Niche
PATIENT SAFETY

An independent investigation into the care and treatment of a mental health service user (MC) in Bristol

May 2014

CONTENTS

1. EXECUTIVE SUMMARY

On 17 March 2012 MC fatally stabbed Mr GN with a samurai sword in the Keystones shared house in Bristol. GN had lived in the house for a number of years. He has been described by his family as a loving and generous son, partner and father to his two children.

MC was on trial leave at the Keystones house, under section 17[1] of the Mental Health Act (1983). He was a patient at Fromeside Medium Secure Unit in Bristol. Keystones Mental Health Support Service provides accommodation, care and support in Bristol for men and women of working age with mental health problems. Their aim is to provide a therapeutic environment and programme which will foster social inclusion and independence.

MC had a long history of contact with mental health services, and had admissions to high and medium secure hospitals in the past. He had also spent time in prison for serious assaults. He had a consistent diagnosis of paranoid schizophrenia and some personality difficulties / dissocial personality disorder. On this admission he had been in Fromeside for twelve months and appeared to be making good progress, was relatively symptom free, was becoming engaged with community activities, complying with medication, and had been free from alcohol and illicit drugs. There had been no actual physical assaults for twelve months. In addition MC appeared to be settling into the Keystones house and reported that he liked it.

MC moved into the house on a period of leave from Fromeside on 5 March 2012. Prior to this he had had two periods of two nights trial leave.

During his earlier trial leave MC had made two trips to Newport to see his brother and had smoked cannabis on both occasions. It is now thought that he acquired the samurai sword which he used in the attack on GN on one of his trips to Newport. The Fromeside multi-disciplinary team reviewed the discharge plan in the light of this use of cannabis, but MC told the team that he had no problems with cannabis and saw no reason to stop using it. He also reported that he was never free from the sense that others could read his thoughts, but that it no longer bothered him as he was used to it. The team decided to delay discharge and continue trial leave with increased supervision from mental health staff. There had been a focus on relapse prevention and early warning signs in his discharge plan.

[1] The responsible clinician (RC) may grant a detained (but not restricted) patient leave of absence under section 17 of the Mental Health Act subject to such conditions (if any) as he or she considers necessary in the interests of the patient or for the protection of other persons. The conditions of such leave should be set out on a section 17 leave form.

During the week before the attack MC was seen in the multi-disciplinary team meeting, and was seen separately by his consultant psychiatrist/responsible clinician (RC)[2], and by the community forensic nurse, as well as by Keystones staff.

On Saturday 17 March 2012 at around 4.00pm MC was watching a rugby match involving Wales on the television in the sitting room. GN was cooking in the kitchen. There may have been some drinking of alcohol, but this has not been verified. The Keystones director had a meeting in the office at the top of the house and arrived for her meeting shortly before 4.00pm. She spoke briefly to both MC and GN and all appeared to be well.

A few minutes later the fire alarm went off, possibly caused by GN cooking. The director came downstairs to turn off the fire alarm, but found that this had already been done by MC. At approximately 4.05pm she met her visitor at the front door, but did not see either of the two men at that time.

When GN was found, shortly after 5.00pm and the police were called MC was missing from the house, but shortly afterwards reported to a police station in another part of Bristol. He was initially charged with murder but then pleaded guilty to manslaughter on the grounds of diminished responsibility. MC was sentenced to a minimum of 12 years imprisonment and at the same time received a Hospital Direction under section 45A[3] of the Mental Health Act (1983) so that he could be transferred immediately to psychiatric hospital for treatment.

Following this tragic incident Avon and Wiltshire Mental Health Partnership NHS Trust (the Trust) conducted an internal investigation which identified three Care Delivery Problems (CDPs) and a number of contributory factors.

The CDPs in the Trust's internal report were:

1. Risk assessment documentation was incomplete
2. Whilst a thorough and comprehensive transfer plan had been made by the team for MC's transition from a medium security hospital to the

[2] The responsible clinician, under the Mental Health Act is the person with overall responsibility for a patient's care and treatment. Before the amendments to the Mental Health Act this person would have been the responsible medical officer (RMO).

[3] Hybrid orders under section 45A of the Mental Health Act allow for convicted mentally disordered offenders to be given a sentence of imprisonment and simultaneously transferred to hospital for psychiatric treatment. In England and Wales their use was initially limited to patients with psychopathic disorder, but more recently treatment of a greater range of offenders under the order, including offenders with co-morbid mental illness, has been allowed. Once it is deemed that psychiatric hospital treatment is no longer necessary the patient can be transferred to prison and the release date is determined by the Parole Board rather than the First Tier Tribunal (Mental Health).

community the care plan which included the crisis and contingency plan, lacked adequate detail.

3. The RiO (the electronic patient record) risk assessment and core assessment did not adequately reflect that Mr MC had been convicted of a Multi-Agency Public Protection Arrangements (MAPPA) eligible offence. Consequently, Avon and Somerset MAPPA were not informed when MC commenced leave and his discharge was planned.

The Trust's investigation also developed a number of lessons to be learnt and recommendations. The recommendations of the internal investigation are in section 11 of this report, and the action plan is at appendix 2.

In April 2013 NHS England commissioned Niche Patient Safety to conduct an independent investigation, with the following objectives.

- To evaluate the mental health care and treatment including risk assessment and risk management;
- To identify key issues, lessons learnt, recommendations and actions by all directly involved in providing the care;
- To assess progress made on the delivery of action plans following the internal investigation;
- To identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies;
- Identify care or service delivery issues, along with the factors that might have contributed to the incident.

This independent investigation has drawn upon the internal process and has studied witness statements, interview transcripts and policies. The team has also interviewed those most closely involved in MC's care and had meetings with members of GN's family.

We are in full accord with the Trust's identification of Care Delivery Problems and their contributory factors and with the recommendations and lessons to be learnt.

In addition, our independent investigation has developed further findings in the following areas:

- Assessment, care and treatment
- Risk assessment and management
- Relapse indicators
- Leave of absence
- Discharge planning

In the light of our findings we believe that it was predictable that there would be some violent episode at some point following MC's move out of medium secure care, but the timing, nature and severity of this violence was not predictable. To have prevented any serious violence MC would most likely have had to remain for a much longer period or even indefinitely in some

form of secure care, and it is unlikely that that would be deemed to be lawful. A somewhat longer pathway within medium secure care may have reduced the possibility of such a serious violent incident, but that is judged with the benefit of hindsight.
Therefore this tragic event was neither predictable (in the nature and seriousness of the event) nor preventable.

