagnosis of ADHD upon which the guideline recommendations are made.*
- *ADHD is a valid clinical condition that can be distinguished from coexisting conditions and the normal spectrum".* (p. 124)

However the Guidance observes that while ADHD is a *"valid clinical disorder that can be distinguished from coexisting conditions …a diagnosis of ADHD should only be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, on the basis of: a full clinical and psychosocial assessment of the person; this should include discussion about behaviour and symptoms in the different domains and settings of the person's everyday life, and a full*

developmental and psychiatric history, and observer reports and assessment of the person's mental state".

The Guidance recommends that
"1.2.2.2 Adults who have previously been treated for ADHD as children or young people and present with symptoms suggestive of continuing ADHD should be referred to general adult psychiatric services for assessment. The symptoms should be associated with at least moderate or severe psychological and/or social or educational or occupational impairment".

However if there is to be a fruitful pathway of care the Guidance recommends:
"Healthcare and education professionals require training to better address the needs of people with ADHD.
1.1.3.1 Trusts should ensure that specialist ADHD teams for children, young people and adults jointly develop age-appropriate training programmes for the diagnosis and management of ADHD for mental health, paediatric, social care, education, forensic and primary care providers and other professionals who have contact with people with ADHD.

1.1.3.2 Child and adult psychiatrists, paediatricians, and other child and adult mental health professionals (including those working in forensic services) should undertake training so that they are able to diagnose ADHD and provide treatment and management in accordance with this guideline."

Reliable and timely identification of ADHD is important because this is a pervasive condition which detrimentally affects most areas of the individual's life.

The Guidance summarises the effects of suffering from ADHD as follows:
"ADHD symptoms are associated with a range of impairments in social, academic, family, mental health and employment outcomes. Longitudinal studies indicate that ADHD symptoms are predictive of both current and future impairments. Impairments also result from the presence of coexisting problems including conduct problems, emotional problems and overlapping neurodevelopmental disorders. Adults with ADHD are found to have lower paid jobs and lower socioeconomic status and have more car accidents. Impairment is an essential criterion when considering the diagnosis of ADHD. The presence of high levels of ADHD symptoms is associated with impairment in multiple domains; it is not possible, however, to delineate clearly a specific number of ADHD symptoms at which significant impairment arises". (p.107)

A theme within the guidance is that while ADHD is a condition which can be distinguished from other mental health conditions it is not always easy to do so. With this in mind the guidance supports the well-established practice of not reaching a conclusion on diagnosis too quickly or firmly but maintaining an open mind and testing the 'preferred' diagnosis against other possible diagnoses, other conditions which may share some symptomatology in common.

"Differential diagnosis and mistaken diagnosis

In adulthood, coexisting conditions include personality disorder (particularly antisocial and borderline), bipolar disorder, obsessive-compulsive disorder and, to a lesser extent, psychotic disorders. Adults with severe mental illness, such as schizophrenia, or severe learning disability often have problems with attention and activity levels yet these disorders do not occur any more frequently in people with ADHD than in the normal population (Mannuzza et al., 1998).

However, there is a difficulty in that attentional problems are common to many psychiatric disorders; thus adults with other psychiatric problems may appear to have symptoms of ADHD. On the other hand this also means that there is a pool of adult psychiatric patients in whom the diagnosis of ADHD has been unidentified and where ineffective treatments have been put in place for alternative diagnoses such as anxiety, depression, cyclothymia and personality disorder. This may account for the high rates of contact reported with mental health services for adults with ADHD (Dalsgaard et al., 2002), which in turn has associated cost implications.

ADHD in adults is frequently misdiagnosed because there are potential 'traps' for the inexperienced ADHD diagnostician. ADHD in adulthood does not present in the same way as ADHD in children who, for example, have more symptoms of hyperactivity. The age criterion is crucial to distinguish ADHD from later onset conditions and, unless care is taken to rule out the existence of the other conditions …

…adults with ADHD may encounter greater obstacles in terms of having the condition identified and recognised and being supported. It is claimed that between 30 and 50% of children with ADHD will carry the disorder through into adulthood (Wender, 1998). Adult experiences of the disorder may be characterised by similar feelings of restlessness and disinhibition as in childhood. In adulthood there is also a strong association with both depression and substance misuse.

ADHD often goes hand-in-hand with other conditions, such as conduct disorder (Green et al., 2005), making behavioural and emotional challenges even more complex….. These complications have ramifications for other areas of the lives of children and young people; for example, it is reported that almost one third of children with hyperkinetic disorders have been excluded from school (Green et al., 2005). Such children may also go on have problems with the law".

Conduct Disorder

In 1995 and 1996 Mr. X was also given the diagnosis of Conduct Disorder.

ICD-10 defines Conduct disorder as follows:

Conduct disorder, unspecified (Code F91.9)

- Mental disorder of childhood and adolescence characterized by repetitive and persistent patterns of conduct in which the rights of others and age-appropriate societal rules are violated; the conduct is more serious than ordinary mischief and pranks.

- Repetitive and persistent aggressive or nonaggressive behaviour in which basic rights of others or social norms are violated. Self esteem is generally low, and an inability to develop social relationships and lack of concern for others may or may not be present.

The NICE Guidance on ADHD observes that a diagnosis of Conduct disorder *"represents more severe behavioural problems: a persistent pattern of behaviour that violates the societal rules and the rights of others. This includes aggression that can take the form of bullying or cruelty to animals, destruction of property, stealing and persistent lying (other than to avoid harm). All these oppositional and conduct disorder problems can be seen in some children with ADHD, but they are not essential features and should not be used as grounds for making the diagnosis of ADHD".*

Personality Disorder

The other diagnostic label which was associated with Mr. X was that of Personality Disorder, particularly Antisocial Personality Disorder. The ICD 10 definition of this disorder is

"Antisocial personality disorder (F60.2)

- *Personality disorder whose essential feature is a pervasive pattern of disregard for, and violation of, the rights of others through aggressive, antisocial behaviour, without remorse or loyalty to anyone.*
- *Personality disorder characterized by conflict with others, low frustration tolerance, inadequate conscience development, and rejection of authority and discipline".*

The NICE Guidance on ADHD identifies the difficulties, both practical and conceptual, in distinguishing between ADHD in adults and personality disorders. The guidance comments

"There is currently considerable nosological confusion that stems from the early onset and persistence of ADHD behavioural symptoms that therefore appear as stable traits or personality characteristics rather than symptoms. The difference in definition between a trait and a symptom is that symptoms represent a change from a normal pre-morbid state, such as the onset of adult depression or psychosis, whereas traits are considered to be enduring characteristics. Current psychiatric training in adult mental health tends to focus on the distinction between symptoms and traits and gives rise to a nosology that does not fit well with the concept of ADHD. First, because of the trait like quality of ADHD phenomena, significant psychopathology often goes unnoticed or is regarded as a personality characteristic, resulting in a different set of treatments and expectations for the clinical course and outcome compared with ADHD. Second, because ADHD phenomena are sometimes associated with persistent disruptive and oppositional behaviour or development of poor interpersonal skills, it is often assumed that this represents an ingrained and therapeutically resistant set of behavioural traits. Further confusion stems from the definition of cluster B personality disorders, like antisocial, borderline and emotionally unstable personality disorder, which include symptoms such as mood instability, impulsivity and anger outbursts that are commonly seen to coexist in adults with ADHD.

The diagnostic issue is to recognise when there is evidence for ADHD, that is whether the operational criteria were fulfilled in childhood and whether ADHD symptoms that started in

childhood have persisted and continue to bring about significant impairments. While the diagnostic focus should be on the main symptoms that define inattention, hyperactivity and impulsivity it is also important to remember that mood instability and impulsivity are commonly seen in adults with ADHD. Care must be taken to distinguish between uncontrolled, impulsive, oppositional and antisocial behaviours that arise in the context of a specific ADHD syndrome from those that do not. For this reason it is often useful to make particular enquiries about symptoms that are more specific to ADHD such as short attention span, variable performance, distractibility, forgetfulness, disorganisation, physical restlessness and over-talkativeness rather than focus only on the occurrence of maladjusted and disruptive behaviours". (p. 130)

The NICE Guidance on Antisocial Personality Disorder (2009) describes this disorder as follows:

"People with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others. The condition is associated with a wide range of interpersonal and social disturbance…As a result of …the child's difficult behaviour, the child's care is often interrupted and transferred to agencies outside the family. This in turn often leads to truancy, having delinquent associates and substance misuse, which frequently result in increased rates of unemployment, poor and unstable housing situations, and inconsistency in relationships in adulthood. Many people with antisocial personality disorder have a criminal conviction and are imprisoned or die prematurely as a result of reckless behaviour.

Criminal behaviour is central to the definition of antisocial personality disorder, although it is often the culmination of previous and long standing difficulties, such as socioeconomic, educational and family problems…

The prevalence of antisocial personality disorder among prisoners is slightly less than 50%....The prevalence of antisocial personality disorder in the general population is 3% in men and 1% in women…

…The course of antisocial personality disorder is variable and although recovery is attainable over time, some people may continue to experience social and interpersonal difficulties. Antisocial personality disorder is often comorbid with depression, anxiety, and alcohol and drug misuse".[64]

10.1.2. Findings

It is not the place of an Independent Investigation to adjudicate on whether the clinicians who assessed a service user arrived at the 'correct' diagnosis but rather to establish whether they

64 National Institute of Health and Clinical Excellence: Clinical Guideline 77 (2009*): Antisocial personality Disorder: Treatment, Management and Prevention*

behaved in a manner that was consistent with current best practice and arrived at what could be regarded as a reasonable conclusion.

From the time Mr. X was 12 or 13 years of age two possible diagnoses were consistently considered by all who saw him: ADHD and Conduct Disorder, which are often regarded as precursors, in childhood, of the adult diagnosis of Personality Disorder, particularly Antisocial Personality Disorder. From around the age of 14 the complicating effects of Mr. X's abuse of illicit drugs and his excessive use of alcohol were also noted.

It was possibly a manifestation of Mr. X's problems that he had numerous accommodation placements and, as a result, there was the little opportunity to come to a conclusive diagnosis of his problem and there was no continuity in the care he received. In 1996, when Mr. X was 17, his GP referred him for a specialist assessment for ADHD. The conclusion of the assessment was that Mr. X *"experiences both Attention Deficit Hyperactivity Disorder as well as Conduct Disorder"*.[65]

In July of the next year the Psychiatrist who was caring for him wrote to the Aldershot Probation Service confirming the diagnosis of ADHD and reported that Mr. X had responded well to Ritalin (methylphenidate). This Psychiatrist was prepared to continue to care for Mr. X however it appears that Mr. X was subsequently sent to the north of England and so once more his care was disrupted.

As he moved into adulthood it was suggested on several occasions that Mr. X might be referred to a specialist facility to be assessed and, if appropriate, treated for adult ADHD. There is no evidence in the clinical notes available to the Independent Investigation that these referrals were made. By the time he was referred to the Mental Health Team for Homeless People in Brighton in 2011 no definitive diagnosis had been arrived at and no treatment plan was in place.

When Mr. X was assessed on 28 February 2011 the SpR took a psychiatric history from Mr. X. The Social Worker, who saw Mr. X together with the SpR, had spoken to Mr. X's foster mother prior to the interview, so they had corroboration of what Mr. X was telling them. This was good practice. Mr. X had brought his partner to the interview and she was able to corroborate his account of his current mental state and behaviour. As Mr. X later reported in Court[66] he was keen to be diagnosed as suffering from ADHD and emphasised the symptoms of this disorder during his assessment.

Given Mr. X's history, the behaviours and symptoms he reported, the course his life had taken, the fact that he had received a diagnosis of ADHD at the age of 17 and that he had apparently responded well, at least for a time, to treatment for this condition and the fact that his foster mother was convinced that this was the condition from which Mr. X suffered, it was appropriate that the SpR should consider the diagnosis of adult ADHD. However given the difficulties, noted above, of making this diagnosis she sought expert opinion by referring Mr. X to the local Neurobehavioural Clinic on 15 March 2011. This was in line with the

65 Clinical notes p 91
66 Summing up of His Honour Judge Scott-Gall 23 January 2012

NICE guidance and was good practice. It is disappointing that this service had only very limited resources and, at that time, there was a waiting time of six months or more before service users could be seen.

Given that symptoms can be common to several diagnostic categories it is generally accepted in psychiatry that it is good practice to consider alternative diagnoses before one arrives at a conclusion as to what disorder an individual is suffering from. As noted above the NICE guidance recommends that at least Antisocial Personality Disorder should be considered as a differential diagnosis when one is considering whether an individual is suffering from ADHD. Mr. X had been diagnosed as suffering from a Conduct Disorder in childhood. It was recorded in Mr. X's notes that he was diagnosed as suffering from a Personality Disorder in 2003, possibly while he was in prison; when he was assessed in Surrey in 2008 Anti-Social Behavioural Disorder was recorded as a differential diagnosis; and when assessed 2010 the Consultant Psychiatrist recorded *"He also possibly has some emotional unstable and antisocial personality traits"*.

In her letters to the Neurobehavioural Clinic and Mr. X's GP the SpR noted that Mr. X had been diagnosed as suffering from a conduct disorder as a child and had been assessed as displaying borderline personality traits in adulthood.

The third area for consideration when arriving at a diagnosis was Mr. X's drug and alcohol misuse. By Mr. X's own account he had misused illicit drugs from around the age of 14 and abused alcohol from a similar age. In 2008 part of his differential diagnosis was *"Mental and Behavioural Disorder due to the harmful effects of alcohol and multiple drug abuse"*. However from December 2008 he consistently denied that he was abusing drugs or drinking alcohol to excess. This was the situation when he was assessed in February 2011. When the SpR assessed Mr. X he was adamant that he was not misusing illicit drugs or drinking. However both the SpR and the Social worker had reservations as to the accuracy of Mr. X's report. Given Mr. X reported abstinence he was not interested in exploring how he might be helped with any substance misuse problems. In March 2011 Mr. X admitted to the Social Worker that he was taking heroin but a few days later he reported that he was again abstinent.

The SpR explained to the Independent Investigation that given the lack of consistency in the care Mr. X had received and the fact that no psychiatrist had had the opportunity to get to know him well and use this knowledge to arrive at a considered diagnosis, her strategy had been to take the opportunity to build up a clear, detailed picture of Mr. X and arrive at a diagnosis in a methodical and measured fashion.

Her plan, following the initial assessment, was:

- to obtain more information about Mr. X from his foster mother, who had a number of reports and assessments on Mr. X which she was willing to share with those caring for her foster son;
- to obtain his clinical notes from the Hampshire Partnership NHS Trust, where he had last been seen;

- to refer Mr. X for a specialist opinion to confirm or excluded the diagnosis of adult ADHD.

The SpR also consulted a colleague who had some expertise in treating adult ADHD. He had advised that she initiate a trial of Concerta XL. This she did when she saw Mr. X for the second, and last, time on 11 April 2011.

Her plan was then, depending on the outcome of and advice from the specialist assessment, to explore the possibility of Mr. X suffering from a personality disorder, possibly Emotionally Unstable Personality Disorder, in more detail.

With respect to the third element of the differential diagnosis the SpR had in mind to try to engage Mr. X with the Substance Misuse Services. However, as noted above, Mr. X denied that he had any substance misuse problems and was not eager to engage with this service. The substance misuse service, for its part, required that those referred were at the stage of showing motivation to address their problem. Given this there was little point in referring him to the substance misuse services at that point in time.

When considering Mr. X's diagnosis one must take note of his reported affective state. From at least November 2008 Mr. X was described as being subjectively low in mood and objectively had some symptoms of mild to moderate depression. However the diagnosis recorded at this time was *"Mental and behavioural Disorder due to the harmful effects of alcohol and multiple drug use; ? Anti-Social Behavioural Disorder"*. He was, however, prescribed the anti-depressant Mirtazapine (30mg *nocte*).[67]

In 2009 Mr. X's foster parents were concerned that he might attempt to commit suicide.[68] However when he was reviewed it was noted that he had stopped taking the Mirtazapine and this was re-started. Again the diagnoses recorded were: Mental and Behavioural Disorder due to the harmful effects of alcohol and multiple drug abuse; ? Antisocial Behaviour Disorder; ? Adult ADHD.[69]

A referral in January 2010 commented that Mr. X had a long history of depression and anxiety.[70] This is the only occasion in the notes available to the Independent Investigation which suggests that Mr. X had ever been given a diagnosis of depression as opposed to merely reporting experiencing a low mood and some other symptoms suggestive of depression.

When Mr. X moved to Brighton in November 2010 his GP again prescribed Mirtazapine at Mr. X's request [71] and the SpR continued this prescription when she reviewed Mr. X. [72]

67 Clinical notes p 77
68 Clinical notes p 80
69 Clinical notes p 84
70 Clinical notes p 85
71 Clinical notes p 5
72 Clinical notes pp 25-27

The Risk Assessment completed on 8 March 2011 recorded that Mr. X and his partner had reported that he had been low in mood for a few months, his appetite and sleep were poor and he had lost interest in things.[73]

10.1.3. Conclusions

The three most obvious possible diagnoses: adult ADHD, Personality Disorder of either the Antisocial or Emotionally Unstable type and Mental and Behavioural Disorder due to the harmful effects of alcohol and multiple drug abuse were identified and considered. The SpR reported that she had a strategy for refining her diagnosis. This involved taking the opportunity to build up a detailed picture of Mr. X and approach his diagnosis in a systematic manner. However, as had happened before in Mr. X's history circumstances intervened and the opportunity to pursue the strategy was denied.

The SpR reported her strategy to the Independent Investigation Team at interview however, in addition, it would have also been good practice to have articulated the differential diagnoses and the strategy for arriving at a clear formulation in Mr. X's clinical notes. This might have aided those who subsequently assumed responsibility for his care and treatment. This is a lesson to be learned. However it has to be acknowledged that Mr. X was under the care of the Mental Health Homeless Team for just six weeks and seen by the SpR on only two occasions before he was arrested on 15 April 2011.

Mr. X's low mood and some of the symptoms associated with depression were noted from around 2008 and though Mr. X was regularly prescribed the anti-depressant Mirtazapine there is no record in the clinical notes available to the Independent Investigation that he was diagnosed as suffering from depression. Rather, it seems, the clinicians who assessed Mr. X regarded his lowered mood, poor appetite, anxiety and agitation as either manifestations of one of the other disorders that were considered in the differential diagnoses or existential phenomena related to Mr. X's circumstances and his response to these.

10.2. Medication and Treatment

10.2.1. Context

The treatment of any serious mental health disorder should have a multi-pronged approach which might include psychological treatments, psychosocial treatments, in-patient care, community support, vocational rehabilitation and pharmacological interventions.

Psychotropic medication (medication capable of affecting cognitive functioning, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers. Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

73 Clinical notes pp 14-15

In prescribing medication there are a number of factors that the prescriber must bear in mind. They include consent to treatment, compliance, monitoring, and side effects.

Consent is defined as *"the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent"* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient's consent to treatment.

Treatment of Adults with ADHD

The NICE Guidance on the treatment of ADHD says

"Drug treatment is the first-line treatment for adults with ADHD with either moderate or severe levels of impairment. Methylphenidate is the first-line drug. Psychological interventions without medication may be effective for some adults with moderate impairment, but there are insufficient data to support this recommendation. If methylphenidate is ineffective or unacceptable, Atomoxetine or Dexamphetamine can be tried. If there is residual impairment despite some benefit from drug treatment, or there is no response to drug treatment, CBT [Cognitive Behaviour Therapy] may be considered. There is the potential for drug misuse and diversion in adults with ADHD, especially in some settings, such as prison, although there is no strong evidence that this is a significant problem.

1.7.1.2 Drug treatment for adults with ADHD should be started only under the guidance of a psychiatrist, nurse prescriber specialising in ADHD or other clinical prescriber with training in the diagnosis and management of ADHD.