In his sentencing of MC the judge in Bristol Crown Court said the following:

> "In my judgement you are particularly dangerous because it can appear to professionals that your mental health is such that you can live in the community, whereas, as this tragic case demonstrates, your behaviour is unpredictable... I am wholly satisfied that you are a significant risk to the public of serious harm... You will not be considered for release whilst it is their thought that you might represent a danger to the public. You will only be released when the authorities are satisfied that any such risk has evaporated." [4]

However, the independent investigation team believes there are lessons to be learnt and has made the following recommendations:

The Trust should:

1. ensure that each new or re-admission to the medium secure unit has a full and comprehensive multi-disciplinary mental health assessment, informed but not dictated, by his/her history. This assessment would lead to a detailed care plan owned by all professionals involved.
2. ensure that forensic multi-disciplinary inpatient teams work more closely with inpatient nursing staff.
3. ensure that, in forensic services, there is a multi-disciplinary discussion and agreement on individual, evidence-based risk assessment, including static, dynamic and personality factors, and a clear link between risk assessment and risk management.
4. ensure that there is very careful history taking on previous risk behaviour and attempts to identify antecedents.
5. ensure that all forensic patients are considered for referral to the local MAPPA process, and the decision, and reasons for it, recorded in the patient's records. (This practice has already been implemented.)
6. ensure that, for forensic patients, any specific risk assessment (eg, fire setting) should be integrated with generic risk assessments and discharge plans.
7. ensure that relapse indicators, questionnaires and prevention strategies are agreed and reinforced by the whole multi-disciplinary team.

[4] *The Law Pages website.* http://www.thelawpages.com

8. ensure that any relapse tools are rigorously tested for validity for the individual patient by examining historical risk behaviour and also reviewing the efficacy of prevention strategies in further situations which could generate frustration or aggression.
9. develop good practice guidance on leave of absence under section 17 of the Mental Health Act, which should, amongst other elements, require responsible clinicians to set out clear criteria and conditions for such leave.
10. ensure that in any multi-disciplinary review of issues arising from a forensic patient's leave of absence the patient's placement is fully informed and fully involved in the discussion.
11. ensure that all pertinent information including evidence-based risk assessments is shared with the organisation to which a forensic patient is being discharged.
12. ensure that, for forensic patients, discharge plans (including meaningful use of time) are fully established, implemented and tested prior to trial leave and discharge, so that the plan and routine for life in the community is firmly embedded prior to actual discharge. This should include awareness of and planning for the seven days of the week and 24 hours in each day.
13. ensure that any future internal investigation of a serious incident should, where appropriate and possible, be undertaken as fully as possible in partnership with other involved agencies and with the involvement of families.

We, as members of the investigating team, would like to again express our condolences to Mr GN's family, and to thank them for their help and willingness to share their thoughts, observations and feelings.

2. INTRODUCTION

In April 2013 Niche Health & Social Care Consulting was commissioned by NHS England, to conduct an independent investigation to examine the care and treatment of MC, a mental health service user who had been in the care of Avon and Wiltshire Mental Health Partnership NHS Trust. Under Department of Health guidance[5] such investigations are required in the following circumstances:

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.

When it is necessary to comply with the State's obligation 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 for 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.

Where NHS England 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.

[5] Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services

3. PURPOSE OF THE INVESTIGATION

In the brief and terms of reference for the investigation NHS England described the investigation as having the following purpose:

Identify whether there were any aspects of the care which could have altered or prevented the incident. The investigation process will also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

The main objectives and terms of reference
The independent investigation's main objectives and terms of reference were developed by NHS England and revised through discussions with GN's family on 12 June 2013, Avon and Wiltshire Partnership Trust and Niche Patient Safety. The objectives were:

To evaluate the mental health care and treatment provided including risk assessment and risk management;

To identify key issues, lessons learnt, recommendations and actions by all directly involved in providing the care;

To assess progress made on the delivery of action plans following the internal investigation;

To identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies;

To identify care or service delivery issues, along with the factors that might have contributed to the incident.

The terms of reference were to:

- Review the assessment, treatment and care that MC received from Avon and Wiltshire Mental Health Partnership NHS Trust and related agencies, and the decision to place MC in the supported living facility.
- Review the care planning and risk assessment policy and procedures.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment.
- Review the documentation and recording of key information.
- Review communication, case management and care delivery.
- Review the Trust's internal investigation of the incident to include timeliness and methodology to identify:

    - if all key issues and lessons have been identified;
    - whether recommendations are appropriate and comprehensive and flow from the lessons learnt;
- Review the Trust's action plans and progress made against them;
- Review processes in place to embed any lessons learnt.
- Review any communication and work with families of victim and perpetrator.
- Establish appropriate contacts and communications with family/carers to ensure appropriate engagement with the investigation process.

Independent investigation members

The investigation team were:

Sue Simmons, Senior Nurse: lead investigator and project manager.
Dr Sherine Mikhail, Consultant Forensic Psychiatrist: peer reviewer.

4. METHODOLOGY

This investigation did not seek to re-investigate the case from the beginning, but to build on investigative work which had already taken place, using

- Clinical records;
- Trust policies and procedures;
- The Trust's Internal Investigation report;
- The Trust's Internal Investigation archive.

In addition the investigation team scrutinised health records, conducted interviews with key professionals and held a number of meetings. The scope and degree of detail of the investigation was extended and more meetings were arranged in the light of early findings.
This review proceeded with reference to the National Patient Safety Agency (NPSA) guidance[6] and used a systematic process which looked beyond individuals and sought to understand the underlying system features and the environmental context in which the incident happened.

Records and reports
The team began by scrutinising the Trust's internal investigation report and appendices. Copies of MC's psychiatric records covering more than ten years were obtained. A chronology covering many years was developed and a more detailed timeline which recorded key aspects of MC's care and treatment over the twelve months before the incident was devised. The main documents reviewed were:

- MC's psychiatric records, including forensic psychiatrists' reports written for the courts
- The Trust's clinical policies
- The Trust's internal investigation report, including statements and interview transcripts
- Keystones' records

Meetings
Meetings were arranged with the help of the victim liaison officer with GN's parents and siblings, and with his ex-partner. In the first meeting the terms of reference and scope of the investigation were discussed and subsequently amended in light of GN's parents' feedback. There was also an on-site meeting with Keystones staff, and with a police officer who had been involved with the police investigation.

A meeting with MC and the two members of the investigation team was arranged for 5 July 2013, but unfortunately did not proceed. A further date was arranged for 30 August 2013 when a face-to-face meeting took place.