1.7.1.3 Before starting drug treatment for adults with ADHD a full assessment should be completed, which should include:

- *full mental health and social assessment*
- *full history and physical examination, including: assessment of history of exercise syncope, undue breathlessness and other cardiovascular symptoms heart rate and blood pressure (plotted on a centile chart) weight, family history of cardiac disease and examination of the cardiovascular system an ECG if there is past medical or family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac examination risk assessment for substance misuse and drug diversion.*

1.7.1.4 Drug treatment for adults with ADHD should always form part of a comprehensive treatment programme that addresses psychological, behavioural and educational or occupational needs.

1.7.1.10 Where there may be concern about the potential for drug misuse and diversion (for example, in prison services), Atomoxetine may be considered as the first line drug treatment for ADHD in adults.

1.7.1.11 Drug treatment for adults with ADHD who also misuse substances should only be prescribed by an appropriately qualified healthcare professional with expertise in managing both ADHD and substance misuse. For adults with ADHD and drug or alcohol addiction disorders there should be close liaison between the professional treating the person's ADHD and an addiction specialist.

1.7.1.12 Antipsychotics are not recommended for the treatment of ADHD in adults. Having said that, the GDG recognises that behaviours that describe ADHD are not strictly symptoms, as this term is usually used to refer to changes in physical or mental state associated with significant morbidity that is a change from a premorbid state: for example, symptoms experienced during an episode of depression or attack of anxiety.

The behavioural and mental phenomena that characterise ADHD are in contrast trait like, in the sense that they are non-episodic and may have been present from early childhood… Older children and adults are usually able to provide detailed descriptions of their subjective experiences of inattention, hyperactivity and impulsivity" (p. 95).[74]

Treatment of Antisocial Personality Disorder

The National Institute for Health and Clinical Excellence (NICE) has also issued guidance on the diagnosis and treatment of Antisocial Personality Disorder. It recommends

"8.1.1.2 Seek to minimise any disruption to therapeutic interventions for people with antisocial personality disorder by:

- *ensuring that in the initial planning and delivery of treatment, transfers from institutional to community settings take into account the need to continue treatment;*
- *avoiding unnecessary transfer of care between institutions whenever possible during an intervention, to prevent disruption to the agreed treatment plan. This should be considered at initial planning of treatment.*

8.4.2 The role of psychological interventions

8.4.2.1 For people with antisocial personality disorder, including those with substance misuse problems, in community and mental health services, consider offering group-based cognitive and behavioural interventions, in order to address problems such as impulsivity, interpersonal difficulties and antisocial behaviour.

8.4.2.4 When providing cognitive and behavioural interventions:

- *assess the level of risk and adjust the duration and intensity of the programme accordingly (participants at all levels of risk may benefit from these interventions;*
- *provide support and encouragement to help participants to attend and complete programmes, including people who are legally mandated to do so.*

8.4.3.1 Pharmacological interventions should not be routinely used for the treatment of antisocial personality disorder or associated behaviours of aggression, anger and impulsivity.

74 NICE Clinical Guidance CG 72 (2008): *Attention Deficit Hyperactivity Disorder: Diagnosis and Management of ADHD in Children, Young People and Adults*

8.4.4.1 For people with antisocial personality disorder who misuse drugs, in particular opioids or stimulants, offer psychological interventions (in particular, contingency management programmes) in line with recommendations in the relevant NICE clinical guideline.

8.4.4.2 For people with antisocial personality disorder who misuse or are dependent on alcohol, offer psychological and pharmacological interventions in line with existing national guidance for the treatment and management of alcohol disorders."

The Guidance comments on the organisation of services. It recommends:
"8.6.1.1 Provision of services for people with antisocial personality disorder often involves significant inter-agency working. Therefore, services should ensure that there are clear pathways for people with antisocial personality disorder so that the most effective multi-agency care is provided. These pathways should:

- *specify the various interventions that are available at each point;*
- *enable effective communication among clinicians and organisations at all points and provide the means to resolve differences and disagreements.*

Clearly agreed local criteria should also be established to facilitate the transfer of people with antisocial personality disorder between services. As far as is possible, shared objective criteria should be developed relating to comprehensive assessment of need and risk.

8.6.1.2 Services should consider establishing antisocial personality disorder networks, where possible linked to other personality disorder networks…These networks should be multi-agency, should actively involve people with antisocial personality disorder and should:

- *take a significant role in training staff, including those in primary care, general, secondary and forensic mental health services, and in the criminal justice system;*
- *have resources to provide specialist support and supervision for staff;*
- *take a central role in the development of standards for and the coordination of clinical pathways;*
- *monitor the effective operation of clinical pathways".*

The Guidance goes on to comment on the competencies, training and supervision of those clinical staff who assess and treat people with an Antisocial Personality Disorder.

"8.6.3.1 All staff working with people with antisocial personality disorder should be familiar with the 'Ten essential shared capabilities: a framework for the whole of the mental health practice' and have a knowledge and awareness of antisocial personality disorder that facilitates effective working with service users, families or carers, and colleagues.

8.6.3.3 Services should ensure that all staff providing psychosocial or pharmacological interventions for the treatment or prevention of antisocial personality disorder are competent

and properly qualified and supervised, and that they adhere closely to the structure and duration of the interventions as set out in the relevant treatment manuals".[75]

10.2.2. Findings

According to the clinical notes available to the Independent Investigation at various times prior to Mr. X being referred to the mental Health Team for Homeless People in Brighton he was prescribed the following medications:

Stimulants:

- Ritalin (methylphenidate)[76]: Ritalin (methylphenidate hydrochloride), is a stimulant used to treat ADHD. Methylphenidate works by increasing the availability of the neurotransmitters dopamine and noradrenaline in areas of the brain that play a part in controlling attention and behaviour.

Anti-depressants:

- Mirtazapine (Zispin). Mirtazapine is primarily used to treat depression however it is also sometimes used to treat various anxiety conditions.

Anti-psychotics:

- Quetiapine (Quetiapine fumarate) is used to treat schizophrenia and bipolar disorder. It is also sometimes used to treat aggression, anger, anxiety, ADHD and depression.
- Depixol (Flupenthixol) is a long-acting injection given once in every two or three weeks to treat schizophrenia. It is also sometimes used in low doses as an antidepressant.
- Trifluoperazine (Stelazine) is primarily used to treat schizophrenia. However it is sometimes used to treat agitation and behavioural problems.

Mood Stabilisers:

- Carbamazepine is primarily used as an anticonvulsant and a mood-stabiliser. However it is also sometimes used to treat ADHD and borderline personality disorder.

Anxiolytics:

- Hydroxyzine is primarily used for the symptomatic relief of anxiety and tension.

Non-Pharmacological Treatments

A number of non-pharmacological interventions were also recommended at various times including:

- referral to the substance misuse and alcohol services;
- referral to specialist ADHD services;
- referral to Forensic services because of Mr. X's offending history;[77]
- cognitive behavioural therapy and the development of social and work skills.

Although these non-pharmacological were recommended, some of them a number of times by various services, it appears that the recommendations were not acted on.

This, then, was the situation when Mr. X arrived in Brighton and was referred to the Mental Health Services in January 2011. He had been prescribed medications from all the major

75 NICE Guideline CG 77 (2008) Antisocial Personality Disorder: Treatment, Management and Prevention
76 Clinical notes p 96
77 Clinical notes p 84

groups commonly used in psychiatry; it did not appear that he had ever received any non-pharmacological interventions and there did not appear to be a recorded strategy in place to address his problems. At the time of referral the only information available to the Mental Health Service was information provided by Mr. X himself and he was keen to be diagnosed as suffering from ADHD and to receive treatment for this. Following his move to Brighton Mr. X was referred by his GP to Secondary Mental Health Services with the request that that he be reviewed with a view to recommencing Quetiapine.[78] Mr. X was seen and assessed by the Specialist Registrar and Social Worker on 28 February 2011 and the plan recorded following this meeting as:

- *"Get copies of old reports from Basingstoke;*
- *Speak to foster mother, with [Mr. X's] permission, for more collateral history;*
- *Investigate local ADHD specialist services for help with diagnosis. Refer if possible;*
- *At request of [Mr. X] and GP start low dose of Quetiapine (50mg to be increased to 100mg if tolerated) for anxiety/ paranoia/ low mood;*
- *Continue Mirtazapine 30mg nocte;*
- *See again in 4-6 weeks once above is done".* [79]

On 15 March 2011 Mr. X was referred to the Neurobehavioral Clinic to be assessment for possible ADHD. This referral was acknowledged on 8 April 2011 but the Mental Health Homeless Team was informed that there was a waiting time of at least six months.[80]

Mr. X was next reviewed by the SpR and Social Worker on 11 April 2011 when a trial of Concerta XL, a slow release version of methylphenidate, was started.

The Social Worker also saw Mr. X on 29 March 2011 and spoke to him at least four times on the telephone as well as speaking to his foster mother on the telephone on a number of occasions.

The Social Worker also liaised with the Probation Service and the Rough Sleepers' team about Mr. X.

10.2.3. Conclusions

Treatment prior to Mr. X's arrival in Brighton and referral to Homeless Team

As noted above the NICE guidance on the treatment of Antisocial Personality Disorder emphases the importance of continuity and coherence of care. Although there are particular reasons why this aspect of care was stressed in this guidance it is a universal characteristic of good quality care. In their various letters to a range of services and professionals Mr. X's foster parents had expressed their concern that that although various professionals had tried to help Mr. X the continuity that was needed was always lacking. This was, in part, because of Mr. X's behaviour; his criminal activities meant that he had spent 13 of previous 15 years in prison and because, it would seem, the 'system' was unable to co-ordinate his care as he moved from placement to placement and between institution and the community and back again. Most areas of England now have a mental health prison in-reach team, part of whose

78 Clinical notes p 5
79 Clinical notes pp 25-27
80 Clinical notes p 43

remit is to provide continuity of care when a person moves from the community to prison and back again. The Independent Investigation has no information as to whether Mr. X was identified as having a mental health problem when he was in prison and there is no information in the records available to the Investigation to indicate that he was followed up by a prison in-reach team. It has to be acknowledged, however, that individuals such as Mr. X who do not have a firm diagnosis or care plan in place and who move around the country present a particular challenge in delivering coherent care.

Mr. X was prescribed a number of medications. He did not feel that he benefited from anti-psychotic medication and it seems unlikely that he took this in a consistent fashion. Mr. X, at times, described himself as being *"paranoid",* however he was using this term in the colloquial sense and there is no record of any clinician regarding him as suffering from a psychotic disorder, though there is one recorded instance of a psychiatrist concluding that if Mr. X was experiencing paranoid feelings this was as a result of his substance misuse rather than a first rank symptom of psychosis. The 'anti-psychotic' medications appear to have been used to address the symptoms Mr. X was reporting: agitation, anxiety, impulsivity, racing thoughts etc. rather than to treat a psychotic illness.

Mr. X at times reported a lowered mood and was prescribed anti-depressant medication. He reported that he believed that he derived some benefit from this medication.

The one medication which Mr. X wanted prescribed and which he and his foster parents believed that he had benefitted from in the past was Ritalin (methylphenidate). However it seems that clinicians were reluctant to prescribe this until he had been assessed in a specialist unit and diagnosed as suffering form ADHD. This was not an unreasonable stance. The problem was that Mr. X never seemed to be anywhere long enough for the plans to have him assessed in such a specialist unit to come to fruition.

Non-pharmacological interventions were recommended on a number of occasions but again these were never realised.

Prior to coming to Brighton there was a lack of consistence and no longer term treatment plan in place.

Treatment in Brighton

Mr. X was seen on two occasions by the SpR and Social Worker, once for an initial assessment and once for a review; he had a further appointment with the Social Worker and, at least, four further telephone contacts with him. Mr. X was referred to the Neurobehavioural Unit for assessment of his ADHD; the Social Worker spoke to Mr. X's foster mother on a number of occasions and he liaised with the Probation Service and with the Rough Sleepers Team. The SpR consulted a senior colleague on the prescribing of Ritalin/Concerta XL. This was a significant amount of contact with and work related to Mr. X in the six week period he was under the care of the Mental Health Homeless Peoples Team.

Mr. X was keen to be prescribed Ritalin and this was discussed with him at his assessment interview. The SpR discussed this option with a senior colleague with experience in this area and was advised to start a trial of this medication. She included this information in her referral letter to the Neurobehavioural Unit in March 2011. It might be argued that ideally it would have been good practice, as in the past, to wait until the outcome of the ADHD assessment was known before commencing treatment with methylphenidate (Ritalin/Concerta XL). However, before the medication was prescribed the Mental Health Homeless Team was informed that there was a waiting time of at least six months before the assessment would take place. In these circumstances it was not reasonable to simply wait and make no decision about treatment. The SpR started a trail of Concerta XL when Mr. X was reviewed in April 2011. However he was arrested for the murder of Mr. A only a few days later, so this trail never got under way.

The NICE Guidance on the treatment of ADHD recommends that: *"Drug treatment for adults with ADHD should be started only under the guidance of a psychiatrist, nurse prescriber specialising in ADHD or other clinical prescriber with training in the diagnosis and management of ADHD".* The SpR consulted a senior colleague who was experienced in this area before she prescribed Concerta XL. She also sought the advice of the local expert service. This was good practice.

The Guidance also comments:
"1.7.1.10 Where there may be concern about the potential for drug misuse and diversion (for example, in prison services), Atomoxetine may be considered as the first line drug treatment for ADHD in adults.

1.7.1.11 Drug treatment for adults with ADHD who also misuse substances should only be prescribed by an appropriately qualified healthcare professional with expertise in managing both ADHD and substance misuse. For adults with ADHD and drug or alcohol addiction disorders there should be close liaison between the professional treating the person's ADHD and an addiction specialist".

The recommendation that drug treatment for people with ADHD who also have a drug or alcohol problem should only be prescribed by professionals who have expertise both areas is, unfortunately, in most areas of England somewhat aspirational. However the recommendation that there should be close liaison between those treating the ADHD, usually the Adult Mental Health Services, and the Substance Misuse Services should be a realisable recommendation.

The Independent Investigation was informed that in the past there were identified members of the Forensic Service and Substance Misuse service associated with the Mental Health Team for Homeless People but this liaison and consultation service had been removed. Similarly a Psychologist had been available to provide consultation and supervision on a monthly basis but the facility had also been removed. This erosion of the service is problematic as a multi-disciplinary discussion about Mr. X's difficulties which included these specialists would have provided a useful opportunity to arrive at a clear formulation of Mr. X's needs and how they

might best be addressed. However, it would be unreasonable to conclude that the absence of such a multidisciplinary forum had either a significant impact on Mr. X's care, as he was under that care of the Team for such a short period of time, or the killing of Mr. A.

Although Mr. X denied that he was abusing drugs or alcohol he did have a history of substance misuse and those assessing him were uncertain as to the accuracy of his reporting in relation to his recent use of illicit substances. In these circumstances it might have been good practice to have considered prescribing Atomoxetine rather than the more commonly prescribed Ritalin or Concerta XL and to have recorded the reasons for opting to prescribe one of these medications. It might have also been good practice in these circumstances to have put in place an explicit medicines management plan, perhaps with advice from the substance misuse service, to ensure Mr. X's appropriate use of and compliance with his prescription of Concerta XL.

The Guidance recommends that before Ritalin/Concerta XL is prescribed the service user's physical health, particularly the functioning of the cardiovascular system, should be reviewed. It would have been good collaborative practice to have brought this recommendation to the attention of Mr. X's GP before Concerta XL was prescribed.

Mr. X's GP had referred him to the Mental Health Service for advice about re-commencing prescribing Quetiapine. The SpR recommended that he be started on a low dose of Quetiapine to address the reported symptoms of *"anxiety/ paranoia/ low mood".* She also recommended that he continue with his anti-depressant medication, Mirtazapine. As we have noted already at this time there was little information available on Mr. X and the strategy being pursued was to obtain more information to enable a firm and clear formulation to be arrived at. In these circumstances it was reasonable to wait until more information and the clearer formulation was available before a more radical approach to Mr. X medicine regime was considered.

The Guidance on Antisocial Personality Disorder identifies the importance of interagency communication. We have already noted the limited availability of forensic and substance misuse input into the Mental Health Team for Homeless People. This was a service issue beyond the remit of the clinical staff caring for Mr. X. It should be noted, however, that the Social Worker liaised with the Probation Service and the Rough Sleepers' Team; the CPN in the Criminal Justice Team informed the Mental Health Homeless Team of Mr. X's appearance in Court and the outcome of his assessment. This was all good practice.

Prior to Mr. X coming to Brighton various psychological and psychosocial assessments and interventions had been recommended but none, it appears, had been realised. There is no record to suggest that any psychological or psychosocial intervention was considered during the brief period Mr. X was under the care of the Mental Health Homeless Team. However in discussion with the Team this Investigation was informed that depending upon the outcome of Mr. X's assessment for ADHD, and any recommendations that might accompany it, a more comprehensive plan as to how to address Mr. X's problems and needs would have been

considered. The Homeless Team were familiar with setting up such packages of care and had good relations with other services within the Trust. Given the limited time Mr. X was under the care of the Mental Health Team for Homeless People and his own desire to be diagnosed as suffering from ADHD and prescribed Ritalin there is little comment this Investigation can make on this aspect of Mr. X's care.

The NICE Guidance on the treatment of ADHD, of Antisocial Personality Disorder and of Substance Misuse all emphasise the importance of front line clinicians having appropriate training, supervision and timely access to consultation and advice. If a team such as the Mental Health Team for the Homeless is to provide an effective and efficient service for a population as diverse and often chaotic as homeless people it is important that this aspect of the guidance is followed. This Investigation was informed, as noted above, that the Substance Misuse and Forensic Liaison Workers and psychology consultation and supervision had been removed from the Team, there was no Personality Disorder Service within Brighton which the Team could access, the Substance Misuse Service did not accept referrals of people who were not yet at the stage of displaying motivation to address their substance misuse problems and did not provide input into the team to facilitate the development of this motivation, and the Team did not receive regular training on the issues identified in the NICE guidance and noted here. This is an area in need of review by the Trust and the commissioner of services.

- **Service Issue**
  Although the Mental Health Team for Homeless People has to deal with a diverse population a significant proportion of whom have Personality Disorders, substance misuse problems and/or ADHD the clinical staff did not have access to timely advice, support, supervision and training on the more specialist areas of these disorders as recommended in the relevant NICE guidance. It would not be reasonable, however, to conclude that in Mr. X's case this had a significant impact on his care or had any causal relationship with the killing of Mr. A.

- **Service Issue**
  The workers from the Forensic and Substance Misuse Services who had, formerly, been attached to the Mental Health Team for Homeless People and the psychology consultation and supervision had been removed and the team did not have ready access to a Personality Disorder service, a Dual Diagnosis service or an ADHD service. The absence of timely access to such services by a team which has to provide assessment, care and treatment to a population such as homeless people makes it difficult for that team to provide a responsive, effective, efficient and safe service. This is an issue which the Trust together with its commissioner should review.

10.3. Use of the Mental Health Act (1983 & 2007)

10.3.1. Context

The Department of Health summarises the Mental Health Act as follows:

"1. The main purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

2. Part 2 of the Act sets out the civil procedures under which people can be detained in hospital for assessment or treatment of mental disorder. Detention under these procedures normally requires a formal application by either an Approved Mental Health Professional (AMHP) or the patient's nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies...

…5. Part 3 of the Act concerns the criminal justice system. It provides powers for Crown or Magistrates' Courts to remand an accused person to hospital either for treatment or a report on their mental disorder. It also provides powers for a Court to make a hospital order……for the detention in hospital of a person convicted of an offence who requires treatment and care. The Court may also make a guardianship order.

The goal of the Act then is to ensure that people with a 'mental disorder' receive assessment and treatment. The Code of Practice to the Act provides some clarification as to what constitutes a 'mental disorder'. It comments:

"3.8 Section 1(3) of the Act states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act".[81]

At any one time there are up to 15,000 people detained by the Mental Health Act. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[82]

81 Department of Health (2008) *Code of Practice: Mental Health Act 1983*
82 Mental Health Act Commission 12th Biennial Report. 2005-2007

10.3.2. Findings

Although Mr. X did, on one occasion,[83] report that he had been detained under the Mental Health Act there is no evidence of this in any of the clinical records available to the Independent Investigation.