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

Further meetings were held towards the end of the process with GN's parents and with MC.

Interviews
There were interviews with:

- the main author of the internal investigation
- MC's consultant psychiatrist (responsible clinician under the Mental Health Act),
- the community forensic nurse who referred MC to Keystones
- the Keystones director who found GN after the attack

These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature.

Correspondence
There was correspondence with HM Coroner asking for access to any documents held in his office. He confirmed that there had been no inquest and that he would have no further documents in addition to those held by the police.

There were also a number of attempts to make contact with MC's father through the police liaison officer but unfortunately it was not possible to establish contact.

Policies
In addition to the Trust's policies we referred to relevant national policies and guidelines, including Standards for Medium Secure Units[7], Implementation Criteria from the Quality Network for Forensic Mental Health Services[8], and DH Best Practice Guidance[9].

Analysis
The documents from these sources were then rigorously analysed to develop themes and findings, and in particular to identify factors which may have contributed to the incident. Wherever possible information was triangulated, that is checked against other sources for reliability. As far as possible we have endeavoured to eliminate or minimise hindsight or

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[7] *Royal College of Psychiatrists. Standards for Medium Secure Units.* *http://www.rcpsych.ac.uk/pdf/Final%20Standards%20for%20Medium%20Secure%20Units%20PDF.pdf*

[8] *Royal College of Psychiatrists (2010) Quality Network for Forensic Mental Health Services. Implementation Criteria for Recommended Specification: Adult Medium Secure Units.* *http://www.rcpsych.ac.uk/PDF/Implementation%20Criteria_Second%20Edition.pdf* *(Fromeside appears to be a member of this network)*

[9] *DH (2007) Best Practice Guidance: Specification for adult medium-secure services*

outcome bias[10] in this process. We have endeavoured to work with the information which was available to the Fromeside team at the time. However, where hindsight has informed some of our judgements we have identified this.

The investigating team would like to express our thanks to interviewees and members of staff of the Trust and Keystones for their help and co-operation.

[10]Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident.

Outcome bias is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

5. SUMMARY OF THE INCIDENT

Incident description and consequences (obtained from the internal investigation report and interviews)

GN had lived in the Filton Avenue house, run by Keystones, for several years and was 33 years old. He had been adopted at the age of two and was close to and remained in regular contact with his adoptive parents and his siblings. He had two young children with his ex-partner who described him as a good, generous friend to her and a loving father to his two children whom he saw regularly.

MC had a long history of contact with mental health and criminal justice services. He moved into the house on a period of leave from Fromeside on 5/3/13. Prior to this he had had two periods of two nights trial leave, during which he travelled outside of Bristol, to Newport, and used some cannabis.

MC was seen by staff from Fromeside on 9 March 2012 and then, on 12 March 2012, it was decided that he would be taken back to the ward following his trip to Newport to see his brother. He attended a patient care review (PCR) meeting on 13 March 2012 and it was agreed that he could return to Keystones, but that he would not be discharged as planned. Instead his leave would be extended. It is not known whether his father visited him at Filton Avenue on 14 March 2012, although MC told staff on 13 March 2012 that he planned to do so.

MC was seen by his consultant psychiatrist on 15 March 2012.

On Saturday 17 March 2012 at around 4.00pm MC was watching a rugby match involving Wales on the television in the sitting room. GN was cooking in the kitchen. There have been unverified reports that there may have been some drinking of alcohol. The Keystones director had a meeting in the office at the top of the house and arrived for her meeting shortly before 4.00pm. She spoke briefly to both MC and GN and all appeared to be well.

A few minutes later the fire alarm went off, possibly caused by GN cooking. The director came downstairs to turn off the fire alarm, but found that this had already been done by MC.

At approximately 4.05pm the director met her visitor at the front door. She did not see either MC or GN at that time and she thinks the door to the sitting room may have been closed.

MC has since told psychiatrists that he felt that GN could read his thoughts and was laughing at him. He reported that he had gone to his bedroom (which was next door on the ground floor) collected a samurai sword and stabbed him. It is not known what time this happened.

At 5.10pm the director was told by the member of staff who was on call that she had received a telephone call from one of the residents to say that GN was injured. He was found to have multiple injuries. An ambulance was called but he died on arrival at hospital.

When the police arrived it was found that MC was missing from the house. He went to a police station shortly afterwards and was taken into custody.

MC was charged with murder and pleaded guilty to manslaughter on the grounds of diminished responsibility. He received a hybrid order[11] under section 45A of the Mental Health Act. This is a prison sentence (in this case for a minimum of 12 years), which allows the authorities to transfer him to a hospital for psychiatric treatment, and then transfer to prison at a later date.

[11] Hybrid orders under section 45A of the Mental Health Act allow for convicted mentally disordered offenders to be given a sentence of imprisonment and simultaneously transferred to hospital for psychiatric treatment. In England and Wales their use was initially limited to patients with psychopathic disorder, but more recently treatment of a greater range of offenders under the order, including offenders with co-morbid mental illness, has been allowed. Once it is deemed that psychiatric hospital treatment is no longer necessary the patient can be transferred to prison and the release date is determined by the Parole Board rather than the First Tier Tribunal (Mental Health).

6. PROFILE OF THE TWO MAIN CARE SETTINGS

6.1 Fromeside Medium Secure Unit

Fromeside is a medium secure hospital run by Avon and Wiltshire Mental Health Partnership NHS Trust (the Trust) with 80 beds and is part of the West of England Forensic Mental Health Service. It is based in the grounds of Blackberry Hill Hospital in Bristol. There are seven wards which care for men and a new self-contained ward for women. The wards for men provide care for patients at different stages of their treatment and recovery, from acute admission through to rehabilitation, greater independence and preparation for discharge. Patients can be admitted from the courts having been involved with the criminal justice system, from high secure hospitals or from general psychiatric hospitals because they present risks to others or themselves or have histories which require care within a medium secure environment.

When service users are ready to move on to discharge in the community there is a team of community forensic nurses able to work alongside community teams to support this.

Patient care review (PCR) meetings involve the patient and all members of the multi-disciplinary team and happen weekly on Bradley Brook (the admission ward) and fortnightly on other wards. Care Programme Approach (CPA)[12] reviews take place every 4-6 months.

With the exception of ward-based nursing staff the members of the multi-disciplinary team are organised into locality teams. The team caring for MC were the Gloucestershire team and remained involved in his care throughout his admission and his moves between different wards. The team comprised psychiatrists (led by Dr Z), clinical psychologists, a social worker, occupational therapists, and a community forensic nurse.