During the very brief time Mr. X was under the care of the Mental Health Team for Homeless People there were never any indications that that his mental state was such that he required an assessment under the Mental Health Act (1983 & 2007).

10.4. The Care Programme Approach (CPA)

9.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 to promote coherent, co-ordinated and comprehensive care for people with severe mental health difficulties.[84] Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach.*[85]

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long-term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s). This should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
    - to keep in close contact with the patient;
    - to monitor that the agreed programme of care remains relevant; and
    - to take immediate action if it is not;
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need, after this date people were cared for under the CPA

83 Clinical notes p 5
84 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990
85 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

process or placed on 'standard care'. In *Refocusing the Care Programme Approach* (2008) the Department of Health noted *"It is clear that all service users should have access to high quality, evidence-based mental health services. For those requiring standard CPA it has never been the intention that complicated systems of support should surround this as they are unnecessary. The rights that service users have to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be good practice for all"*.

Trust CPA Policy

The Sussex Partnership NHS Foundation Trust CPA policy references and echoes the Department of Health guidance. The policy identifies that *"The CPA will be applicable to all adults and older people with mental health problems who have complex needs and are in contact with the secondary mental health system. Its principles may equally apply to those adults with less complex needs"*.

In identifying who should be cared for under the CPA protocol the Trust policy quotes *Refocusing the Care Programme Approach.*

"Characteristics to consider when deciding if support of CPA is needed:

- *Severe mental disorder (including Personality Disorder) with a high degree of clinical complexity;*
- *Current or potential risk(s), including:*
    - *Suicide, self-harm, harm to others (including history of offending);*
    - *Relapse history requiring urgent response;*
    - *Self-neglect/non-concordance with treatment plan;*
    - *Vulnerable adult; adult/child protection e.g. exploitation e.g. financial/sexual;*
    - *Financial difficulties related to mental illness;*
    - *Disinhibition;*
    - *Physical/emotional abuse;*
    - *Cognitive impairment;*
    - *Child protection issues.*
- *Current or significant history of severe distress/instability or disengagement;*
- *Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability;*
- *Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies;*
- *Currently/recently detained under Mental Health Act or referred to Crisis/Home Treatment team;*
- *Significant reliance on carer(s) or has own significant caring responsibilities;*
- *Experiencing disadvantage or difficulty as a result of:*
    - *Parenting responsibilities;*
    - *Physical health problems/disability;*
    - *Unsettled accommodation/housing issues;*
    - *Employment issues when mentally ill;*

- *Significant impairment of function due to mental illness;*
- *Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues."*

The policy then goes on to identify the similarities and differences between service responses for those needing care under CPA and those receiving standard care. The policy states that service users requiring CPA are characterised by having complex needs, multi-agency input, and presenting higher levels of risk; while those not requiring care under this protocol have more straightforward needs, receive care from one agency or experience no problems with accessing other agencies and/or support services, and present a lower level of risk.

For those service users on standard care the policy comments:
"What the service users should expect:

- *Support from professional(s) as part of clinical/ practitioner role. Lead practitioner identified;*
- *Service user self-directed care, with support;*
- *A full assessment of need for clinical care and treatment, including risk assessment;*
- *An assessment of social care needs against FACS eligibility criteria (plus Direct Payments);*
- *Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter);*
- *On-going review as required but at least annually;*
- *On-going consideration of need for move to CPA if risk or circumstances change;*
- *Self-directed care, with some support if necessary;*
- *Carers identified and informed of rights to own assessment".*

The policy indicated that those not receiving care and treatment under the CPA protocol will have a 'Lead Practitioner' rather than a Care Co-Ordinator. *"The Lead Practitioner has responsibility for facilitating the delivery of care to the service user who has been identified as having straightforward needs so does not require the more formal approach of CPA. They are likely to only have contact with one agency and this will be the person identified as being most appropriate from that agency".*

10.4.2. Findings

Mr. X was referred to the Secondary Mental Health Services in Brighton on two occasions. On the first occasion, 4 January 2011, having provided some details of Mr. X's history and outlining his current problems the GP requested that Mr. X be reviewed by a Psychiatrist with a view to recommencing Quetiapine.[86] On the second occasion, 28 January, a second GP from the same surgery, provided additional background information and an up-date on Mr. X's condition. She requested an assessment of Mr. X's mental health.

86 Clinical notes p 5

Following this second referral Mr. X was seen and assessed jointly by the SpR and the Social Worker from the Mental Health Team for Homeless People. They took a history from Mr. X and also obtained additional information from Mr. X's foster mother and his partner. This was good practice and consistent with both national guidance and the Trust's CPA policy.

The SpR and Social Worker discussed their strategy of seeking further information, referring him for a specialist assessment for ADHD and considered prescribing medication to treat the ADHD with Mr. X. The SpR wrote to the GP immediately after the assessment informing him of the outcome of the assessment and the plan. A date was agreed to re-assess Mr. X in the light of the new information and his response to the medication he was being prescribed. Advice was sought on prescribing medication for ADHD. Mr. X was reviewed again by the SpR and Social Worker on 11 April 2011 and arrangements were put in place to offer Mr. X a further review appointment and for contact to be maintained between appointments.

Although the Social Worker was not formally named as Mr. X's Lead Practitioner in any of the records available to this Independent Investigation he clearly fulfilled this role: he maintained contact with Mr. X between appointments, both meeting him and speaking to him by telephone, he contacted Mr. X's foster mother, obtaining information from her and providing her with information and support, he identified how to refer Mr. X to the Neurobehavioural Clinic and he liaised with the Probation Service and the Rough Sleepers' Team.

10.4.3. Conclusion

The Independent Investigation Team concluded that the standard level identified in *Refocusing the Care Programme Approach "The rights that service users have to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be good practice for all"* was met in Mr. X's case. The Independent Investigation Team concluded that the care Mr. X received was compliant with Trust policy.

However, given Mr. X's complex presentation, his forensic history with a significant proportion of his life having been spent in prison, his current involvement with the criminal justice system, his history of impulsive behaviour placing himself and others at risk, the diagnostic challenge he presented, the range of medications he had been prescribed, his lack of appropriate accommodation, his history of drug and alcohol misuse and the uncertainty as to whether Mr. X was misusing these substances at that time, the concerns about the vulnerability and exploitation of his foster mother, and the fact that he was involved with several agencies: Housing, Probation, the Police and the mental health services, should have given rise to consideration of providing Mr. X's care under the CPA protocols.

Had Mr. X been cared for under the CPA protocol his assessments and care planning would have had a more formal and prescribed structure and there may have been more multi-disciplinary involvement and discussion of his needs and the most appropriate ways in which to meet these. However, having said this, the Independent Investigation Team acknowledges

that Mr. X was assessed and his care plan drawn up by a psychiatrist and a social worker, so there was a multi-disciplinary dimension to his care. In the short time that Mr. X was under the care of the Mental Health Homeless Team, given that his initial care plan was focused primarily on obtaining information, identifying his needs, obtaining a specialist assessment and monitoring his response to medication, it seems unlikely that him being cared for under the CPA process would have made a substantial difference to the care he received. However had Mr. X remained under that care of the Team for a longer period this situation may have changed and the CPA process might have ensured a more robust, comprehensive and recovery focused care package.

10.5. Risk Assessment

10.5.1. National Context

Risk assessment and management planning should not be seen as free standing activities. They are integral elements in meeting a service user's health and social care needs. In his forward to *Best Practice in Managing Risk (2007*) Louis Appleby commented:
"Safety is at the centre of all good healthcare. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk".[87]

The guidance goes on to list 16 principles which should characterise the assessment and management of risk. These are listed below:

"Best practice
1. *Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience and clinical judgement.*
Fundamentals
2. *Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.*
3. *Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.*
4. *Risk management must be built on recognition of the service user's strengths and should emphasise recovery.*
5. *Risk management requires an organisational strategy as well as efforts by the individual practitioner.*
Basic ideas in risk management
6. *Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.*

87 DoH (2007), *Best Practice in Managing Risk*

7. *Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.*
8. *Knowledge and understanding of mental health legislation is an important component of risk management.*
9. *The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.*
10. *Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.*
11. *Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.*
Working with service users and carers
12. *All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.*
13. *Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and recognition that each service user requires a consistent and individualised approach.*
Individual practice and team working
14. *Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.*
15. *All staff involved in risk management should receive relevant training, which should be updated at least every three years.*
16. *A risk management plan is only as good as the time and effort put into communicating its findings to others".*[88]

Antisocial Personality Disorder

In its Guidance on Antisocial Personality Disorder NICE identifies the importance of undertaking a robust risk assessment for this population. It recommends:

"6.2.8.3 When assessing the risk of violence in secondary care mental health services take a detailed history of violence and consider and record:

- *current or previous violence, including severity, circumstances, precipitants and victims;*
- *contact with the criminal justice system, including convictions and periods of imprisonment;*
- *the presence of comorbid mental disorder and/or substance misuse;*
- *current life stressors, relationships and life events;*
- *additional information from written records or families and carers (subject to the person's consent and right to confidentiality), as the person with antisocial personality disorder might not always be a reliable source of information.*

88 DoH (2007), *Best Practice in Managing Risk* pp 5-6

6.2.8.4 The initial risk management should be directed at crisis resolution and ameliorating any acute aggravating factors. The history of previous violence should be an important guide in the development of any future violence risk management plan.
6.2.8.5 Staff in secondary care mental health services should consider a referral to forensic services where there is:

- *current violence or threat that suggests immediate risk or disruption to the operation of the service;*
- *a history of serious violence, including predatory offending or targeting of children or other vulnerable people".*[89]

With respect to the risk management plan it comments:
"The key to effective risk management is the assessment of risk as a multi-faceted construct using a descriptive approach rather than an estimate of high, medium or low risk. A description of the nature of the risk, including the factors likely to increase or decrease it, should lead seamlessly to a management plan".[90]

Multi-Agency Public Protection Arrangements (MAPPA)
Multi-Agency Public Protection Arrangements (MAPPA) are put in place to protect the public by facilitating the sharing of information, ensuring that there are risk assessments and risk management plans in place and co-ordinating the actions of responsible bodies.

Three categories of individuals are identified as falling within the remit of MAPPA:

Category 1: Registered Sex Offenders.

Category 2: All offenders who have received a custodial sentence of 12 months or more in prison for a sexual or violent offence and whilst they remain under Probation supervision.

Category 3: Anyone else who poses a *"risk of serious harm to the public"* who has received a conviction and whose risk would be better managed in a multi-agency setting.

One of the requirements of MAPPA is that a formal risk assessment is carried out and on the basis of this the individual is allocated to one of the three tiers of multi-agency management:

- **Level One:** the normal inter-agency management of the offender in the community by one agency, with some liaison.
- **Level Two:** Multi-Agency Public Protection meetings (MAPPs) will be held where the offender's management will be discussed between the various agencies involved in his/her case.
- **Level Three:** essentially the same as Level Two, except that senior management representatives will be in attendance and greater resources are expected to be used in the management of the offender.

89 NICE Guidance CG 77 (2010 Antisocial Personality Disorder: Treatment, management and Prevention, p 162
90 Ibid p 163

Risk Assessment
Before a management plan is put in place it is expected that a detailed risk assessment takes place to identify the circumstances that are most likely to lead to a further serious offence.

Management Plan
The management plan identifies the steps that will be taken to reduce the risk of future offending; the actions and responsibilities of the agencies involved and how information will be shared.

10.5.2. Local Context
The Sussex Partnership NHS Foundation Trust Clinical Risk Assessment and Management Policy and Procedure (2012) echoes and references much of the Best Practice Guidance.

The policy notes that:
"Risk assessment and management are an integral part of a service user's care and should be undertaken in the wider context of a holistic and recovery approach to care planning.

1.4.5
Risk assessments and risk management plans should involve:

- *engagement and the building of a trusting relationship with the service user and carer;*
- *collaboration with the service user and carer;*
- *discussion and consultation with all members of the multidisciplinary team, private services, and other agencies involved in the service user's care;*
- *structured clinical (or professional) judgement supported by the best evidence and information available in order that the best decision is made at the time;*
- *a stepped approach and use of agreed risk tools for each care group and service area reflecting the level of detail or speciality required."*(p.5)

The policy requires at least a risk screening to be undertaken for all service users at the point of first contact with the service. It continues:
"Service users who present risks that require more detailed investigation for effective management will have a more comprehensive risk assessment to include a formulation and a risk management plan [Level 1 or equivalent]. Service users who pose high risk/s and/or require complex management will have a multidisciplinary/multi-agency formulation and risk management plan (Level 2 or equivalent).

2.4
Level 1 comprehensive risk assessment and management plans can be completed by a single practitioner but where there is multidisciplinary (MDT) or multiagency input into the assessment or plan, this must be documented. When a level 2 risk assessment and management plan is indicated, this must reflect input from all involved and relevant parties.

2.5
The risk assessment must be undertaken in collaboration with the service user and carer, and when this has not been possible, the rationale for not doing so must be clearly documented". (P. 6)

"Service users with identified high risk behaviours requiring further assessment to ensure effective management, will have a level 2 Multi-disciplinary (MDT)/Multi-agency (or equivalent inpatient MDT review) review of their risks (building on the comprehensive screening assessment) and MDT/Multiagency input regarding the risk management plan. This will include all service users admitted into acute/rehabilitation or secure and forensic inpatient care, and Assertive Outreach Teams". (P.10)

The policy provides the following descriptions of high medium and low risk service users:
"High Risk: This service user presents a risk of committing an act that is either planned or spontaneous, which is very likely to cause serious harm. There are few, if any, protective factors to mitigate or reduce that risk.

Medium risk: This service user is capable of causing serious harm, but in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The service user evidences the capacity to engage and occasionally, to contribute helpfully, to planned risk management strategies and may respond to treatment. This patient may become a high risk in the absence of the protective factors identified in this assessment.

Low risk: This service user may have caused, attempted or threatened serious harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. He is likely to cooperate well and contribute helpfully to risk management planning and he may respond to treatment. In all probable future scenarios in which risk might become an issue, a sufficient number of protective factors (e.g., rule adherence, good response to treatment, trusting relationships with staff) to support ongoing desistance from harmful behaviour can be identified".(P. 18)

10.5.3. Findings

Mr. X had a troubled childhood. He was excluded from school and was placed in a residential school for children with Emotional and Behavioural Difficulties (EBD).[91]

Risk to Others

Mr. X had a substantial forensic history. In 1991 he was described by an Educational Psychologist as displaying "*inattention, impulsivity, over activity, a predisposition to seek immediate satisfaction and an impaired ability to moderate arousal and inhibit responding".*[92] In 1995, when he was before the Aldershot Youth Court, it was reported that he had been one of a group of youths who had attacked a 14-year old boy and on another

91 Clinical notes p 87
92 Clinical notes p 88

occasion he had broken a chair and threatened staff at the childrens' home. At that time he had been charged with more than 30 offences of theft.[93]

A report in 1996 recorded that *"A picture emerges where [Mr. X] lacks personal responsibility, and where we observe an increasingly established, repetitive and persistent pattern of antisocial behaviour.*
[Mr. X] has little empathy and little concern for the feelings and well-being of his foster parents.
His self-esteem is extremely low, even though he attempts to project an image of toughness".[94]

Mr. X first went to prison at the age of 17 and by June 2010 he had spent a total of eight and a half years in prison. His longest sentence was between 2003 and 2008 for grievous bodily harm.

In his summing up at Mr. X's trial for the murder of Mr. A His Honour Judge Scott-Gall drew the jury's attention to the fact that they had been informed of seven convictions for aggravated burglary, common assault, battery, assaulting a police officer in the execution of his duty, assault occasioning actual bodily harm, common assault and affray. In his evidence Mr. X had admitted to committing many more offences. In fact the CPN who assessed Mr. X at the Magistrates' Court in February 2011 recorded that Mr. X had 28 convictions related to 99 offences.[95] Mr. X himself reported that he had spent 13 of the 15 years prior to moving to Brighton in November 2010 in prison.

When Mr. X was assessed in 2010 his risk of harming others was rated as low to moderate, however it was concluded that that there was a significant risk of harm to others when Mr. X was under the influence of alcohol.[96]

When his GP referred Mr. X to the Secondary Mental Health Services in January 2011 he noted that Mr. X had recently been in trouble for biting someone on the cheek and he had damaged his hand as a consequence of a *"punch injury".* Following her assessment of Mr. X in February 2011 the SpR in noted in her letter to the GP *"Risk of physical aggression to others when provoked".*[97]

In addition to the identified risk of physical harm to others and his acquisitive offences Mr. X continually sought money from his foster mother and was perceived as exploiting her for his own financial advantage. This aspect of the risk Mr. X posed is discussed in more detail in the section dealing with Safeguarding Vulnerable Adults.

93 Clinical notes p 89
94 Clinical notes pp 91-92
95 Clinical notes p 36
96 Clinical notes pp 81-83
97 Clinical notes pp 25-27

Risk to Self

At various times Mr. X reported that his mood was low and his foster parents were concerned that he might harm himself. For example in 2009 Mr. X's then GP informed the Consultant Psychiatrist that Mr. X's foster parents considered him to be a suicide risk and Mr. X had reported that he would *"do himself in"* rather than kill someone else.[98]

In 2010 it was recorded that in 1997 Mr. X had taken an overdose of Ritalin and in 2003 an overdose of Carbamazepine. However Mr. X's risk of self-harm was rated as low at that time.[99]

From an early age it had been noted that Mr. X's lack of impulse control placed him at risk. A report in 1996 noted *"Disinhibition and lack of impulse control is further demonstrated by [Mr. X] having acquired 'more that his fair share of fractures', and significantly, having suffered the consequences of a serious road accident in 1988, when he ran across the road in a rage and was struck by a car. This latter incident resulted in a 6-week hospital stay, which included a period of unconsciousness, the onset of pancreatitis, and two abdominal operations"*. The GP referring Mr. X to the Mental Health Services in 2011 recorded a remarkably similar story when he reported that since moving to Brighton Mr. X had attended his GP Surgery *"regularly"* and had attended the local Accident and Emergency Department on several occasions. Mr. X had recently been hit by a car, whilst running across a road to the aid of his girlfriend. He had sustained a fracture to his tibia. [100]

When Mr. X was assessed in February 2011 the SpR described Mr. X as *"unkempt and pale with a number of scars, cuts and bruises on his face. There was some body odour and signs of poor personal hygiene."* [101]

Risk Assessment

On 8 March 2011 the Social Worker completed the Trust's Level 1 Risk Assessment (Comprehensive Screening) based on the information that Mr. X, his partner and his foster mother had provided on 28 February 2011, and the information contained in the GP referral letters on 4 and 28 January 2011 and the information contained in the Forensic CNPs letter.

Assessed Risk to Self

Suicide risk indicators: it was recorded that in the past Mr. X had misused illicit drugs, that he believed he had no control over his life and that he was unemployed. However he had not made an attempt on his life and had not expressed feelings of hopelessness.

At the time of the assessment he reported that he was not misusing illicit drugs. He had not made an attempt on his life and had not expressed feelings of hopelessness. It was noted that he had not been diagnosed with a major psychiatric illness.

98 Clinical notes p 80
99 Clinical notes p 81-83
100 Clinical notes p 7-8
101 Clinical notes pp 25-27

It was observed that Mr. X and his partner had reported that he had been low in mood for a few months, his appetite and sleep were poor and he had lost interest in things. Mr. X said he had stopped misusing drugs and alcohol eight years previously. His foster mother had reported that Mr. X acted impulsively and did not appear to learn from his mistakes.

Neglect risk indicators: No indicators of previous neglect were identified. However it was noted that at the time of the assessment Mr. X was not eating properly, he was having difficulty managing his physical health, he was living in inadequate accommodation, he had difficulty in maintaining his physical hygiene and he had financial difficulties. It was noted when assessed on 28 February 2011 that he was unkempt, pale and had a number of scars, cuts and bruises on his face; there was some body odour and signs of poor personal hygiene; his appetite was poor and he had pain from a fractured tibia and injuries to both hands. His foster mother had reported that Mr. X had been asking her for money.

Assessed Risk to Others

Aggression/Violence: It was recorded that previously Mr. X had been involved in incidents of violence, he had used weapons, he had misused drugs and alcohol, there were known personal triggers associated with his violence and that he had engaged in dangerous impulsive acts. However he had not experienced paranoid delusions about others, or command hallucinations and he had not been in a special hospital, medium or low secure unit.

His current risk indicators were the same as the historical ones except that Mr. X was recorded as no longer misusing drugs and alcohol, he was now recorded as experiencing paranoid delusions about others and that he had formerly been in a low secure unit.

Mr. X reported that he had spent 13 of the previous 15 years in prison for offences such as assault and carrying weapons. At the time of the assessment Mr. X was awaiting sentencing for possession of a knife, threatening a police officer, aggravated assault and breaking conditional discharge conditions. He described feeling paranoid, anxious and unsafe much of the time but could not explain why. Mr. X recognised that he often misinterpreted the actions of others as being hostile and consequently got into fights. It was decided that a more detailed risk assessment was not required at this time.

The formulation of risk was:

- *"Low mood at present, no current risk of suicide.*
- *Some evidence of self neglect, insecurely housed, living at friend's who is currently in hospital.*
- *History and current reports of aggression and violence towards others".*

The management plan was much as that recorded in the SpR's letter on 28 February 2011:

1. *"Get copies of old report from CMHT in Basingstoke.*
2. *Contact foster mother for copies of old reports.*
3. *Get list of previous convictions.*
4. *Started on low dose of Quetiapine for anxiety/paranoia/low mood.*

5. *Continue Mirtazapine".*[102]

10.5.4. Conclusions

Mr. X's clinical records chronicle a long forensic history including a number of convictions for violence with him having spent a significant proportion of his life in prison. At an early age it had been noted that he had difficulty with impulse control and learning from the consequences of his actions. This difficulty manifested itself in later life not only in violent and disinhibited behaviour towards others and the property of others but also in putting himself in danger as a result of his ill-considered behaviour. Mr. X was also regarded as being exploitative at least towards his foster mother from whom he sought money on a regular basis often by exaggerating his plight and subjecting her to what the clinical team regarded as emotional blackmail.[103]

As required by the Trust Clinical Risk Management Policy a Level 1 risk assessment was completed. In line with good practice and Trust policy this was informed by corroborative information from Mr. X's partner and foster mother as well information provided by Mr. X's GPs. There is no evidence in the record, however, that these individuals were made aware that they were contributing to a risk assessment and developing a risk management plan and the assessment was not signed by Mr. X.

The Internal Investigation noted that the risk assessment was saved in draft format and recommended that staff should be reminded not to save risk assessments in this manner.

The assessment recorded in Mr. X's clinical notes was an initial assessment and given the limited information available part of the management plan was to seek further information. This was appropriate.

The Trust's Clinical Risk Assessment and Management policy identifies those posing a high risk as follows *"This service user presents a risk of committing an act that is either planned or spontaneous, which is very likely to cause serious harm. There are few, if any, protective factors to mitigate or reduce that risk"*. This description would appear to appear to apply to Mr. X. One of the reasons for having such a categorical system is to provide an indication of those who need more careful assessment, a clearer understanding of the risk they pose, why they pose such risk and to put in place a more comprehensive risk management plan. In Mr. X's case it was decided that a more comprehensive assessment was not needed and the risk formulation and risk planning were not as robust as one might have expected.

The Department of Health guidance recommends:
*"Structured clinical (or professional) judgement is the approach that offers the most potential where **violence** risk management is the objective. This approach involves the practitioner making a judgement about risk on the basis of combining:*

- *an assessment of clearly defined factors derived from research;*

102 Clinical notes pp 14-15
103Clinical notes p 48

- *clinical experience and knowledge of the service user; and*
- *the service user's own view of their experience*".

The NICE guidance on Antisocial Personality Disorder comments:
"The key to effective risk management is the assessment of risk as a multi-faceted construct using a descriptive approach rather than an estimate of high, medium or low risk. A description of the nature of the risk, including the factors likely to increase or decrease it, should lead seamlessly to a management plan".[104]

This reflective formulation leading seamlessly to a risk management plan was not evident in Mr. X's case. The risk formulation should provide an understanding of the risk, risk triggers and protective factors and this understanding should inform the plan to reduce and manage risk and promote positive outcomes. The formulation accompanying Mr. X's risk assessment did not achieve this. It merely listed some known factors related to risks associated with Mr. X.

Various triggers associated with the risks posed by Mr. X had been identified including: his impulsivity, his use of drugs and alcohol, him (mis)perceiving himself as being threatened and responding aggressively, and his social and living situation. These were not explored in the formulation and the management plan did not set out how they might be addressed.

As has been noted Mr. X had a long forensic history, he was in contact with the Probation Service and was due to return to Court. Given his history and the risk factors that were present at the time, the likelihood that Mr. X would again come into conflict with the law was highly likely. In the past it had been suggested that Mr. X might be referred to Forensic Services for assessment and advice. It would have been appropriate to consider such a referral at this time. It would also have been good practice, at least, to have considered how the various agencies with whom Mr. X was involved: Probation, Police, Housing, the Rough Sleepers' Team, GPs, Mental Health Services and, possibly, Substance Misuse Services might have been brought together to share information, arrive at a common view of the risks Mr. X posed and agree a common approach to addressing these needs. This is the remit of MAPPA and Mr. X would appear to fall within Category Three of the MAPPA structure *"Anyone else who poses a 'risk of serious harm to the public' who has received a conviction and whose risk would be better managed in a multi-agency setting".* If Mr. X did not meet the local interpretation of MAPPA guidance, then a local 'sub-MAPPA' protocol or even a Multi-agency Professionals meeting might have been used to realise the same ends.

Given that Mr. X's identified risks included putting himself at risk resulting in him sustaining more or less serious physical injuries, it was particularly important that his GPs were involved in the assessment and care planning process. Similarly, although Mr. X denied that he was abusing drugs and alcohol, given that there was some uncertainty about the veracity of his reports it would have been appropriate to have included Substance Misuse Services in the

104 Ibid p 163

assessment and care planning process, if only to obtain their advice and insights and establish at what point it might be most useful to engage them in Mr. X's care.

It has to be acknowledged that Mr. X was only under the care of the Mental Health Team for Homeless People for a short period of time, and it would be unrealistic to have expected the Team to have achieved all that has been identified here in that short space of time. However, while the Independent Investigation considered it good practice for the clinical team to have identified that they needed more information and actively sought this out, it has to be noted that formulation, an understanding of risks and why they are present, is part of the risk assessment process and should be present, if only in an embryonic form, as an element of even the initial assessment. As the National Guidance and the Trust policy point out risk assessment is an ongoing, iterative and dynamic process and the initial formulations should be refined and revised as new information becomes available, but, from the time of the first assessment, there should be some shared understanding of the risk which informs both how the individual should be responded to and what further information is needed and why.

- **Service Issue**
  Although a risk assessment was undertaken in line with Trust policy the formulation and management plan accompanying this assessment were not as robust as might have been expected and did not fulfil the requirements of providing an understanding of the risks associated with Mr. X or how to manage these. However it would not be reasonable to conclude that this had any causal relationship with the killing of Mr. A.

10.6. Referral and Engagement

10.6.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user. These occasions require good consultation, communication and liaison. These stages are critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

10.6.2. Findings

Referral

Having been released from Winchester Prison Mr. X moved to Brighton and on 1 December 2010 he approached the Local Authority for accommodation.[105]

On 4 January 2011 a GP in Brighton wrote to the Central Access Team of the Secondary Mental Health Services. This referral letter appears to have been received on 14 January 2011. The GP reported that Mr. X had registered with the surgery the previous November in 2010. He had been under the care of a CMHT in Basingstoke; his foster father had died recently and Mr. X was possibility suffering a grief reaction; he felt irritable and frustrated. Mr. X had been diagnosed as suffering from ADHD and had been prescribed Ritalin. He had

105 Clinical notes p 39

also been prescribed Mirtazapine, Quetiapine, Depixol and Carbamazepine and had been detained under the Mental Health Act. The GP had prescribed Mirtazapine and Hydroxyzine for Mr. X and referred him with the request that he be reviewed with a view to recommencing Quetiapine.[106]

A "Single Point of Access Recording Sheet" recorded that a referral had been received on 14 January 2011 and Mr. X's case had been allocated to a *"Medic"* on 17 January 2011. The Basingstoke CMHT was contacted for Mr. X's clinical notes and Brighton services were advised that a consent form from Mr. X was required.[107]

On 28 January 2011 a second GP referred Mr. X, this time to the Mental Health Team for Homeless People in Brighton. The referral letter again reported that Mr. X had recently moved to Brighton, he had had been under the care of a CMHT in Basingstoke, he had been diagnosed as suffering from ADHD, and he had misused illicit substances though he denied abusing any substances at that time. Mr. X was complaining of a difficulty in concentrating and of feeling angry and irritable.

Mr. X had attended his GP surgery "*regularly"* and had attended the local Accident and Emergency Department on several occasions. Mr. X had recently been in trouble for biting someone on the cheek, he had damaged some bones in his hand and had nearly been run over by a car whilst running across a road to the aid of his girlfriend.

The GP reported that it was difficult to get a coherent history from Mr. X. He was crying and saying that he could not cope. The GP was requesting an assessment of Mr. X's mental health. [108]

On **31 January 2011** a Mental Health Homeless Team referral from was completed.[109]

On **1 February 2011** it was recorded that a *"new"* referral had been received from Mr. X's GP and, as he was homeless and after discussion with the Central Access Team, the Mental Health Homeless team were to take the original referral. The GP was to be advised of this. The referral was to be discussed at the team meeting the next day.[110]

The Mental Health Homeless Team wrote to Mr. X's GP informing him that the referral he had made on 4 January 2011 had been passed to the Mental Health Homeless Team because Mr. X was in emergency accommodation.[111]

On the same day the Forensic CPN with the Criminal Justice Liaison Team wrote that Mr. X had been in the Magistrates' Court on a charge of theft. The letter noted that Mr. X was on crutches following him having been hit by a car the previous week. Mr. X smelt of alcohol and he was irritable and somewhat agitated. Mr. X had asked if the CPN could speed up his

106 Clinical notes p 5
107 Clinical notes p 11
108 Clinical notes pp 7-8
109 Clinical notes pp 2-3
110 Clinical notes p 44
111 Clinical notes p 4

appointment with a Psychiatrist to discuss his medication. There was no evidence of psychotic symptoms.[112]

On 2 February 2011 Mr. X's referral was discussed at the Homeless Peoples' Team meeting and an appointment was made for him to see the SpR and Social Worker on 7 February 2011. Mr. X was telephoned and given the details of the appointment.[113] Mr. X's GPs were informed of this appointment the next day.[114]

Mr. X failed to attend his appointment on 7 February 201 and the Social Worker telephoned him and arranged a new appointment for 28 February 2011.[115] This was confirmed in writing the following day.[116]

Prior to the meeting on 28 February 2011 the Social Worker telephoned Mr. X's foster mother to find out which of the two CMHTs in Basingstoke had been caring for him. Mr. X's foster mother was unsure which CMHT had been caring for Mr. X but she volunteered some background information about Mr. X and his psychiatric history.[117] Mr. X attended his appointment on 28 February 2011 and the SpR wrote to his GP the same day reporting her conclusions, plan and recommendations.[118]

10.6.3. Conclusions

Mr. X's initial GP referral was sent to the single point of entry for the Secondary Mental Health Services but for some reason that remains unclear it took 10 days for this referral to be received and entered into the system. Mr. X's notes were then sought from Basingstoke, which was an appropriate response in preparation for Mr. X being assessed. However two weaknesses were evident in the system at this point:

First: the Central Access Team did not appear to recognise that Mr. X's address was temporary emergency accommodation, identify him as a homeless person and pass his referral on to the Team for Homeless People. Although the Team for Homeless People accepted referrals directly from GPs, either because the GP was unaware of this or because he did not recognise Mr. X's address as being temporary emergency accommodation, he referred Mr. X to Secondary Mental Health Services via the more standard route which slowed down his acceptance by the appropriate clinical team.

Second: there is no record that the Central Access Team made contact with the GP during this period. Had they done so it is possible that Mr. X would have been identified as a homeless person and his referral passed to the appropriate clinical team in a more timely manner. Mr. X was not a rough sleeper but, nevertheless, being homeless and, therefore likely to be more difficult to contact and engage, it is important that referrals of individuals from this population are responded to in a timely manner.

112 Clinical notes p 36
113 Clinical notes p 44
114 Clinical notes p 35
115 Clinical notes p 44
116 Clinical notes p 34
117 Clinical notes p 44
118 Clinical notes pp 25-27

Mr. X was referred for a second time on 28 January 2011, almost a month after the first referral was made. This time the referral was made directly to the Team for Homeless People and the response was much prompter. The referral was received on the 31 January 2011, the next day it was discussed with the Central Access Team and the GPs were informed that the Homeless Team had accepted the referral and that Mr. X had been given an appointment for the 7 January. Mr. X himself was telephoned to inform him of the referral and the time and place of his appointment. This was good practice.

Mr. X failed to attend his appointment on 7 February, however the Social Worker telephoned him immediately to discover why he had had not kept the appointment and arranged a new appointment for him. This was confirmed in writing the next day. Again this was good practice.

Mr. X was seen by the SpR and Social Worker on 28 February 2011 and the SpR wrote to the GP on the same day. Once again this was good practice.

Once Mr. X was referred to the Mental Health Team for Homeless People he was contacted quickly, timely efforts were made to engage him and his GPs were kept informed of his appointments and the outcome of his assessment. The only possible blemish on this example of good care is there is no evidence in the records available to this Investigation to suggest that Mr. X's GP was informed when he failed to attend his initial appointment on 7 January 2011. It is possible however that the appointment letter informing Mr. X of his appointment on 28 February was copied to Mr. X's GP.

- **Service Issue**
  Mr. X was not identified as a homeless person when he was initially referred to Secondary Mental Health Services. This delayed his assessment and engagement by the appropriate clinical team, the Mental Health Team for Homeless People, by almost a month. It would not be reasonable, however, to conclude that this delay had any causal relationship with the killing of Mr. A.

10.7. Safeguarding Vulnerable Adults

10.7.1. National Context

Safeguarding Adults is a responsibility placed on Local Authorities through the *No Secrets* guidance which was issued under Section 7 of the Local Authority and Social Services Act 1970. Through this legislation, statutory social care organisations have a duty of partnership to work with other statutory bodies to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice.

The *No Secrets* statutory guidance was developed in response to several serious incidents, and states that: [119]

119 Department of Health (2000) No secrets: *Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, DH, London

"The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety". (Paragraph 1.2)

This document was supported by a further document produced by the Association of Directors of Social Services which describes a framework for good practice and outcomes in adult protection.[120]

By 2008, based on the content of both of these documents, Local Authorities were expected to have a Safeguarding Board/Committee and a safeguarding framework/procedure in place. Social care staff were expected to be trained in this area of work and to be familiar with adult safeguarding policies and procedures and clear as to how to respond to issues as they arose.

There was an expectation by the Department of Health that *No Secrets* would apply to all statutory agencies, however this is statutory *guidance* and it took some time before it was fully implemented in the NHS.

In October 2008, the Department of Health carried out a national consultation exercise[121] to discover to what extent the *No Secrets* guidance had been implemented across agencies and to find out how it could be improved. Over 12,000 people took part in the consultation. There were around 500 responses in total but only 67 of these were from NHS organisations.

One of the key findings was the absence of adult safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns were considered in the wider safeguarding arena. In response, the Department of Health published a document which tied existing systems of Clinical Governance into adult safeguarding in order to clarify responsibilities and expectations of NHS staff in relation to this issue. [122]

The Department of Health funded an adult safeguarding campaign in 2010, to raise awareness of adult safeguarding amongst nurses and midwives.

Recently, the British Medical Association published a toolkit to support GP Practices in dealing with this issue but, as yet, it has not been implemented in the majority of Practices.[123]

Safeguarding Process

When safeguarding is working effectively:

- all staff have a basic understanding of safeguarding and can make a prompt referral to the right place in order to elicit a response;

120 Association of Directors of Social Services (2005) Safeguarding Adults *A National Framework of Standards for Good practice and outcomes in adult protection work,* ADSS, London

121 Department of Health (2008) *Safeguarding Adult', the review of the No secrets guidance,* DH, London

122 Department of Health (2010) Clinical Governance and Adult Safeguarding *An integrated approach* DH, London

123 British Medical Association (2011) Safeguarding Vulnerable Adults *A Toolkit for General Practitioners,* BMA London

- staff who deal directly with safeguarding will pick up the referral and respond to it, within a short agreed timescale, in order to ensure the safety of the individual;
- immediate action/referral to the Police, if necessary, takes place when a crime has been committed;
- a strategy planning meeting will be called involving all those who have knowledge of the case to agree what is known and what further investigation should take place and a protection plan should be put in place, after discussion with the individual;
- an investigation will be conducted;
- Case Conferences will take place at specific intervals to hear the outcomes of the investigation and to monitor the protection plan;
- the case should be closed once the issue has been resolved and ongoing safety assured.

10.7.2. Trust Policy on Safeguard Adults

The Trust had an up-to-date Safeguarding Vulnerable Adults policy which echoed the guidance described above.

The Trust policy identified Vulnerable Adult as follows:
"This term refers to any person aged 18 years or over who is or may be in need of Community Care services by reason of mental or other disabilities, age or illness; who is or may be unable to take care of himself/herself or unable to be able to protect himself/herself from harm or serious exploitation".[124]

The groups of individuals who might be considered vulnerable are:
"People who are considered vulnerable and are likely to fall within the eligibility criteria for assessment and receipt of Social and Healthcare services:

- *Adults with mental health needs*
- *Adults with learning disabilities*
- *Adults with a physical or sensory disability*
- *Older people, mentally infirm or frail*
- *Adults made chronically vulnerable by reason of alcohol and substance misuse or addiction*
- *Adults who are seriously or terminally ill*
- *Carers*
- *Poverty or homelessness, social or emotional needs".*[125]

Abuse is defined as:
"Physical, sexual, financial, emotional, discriminatory or psychological violation, or neglect of a person unable to protect themselves or to prevent abuse from happening or to remove themselves from abuse or potential abuse from others". [126]

The Policy sets out in flow diagram form the procedure for raising a safeguarding alert.

124 Sussex Partnership NHS Foundation Trust (2010): Safeguarding Vulnerable Adults Policy p 11
125 Ibid p 12
126 Ibid p 11

10.7 3. Findings

There were four individuals whose vulnerability might be considered in the context of Mr. X's care and treatment: the victim, Mr. A, Mr. X's partner, Mr. X's foster mother and Mr. X himself.

Mr. A

Mr. A was not known to the mental health services in Brighton, though he had had some contact with the substance misuse services. The clinical team providing the care and treatment for Mr. X did not know Mr. A and was not aware that Mr. X and his partner were staying at Mr. A's flat. Given this, the clinical team was not in a position to address any vulnerability that Mr. A might have presented with. It appears, however, that Mr. A was a vulnerable person and the Brighton and Hove Safeguarding Adult Board commissioned a Serious Case Review. This was reported in April 2012 and although the Review is wide ranging and made recommendations including some related to interagency co-operation and co-ordination, it did not identify any findings or recommendations of immediate relevance to the care and treatment of Mr. X.

Mr. X's Partner

Mr. X's partner had a history of abusing illicit substances and she had been in contact with substance misuse services; she had a forensic history and had been released from prison in December 2010; she was homeless; and, according to her own report, she had miscarried twins in January 2010. She therefore belonged to several of those groups which are often associated with vulnerability.