MC was first admitted to Bradley Brook which is a high dependency admission ward. He later moved to Avon which is a rehabilitation ward and finally to Siston which is a pre-discharge ward promoting increasing self-care and independence.

[12] The Care Programme Approach (CPA) is a process for the assessment, planning and reviewing of someone's mental health care needs. CPA is for someone who has a diagnosis of severe mental disorder. There will normally be a care co-ordinator who co-ordinates the input of the multi-disciplinary team and the team will hold regular review meetings.

6.2 Keystones

Keystones Mental Health Support Services is an independent limited company which provides accommodation, care and support in Bristol for men and women of working age with mental health problems. The aim is to provide a therapeutic environment and programme whilst fostering social inclusion for residents and promoting their independence. Residents sign a licence agreement for their accommodation with Keystones[13].

At the time of this incident there were five houses providing different levels of support and a number of independent flats. Filton Avenue is the house which normally takes new referrals as there are more staff based there. It is a large house with six single bedrooms, a large sitting room and a large kitchen with dining space. Residents will do their own shopping and cooking, with some help if needed. There are a wide range of educational, therapeutic and leisure activities, some of which replicate the activity programme in Fromeside. Staff are on duty between 10am and 6pm Monday to Friday. There is someone on-call 24 hours a day, seven days a week and a security visit in the evenings. At weekends a member of staff calls into each house briefly twice a day and will speak to all those in the house. It is estimated that each resident will receive at least ten hours of staff time per week, some of this in groups and some in individual sessions.

During its nine years of operation Keystones has admitted a large number of people from Fromeside and, we were told, has had a high degree of success with residents who have significant mental health problems and rehabilitation needs. The team at Keystones is well known to Fromeside staff and there is clearly a high degree of trust between both teams. There appears to have been no doubt in either team that this was an appropriate placement for MC.

[13] In legal terms, a licence is a permission from the owner to occupy the accommodation, whereas a tenancy is a form of ownership of the accommodation. Under a licence agreement the landlord has the right to enter the resident's room. Examples of a licence are a person staying in a hotel, hostel or guesthouse or a person sharing a house with the owner.

7. MC'S PERSONAL, SOCIAL, PSYCHIATRIC AND FORENSIC HISTORY (OBTAINED FROM CASE RECORDS AND REPORTS)

7.1 Childhood and family background.

MC was born in 1965 in Germany, where his father was stationed with the Royal Air Force as a fireman. He was the youngest of three boys.

The family returned to live in the UK when MC was two years old. They initially lived in Scotland, before moving a number of times to different locations in England and Wales. MC changed primary schools each time the family moved.

MC described his early years as 'unpleasant'. He described his mother as being an alcoholic and stated that during his childhood she was admitted to hospital a number of times for detoxification. At the time MC recalled being aware that something was wrong with his mother but was unsure of what. Whilst his mother was in hospital MC was cared for by his aunts and grandfather, often having to change schools. He said that his father was often absent during his childhood.

MC stated that throughout his childhood he felt unloved and perceived others as bullying him or being uninterested in him.

In his teenage years MC's parents divorced and he remained in the care of his mother who continued to drink heavily. At this time MC reported starting to abuse substances, particularly solvents and alcohol as well as engaging in criminal behaviours in the form of burglary and criminal damage. He was removed from the care of his mother when aged 15 and placed in a children's home. According to MC his move into the care of social services was because his mother was unable to care for him, as well as his behaviour being 'out of control'. Whilst in care MC reported that he regularly stayed overnight with his father. However, he was returned to live in full time care of the authority after he attacked his brother with a knife.

When MC was aged 17, his mother died after falling downstairs. He was discharged from the care order at the age of 18 and at that time went to live with his father for a short period of time before moving into bed and breakfast accommodation. MC lost contact with his brother and father following the assaults, and until 2006 MC had no contact with his family. Whilst at Broadmoor High Secure hospital, MC traced his father through the Salvation Army. His father started visiting him in or around 2010, and he had recently rekindled a relationship with his brother in Newport, who had been diagnosed with throat cancer.

7.2 Education and Employment History

MC attended five or six different primary schools as the family moved around the country. He said that he never really enjoyed school and found these years difficult. Reports suggest no significant incidents until the age of 14 years when he started truanting and glue sniffing. He was expelled at the age of 15 due to continued truanting and substance abuse. He briefly started another school, however left at 15 without any qualifications. MC reported that at this time his parents had divorced and he was living in the care of his mother and was therefore able to truant from school with no repercussions from his father.

After leaving school MC reported that he spent his time with friends, smoking cannabis and using solvents. MC has no history of paid employment. As part of his rehabilitation from St Andrews Hospital MC worked at a warehouse for a month in 1988. However he chose to return to Gloucester and not follow through his work placement. He also carried out some voluntary work for Oxfam whilst at St Andrews.

7.3 Relationship history

MC described a lack of important intimate relationships. He described his first sexual relationship at the age of 15 with a girl he met at the local shop. MC reported that he dated this girl for approximately six months and described the relationship as being mainly sexual in nature.

Whilst at St Andrew's Hospital MC dated a woman whom he met at the workshop where he was doing a work placement. He described the relationship as 'casual' and ended it after approximately six months.

During his twenties and thirties MC described having sexual relationships with a number of women, usually one night stands. He said he had never been 'in love' and expressed how he found it difficult to form relationships and trust others.

In November 2011 whilst working on his care plan with a member of nursing staff he said he had a daughter whom he last saw ten years earlier when she was a baby. This information does not initially appear to have been told to anyone else apart from this nurse, but was confirmed in the independent investigation team's discussions with MC, who also stated that he had no further contact or news of her.

7.4 Psychiatric, substance misuse and forensic history

This section has been compiled from a number of reports, and pulls together MC's psychiatric, substance misuse and forensic histories in different decades in order to illuminate the links.

7.4.1 Teenage years

MC began drinking alcohol from a young age; he first tried alcohol at the age of 11 when he drank two glasses of cider. He started to drink regularly at the age of 15 and at around the same time began sniffing glue and smoking cannabis. MC described how drinking alcohol made him feel good, helped him to socialise with others and distracted him from difficulties at home. However he later reflected that he was getting into more fights.

His cannabis use increased from the age of 18.

MC's first offence was at the age of ten when he was caught shoplifting. At the age of 15 he was convicted of criminal damage and burglary, and he received a 12 month supervision order. His violent offending commenced aged 18 when he had a fight, when intoxicated, with an acquaintance in the street and hit him over the head with a milk bottle. MC was convicted of grievous bodily harm, (GBH), actual bodily harm (ABH), and possession of an offensive weapon. He served 12 months of a 20 month prison sentence.