Mr. X was known to have a forensic history and had several convictions for violence; there were reports that he had behaved threateningly or violently towards a partner in the past;[127] his partner reported that she had recently had a miscarriage and there was a report that she had had her nose broken when she was attacked.[128] These circumstances raise the possibility that Mr. X's partner might have been considered to be vulnerable. However, this was not the view of those who knew her nor the view expressed at her trial. Indeed it was suggested several times that Mr. X's partner was more likely to exploit others for financial gain that to be a victim of exploitation herself, though an individual can be both the victim of abuse and a perpetrator. No concerns about the safety of Mr. X's partner where brought to the attention of the clinical team caring for Mr. X. She was present at all three of Mr. X's interviews and commented on his mental state and behaviour. She did comment at the appointment on 11 April that she hoped that the medication, Concerta XL, which was discussed at this appointment would *"moderate [Mr. X] being 'snappy' towards her"*.[129] It emerged at the trial of Mr. X and his partner that they had a volatile relationship but the consensus opinion was that Mr. X's partner was an active participant in this and not a passive victim. However, this information was not available to Mr. X's clinical team during the brief period he was under its care.

127 Clinical notes pp 79, 81-83
128 Clinical notes pp 7-8
[129] Clinical notes p 50

The care and treatment of Mr. X's partner is not the subject of this Investigation and, in consequence, there is very limited information available to the Investigation on Mr. X's partner. However those who knew her and the Court were confident that she had capacity. There is no good evidence that she was exploited or abused and those who knew her did not regard her as a vulnerable person.

Mr. X

Mr. X had a troubled childhood, significant proportions of which were spent in care and in institutions of various kinds. By his own account he was abused during this period. Whatever Mr. X's true diagnosis it was agreed that he behaved in an impulsive manner, found it difficult to learn from his experience and, as a result, was frequently in conflict with both those around him and the law. His impulsiveness and irritability resulted in a number of physical injuries and prison sentences.

Mr. X had a history of both drug and alcohol abuse. At the time he was under the care of the Homeless Team he denied abusing drugs and alcohol though it is known that, on at least one occasion during this period, he used heroin and on another occasion he was recorded as smelling of alcohol.

Mr. X was homeless and, according to his report, at times slept rough.

Mr. X's foster mother was concerned that her foster son was vulnerable to exploitation by others because of his impulsive nature and especially vulnerable if others knew that he had, or had access to, money. She put forward this view whenever she spoke to the Mental Health Homeless Team.

At least some members of the clinical team were of the opinion that those around Mr. X saw him primarily as a potential source of funds, particularly when they heard that his foster father had died and he might inherit some money. At least in this limited sense he was viewed as vulnerable. The opinion was also expressed that Mr. X lived his life in a *"constant drama"* and this placed him at risk of conflict with those around him and conflict with the law.

The Risk Assessment completed on 8 March 2011 noted under the heading *"Neglect"* that Mr. X was not eating properly, he was having difficulty managing his physical health, he was living in inadequate accommodation, he had difficulty in maintaining his physical hygiene and he had financial difficulties. It was also noted that his foster mother had reported that Mr. X had been asking her for money.

When Mr. X was seen for assessment on 28 February 2011 the SpR described him as: *"unkempt and pale with a number of scars, cuts and bruises on his face. There was some body odour and signs of poor personal hygiene"*.[130] However when the Social Worker met Mr. X on 29 March 2011 he recorded: *"[Mr. X] looked well, he had his head shaved from the*

130 Clinical notes p 26

last time we met and he was well dressed".[131] The Independent Investigation Team discussed Mr. X presentation and whether it was an indication of his vulnerability with the clinical team. They were of the opinion that Mr. X's appearance was more a reflection of his activity on the previous day; that is whether he had money and whether he had chosen to spend this on drugs or alcohol, in which case he would appear poorly kempt and his personal hygiene would suffer, or on clothes, in which case he would present a more positive image of himself. Mr. X's personal appearance also reflected, to some degree, where he had spent the previous evening, which of course, partly determined and was partly determined by his activities.

The clinical team identified potential vulnerabilities which Mr. X shared with many of the users of their service. However they felt that he was 'street wise' and knew how to access the benefits system and other facilities that were available to him. Similarly the Homeless Persons' Officer at the Local Authority, having reviewed Mr. X's situation, decided that Mr. X was *"not in priority need"*. He quoted the criterion that the council used in deciding whether a person is vulnerable *"a homeless person is vulnerable if they would be less able to fend for themselves than an ordinary person so that they would suffer injury or detriment, in circumstances where a less vulnerable person would be able to cope without harmful effects"* (R V. Camden LBC ex Pereira).[132]

Vulnerability, of course, implies the possibility of suffering harm but the opinion of those who met Mr. X and assessed him was that while he possessed characteristics which placed him at risk, and in this sense rendered him vulnerable, there was no evidence at that time that he was the victim of abuse as a result of that vulnerability and, in consequence, no basis on which a safeguarding alert could have been initiated. In addition Mr. X was regarded as having capacity to make informed decisions.

It has to be noted that Mr. X was under the care of the Mental Health Homeless Team for only a short period of time, six weeks, and within that time contact had been made with the Probation Service, the Rough Sleepers' Team and Mr. X's GP. Had Mr. X remained with the Homeless Team longer and had his vulnerability become more evident and had abuse been identified the possibility of putting in place a protection plan was already available.

Mr. X's Foster Mother

Even before Mr. X was seen by the Homeless Team the GP referring him had identified that Mr. X might be exploiting his foster mother. In his referral letter of 28 January 2011 he reported that Mr. X's foster mother had been sending him money but appeared to be *"under severe stress with all this, particularly since her husband died in December"*.[133]

The Social Worker contacted Mr. X's foster mother prior to his first meeting with Mr. X on 28 February 2011 and a number of the themes that were repeated in subsequent conversations were rehearsed including her concerns that Mr. X was homeless and without money and that

131 Clinical notes p 49
132 Clinical notes p 39
133 Clinical notes pp 7-8

she was regularly sending him funds. This was included in the Risk Assessment of 8 March 2011.[134] [135]

In a telephone call on 21 March 2011 Mr. X's foster mother informed the Social Worker that Mr. X had told her he was homeless again and she was sending him money to stay in a local hotel. She estimated that she had sent him around £2,000 already that year. The Social Worker urged Mr. X's foster mother not to give Mr. X any more money. He told her that there were support services available in Brighton to help Mr. X and her continued financial support could be counter productive.[136] Despite this advice, later that day she sent a further £50.00 to Mr. X because, he had told her, he was sleeping rough and had no money for food.[137]

On 28 March 2011 Mr. X's foster mother told the Social Worker that she was feeling stressed because of Mr. X's situation. He observed *"Even when clarifying the situation for [Mr. X's foster mother] she will still be vulnerable to emotional blackmail from [Mr. X], leading her to continue to send him money. [Mr. X] may not be the main instigator of exploiting his foster mother; it may be others aware of [Mr. X's] vulnerability and his foster mother's financial support".*[138]

The Social Worker spoke to Mr. X about the effects his behaviour was having on his foster mother[139] but there is no evidence that this had any effects on Mr. X's behaviour. He also encouraged Mr. X's foster mother to consider her own needs.

The Clinical Team caring for Mr. X identified that she was vulnerable and, probably, being financially exploited by her foster son. They provided her with support and advice but this did not appear to have any effect on her behaviour. The Social Worker also spoke to Mr. X and brought to his notice the effects of his behaviour on his foster mother but, again, this had little effect.

The question arises as to whether further action should have been taken under the Safeguarding Vulnerable Adults procedures. Three factors come into place here: capacity, time and geography.

From her letters it would seem that Mr. X's foster mother was an intellectually able and articulate lady. Given this it was not unreasonable to begin by discussing with her Mr. X's behaviour, the effects this was having on her and the consequences of her behaviour. The Social Worker, in particular, but also other members of the clinical team adopted this approach. Unfortunately this appeared to have little effect on Mr. X's foster mother's behaviour. Aware that something more might need to be done Mr. X's foster mother was advised to discuss the situation with her GP who knew her and her situation well and could offer her informed advice.

134 Clinical notes p 44
135 Clinical notes pp 14-15
136 Clinical notes p 46
137 Clinical notes p 46
138 Clinical notes p 48
139 Clinical notes p 49

As has been noted a number of times Mr. X was under the care of the Mental Health Homeless Team for only a short space of time and by the time it was evident that the approach that had been adopted was unlikely to bear fruit Mr. X was again in custody.

Mr. X's foster mother lived in Hampshire while Mr. X was receiving care in Brighton. This meant that the clinical team would have had to contact the appropriate people in Hampshire to peruse a safeguarding alert. This was discussed with the Clinical Team but they were of the opinion that while this was not an everyday occurrence, given the population which they served, it was not an unknown situation and one that they could have dealt with successfully.

The clinical team identified that Mr. X's foster mother was vulnerable and possibly being financially exploited and it initiated some, not unreasonable, interventions. However it might have been better practice having noted this situation to have discussed the possible option and drawn up a clear plan to address the situation. This might have been done as part of the risk management planning when it was noted that he was asking his mother for money.

- **Service issue**
  It would have been good practice, having noted that Mr. X's foster mother was vulnerable and possibly being financially exploited by her foster son, to have reviewed the options available to address this problem and put in place an explicit plan of action.

10.8. Carer Assessment and Carer Experience

10.8.1. Context

The engagement of service users in their own care has long been regarded as good practice. The NHS and Community Care Act 1990 stated that *"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes"*. In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. Also that it will *"deliver continuity of care for as long as this is needed"*, *"offer choices which promote independence"* and *"be accessible so that help can be obtained when and where it is needed"*.

Carer Involvement

The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also gave carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared-for person's type and level of service provision required.

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they care for.

The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. It also facilitated co-operation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
- have their own written care plan which is given to them and implemented in discussion with them.

10.8.2. Findings

Mr. X's partner

The Internal Investigation found that the clinical staff failed to address the care needs of Mr. X's partner.

Mr. X's partner accompanied him to his two appointments with the SpR and Social Worker on 28 February and 11 April and was present when he met the Social Worker on 29 March 2011. The clinical records available show that she was able to indicate that she provided information on Mr. X's mental state and behaviour.

When the Social Worker met Mr. X and his partner on 29 March 2011 they reported that they were *"sofa surfing".* They were trying to obtain accommodation together and were exploring the possibility of Mr. X's partner claiming carer's allowance as they believed that this would improve their chances of being housed as couple. The Social Worker provided them with the contact details of the Welfare Rights Advice Team and MACS Welfare Benefits Advice lines to help them with their application.

The Social Worker noted that Mr. X's main topic of conversation at this meeting was himself and his circumstances interspersed with stating his love and affection for his partner, their interdependence and their need to be housed as couple.

On the other hand Mr. X informed his foster mother on 22 March 2011 that he was no longer in a relationship. It was reported at the trial of Mr. X and his partner that they had a volatile relationship.

Mr. X's partner had a substance misuse problem and was in contact with the Substance Misuse Services and was well known by this service though she was not well engaged.

Mr. X reported that his partner had miscarried twins in January 2011 and she had informed him, and he believed that they were his babies. This information was repeated in Court. However it was also reported at the trial that Mr. X and his partner met on either 30 December or New Year's Eve 2010.

10.8.3. Conclusions

It appears that Mr. X's partner was appropriately involved in identifying Mr. X's needs, with his active encouragement.

However as the Internal Investigation concluded, no consideration was given to Mr. X's partner's needs. She was an individual with a number of identified needs and given that she was already in contact with the Substance Misuse Services it would have been good practice to have assessed her needs and considered putting in place a carer's package together. There is no evidence that this was done.

As has been pointed out a number of times Mr. X was in contact with the Mental Health Homeless Team for only a short period and, with this in mind, it is tempting to conclude that there was not enough time to address Mr. X's needs and put in place a package of care for him and also to assess his partner's needs and address these. However it is good practice to consider the needs of carers form the beginning of one's contact with the service user. As a standard part of assessing the needs of the service user consideration should be given to offering a carer's assessment to his or her carers. There is no evidence in the records available to the Independent Investigation that this was done.

Mr. X's Foster Mother

Despite his difficulties and challenging behaviour Mr. X's foster parents remained supportive and nurturing towards him. They advocated strongly, on his behalf, that he have access to the services that they believed would help him.

When Mr. X moved to Brighton, with his permission, the Social Worker contacted his foster mother and she provided the Homeless Team with a substantial amount of information including professional reports of assessments which might not otherwise have been available. She also continued to advocate for her foster son and put forward a cogent explanation of his behaviour to help the clinical team care for and support Mr. X.

It would seem then that Mr. X's foster mother was appropriately involved in identifying his needs. She was kept informed about what was being done to help her foster son although she frequently expressed the opinion that this was not enough.

Mr. X's foster mother was not his carer though she was the individual who had provided him with long term support, both material and emotional, and been his advocate. Mr. X's situation and behaviour both stressed and distressed his foster mother. This was recognised by the clinical team and they offered her support and advised her contact her GP who knew her and her situation well, and so was in a position to offer her informed advice. The team were also

of the opinion that Mr. X was exploiting his foster mother financially. We have addressed this issue in the section of the report dealing with the Safeguarding of Vulnerable Adults.

The available information indicates that Mr. X's foster mother was appropriately involved in identifying his needs and planning his care. Her own needs were recognised and the team attempted to address these. Had Mr. X remained with the Mental Health Homeless Team for a longer period of time a more formal and systematic way of meeting Mr. X's foster mother's need would have had to have been identified. The clinical team recognised this and the need for a plan relating to who should speak to her, when, and on what basis, was identified in Mr. X's clinical notes.

10.9. Service User Involvement in Care Planning

10.9.1. Context

The engagement of service users in their own care has long been held to be good practice. The NHS and Community Care Act 1990 stated that:
"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in planning and delivery of care"*. It also stated that services would *"deliver continuity of care for as long as this is needed*", *"offer choices which promote independence"* and *"be accessible so that help can be obtained when and where it is needed".*

10.9.2. Findings

It was Mr. X who approached his GP and asked that he be assessed and treated for ADHD. When he met the Forensic CPN on 1 February 2011 he requested that the CPN tried to speed up his appointment with the Psychiatrist and when he was assessed by the SpR and Social Worker on 28 February 2011 he again asked to be assessed and treated for ADHD. It was recorded that he was pleased that his request had been recognised, that he was to be referred for a specialist assessment for ADHD and that a prescription of Ritalin was being discussed.

He was offered an appointment with the Social Worker and SpR on the 7 February but chose not to keep this. However he subsequently made contact with the Social Worker on a number of occasions requesting help with finding accommodation and discussing his relationship with his foster mother.

10.9.3. Conclusions

Although Mr. X was not being cared for under the formal CPA process, and there are no records signed by him that he agreed with the conclusion of the assessment or the plan that

was being put in place, it is evident from the records that are available that Mr. X was proactive in identifying his needs and seeking out help to address these. In this sense he was fully involved in the assessment of his needs and planning of his care.

There is no evidence that the SpR's letters to Mr. X's GP and to the Neurobehavioural Clinic or the risk assessment completed on 8 March 2011 were copied to Mr. X. It would have been good practice if they had been.

10.10. Housing

10.10.1. Context

Local Authorities, under the Housing Act 1996, have a responsibility to provide advice and support to those who find themselves homeless. The statutory responsibilities of Local Authorities in relation to homelessness primarily address the needs of families and they do not have a statutory responsibility to provide long-term accommodation for single people unless they are vulnerable individuals, or individuals who are more likely to be adversely affected by or less able to cope with homelessness.

If an individual is eligible for assistance, legally homeless or threatened with homelessness, in priority need and not intentionally homeless the Local Authority has to help. If a person does not qualify as homeless the Local Authority does not have a duty to arrange long-term accommodation, however it has to, at least, provide advice and guidance to help the person find accommodation or help them find a temporary solution to their accommodation problems.[140]

10.10.2. Findings

Mr. X was homeless from the time he arrived in Brighton. He approached the Local Authority for accommodation on 1 December 2010 having been released from Winchester Prison. Due to the severe weather conditions at that time and because he had a septic foot for which he had been treated at the Royal Sussex County Hospital the Council exercised its discretion and provided emergency accommodation for Mr. X.[141]

On 12 April 2011 The Homeless Persons' Officer at the Local Authority wrote to Mr. X. This letter stated *"Although it is accepted that you are eligible for assistance and homeless, the law states that it is also necessary for a homeless person to be in 'priority need' before there is a duty to provide accommodation on a long term basis"*.[142]

The letter set out the criteria the Local Authority has to take into consideration when considering whether an individual is in 'priority need'. These include being pregnant or a member of their household being pregnant, and/or being vulnerable as a result of mental illness or physical disability or other special reason (for example: having been in prison).[143]

140 www.homeless.org.uk downloaded on 10/12/2012
141 Clinical notes p 39
142 Clinical notes p 38
143 Clinical notes p 39

The letter acknowledged that Mr. X's partner had also presented to the Local Authority seeking accommodation. However the author of the letter concluded *"The council is therefore satisfied that she is not someone who would reasonably be expected to reside with you and is not in Priority Need through pregnancy"*.[144]

This letter recorded the information that had been collected in relation to Mr. X's physical and mental health and concluded that *"the council is satisfied that you [Mr. X] are not in Priority Need as per the Act"* and in consequence had no duty to provide accommodation.[145] Mr. X was informed that he should leave the emergency, accommodation that had been provided by 19 January 2011.[146]

It appears that from this time Mr. X had no permanent accommodation. He told his foster mother that he was sleeping rough and asked her for money, which she sent him, to stay in private bed and breakfast accommodation. However it is unclear how much of the information Mr. X gave to his foster mother was true. Mr. X told the Social Worker, on 29 March 2011, that he and his partner were *"sofa surfing*" and this was the information that was presented at Mr. X's trial. They also told the Social Worker that they were trying to obtain accommodation together and were exploring the possibility of Mr. X's partner claiming carer's allowance as they believed that this would improve their chances of being housed as couple.

It seems, from the information presented at the trial of Mr. X and his partner, that from around this time they were staying at the flat of Mr. A, Mr. X's victim.

10.10.3. Conclusions

Throughout his time in Brighton Mr. X was homeless or in emergency, temporary accommodation. For much of the time between mid January 2011 and the killing on 14 April 2011 he and his partner were, according to their own account, *"sofa surfing"* and from around late March they were staying in the flat of the victim, Mr. A.

While he was under the care of the Sussex Partnership NHS Foundation Trust, Mr. X was cared for by the Mental Health Team for Homeless People. The Social Worker in this team provided them with the contact details of the Welfare Rights Advice Team and MACS Welfare Benefits Advice lines to help them with their application for accommodation. He also liaised with the Rough Sleepers' Team regarding Mr. X.

To provide accommodation was not within the remit or gift of the Mental Health Homeless Team and there was little more that they could have done which would have affected Mr. X's status or secured him appropriate accommodation.

144 Clinical notes p 41
145 Clinical notes p 41
146 Clinical notes p 41

The Local Authority Homeless Persons' Officer reviewed Mr. X's eligibility for accommodation. He concluded that although Mr. X had recently been released from prison and was in contact with mental health services he was not in 'priority need' and was not vulnerable in the sense that a *"homeless person is vulnerable if they would be less able to fend for themselves than an ordinary person so that they would suffer injury or detriment, in circumstances where a less vulnerable person would be able to cope without harmful effects"*.[147]

He noted that Mr. X's partner had also contacted the Local Authority seeking accommodation and in his letter he stated *"At no point did she mention that she was pregnant or that she had a partner. The council is therefore satisfied that she is not somebody who would reasonably be expected to reside with you and is not herself in Priority Need through Pregnancy"*.[148]

This is a poor piece of reasoning. The absence of evidence of something is not evidence of the absence of that thing. If the fact that Mr. X was in a relationship and his partner was pregnant was to form part of the logic for deciding whether Mr. X was eligible for council provided accommodation it should have been properly tested. Mr. X's partner should have been asked if she was in, and intended to remain in, a relationship with Mr. X and if she was pregnant.

The facts, as we know them, are that Mr. X and his partner did remain in a relationship until the time of the killing; they remained living together, all be it in a peripatetic fashion. Mr. X believed that his partner was pregnant, she maintained that this was the case in Court and the Judge appeared to accept this in his summing up.

Whether, these facts would have made any difference to the decision about Mr. X's eligibility for accommodation had they been known at the time the assessment was made we are not in a position to say. It should be noted however that although Mr. X was provided with the information on how to challenge this decision there is not evidence available to this Investigation that he did so.

Mr. X had spent much of his life in institutional care and from as early as 1997 it was noted that it would be in his best interest if he lived in a structured and calm environment *"with clear expectation in which the individual is assisted to develop the skills that he has failed to learn over the years…These skills include the essential life skills…He has never gained those kind of skills and therefore cannot be expected to demonstrate them at present unless he is first trained in them"*.[149]

Had Mr. X been provided with accommodation then it is unlikely that he and his partner would have been living in Mr. A's flat and the occasion of the killing would not have arisen, at least at that time. However, as has been noted, the provision of accommodation was not within the gift of the Mental Health Homeless Team and the Officer of the Local Authority

147 Clinical notes p 39
148 Clinical notes p 41
149 Clinical notes p 97

concluded, on the basis of the information available to him, that Mr. X did not meet the locally employed criteria for the provision of accommodation.

It has been concluded elsewhere in this report that given Mr. X's history, his personal characteristics and his social circumstances it was highly likely that he would, at some point, come into conflict with the law. To what degree the provision of more permanent accommodation would have ameliorated the situation and reduced this probability can only be a matter of speculation but it is likely that it would have reduced the likelihood to some extent rather than increased it.

10.11. Documentation and Professional Communication

10.11.1. Context

"Effective inter-agency working is fundamental to the delivery of good mental health care and mental health promotion".[150] Jenkins *et al* (2002)

The Care Programme Approach when used effectively should ensure that both inter-agency communication and working takes place in a service user-centric manner. Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone.[151] The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.[152] The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

10.11.2. Findings

Three types of record are available for the time Mr. X was under the care of the Mental Health Team for Homeless People: contemporaneous electronic records (including a draft risk assessment), e-mail contacts with the Probation Service and Neurobehavioural Clinic, and correspondence with the GP and the Neurobehavioural Clinic.

There were 19 entries made on the electronic record between 11 January 2011 and 11 April 2011 when the Mental Health Services were dealing with Mr. X's referral and providing his care. Further entries were made after Mr. X had been arrested and charged with murder. These entries appear to be contemporaneous and provide a good record of the contact the Homeless Team had with Mr. X. They record decisions taken and actions undertaken. This was good practice. Like many electronic records they tend to be brief and factual and, with a few exceptions, do not record, in any detail, the thinking of the team. This Investigation was told that although there were a significant number of entries made in Mr. X's record and most contacts with him and his foster mother were recorded, there may have been further

150 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) p 121
151 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999). p144.
152 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

telephone contacts with Mr. X's mother by team members other than the Social Worker which were not recorded on the electronic record.

It was also reported that Mr. X may have been discussed at multi-disciplinary Team meetings but this has not been recorded in the electronic record.

The Mental Health Team for Homeless People responded promptly when it received Mr. X's referral. After each of the two meetings between Mr. X, the SpR and the Social Worker, the SpR wrote to the GP informing him of the outcome of the meeting and the decisions that had been made.

The only possible blemishes in this good communication between The Homeless Team and Mr. X's GP is that there is no evidence in the records available to this Investigation that Mr. X's GP was informed when Mr. X failed to attend his initial appointment on 7 January 2011. It is possible however that the appointment letter informing Mr. X of his appointment on 28 February was copied to Mr. X's GP.

It is recorded in the internal investigation that the SpR wrote to Mr. X's GP on 14 April 2011 regarding Mr. X's appointment. Unfortunately this letter was not available in the clinical records made available to the Independent Investigation.

It should also be recorded that the Forensic CPN who assessed Mr. X at the Magistrates' Court recorded and communicated his findings and conclusions in a timely manner.

Mr. X was in contact with the Probation Service. The Social Worker liaised with the Probation Service both by telephone and e-mail and these contacts are recorded in the electronic record

10.11.3. Conclusions

The Internal Investigation found that the Risk Assessment completed on 8 March 2011 was saved in draft format and recommended that staff should be reminded not to do this.

The documentation relating to Mr. X provides a detailed account of the contact the Mental Health Team for Homeless People had with Mr. X and with other professionals and agencies. One improvement that the Trust might consider promoting is to ensure that the reasons why decisions are taken and the options considered are recorded in sufficient detail to allow the reader to understand why one option or action was decided on rather than another. This is particularly important where a formulation and common understanding of a service user's problems is arrived at in a multi-disciplinary forum. The key elements of the discussion and the formulation should be captured in the clinical record.

10.12. Adherence to Local and National Policy and Procedure

10.12.1. Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients*".[153] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

10.12.2. Findings

The Sussex Partnership NHS Foundation Trust had in place policies relevant to the care and support of Mr. X. The CPA, Clinical Risk and Safeguarding Vulnerable Adults policies were informed by current best practice guidance and were of a good standard.

10.1.12.3. Conclusions

The evidence available from this Investigation suggested that staff complied with Trust policies. However there were occasions where best practice guidance would suggest that staff might have gone further than the letter of the policy and the completion of the requisite form. For example there might have been a more compete and robust formulation of Mr. X's needs, in particular a more robust formulation of the risks he presented. There could also have been

153 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p 328

a more timely approach to the carer's assessment and a more proactive approach to Safeguarding Vulnerable Adults.

10.13. Management of the Clinical Care and Treatment of Mr. X

10.13.1. Context

This section of the report serves as a summary section which considers the overall management and co-ordination of the care Mr. X received from the Sussex Partnership NHS Foundation Trust.

10.13.2. Findings

On 4 January 2011 a GP in Brighton referred Mr. X to the Central Access Team of the Secondary Mental Health Services requesting that Mr. X be reviewed with a view to recommencing Quetiapine.[154] This referral letter appears to have been received on 14 January 2011 and Mr. X's case was allocated to a *"Medic"* on 17 January 2011.[155] However there is no record of contact being made with the GP at this time and on 28 January 2011 a second GP referred Mr. X, this time to the Mental Health Team for Homeless People.[156] The Homeless Team wrote to the GP on 1 February 2011 informing him that the referral made on 4 January 2011 had been passed to the Mental Health Homeless Team because Mr. X was in emergency accommodation and that Mr. X had been given an appointment for 7 February 2011.[157] Mr. X was telephoned and given the details of the appointment.[158]

Mr. X failed to attend his appointment on 7 February 2011. The Social Worker immediately telephoned him and arranged a new appointment for 28 February 2011.[159] This was confirmed in writing the next day.[160]

Prior to the meeting on 28 February 2011 the Social Worker contacted Mr. X's foster mother, with his permission, and received background information about Mr. X and his mental health history.[161] Mr. X attended his appointment on 28 February 2011 and the SpR wrote to his GP the same day reporting her conclusions, plan and recommendations.[162]

The Social Worker fulfilled the role of Lead Professional. Following the assessment appointment he completed a risk assessment (8 March 2011). He maintained contact with Mr. X by telephone and met both him and his partner on 29 March 2011. He identified how to refer Mr. X to the Neurobehavioral Clinic and liaised with the Probation Service and the Rough Sleepers' Team.

154 Clinical notes p 5
155 Clinical notes p 11
156 Clinical notes pp 7-8
157 Clinical notes p 4
158 Clinical notes p 44
159 Clinical notes p 44
160 Clinical notes p 34
161 Clinical notes p 44
162 Clinical notes pp 25-27

As had been set out in Mr. X's care plan on 28 February 2011, the SpR referred Mr. X to the Neurobehavioural Clinic. She also sought the advice of an experienced colleague on prescribing medication for ADHD. The Homeless Team also requested Mr. X's clinical notes from Basingstoke.

10.13.3. Conclusions

There was a delay in responding to the first GP referral and Mr. X was not initially identified as being a homeless person and, in consequence, his referral was not passed to the Mental Health Homeless Team until the second GP referral was made. This referral was addressed to the Homeless Team. This initial aspect of Mr. X's care pathway manifested a weakness in accessing secondary mental health services.

Once Mr. X's care was allocated to the Homeless Team the processes of communication, engagement and assessing Mr. X's needs progressed in a more efficient and timely manner. The Homeless Team contacted the GP to inform him which team was going to assess Mr. X and when the assessment would take place.

Unfortunately Mr. X did not attend his appointment on 7 February 2011. Although he was contacted on the same day he was not offered a further appointment until 28 February, three weeks later. This seems a rather long delay given that Mr. X had initially been referred on 4 January. However, it has to be noted that the GP had asked for advice on medication and Mr. X's case had been, appropriately, allocated to a Psychiatrist and a Social Worker. The Mental Health Homeless Team did not have access to a full time psychiatrist. The SpR was available to the Team only one day a week and the Social Worker had only recently been seconded to the Team and worked there only on a part time basis. This delay represents a resource issue.

Mr. X was seen and assessed on 28 February 2011. The national guidance underpinning CPA and the Trust policy were adhered to: a history was taken from Mr. X and corroborative information was obtained from Mr. X's partner and foster mother. A plan was discussed with Mr. X, and Mr. X's GP was informed of this, the plan was put into effect and a date was set to review this. A risk assessment was completed.

Given Mr. X's history and his complex presentation it might have been good practice to have considered providing his care under the CPA protocol, however given the short time he was under the care of the Mental Health Homeless Team it is unlikely that had this been done it would have made a significant difference to the care he received.

The Risk Assessment although completed using the prescribed Trust form lacked a robust formulation and management plan which addressed the identified risk factors. This represented a shortcoming in the assessment of Mr. X's needs and the planning of his care.

In the period between the first assessment on 28 February 2011 and the review appointment on 11 April 2011 the Social Worker maintained contact with Mr. X and his foster mother and he liaised with the other agencies which were involved in Mr. X care.

The Independent Investigation concluded that while Mr. X was under the care of the Mental Health Team for Homeless People he received care and support consonant with the principles of the Care Programme Approach, there was a multi-disciplinary element to his care, his partner and foster mother were appropriately involved in his care and there was cross agency liaison. This was good practice. Whilst there are some lessons for learning identified relating to the care and treatment Mr. X received, these do not constitute significant breaches and were not found to have either caused or contributed to the murder of Mr. A by Mr. X.

10.14. Clinical Governance and Performance

10.14.1. Context

"Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish".[163]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. X was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information about how the national performance framework is managed.

During the time that Mr. X was receiving his care and treatment the Trust should also have been subject to robust performance monitoring and review from local statutory authorities charged with the commissioning of local Mental Health Services.

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr. A. The issues that have been set out below are those which have relevance to the care and treatment that Mr. X received.

10.1.14.2. Findings

The following information has been taken from the Trust's 2012/1013 Annual Quality Report.

163 Department of Health http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

The Trust sets itself 'stretch' targets on all aspects of quality, via annual objectives, each with markers and measures. Progress is reviewed at the Trust Board on a monthly basis to ensure corrective action is taken where needed.

Priorities for Improvement 2012/2013

These include:

- treating service users with dignity and respect;
- a compassionate and caring approach;
- safe environments;
- providing care and treatment that staff and patients would recommend to their family and friends.

These quality markers are measured and examined at every Board meeting by the use of a summary dashboard.

Priorities for Improvement for 2013/2014

These include:

- improving the patient experience (The Trust is working with the friends and family test introduced by David Cameron in 2012 to ensure that all services are improved);
- safety (the safety thermometer developed as a result of the Staffordshire Inquiry is used and the Trust will work closely with the Clinical Commissioning Groups to ensure incidents are managed properly);
- effectiveness (services are in the process of being aligned to outcome focused care pathways which incorporate National Institute of Clinical Excellence guidance, this will be linked to Payment by Results and Commissioning for Quality Improvement requirements);

Care Quality Commission (CQC)

Sussex Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'without condition'. The Care Quality Commission has not taken enforcement action against Sussex Partnership during 2012-13.

The Trust has participated in special reviews and investigations by the Care Quality Commission during 2012-13 in relation to the management of ligature anchor points at the Department of Psychiatry, Eastbourne and Mill View Hospital, Hove.

Follow up special reviews and investigation visits took place in March 2013. Inspection reports have been shared for Mill View Hospital and the Department of Psychiatry, which demonstrate the essential standards of Care and welfare of people who use services and Safety and suitability of premises have now been met. The CQC's judgement was that patients received safe, appropriate and personalised treatment and support through the coordinated assessment, planning and delivery of care at both locations. Since the last inspections the locations have improved the care planning documentation and the inspection

reports note that care plans documented the plan of treatment and reflected the care and support people received.

The inspection reports reflect that the CQC are satisfied that there are systems in place to manage both individual and environmental risks at the locations. The CQC were satisfied that the hospitals had undertaken a major programme of environmental upgrades, refurbishment and redecoration to provide a safe and therapeutic care.

Sussex Partnership has made the following progress by 31 March 2013 in taking such action as prioritising removing high risk ligature points from areas where vulnerable patients had unaccompanied access. This has been achieved by replacing windows, providing anti-ligature fixings in bathrooms and high risk areas. The CQC are satisfied that the Trust was taking appropriate steps to manage the environmental risks in order to keep people safe at Mill View Hospital and Department of Psychiatry. The Downs Nursing Home also received a compliance visit from the CQC in March 2013. It was judged as fully compliant with all outcomes assessed against.

Organisational Learning from Internal and External Reviews

One of the Trust's 2012-13 quality priorities was to deliver safe services by demonstrating learning from internal and external reviews. In Quarter 1 the Trust's Report and Learn bulletin was revised. It now shows a clearer link between incidents and the learning. The serious incident section also focuses on a small number of themes or learning in order that managers and professional leaders are able to focus on priorities.

In Quarter 2 the Trust committed to ensuring that serious incident reviews are only signed off when confirmation has been received about when, and by whom, the review will be fed back. A recent audit of this demonstrated 100% compliance. Throughout 2012-13 all internal reviews have been undertaken by an objective peer with the recognised training to undertake the review. Furthermore, from 2012-13 action plans have been written and owned by the manager responsible for the service. This ensures that from the construction of the action plan, actions are locally owned and delivered. The Trust holds a central risk register of all open actions and maintains a log of progress made.

In 2013-14 one of the Trust's priorities for improvement is to review and revise the Serious Incident review process. The Nurse Consultant for Patient Safety will be working closely with the Executive Director of Nursing and Quality to ensure national best practice is reflected in the local incident review process. The review will be out for consultation by July 2013 with implementation no later than September 2013.

The Trust is also committed to implement the Medical Early Warning Signs (MEWS) model for full roll out by January 2014. Training in MEWS commenced in January 2013. All inpatient services will have an identified trainer by April 2013. Each inpatient service will submit a training implementation plan by the end of Quarter 1 2013-14 with at least 50% of staff trained by Quarter 2. In Quarter 3 each inpatient ward will have hit a minimum of 85%

compliance with training enabling them to roll out the model. The Trust will begin an early evaluation or stock take of the approach by Quarter 4 13-14.

Clinical Leadership and Governance Structures

The Trust has recently re-developed its clinical leadership and governance structures. Full details can be found at Full details can be found at: http://staff.sussexpartnership.nhs.uk/staff/corporate/comms/wmb/?assetdetesctl6829718=391773.

The Trust states:

"This new structure aims to reduce bureaucracy and improve clinical engagement through a flatter structure with distributed leadership, and greater involvement in decision-making. The interactive network model is a framework for effective working, there is, of course, no substitute for good leadership or getting the right people on the right tasks. The management restructure, intends to do just that, and the changes outlined in this paper will be underpinned by a robust programme designed to provide leaders for the future and develop managerial maturity. To this end, we will be reviewing in-house programmes designed for managers and providing a more integrated and focused approach to development and talent management.

This structure provides an opportunity for senior clinicians to step up and become much more involved in leading the organisation. This is a big ask as the future will be challenging, to meet the challenge of improving quality, productivity and efficiency we need to work differently, be less centrally driven and more customer-focused. However, this is a new way of working, getting it right involves full commitment to our strategic aims, a robust grip on the detail, and a willingness to work vertically and horizontally to deliver…

… The divisional structures are based on matching local and clinical need, achieving best fit in terms of service clusters. This is in keeping with the overarching guiding principle that 'form should follow function'. In core divisions we need to embrace consistency and promote best practice, while we develop effective relationships with clinical commissioning groups (CCGs).

Specialist divisions have various commissioning arrangements in and beyond Sussex as services grow and funding is less reliant on block contracts. The inclusion of Kent and Medway within the Children and Young Peoples' Division (CYPD) requires a purpose-built governance structure to support the scale and geographical spread of this new service. In the Adult Specialist Division (ASD) services are diverse and there is a need to use the synergies between care pathways and focus on our aim to lead the way in this field.

While recognising the inherent differences, clinical leadership structures are based on the same principles and designed by division...

… The Senior Clinical Director post

To ensure consistency and maximise learning in core services a new role is being introduced; the senior clinical director (SCD). There are three of these posts and their role is to bring a mixed clinical perspective to strategic planning for care groups trust- wide. Each represents a different component of service, and together they represent the journey from primary to secondary care, care clusters and care pathways. Their experience of clinical leadership within the organisation provides the stability going forward with this more ambitious organisational structure. They are accountable to the chief operating officer and will work in partnership with a service director to:

- *develop divisional clinical leadership*
- *identify the context for change*
- *facilitate transformation through innovation and improvement*
- *ensure patient safety*
- *critically evaluate services*

It is envisaged the SCDs will spend less time on operational management than they did in their clinical director role, this is because the structure seeks to embed decision-making closer to the frontline, supported by an approach to workforce planning processes which will aim to coordinate skills and special interests in a way that is more beneficial. Post holders will be supported through training and personal development and will have clarity of role to prevent upward delegation. This principle applies across all operational services

The Divisional Clinical Lead post

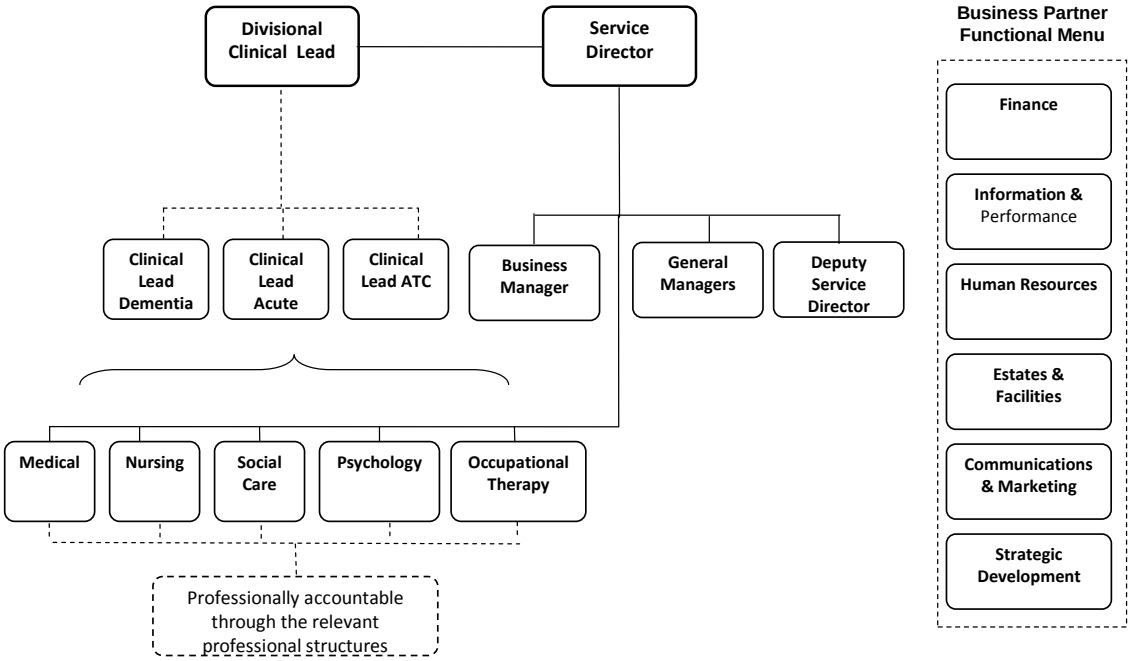
The DLT will be chaired by the divisional clinical lead (DCL), a new post. This role, unlike the SCDs, is not care group specific, and the post holder is accountable to and jointly responsible with the service director for the integrated services within the division. The DCL will be professionally accountable to an appropriate SCD or senior professional within the relevant professional structure.