He reported that his mental health deteriorated at the age of 17 years following the death of his mother. He reported starting to feel paranoid and he had delusional beliefs that others were plotting against him and that they could read his thoughts. He reported having thoughts of suicide in order to get away from his psychotic experiences.

7.4.2 Twenties

During his twenties MC reported experimenting with LSD and continued to use the drug intermittently for a number of years. By his late twenties MC was regularly using stimulants, specifically crack cocaine and amphetamines, which he described as his drug of choice.

Between 1984 and 1994 MC was convicted of ten offences against a person, including seven charges related to wounding or ABH or other charges of threatening or verbally abusive behaviour. He also has two charges of carrying offensive weapons in 1986. During a similar period he committed eleven offences of criminal damage against property, including fraud, burglary and shoplifting.

At the age of 20 MC assaulted his brother and his father, breaking his father's arm. He was admitted to Coney Hill Hospital in Gloucester and stayed there for nine weeks. He was diagnosed with paranoid schizophrenia.

In 1986 he again assaulted his father, this time with a hammer. MC reported that he blamed his father for things going wrong in his life. He also reported that he had been using cannabis on a daily basis and thought that he was being watched by others. He was again admitted to Coney Hill Hospital under Section 37 of the Mental Health Act and then transferred to St Andrew's Hospital in Northampton (specialist medium and low secure care) where he remained for 20 months.

Whilst at St Andrews MC reported that his mental health improved significantly. He related such improvements to being on depot medication as well as having structure to his daily routine including occupational therapy and activities. Following discharge from St Andrews MC returned to live in Gloucester and continued to receive depot medication and community nurse follow up.

It appears that there were several convictions for wounding and assault during the early nineties. In 1993 it appears that MC stopped taking his psychiatric medication and started to abuse substances, specifically amphetamines and cannabis. During this time he was of no fixed abode and was residing in hostels, moving around the London area.

In 1994 MC was admitted to Barrow Hospital (a psychiatric hospital in Bristol which closed in 2006) under Section 3 of the Mental Health Act (1983) after spitting on a woman in the street. He reported thinking that the woman could read his mind and was trying to make him feel angry. MC also reported that it was at this time that he first self-harmed by cutting his wrists in an attempt to kill himself and escape from his psychotic experiences. He was discharged after five months.

MC cited a number of reasons for his drug use; these varied according to the different substances. He reported that cannabis helped him to relax whereas amphetamines and alcohol enabled him to be more confident and assertive in social situations. MC also described being easily influenced by peers.

MC has always acknowledged that amphetamines can trigger feelings of paranoia and can lead to deterioration in his mental health. MC also acknowledged that such paranoid beliefs have in the past been associated with aggressive/violent outbursts. However, he was less clear about any detrimental effects of cannabis on his mental health, and latterly he denied any problems associated with its use.

MC also acknowledged that his use of alcohol was often associated with his offending. He recognised how a number of his previous acts of violence have occurred whilst being intoxicated with alcohol.

7.4.3 Thirties

MC described his heaviest period of drinking as being in his early thirties when he was living with his brother for some of the time. Between 1994 and 1999 MC lived in the Gloucester area but regularly moved around, living on the streets and in hostels in London, Glasgow, Leeds and Manchester. The second half of his thirties was spent largely in prison or secure hospital care.

There were three separate assaults on women between July 2000 and May 2001. MC believed that the women were witches; he believed that they were trying to control his thoughts and make him feel angry. He was convicted of common assault, ABH and affray and sentenced to five years custodial sentence. He first was admitted to Fromeside, under the care of Dr Z for assessment, and during this period (9 May 2001) seriously assaulted a female nurse, kicking her in the shoulder and neck and on separate occasions attempted to assault another nurse and made threats to kill two other members of nursing staff. He was convicted and served three years and four months in prison. During the latter part of his sentence he became more disturbed, isolated himself and shaved off his body hair. He was observed smiling and giggling to himself and appeared to be hostile to women. MC was assessed for admission to Broadmoor and found to be thin, with a marked pallor, apparent poor personal hygiene, dry and flaky skin, fidgety hands and restlessness and a markedly guarded manner on interview. Two days before his release date from prison in November 2003 he was transferred to Broadmoor on the direction of the Ministry of Justice. On assessment during his first few days in Broadmoor he displayed significantly disturbed, bizarre and apparently psychotic behaviour. He was occasionally hostile and threatening to fellow patients and staff, requiring on one occasion a period in seclusion. In April 2004 his diagnosis for Mental Health Act purposes was reclassified from mental illness to mental illness and psychopathic disorder.

In August 2004 MC was transferred from Broadmoor back to Fromeside for a trial period. However, he was transferred back to Broadmoor within a month following a serious unprovoked assault on another male service user, punching the victim in the head whilst he was lying on a sofa in a communal area. MC described feeling intense anger which was triggered by the other service user's behaviour on the ward and lack of personal hygiene. Immediately after the assault there were no signs of paranoia or psychosis. However nursing staff noted that he had been more aloof, colder and less sociable in the preceding 24-48 hours. MC explained that at the time he did not like being at Fromeside and wanted to be transferred back to Broadmoor and that he knew that if he assaulted another service user he would be transferred. MC stated that he did not feel able to talk to staff about the difficulties he was experiencing and therefore perceived that assaulting another service user was the only way to make a transfer happen.

In or around late 2004 while in Broadmoor he changed both his first name and surname from those given at birth.

7.4.4 Forties

In June 2005 MC assaulted another patient whilst at Broadmoor, hitting him around the head with a metal cup and punching him in the face. He was considered to have been psychotic at the time of the assault and was started on mood stabilising medication and his mental state was described as improving. The diagnosis of paranoid schizophrenia was confirmed with the addition of dissocial personality disorder.

He engaged in anger management, problem solving skills training and group work aimed at understanding personality disorder. His mental health remained stable for approximately three years. In 2008 MC completed psychological work around his aggressive behaviour and substance misuse, engaged in occupational therapy sessions, and started work on understanding his illness and relapse prevention. It was therefore felt that a trial period in medium security would be appropriate and he was transferred back to Fromeside for a six month period of trial leave in July 2008. MC denied all psychotic experiences and gave negative drug screens until July 2009 when he admitted drinking alcohol and smoking "a few puffs" of cannabis. Despite this his mental state appeared to have remained stable. He participated in a wide range of therapeutic interventions in relation to his drug and alcohol use including one-to-one drugs work. He also worked with the clinical psychologist on the team on a relapse management plan and a Wellness Recovery Action Plan® (WRAP)[14].