Reporting to the divisional clinical lead, will be clinical leads, each of whom will take on the responsibility for a functional service area, (i.e. Acute Care, ATCs, etc) in partnership with a general manager. These clinical leads will report to the divisional clinical lead and be jointly accountable with the general manager for the delivery of their objectives.

The post will be open to applicants from any profession, provided they have experience of professional leadership at a senior level.

The chart below indicates responsibilities and accountability within a DLT in core services.

Divisional Leadership Team



10.1.14.3. Conclusions

The Independent Investigation Team found the governance structures and processes in place at the Sussex Partnership NHS Foundation Trust to be robust. The new structures are in the process of being embedded and will be subject to monitoring and review by the Trust Board and local scrutiny and commissioning agencies.

11. Summary of Findings and Conclusions of the Independent Investigation

11.1. Diagnosis

From the time Mr. X was 12 or 13 years of age two possible diagnoses were consistently considered by all who saw him: ADHD and Personality Disorder, or Conduct Disorder when he was a child. From around the age of 14 years the complicating effects of illicit drug use and excessive alcohol use was also noted.

The three most obvious possible diagnoses: adult ADHD, Personality Disorder (of either the Antisocial or Emotionally Unstable type) and Mental and Behavioural Disorder due to the harmful effects of alcohol and multiple drug abuse, were identified and considered by the Specialist Registrar (SpR) in the Mental Health Team for Homeless People. She reported that she had a strategy for refining her diagnosis. This involved taking the opportunity to build up a detailed picture of Mr. X and approaching his diagnosis in a systematic manner. However, as had happened before in Mr. X's history circumstances intervened and the opportunity to pursue the strategy was denied.

The SpR reported her strategy to the Independent Investigation Team at interview however it would have been good practice to have articulated the differential diagnoses and the strategy for arriving at a clear formulation in Mr. X's clinical notes. However it has to be acknowledged that Mr. X was under the care of the Mental Health Homeless Team for just 10 weeks from the time he was referred to the Team and six weeks from the time he was first seen; he was seen by the SpR on only two occasions before he was arrested on 15 April 2011.

11.2. Medication and Treatment

Prior to his arrival in Brighton there was no continuity in the care Mr. X received. In their letters to a range of services and professionals Mr. X's foster parents expressed their concern that although various professionals had tried to help Mr. X the continuity that was needed was always lacking. This was in part due to the fact that Mr. X had spent 13 of the previous 15 years in prison.

Mr. X was keen to be prescribed Ritalin (methylphenidate). The SpR discussed this option with a senior, experienced colleague and was advised to start a trial of Concerta XL, the prolonged release version of methylphenidate. It might be argued that it would have been good practice to wait for the outcome of the ADHD assessment before commencing treatment, however, the team was informed that there would be a waiting time of at least six months before the assessment would take place. In these circumstances it was not reasonable to wait and make no decision about treatment. The SpR started a trial of Concerta XL when Mr. X was reviewed in April 2011. However he was arrested for the murder of Mr. A only a few days later, so this trial never got under-way.

The NICE Guidance on the treatment of ADHD recommends that medication for the treatment of ADHD should only be prescribed under the guidance of someone with

appropriate experience in the area. The SpR consulted a senior colleague who was experienced in this area before she prescribed Concerta XL.

The Guidance also comments that where there is concern about drug misuse and diversion, then consideration should be given to prescribing Atomoxetine rather than Ritalin/Concerta XL. There is no evidence in the clinical notes that this recommendation was considered or that a medicines management plan was put in place.

The NICE Guidance on the treatment of ADHD, of Antisocial Personality Disorder and of Substance Misuse all emphasise the importance of front line clinicians having appropriate training, supervision and access to consultation and advice. Disappointingly the liaison workers form the Substance Misuse and Forensic services and the monthly psychology consultation and supervision session had been removed from the Team, there was no Personality Disorder Service which the Team could access, the Substance Misuse Service did not accept referrals of people who were not yet at the stage of displaying motivation to address their substance misuse problems, and the Team did not receive regular training on the issues identified in the NICE guidance on these disorders. This is an area in need of review by the Trust and its commissioners.

- **Service Issue**
  Although the Mental Health Team for Homeless People has to deal with a diverse population a significant proportion of whom have Personality Disorders, substance misuse problems and/or ADHD the clinical staff did not have access to timely advice, support, supervision and training on the more specialist areas of these disorders as recommended in the relevant NICE guidance. It would not be reasonable, however, to conclude that in Mr. X's case this had a significant impact on his care or had any causal relationship with the killing of Mr. A.

- **Service Issue**
  The workers from the Forensic and Substance Misuse services who had, formerly, been attached to the Mental Health Team for Homeless People and the psychology consultation and supervision had been removed and the team did not have ready access to a Personality Disorder service, a Dual Diagnosis service or an ADHD service. The absence of timely access to such services by a team which has to provide assessment, care and treatment to a population such as homeless people makes it difficult for that team to provide a responsive, effective, efficient and safe service. This is an issue which the Trust together with its commissioner should review.

11.3. Use of the Mental Health Act (1983 & 2007)

Although Mr. X did, on one occasion,[164] report that he had been detained under the Mental Health Act there is no evidence of this in any of the clinical records available to the Independent Investigation.

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During the brief time Mr. X was under the care of the Mental Health Team for Homeless People there were never any indications that his mental state was such that he required an assessment under the Mental Health Act (1983 & 2007).

11.4. The Care Programme Approach

The Independent Investigation concluded that the standard identified in *Refocusing the Care Programme Approach:* an assessment of needs, the development of a care plan and a review of the efficacy of the care, was met in Mr. X's case. The Independent Investigation concluded that the care Mr. X received was compliant with Trust policy.

However, given Mr. X's complex presentation it would have been good practice to have considered providing Mr. X's care under the CPA protocols.

Had Mr. X been cared for under the CPA protocol his assessments and care planning would have had a more formal and prescribed structure and there may have been more multi-disciplinary involvement and discussion of his needs and the most appropriate ways in which to meet these. However, having said this the Independent Investigation acknowledges that there was a multi-disciplinary dimension to his care, and given his relatively brief contact with the Homeless Team it seems unlikely that him being cared for under the CPA process would have made a substantial difference to the care he received. However had Mr. X remained under that care of the Team for a longer period this situation may have changed and the CPA process might have ensure a more robust, comprehensive and recovery focused care package.

11.5. Risk Assessment

At an early age it had been noted that Mr. X had difficulty with impulse control and learning from the consequences of his actions. Mr. X exhibited violent and disinhibited behaviour towards others and placed himself in danger as a result of his ill-considered behaviour.[165]

As required by the Trust Clinical Risk Management policy a risk assessment was completed and corroborative information was sought from Mr. X's partner and foster mother. This assessment was an initial assessment and given the limited information available the management plan was to seek further information. This was appropriate.

However given the information that was available the risk formulation and risk planning were not as robust as one might have expected. The risk formulation did not provide an understanding of the risk, risk triggers and protective factors nor inform the plan to reduce and manage risk.

Given Mr. X forensic history it would have been appropriate to have considered a referral to the Forensic services. It would also have been good practice to have considered how the various agencies with whom Mr. X was involved might have been brought together to share

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information, arrive at a common view of the risks Mr. X posed and agree a common approach to addressing these needs.

- **Service Issue**
  Although a risk assessment was undertaken in line with Trust policy the formulation and management plan accompanying this assessment were not as robust as might have been expected and did not fulfil the requirements of providing an understanding of the risks associated with Mr. X or how to manage these. However it would not be reasonable to conclude that this had any causal relationship with the killing of Mr. A.

11.6. Referral and Engagement

The Central Access Team did not recognise that Mr. X was a homeless person and pass his referral on to the Team for Homeless People. There is no record that the Central Access Team made contact with the GP, had they done so it is possible that Mr. X would have been identified as a homeless person and his referral passed to the appropriate clinical team in a more timely manner. As Mr. X was homeless and, therefore, likely to be more difficult to contact and engage it was important that his referral was responded to in a timely manner. This was a weakness in accessing Secondary Mental Health Services.

Once Mr. X was referred to the Mental Health Team for Homeless People he was contacted quickly, timely efforts were made to engage him and his GPs were kept informed of his appointments and the outcome of his assessment. The only possible blemish on this example of good care is there is no evidence in the records available to this Investigation that Mr. X's GP was informed when he failed to attend his initial appointment on 7 January 2011. It is possible however that the appointment letter informing Mr. X of his appointment on 28 February was copied to Mr. X's GP.

- **Service Issue**
  Mr. X was not identified as a homeless person when he was initially referred to Secondary Mental Health Services. This delayed his assessment and engagement by the appropriate clinical team, the Mental Health Team for Homeless People, by almost a month. It would not be reasonable, however, to conclude that this delay had any causal relationship with the killing of Mr. A.

11.7. Safeguarding Vulnerable Adults

There were four people whose vulnerability might be considered in the context of Mr. X's care and treatment: the victim, Mr. A, Mr. X's partner, Mr. X's foster mother and Mr. X himself.

Mr. A was not known to the mental health services in Brighton, though he had had some contact with the substance misuse services. It appears that Mr. A was a vulnerable person and the Brighton and Hove Safeguarding Adult Board commissioned a Serious Case Review. Although the Review is wide ranging and made recommendations including some related to

interagency co-operation and co-ordination, it did not identify any findings or recommendations of immediate relevance to the care and treatment of Mr. X.

The care and treatment of Mr. X's partner is not the subject of this Investigation and, in consequence, there is very limited information available to the Investigation on her. However those who knew her and the Court were confident that she had capacity. There is no good evidence that she was exploited or abused and those who knew her did not regard her as a vulnerable person.

The clinical team caring for Mr. X identified potential vulnerabilities which Mr. X shared with many of the users of their service. However they felt that he was 'street wise' and knew how to access the benefits system and other facilities that were available to him. Similarly the Homeless Persons' Officer at the Local Authority, having reviewed Mr. X's situation, decided that Mr. X was *"not in priority need"* and not a vulnerable person as defined by the criteria employed by the Local Authority Housing Department.[166]

Vulnerability implies the possibility of suffering harm but the opinion of those who met Mr. X and assessed him was that while he possessed characteristics which placed him at risk, and in this sense rendered him vulnerable, there was no evidence at that time that he was the victim of abuse as a result of that vulnerability and no basis on which a safeguarding alert could have been initiated.

The clinical team identified that Mr. X's foster mother was vulnerable and possibly being financially exploited. It initiated some, not unreasonable, interventions. However it might have been better practice, having noted this situation, to have discussed the possible options and drawn up a clear plan to address the situation. This might have been done as part of the risk management planning when it was noted that Mr. X was asking his mother for money.

- **Service Issue**
  It would have been good practice, having noted the Mr. X's foster mother was vulnerable and possibly being financially exploited by her foster son, to have reviewed the options available to address this problem and put in place an explicit plan of action.

11.8. Carer Assessment and Carer Experience

It appears that Mr. X's partner was appropriately involved in identifying Mr. X needs, with his active encouragement.

However as the Internal Investigation concluded, no consideration was given to Mr. X's partner's needs. She was an individual with a number of identified needs and given that she was already in contact with the Substance Misuse Services it would have been good practice to have assessed her needs and considered putting in place a carer's package together with those who knew her. There is no evidence that this was done.

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Mr. X was in contact with the Mental Health Homeless Team for only a short period of time and, with this in mind, it is tempting to conclude that there was not enough time to address Mr. X's needs and put in place a package of care for him and also to assess his partner's needs and address these. However it is good practice to consider the needs of carers from the beginning of one's contact with the service user. As a standard part of assessing the needs of the service user consideration should be given to offering a carer's assessment to his or her carers. There is no evidence in the records available to the Independent Investigation that this was done. This did not reflect best practice.

Mr. X's Foster Mother

Despite his difficulties and challenging behaviour Mr. X's foster parents remained supportive and nurturing towards him. They advocated strongly, on his behalf, that he have access to the services that they believed would help him.

The available information indicates that Mr. X's foster mother was appropriately involved in identifying his needs and planning his care. Her own needs were recognised and the team attempted to address these. Had Mr. X remained with the Homeless Team for a longer period of time a more formal and systematic way of meeting Mr. X's foster mother's need would have had to have been identified. The clinical Team recognised this and the need for such a plan was identified in Mr. X's clinical notes.

11.9. Service User Involvement in Care Planning

Although Mr. X was not being cared for under the formal CPA process and there are no records signed by him that he agreed with the conclusion of the assessment or the plan that was being put in place. It is evident from the records that Mr. X was proactive in identifying his needs and seeking help to address these. In this sense he was fully involved in the assessment of his needs and planning of his care.

There is no evidence that the SpR's letters to Mr. X's GP and to the Neurobehavioural clinic or the risk assessment completed on 8 March 2011 were copied to Mr. X. It would have been good practice if they had been.

11.10. Housing

While living in Brighton Mr. X was homeless and for much of the time he and his partner were *"sofa surfing"*. From around late March they were staying in the flat of the victim, Mr. A. Mr. X's care was provided by the Mental Health Team for Homeless People and the Social Worker in this team provided Mr. X with the contact details of those who might help him find accommodation. To provide accommodation was not within the gift of the Homeless Team and there was little more that it could have done which would have secured Mr. X appropriate accommodation. The Local Authority Homeless Persons' Officer reviewed Mr. X's eligibility for accommodation and concluded that he was not in 'priority need'.

Had Mr. X been provided with accommodation it is unlikely that he and his partner would have been living in Mr. A's flat and the occasion of the killing would not have arisen at that time.

Given Mr. X's history, his personal characteristics and his social circumstances it was highly likely that he would, at some point, come into conflict with the law. To what degree the provision of appropriate accommodation would have ameliorated the situation and reduced this probability can only be a matter of speculation but it is likely that it would have reduced the likelihood to some extent.

11.11. Documentation and Professional Communication

The Internal Investigation found that the Risk Assessment completed on 8 March 2011 was saved in draft format and recommended that staff should be reminded not to do this.

The documentation relating to Mr. X provides a detailed account of the contact the Mental Health Team for Homeless People had with him and with other professionals and agencies. One improvement that the Trust might consider promoting is to ensure that the options considered and the reasons why decisions are taken are recorded in sufficient detail to allow the reader to understand why one option or action was decided on rather than another. This is particularly important where a formulation of a service user's problems is arrived at in a multi-disciplinary forum. The key elements of the discussion and the formulation should be captured in the clinical record.

11.12. Adherence to Local and National Policy and Procedure

The evidence made available to this Investigation suggested that staff complied with Trust policies. However there were occasions where best practice would suggest that staff might have gone further. For example there might have been a more complete and robust formulation of Mr. X's needs, in particular a more robust formulation of the risks he presented. There could have been a more timely approach to the carer's assessment and a more proactive approach to Safeguarding Vulnerable Adults.

11.13. Management of the Clinical Care and Treatment of Mr. X

There was a delay in responding to the initial GP referral and the referral was not passed to the Homeless Team until a second GP referral was made. This was a weakness in accessing Secondary Mental Health Care.

Once Mr. X's care was allocated to the Homeless Team the processes of communication, engagement and assessing Mr. X's needs progressed in a more efficient and timely manner.

Mr. X did not attend his initial appointment and a further appointment could not be arranged for three weeks as the GP had asked for advice on medication and the Homeless Team did not have access to a full time psychiatrist. This delay represents a resource issue.

The Independent Investigation concluded that while Mr. X was under the care of the Mental Health Team for Homeless People he received care and support consonant with the principles of the Care Programme Approach, there was a multi-disciplinary element to his care, his partner and foster mother were appropriately involved in his care and there was cross agency liaison. This was good practice.

Given Mr. X's history and complex presentation it might have been good practice to have considered providing his care under the CPA protocol, however given the short time he was under the care of the Homeless Team it is unlikely that had this been done it would have made a significant difference in the care he received.

11.14. Conclusions

Mr. X was referred to the Central Access Team, the point of entry for Secondary Mental Health Services but he was not recognised as being homeless and his referral was not passed to the Mental Health Team for Homeless People until a second GP referral was made. This represented a weakness in accessing mental health services.

However, once Mr. X was under the care of the Homeless Team he was quickly contacted. The approach to providing care followed the principles of the CPA. There was multi-disciplinary input into his care and multi-agency liaison and his foster mother and partner were appropriately involved. The relevant diagnoses were considered and, after consultation, relevant medication was prescribed.

It is tempting in Mr. X's case to suggest that more could have been done but this has to be weighed against what was possible. Mr. X was only in contact with the Homeless Team for approximately 10 weeks from the time of referral to that team and, as he failed to attend his first assessment appointment, only six weeks from the time he was first seen. Resources and the limited access to specialist services hindered a more speedy approach to addressing his needs.

There were aspects of Mr. X's care which were under the control of the clinical team which might have been improved: a clear and explicit formulation of Mr. X's problems and needs, a clear statement of the differential diagnoses and the strategy for arriving at a firm diagnosis, an explicit formulation of risk, a more robust a risk management plan, and improved multi-agency planning. Any of these might have had an impact on Mr. X's care had he remained under the care of the Homeless Team for longer but, given his short tenure with the Team, it would not be reasonable to conclude that any of these factors did significantly affect the care and treatment he received.

Overall Mr. X received supportive and proactively delivered care from the Mental Health Team for Homeless people. The Independent Investigation Team concluded that there were no acts or omissions on the part of the Mental Health Services which were related with causation to Mr. A being killed by Mr. X on 14 April 2011. A number of service issues have, however, been identified which if appropriately addressed might improve the care and treatment of other service users in the future.

12. Sussex Partnership NHS Foundation Trust Response to the Incident and Internal Investigation

12.1. The Trust Serious Untoward Incident Process

The Sussex Partnership NHS Foundation Trust has a clear policy and procedure in place for reporting, investigating and managing serious untoward incidents. The policy required an initial notification of a serious incident to the Governance Support Team with 24 hours, a serious incident reviewer to be appointed within three days, and a first draft of the investigation report to be prepared with 25 days.

12.2. The Trust Internal Investigation Process

A Trust Incident form was completed by the Mental Health Team for Homeless People on 19 April 2011. The form recorded that Mr. X had been arrested for the murder of a member of the public. It appears from the clinical record that the incident form was completed as soon as the manager was informed of Mr. X's arrest by the Forensic Services.

An investigation team made up of the Serious Untoward Incident Manager and the General Manger, Substance Misuse was appointed to undertake the serious incident review. In addition a review panel was put in place. This consisted of the:

- Service Director: Substance Misuse Services;
- Director of Governance.

The investigation team was made up of senior members of the Trust staff with relevant expertise and experience. The addition of the review panel was an example of good governance and added to the robustness of the investigation, its finding and recommendation.

The Level 2 (SUI) Root cause Analysis Investigation Report was competed on 1 June 2011.

Unlike the current Independent Investigation the Trust's Internal Investigation examined the care and treatment of both Mr. X and his partner. The Terms of Reference for the investigation were:

- to establish the facts;
- to establish any root causes to the incident;
- to provide a report recording the investigation process;
- to establish and record notable practice and any identified service/care delivery problems;
- to establish how risk of a recurrence may be reduced;
- to formulate recommendations;
- to provide a means of sharing learning from the incident.

These are appropriate terms of reference for an internal investigation. The one element that the Trust might consider including in the terms of reference for future investigations is to establish Trust policy and established best practice have been followed.

Methodology

This Investigation was classified by the Trust as a *"Level 2 – Comprehensive investigation"*. The Investigation process and methodology was described as follows:

- *"Gathering information by reviewing eCPA notes and statements and conversations with staff;*
- *Incident mapping by completing a tabular timeline from notes and statements/conversations information;*
- *Discussion with investigating police officers to establish facts"*.

It is evident from both the structure and content of the internal investigation report that a Root Cause Analysis approach, as recommended by the National Patient Safety Agency, was employed. This was an appropriate methodology to such an investigation.

Findings of the Internal Investigation

The Internal Investigation concluded that *"The root cause of the attack is suggested by the criminal investigation to have been based in the personal relationship dynamics between the victim and the perpetrators. The relationship was social and not known to the service.*

No root cause related to the care package has been identified, including misuse of substances".