In October 2009, as plans for his discharge from Fromeside were being made, he went absent without leave and handed himself into a police station in Dublin. Plans for discharge were temporarily halted.

In November 2009, MC was subsequently discharged to low-level supported accommodation in Cheltenham on a community treatment order (CTO)[15] under the care of the assertive outreach team. For the next few months he received significant support from the Fromeside team, in particular the

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[14] The toolkit known as the Wellness Recovery Action Plan® has been developed by a group of people who experience mental health challenges. These people learned that they can identify what makes them well, and then use their own Wellness Tools to relieve difficult feelings and maintain wellness.

[15] Community Treatment Orders were introduced in November 2008. A patient's responsible clinician may apply under the Mental Health Act for supervised community treatment (SCT) under the conditions of a community treatment order. The purpose of SCT is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to help to prevent relapse. (Mental Health Act Code of Practice, para 25.2). The responsible clinician may specify conditions including:

(a) ensuring that the patient receives medical treatment;
(b) preventing risk of harm to the patient's health or safety;
(c) protecting other persons.

community forensic nurse who liaised closely with the Cheltenham community team.

As Dr Z stated in interview with the independent investigation team,

> 'We planned his discharge quite carefully because we had the view that he is somebody who felt comfortable with a fairly tight, quite a narrow range of security. .....if you move to a position of increased liberty, reduced supervision, my theory was that it would create a reaction in him to shift the equilibrium back towards a point at which he felt more comfortable. We were treading this sensitive line.'

During the summer of 2010 MC was using cannabis, and on one occasion had used amphetamines which resulted in him being found by the police dancing on the roof and appearing to be intoxicated. MC was recalled under his community treatment order and was admitted to an acute inpatient unit for two weeks.

Following discharge, MC organised and moved into his own accommodation, with some support from a housing charity. This flat was much less central than the hostel and he was more isolated with much less social support or contact. However it was reported that he was doing well, and the assertive outreach team was considering reducing his flupenthixol decanoate (Depixol) medication. His visits were reduced from weekly to fortnightly with plans to transfer his care to the recovery team.

It appeared that MC had not made any friends in his building and felt lonely and isolated. In addition his days became unstructured. In January 2011 MC's brother was diagnosed with throat cancer and MC described this time as "worrying". In March 2011 his brother was told that he was clear of cancer.

On 5 March 2011 MC set fire to items in his flat. He was experiencing difficulty sleeping as he believed with increasing conviction that items in his room (TV, bed etc) were broadcasting his thoughts to the world. He found the experience to be very distressing. He made a decision to set fire to the objects to stop them broadcasting his thoughts. Much later when working on a fire setting report, MC said that he initially wanted to go to prison as he liked being locked up and that he wanted to be "out of my flat".

MC was initially assessed as not experiencing a relapse in his psychosis, but he was remanded into custody in order that a forensic psychiatric assessment could be conducted. He was then admitted to Wotton Lawn Hospital in Gloucester, where his behaviour quickly became disturbed. He smashed a microwave oven, assaulted a member of staff and made claims that he would continue to act in a violent way until he was admitted to Broadmoor Hospital. Subsequently, MC was transferred to Fromeside Medium Secure Unit. Later he said that he would have chosen Fromeside

over Broadmoor as you could no longer smoke at Broadmoor whereas you could at Fromeside.
The Fromeside team hypothesised that the fire setting and violence may have resulted from an abrupt accentuation of psychotic symptoms caused by cannabis use.

Shortly after his admission to Fromeside in March 2011 he punched a member of staff after not being allowed access to the garden to smoke.

The 12 month chronology in the next section of this report starts from this point in March 2011.

MC has been described by some of the professional staff who were involved in his care as sometimes being distant, aloof, sometimes suspicious, sometimes with a marked 'edge' and emotionally cold. He was not someone whom others would generally warm to. His physical appearance could also contribute to this, as he was tall, often shaved his head and could, on occasion, look intimidating. During the last two years before the homicide, however, several people said that he appeared slightly warmer, friendlier and more talkative at times. The community forensic nurse (CFN) described him on his last contact with him, a few days before the homicide, as smiling, welcoming, chatting to other residents, relaxed, and apparently settling in well to Keystones.

7.4.5 Summary

In summary, MC had a longstanding history of offending. In September 2011 it was reported that he had 29 convictions relating to 61 offences. These included offences against people and property. He reported using a variety of illicit substances, including cannabis, amphetamines, heroin, crack cocaine, LSD, magic mushrooms and solvents. He had a significant history of contact with the police and secure mental health services.

8. SUMMARY OF MC'S CARE FROM MARCH 2011 TO MARCH 2012

(Please see the full chronology at appendix 1)

10/3/11 Admitted to Bradley Brook (Fromeside) from Greyfriars Hospital, on section 3. Had been admitted to Greyfriars after setting fire to property in his flat.

11/3/11 Punched a female member of nursing staff after making a request to go into garden for a cigarette at 6.45 am and having this request refused. Restrained and given medication.
There followed a period of being fairly settled, although sometimes a bit 'edgy' and slightly suspicious, but generally 'warm' with good eye contact.

15/3/11 At Patient Care Review (PCR) Dr Z said that MC probably had paranoid schizophrenia and may also have a personality disorder.

16/3/11 Social worker talks to MC about making contact with his father (nearest relative under the MHA) and asks if she can speak to him. MC says he will think about it.

27/3/11 Told staff that he is sometimes frustrated by other patients, and that he would like to live in Bristol when discharged.

30/3/11 MC tells social worker that she could phone his father if she wishes.

5/4/11 Social circumstances report written by forensic social worker for first tier tribunal.
She has spoken to MC's father. He told her that he thought that MC had 'gone downhill very fast' in flat in Cheltenham. He felt that MC had been depressed and that he was institutionalised. MC's father did not wish to become involved as nearest relative, but would 'leave it to the professionals'.

27/4/11 MC tells staff that he is increasingly frustrated by another patient who 'keeps on at him'. Tells staff he feels like assaulting him.

3/5/11 In PCR says he would like to move to Avon ward and to stop diazepam.

5/5/11 Court appearance. Outcome was for him to continue on a notional section 37[16] hospital order.

18/5/11 Transferred to Avon ward

24/5/11 In PCR meeting he appeared a little more anxious. No hallucinations, but said that he still believed people could read his thoughts. 50% sure that this was result of mental illness.