The Independent Investigation is in agreement with these findings

The Internal Investigation made the following recommendations (relating to the care and treatment of Mr. X):

- *"All staff to be reminded not to save risk assessments in draft;*
- *New risk assessments to be completed at each assessment and audited on a regular basis;*
- *All staff to be reminded about the importance of exploring the care needs of partners/families/carers. To be noted where there is a past history of violence or poor impulse control this becomes a greater priority"*.

The Trust reported the following action plan and progress to addressing the recommendations:

SUI ACTION PLAN

Findings	Action Required	Completion	Current Status as at (date)
Direct Findings		**Date**	
Other identified issues			
Team Practice issue regarding not saving the risk assessment but leaving in draft.	Team leader to review all risk assessments on caseload and ensure all correctly saved on the eCPA system.	Oct 2011	Action plan disseminated.
To ensure all documentation is clear, where an update is made entries, amendments should be clear, initialled and dated.	All staff to be reminded of standards for record keeping. Development of case note audit relevant to Substance Misuse services.	Nov 2011	Action plan disseminated.
Substance Misuse Service needs to implement a Nebula system (web based) which can be accessed by Mental Health Services.	Design, cost and implement an ECPA equivalent web based system.	Nov 2011	Action plan disseminated
New risk assessment to be completed at each assessment and audited on a regular basis.	All staff to be reminded of trust risk assessment/management policy. Development of case note audit relevant to Substance Misuse services.	Nov 2011	Action plan disseminated.
All staff to be reminded about the importance of exploring the care needs of partners / families / carers. To be noted also that in cases where there is a past history of violence or poor impulse control this becomes a greater priority.	Allocate carers champions. Development of case note audit relevant to Substance Misuse services.	Nov 2011	Action plan disseminated.

Given Mr. X's brief contact with the Mental Health Team for Homeless People and the findings of the Internal Investigation there are reasonable and appropriate recommendations.

Conclusions

The Independent Investigation concluded that the internal investigation was appropriately conducted by suitable experienced members of staff; and its terms of reference and the methodology were appropriate. The Independent Investigation concurs with the findings of the Internal Investigation and the recommendations were appropriate.

The Independent Investigation Team concluded that although the report of the internal investigation was clearly set out and of a good standard it might have benefited by including

a more explicit analysis of the evidence available to it and of explicitly comparing that care and treatment Mr. X received with established best practice and Trust policy.

12.3. Dissemination and Staff Involvement

The Manager and Consultant Psychiatrist of the Homeless Team were invited to a managers'/professionals' meeting which the Consultant Psychiatrist was unable to attend. This meeting appears to have been primarily aimed at clarifying issues relating to the investigation rather than providing feedback to the clinicians and team which had provided Mr. X's care.

None of the clinicians interviewed by the Independent Investigation Team had seen the internal investigation report until they had requested to read it in preparation for interview by this Investigation. The staff of the Homeless Team reported that they had received no feedback on the report and there was no discussion with them about the findings or recommendations of the report. They were not aware of the recommendations of the internal investigation and so were unable to comment on whether the internal investigation had promoted an improvement in the services provided by this team.

The purpose of an internal investigation is to ensure that services are safe, to provide an opportunity to improve service quality and to support reflective practice. It is disappointing that appropriate feedback was not provided to the clinical team. This was a missed opportunity to engage clinical staff in identifying potential service improvements and for the organisation to learn from the clinicians about the challenges in delivering a high quality service to a population with complex presentations and, often, chaotic life styles in the context of increasing demand and reducing resources.

The Independent Investigation was informed that since the time of this internal investigation the process for engaging and providing feedback to clinical teams has changed. The Oxford Review model has been adopted and the author/lead investigator now arranges meetings with clinical teams to share the findings of the investigation identify any learning and discuss how service might be improved.

With respect to the lack of information regarding the recommendations emanating from the report provided to the Homeless Team the Independent Investigation was informed that the recommendations of several investigations had been amalgamated into a single corporate action plan. While the Independent Investigation agrees that it is appropriate to put in place a single coherent action plan to underpin a quality improvement programme, we would suggest that the recommendation emanating from an investigation should be discussed with the clinical team involved. This would support an ethos of reflective practice, it would provide an opportunity for 'front line' clinical staff to make observations as to how the goal(s) of the recommendations might be realised more effectively, and such a process would serve to increase the engagement of staff. It should be noted, however, that the internal investigation did not identify a root cause, relating to the care Mr. X received, for the killing of Mr. A and did not recommend any substantial changes of practice in the team.

12.4. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance recommends that the patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is transferable when considering any harm that may have occurred to members of the public resulting from a potential healthcare failure.

The Guidance was revised and reissued in 2009 and all Trusts were expected to have a compliant policy in place by November 2010. The Sussex Partnership NHS Foundation Trust approved a revised *Being Open* policy in November 2010. This set out the principles of openness as recommended in the NPSA guidance and put in place guidelines and protocols to be followed.

The Trust policy recommends that the most senior person involved in the care and treatment of a service user should contact him/her and his/her family and provide the relevant information, apologise and offer emotional support.

In line with the Trust policy the Team manager tried to contact Mr. X's foster mother on 21 April 2011 and several times over the following days without success. She finally managed to speak to Mr. X foster mother on 27 April 2011 and recorded that she had a *"long supportive conversation"*[167] with her. Mr. X's foster mother contacted the team again on 24 May 2011 to discuss his situation at that time.

There is no record of the Trust contacting the family of the victim or of either family being asked to contribute to the internal investigation. Particularly in the case of Mr. X's foster mother it would have been good practice to have involved her in this way.

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12.5. Staff Support

The Trust *Being Open* policy acknowledges

"When an incident occurs, staff involved in the Patient's clinical care may also require emotional support and advice. Clinicians who have been involved directly in the incident, and those with the responsibility for 'Being Open' discussions, should be given access to appropriate assistance, support and any information they need to fulfil this role".

Prior to the Internal Investigation

The manager of the Homeless Team organised support for the Team and a debriefing session was held on 23 May 2011. The team members reported that they felt emotionally supported within the team and though they were aware that the Trust had other support provisions available did not feel that they needed this.

Staff Support During the Independent Investigation

The Trust worked with the Independent Investigation Team to support staff in practical ways to ensure that:

1. Information was sent, and received, to advise each witness what was expected of them.
2. Information was sent, and received, regarding the purpose of the investigation.
3. A workshop for witness was held which informed them about the investigation process, what was expected of them as witnesses and answered any questions they had at that time.

13. Lessons Learned

A major theme which emerges from this Investigation is that of timeliness.

All services should respond in a timely manner to requests for input and, in recent years, this element of responsiveness has been the subject of targets and Key Performance Indicators (KPIs). Given the often chaotic lifestyles that characterise the lives of many homeless people and the common reluctance of this population to engage with services it is especially important that when a referral is made it should be responded to quickly and procedures put in train to engage the individual. In Mr. X's case there was a month's delay between him first being referred to Secondary Mental Health Services and him being offered an appointment, and a further three weeks before he was seen for the first time. As Mr. X was keen to be seen, assessed and treated for ADHD there is no evidence that this delay had any impact on either his engagement or the care he received. However, the purpose of Investigations of this kind is to look at the past to learn lessons for the future. The lesson to be learned here is that, especially for the homeless population, it is important that they are identified as homeless in a timely manner and their referral passed to the Mental Health Team for Homeless People quickly so that this team can put into effect its skills in engaging this difficult to engage population without unnecessary delay.

A second area in which timeliness is important illustrated by Mr. X's case was the process of access to specialist services. The Team for Homeless People in Brighton did not have timely access to an ADHD service, a Personality Disorder service or a Dual Diagnosis service. It is impossible to know what impact access to such services would have had on the care and treatment Mr. X received. However, as each of these services is the subject of NICE guidance we must assume that following the guidance by accessing the recommended services would have increased the likelihood of Mr. X receiving more effective and efficient treatment.

A third area illustrating the timeliness theme is the accessing and sharing of information. Even before Mr. X was seen the Central Access Team had identified that he had been seen elsewhere and had set about obtaining his clinical notes. This was good practice. However although some records were sent from Basingstoke it is not clear that a full clinical record was available to those caring for Mr. X even at the point of his arrest. A significant proportion of the information made available to the clinical team was provided by Mr. X's foster mother. It was good practice on the part of the Homeless Team that they contacted her and fortuitous that she had this information.

Mr. X had spent a significant proportion of his adult life in prison and there are a number of references in his notes to him being seen by Psychiatrists while in prison. However there were no clinical notes available to Mr. X's treating team in Brighton.

It seems self evident that the clinicians caring for Mr. X would have been able to more accurately and quickly assess his needs and put in place care and risk management plans if they had been able to build on the assessments and interventions of their predecessors. To

change this state of affairs is not, of course, within the power of the Trust but if timely and coherent care is to be delivered those charged with ensuring high quality and efficient care in the NHS, the National Commissioning Board, should address this issue of timely access to a service user's clinical record.

Complementing the timely access to specialist services has to be the appropriate training and supervision of staff as recommended in the various NICE guidelines. This has to be done again in a timely manner, if staff are to practice safely and service users are to receive high quality and safe services. The provision of such training is the responsibility of the Trust; the implementation of the training is the responsibility of the team/service manager following Trust policy and procedure; and the clinician is responsible for ensuring that s/he is competent to undertake the clinical activities required of his/her post.

A final timeliness issue illustrated by Mr. X's case is interagency collaboration and co-ordination of assessment planning and activity. The Social Worker contacted the Probation Service when he was informed that Mr. X was in contact with this service. He also contacted the Rough Sleepers' Team. This was good practice. Given the high probability that Mr. X would commit another offence and given the fact that the time he had spent outside prison since the age of 17 years had been short and the fact that he found it difficult to control his impulsivity, it was likely not only that Mr. X would come into contact with the Criminal Justice System again in the future, but that this would be in the near future, it would have been desirable if the various agencies had been able to share information and co-ordinate their inputs in a timely manner.

14. Notable Practice

Internal Investigation Findings

The internal investigation identified the following notable practice relating to the care and treatment received by Mr. X:

- *"timely response by the Homelessness team to referral;*
- *proactive engagement by the Homelessness team of contacting patients by phone to notify of appointment;*
- *assertive follow up after DNA;*
- *contact by Homelessness Team with [Mr. X's] next of kin (foster mother);*
- *engagement by Homelessness Team with [Mr. X];*
- *good communication with GP by Homelessness Team;*
- *assertive links made with probation by Homelessness Team".*

Independent Investigation Findings

The Independent Investigation Team concurs with the findings of the Trust's internal investigation.

15. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Sussex Partnership NHS Foundation Trust to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice has been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can further improve services and consolidate the learning from this investigation process. It was noted by this Investigation that the action plan from the Trust's internal investigation process has been successfully completed. The recommendations set out below address the outstanding issues.

15.1 Diagnosis

The SpR reported her strategy to the Independent Investigation at interview however, it would have been good practice to have articulated the differential diagnoses and the strategy for arriving at a clear formulation in Mr. X's clinical notes. However it has to be acknowledged that Mr. X was under the care of the Mental Health Homeless Team for just six weeks and was seen by the SpR on only two occasions before he was arrested on 15 April 2011.

Recommendation One

- **The Trust will ensure that all clinical policies and procedures are amended to instruct clinicians of the importance of providing a differential diagnosis where indicated as clinically appropriate. These amendments will also include instructions as to the importance of providing a clear formulation and the guidance for doing so.**

15.2 Medication and Treatment

Service Issue

- **Although the Mental Health Team for Homeless People has to deal with a diverse population a significant proportion of whom have Personality disorders, substance misuse problems and/or ADHD the clinical staff did not have access to timely advice, support, supervision and training on the more specialist areas of these disorders as recommended in the relevant NICE guidance. It would not be reasonable, however, to conclude that in Mr. X's case this had a significant impact on his care or had any causal relationship with the killing of Mr. A.**

Service Issue

- **The workers from the Forensic and Substance Misuse services who had, formerly, been attached to the Mental Health Team for Homeless People and the psychology consultation and supervision had been removed and the team did not have ready access to a Personality Disorder service, a Dual Diagnosis service or an ADHD service. The absence of timely access to such services by a team which has to provide assessment, care and treatment to a population such as homeless people makes it difficult for that team to provide a responsive, effective, efficient and safe service. This is an issue which the Trust together with its commissioner should review.**

Progress Made by the Trust since the Completion of the Independent Investigation: Dual Diagnosis

Sussex Partnership NHS Foundation Trust (SPFT) has a Trust-wide dual diagnosis strategy with local implementation groups across the three core Divisions. The implementation of the strategy is supported by the Nurse Consultant for Dual Diagnosis. The implementation group in Brighton and Hove is led by the Clinical Commissioning Group and attended by both statutory and community and voluntary sector partners engaged in the delivery of adult mental health and substance misuse services in the City. Recent developments have included the development of a specific dual diagnosis care plan which is being trailed in Brighton & Hove. The evaluation of this project includes patient, carers and staff focus groups. If successful it is envisaged that this care plan will be expanded across the whole of Sussex.

Substance Misuse Services in Brighton & Hove are commissioned by the Council's Public Health Directorate since this has transferred from the Primary Care Trust in April 2013. Substance Misuse services in the City are currently delivered jointly between SPFT and the Crime Reduction Initiative. This service is due to tendered in the financial year 14/15. Prior to this mental health commissioners have created a short life working group to evaluate whether far greater integration between adult mental health and substance misuse services would be of benefit to patients and carers. SPFT are key stakeholders in this evaluation. It is proposed that staffs from substance misuse services are co-located with adult mental health staff specifically to meet the dual diagnosis agenda and improve both assessment and treatment outcomes for patients.

Recommendation Two

- **The Trust will examine all extant clinical policies and procedures to ensure that NICE guidance is embedded within them. The Trust training and development needs analyses will be constructed to ensure that an explicit link is made to the requirements of the NICE guidance with particular reference to substance misuse and Personality Disorder.**

15.3 The Care Programme Approach (CPA)

Given Mr. X's complex presentation it would have been good practice to have considered providing Mr. X's care under the CPA protocols.

Progress Made by the Trust since the Completion of the Independent Investigation:
All services in Brighton and Hove provide care and treatment under the umbrella of the Care Programme Approach. The Trust has taken steps recently to revitalise the CPA in Assessment and Treatment Services across Sussex supported by the Trust-wide leadership group.

The Trust has recently undertaken a significant organisational change programme and reorganised clinical services around a 'functional' model rather than the traditional adults / older people service configuration. The current adult services in Brighton and Hove are now organised into Assessment and Treatment Teams and Recovery and Well Being Teams. The Care Programme Approach is used within these services but there is a differentiation between the role of Lead Practitioner and Care Coordinator. The distinction is made on the grounds of complexity, risk, diagnosis, assessed need and the requirements for on-going involvement from secondary care.

The Trust CPA Policy is currently undergoing a consultation process led by the adult mental health Strategic Governance Group.

Recommendation Three

- **The Trust will conduct a review of the role of Lead Practitioner and Care Coordinator within the Assessment and Treatment Centres in light of the requirements of CPA. This has been raised in Brighton and Hove and is being considered by the Divisional Leadership Team and the Community Governance Group in light of the Trust-wide evaluation of the Assessment and Treatment Service model being undertaken by Adult Mental Health and Dementia and Later Life.**

15.4 Risk Assessment

Service Issue

- **Although a risk assessment was undertaken in line with Trust policy the formulation and management plan accompanying this assessment were not as robust as might have been expected and did not fulfil the requirements of providing an understanding of the risks associated with Mr. X or how to manage these. However it would not be reasonable to conclude that this had any causal relationship with the killing of Mr. A.**

Progress Made by the Trust since the Completion of the internal investigation:
The Trust has already fulfilled the recommendation set by the internal investigation regarding the improvement of risk assessment procedures. In addition the Independent Investigation has set another supporting recommendation.

Recommendation Four

- **The Trust will conduct an audit of its risk assessment processes within six months of the publication of this report to determine:**
  - **the compliance of all clinicians in the completion of risk assessments for every service user;**
  - **the compliance of all clinicians in the development of risk management plans;**
  - **the compliance of all clinicians in completing all risk assessment documentation and not using drafts in place of comprehensive records.**

15.5 Referral and Engagement

Service Issue

- **Mr. X was not identified as a homeless person when he was initially referred to Secondary Mental Health Services. This delayed his assessment and engagement by the appropriate clinical team, the Mental Health Team for Homeless People, by almost a month. It would not be reasonable, however, to conclude that this delay had any causal relationship with the killing of Mr. A.**

Recommendation Five

- **The Trust will conduct an audit in conjunction with Primary Care stakeholders to ascertain the timeliness of referral processes. This audit to be completed within six months of the publication of this report. The Trust will ensure that referral pathways are revised if necessary in the light of the audit findings.**

15.6 Safeguarding Vulnerable Adults

Service Issue

- **It would have been good practice, having noted that Mr. X's foster mother was vulnerable and possibly being financially exploited by her foster son, to have reviewed the options available to address this problem and put in place an explicit plan of action.**

Recommendation Six

- **The Trust will:**
  - **review its vulnerable adults policy to ensure that a scenario such as that presented by Mr. X's mother is addressed;**
  - **review current vulnerable adult training and supervision processes to ensure that the vulnerability of the families and friends of service users**

are understood and clear pathways of protection and support are delineated.

15.7 Service User Involvement in Care Planning

There is no evidence that the Specialist Registrar's letters to Mr. X's GP and to the Neurobehavioural Clinic or the risk assessment completed on 8 March 2011 were copied to Mr. X. It would have been good practice if they had been.

Recommendation Seven

- **The Trust will:**
  - **ensure that all relevant policies and procedures are reviewed, and amended where necessary, to ensure that all clinical staff are advised of the importance of copying in service users to all clinical letters and communications;**
  - **ensure that the Trust audits the compliance of this practice within six months of this report being published.**

15.9 Documentation and Professional Communication

One improvement that the Trust should consider promoting is to ensure that when clinical options are considered the reasons why decisions are taken are recorded in sufficient detail to allow the reader to understand why one option or action was decided upon rather than another. This is particularly important where a formulation of a service user's problems is arrived at in a multi-disciplinary forum. The key elements of the discussion and the formulation should be captured in the clinical record.

Recommendation Eight

- **The Trust will ensure that all relevant policies and procedures are reviewed, and amended where necessary, to ensure that all clinical staff are advised of the importance of recording the clinical decision making process and rationale within each service user's record.**

16. Glossary

Atomoxetine	**Atomoxetine** is a selective norepinephrine reuptake inhibitor. It is prescribed for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Carbamazepine	Carbamazepine is primarily used as an anticonvulsant and a mood-stabiliser. However it is also sometimes used to treat ADHD and borderline personality disorder.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user-centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Co-dydramol	Co-dydramol is a compound analgesic containing Dihydrocodeine Tartrate and Paracetamol. Co-dydramol is used for the relief of moderate pain.
Depixol	Depixol (Flupenthixol) is a long-acting injection given once in every two or three weeks to treat schizophrenia. It is also sometimes use in low doses as an antidepressant.
Enhanced CPA	This was the highest level of CPA that a person could be placed on prior to October 2008. This level requires a robust level of supervision and support.
Hydroxyzine	Hydroxyzine is an anxiolytic. It is primarily used for the symptomatic relief of anxiety and tension.
Mental Health Act (1983 & 2007)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition. The Act was revised and amended in 2007.

Methylphenidate Hydrochloride	The generic name for Ritalin (see Ritalin).
Mirtazapine	Mirtazapine (Zispin) is primarily used to treat depression however it is also sometimes used to treat various anxiety conditions.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
Ritalin	Ritalin (methylphenidate hydrochloride), is a stimulant used to treat ADHD. Methylphenidate works by increases the availability of the neurotransmitters dopamine and noradrenaline in areas of the brain that play a part in controlling attention and behaviour.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.
Stelazine	Trifluoperazine (Stelazine) is primarily used to treat schizophrenia. However it is sometimes use to treat agitation and behavioural problems.
Quetiapine	Quetiapine (Quetiapine fumarate) is used to treat schizophrenia and bipolar disorder. It is also sometimes used to treat aggression, anger, anxiety, ADHD and depression.