31/5/11 CPA meeting, discussed future placement, support, drugs, relapse prevention, fire setting work.

5/7/11 Some tension between patients re MC listening to music on the television while others wished to watch a different channel. Still reporting that others could read his thoughts but he was 'not bothered by this'.

[16] The term refers to a patient who is treated as if subject to a hospital order under s37 of the Mental Health Act

25/7/11 MC informed his named nurse that he had been told that police would not pursue charges again him re assault on Fromeside nurse.

2/8/11 Altercation between MC and another patient over what they were watching on the television.

30/8/11 Fire setting report discussed in PCR. The assessment suggested that he remained at risk of actions which would allow him to achieve containment in hospital and that this has implications for placement and discharge.

15/9/11 First yoga class in the community using unescorted leave. Successful trip.

29/9/11 Fire setting report recommended problem solving group and work on relapse prevention. Proposed that he should not have any reduction in support on discharge.

15/11/11 CPA review. Housing and discharge planning discussed. Team agreed that HCR-20[17] should be completed.

22/11/11 Referral to Keystones. The following documents were enclosed with the referral:

- self-completed questionnaires on alcohol, drug misuse and anger management
- information on MC's relapse signature and relapse questionnaire
- his consultant's report for the Mental Health Review Tribunal, dated 4/3/11
- the clinical psychologist's fire-setting assessment, dated 16/9/11
- care plan dated 15/11/11

18/12/11 Several incidents of raised voices between MC and another patient over use of television

23/12/11 Visited Keystones with forensic community nurse. Said that he liked the accommodation and would like to take the vacancy.

3/1/12 In PCR meeting agreed that 9-5 support would be enough as he had had much less in Cheltenham prior to the fire setting. To start stage 4 of self medication.

15/1/12 Care plan developed covering: transition from hospital into community, mental health, leave, rights and self medication. All signed by MC.

23/1/12 Minor incident involving television between MC and another patient. Staff talked about this with MC but he became upset and left the room, banging the door. He later apologised to staff for his behaviour and said he had no issues with other patient.

3/2/12 HCR-20 updated by clinical psychologist.

7/2/12 Attended Fareshare voluntary scheme to register as volunteer. Intended to continue with this once discharged.

8/2/12 MC participated in psychology group 'getting out, staying out'. Also discussed overnight leave and care plan with named nurse.

[17] The HCR-20 is a comprehensive set of evidence-based professional guidelines / risk assessment tool for the assessment and management of violence risk, through the ranking of twenty factors. See paragraph 9.2.2.1 for more information.

9/2/12	New responsible clinician from date of discharge (community consultant) and care co-ordinator confirmed by community mental health team (CMHT) manager.
22/2/12-24/2/12	Two days/nights leave to Filton Avenue, Keystones for trial leave. On return journey with community forensic nurse (CFN), MC told him he had heard from brother that his cancer had returned and he had visited him in Newport and had smoked cannabis.
28/2/12	Told PCR meeting that cannabis is not a problem for him. Team agreed to slow down his discharge by using more section 17[18] leave instead of discharge on community treatment order (CTO) on 5/3/12.
29/2/12-2/3/12	Second period of trial leave to Keystones.
2/3/12	On return to Siston ward MC said that leave had gone well. Urine screen positive for cannabis (possibly from admitted cannabis use on 22/2/12) Section 117 meeting, was attended by Cheltenham CPN and Keystones. Agreed discharge plan and further two weeks leave to Keystones. Very comprehensive discharge plan developed, including ten hours of direct support by staff as well as general support available at the house.
5/3/12	Taken to Filton Avenue, Keystones by CFN for beginning of 2 weeks leave. Section 17 leave form stated that he is 'to abide by the rules and regulations and guidance of staff there. To be free to leave the house at will. No alcohol or illicit drugs. '
7/3/12	Keystones visited by CFN. MC was not there but staff said he had been fine.
9/3/12 Friday	Care co-ordinator (CPN in North Bristol community team) visited Keystones to give depot medication. MC was just coming back from two days visiting his brother in Newport. Had smoked cannabis (believed by team to be significant relapse trigger). A bit suspicious. Depot given. Keystones staff had not known his whereabouts over past two days. Siston ward informed by phone of situation by care co-ordinator. No record of this telephone call.
12/3/12 Monday	CFN informed ward that he would bring MC back. MC had no evidence or signs of paranoia, appeared relaxed. No signs of delusional thinking or symptoms of mental illness. CFN spent around two hours with MC that afternoon, some of it in a local cafe. He reported that MC was physically and psychologically relaxed and showed no signs of paranoia, had good eye contact and denied any problems. CFN told Keystones staff that he was returning MC to the ward because of his cannabis use and his trip to Newport. We have been told by

[18] The responsible clinician may grant a detained (but not restricted) patient leave of absence under section 17 of the Mental Health Act subject to such conditions (if any) as he or she considers necessary in the interests of the patient or for the protection of other persons.

	Keystones staff that they were at the time not aware of his second trip to Newport and thought that CFN was referring to the first trip. MC came back to the ward later that day and said that he was keen to go back to Keystones as his father was visiting him there on Wednesday 14/3/13. Drug screen positive for cannabis and negative for other illicit drugs.
13/3/12 Tuesday	PCR meeting attended by MC. This meeting did not include anyone from Keystones. Reported that he was cleaning the kitchen a lot – a possible relapse indicator, but MC did not think it was of any significance. Agreed that leave could continue and that Dr Z would visit him there. Back to Keystones in the afternoon.
15/3/12 Thursday	MC seen at Keystones by Dr Z. All appeared to be well. Dr Z reported that he felt 'somewhat reassured' as MC appeared calm and settled. Leave extended to 2/4/12.
17/3/12 Saturday 3.50 pm	MC was watching rugby game on television in Filton Avenue. GN was cooking in kitchen. Both seen and briefly spoken to by Keystones director as she entered the building and went upstairs to office.
4.00 pm	Fire alarm went off, possibly caused by GN cooking in the kitchen. Director came downstairs to turn off the fire alarm but this had already been done by MC.
4.02 pm	Director met visitor at the front door. She did not see either MC or GN at this time.
5.10 pm	Director was told about GN being injured by the on-call member of staff who had been phoned by another resident. MC was missing from hostel at time of discovery, but went to police station shortly afterwards and was taken into custody. Homicide believed to have been committed using a samurai sword which MC had in his room. Not known how he came to have the sword in the house.

9. FINDINGS OF THE INDEPENDENT INVESTIGATION

9.1 Assessment, care and treatment

MC was admitted to Bradley Brook ward in Fromeside on 10 March 2011 under the care of the same team as on his previous admission. He had been discharged from that admission sixteen months earlier in November 2011. This was MC's third admission to secure hospital services, indicating that this was someone with a significant forensic history.

The earlier two admissions were:

- St Andrews medium secure unit for twenty months in the late eighties
- Fromeside in 2001, followed by prison and then Broadmoor in 2003 and a return to Fromeside again until November 2009. (This was one continuous period of treatment and we are therefore describing it as one admission.)

MC had a diagnosis of paranoid schizophrenia with some personality difficulties or disorder. This diagnosis appears to have remained relatively consistent over his lengthy history of contact with mental health services. During his last admission to Fromeside Dr Z considered whether there might be some Asperger's-type traits but did not pursue this using any formal testing.

His assessment, care and treatment were provided by the Gloucestershire multi-disciplinary team and the ward nursing staff. The team met with him in patient care reviews (PCRs) on a regular basis, and in Care Programme Approach (CPA) meetings every four-six months. Shortly before his proposed discharge date there was also a section 117[19] meeting.

MC moved through the wards at Fromeside fairly quickly, and it had been planned that this admission would be for no more than twelve months. During his admission he engaged to some extent in occupational therapy activities and groups, but would sometimes decline to be actively involved and would stay on the periphery of groups, simply observing. He actively participated in the Explore Bristol group and started going to a yoga class in the community. He also volunteered to work in Fareshare[20] after discharge.

[19] Section 117 of the Mental Health Act imposes **a** duty on health and social services to provide aftercare services on discharge or extended leave to patients who have been detained under the Act under section 3 or 37.

[20] Fareshare is a charity which aims to minimise the waste of fresh, frozen and long-life food and to send this food into organisations working with vulnerable people. In Bristol there are around 50 volunteers (around half of whom are or have been vulnerable) who help to re-distribute the food throughout the South West.

MC also engaged intermittently with inpatient nursing staff, sometimes using his one-to-one sessions with his named nurse to talk about his future plans and his wish to stay off drugs and be more tolerant of others. However, it appears from the records that he was often quite guarded, possibly quite 'prickly' and did not readily share his feelings and thoughts. Nursing staff also intervened on several occasions in altercations between MC and other patients, including on one occasion on Siston ward shortly before his first leave to Keystones.

9.1.2 Comment

It appears that there was no new, comprehensive multi-disciplinary assessment on this admission. Rather the team appear to have relied to some extent on previous assessments and the fact that he had been in Fromeside before. In our view his assessment on his re-admission to Fromeside should have effectively started from first principles. It appears that the team knew him quite well and may have allowed that to influence their assessment of him, as well as the fact of his not being restricted under section 41[21] of the Mental Health Act, rather than carrying out a thorough, comprehensive assessment once again.

During his admission to Bradley Brook and Avon wards, MC does not appear to have been offered, or possibly refused, referral to appropriate therapeutic groups, e.g. anger management. He said he had taken part in such groups before and did not wish to again. It is not clear whether his reluctance to engage in group work was challenged by the team.

As the staff members who would have spent most time with MC, inpatient nursing staff would have been in an ideal position to contribute valuable information to the PCR meetings about his day-to-day activities and his mental state. This clearly did happen to some extent but more comprehensive reports to the PCR meetings would have been valuable.

Our impression is that he may have influenced the speed with which he moved through the different wards at Fromeside and moved on towards discharge. He appeared relatively well for much of his twelve months as an inpatient and staff may have believed this to be the case. It appears that he requested moving onto the next ward and the next stage of his treatment on both occasions (his move to Avon ward and his move to Siston ward) saying that many of the patients were younger than him and he wanted to move somewhere quieter.

[21] Section 41 is a restriction order, imposed by a court to protect the public from serious harm. The Ministry of Justice, rather than the responsible clinician, has to give permission for leave of absence, transfer between hospitals, and discharge.

Further, we believe that his admission should have been for a longer period with a slower progression on the pathway through Fromeside. This would have enabled more rigorous testing of the following:

- his plans for therapeutic activities and community engagement, including yoga classes and volunteering
- risk indicators and his management of these
- his use of illicit substances, in particular cannabis and its effects on his mental state

During this longer admission it would have been valuable for there to have been an expectation that he would engage more actively in an individual therapeutic programme which could have included anger management, insight orientated work, dealing with frustration and other appropriate interventions. Such interventions could have spanned his discharge by starting and becoming established prior to trial leave/discharge and continuing post discharge.

9.1.3 Recommendations

1. The Trust should ensure that each new or re-admission to the medium secure unit has a full and comprehensive multi-disciplinary mental health assessment informed but not dictated by his/her history. This assessment would lead to a detailed care plan owned by all professionals involved.

2. The Trust should ensure that forensic multi-disciplinary inpatient teams work more closely with inpatient nursing staff.

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9.2 Risk assessment and management

'*Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component of all assessment, planning and review processes*.'[22]

9.2.1 MC was someone who had a lengthy history of aggression and violence when in the community and in hospital settings. The following episodes were recorded during the twelve months prior to the incident.

10/3/11	Admitted to Bradley Brook (Fromeside) from Greyfriars Hospital, on Section 3. Had been admitted to Greyfriars after setting fire to property in his flat, which he believed was broadcasting his thoughts. In Greyfriars he had damaged a microwave oven and thrown a plant at a staff member, resulting in him being taken into police custody and from there to Fromeside.
11/3/11	Punched a female member of nursing staff after making a request to go into garden for a cigarette at 6.45 am and having this request refused. Restrained and given medication.
27/3/11	Told staff that he is sometimes frustrated by other patients.
27/4/11	MC told staff that he was increasingly frustrated by another patient who 'keeps on at him'. Told staff he feels like assaulting him.
2/8/11	Altercation between MC and another patient over what they were watching on the television.
8/8/11	Discussion with named nurse. MC felt the incident over the TV with another patient was entirely the other service user's fault.
18/12/11	Several incidents of raised voices between MC and another patient over use of television.
23/1/12	Minor incident involving television between MC and another patient. Staff talked about this with MC but he became upset and left the room, banging the door. He later apologised to staff for his behaviour and said he had no issues with other patient.

With the exception of the assault on a nurse on the day after his admission, none of these episodes resulted in injury or triggered recording as incidents. However they do appear to indicate that MC had problems with his frustration with other patients and three of these incidents related to the use of the television.

[22] DH (2008) Refocusing the Care Programme Approach: Policy and Positive Practice Guidance

9.2.2 HCR-20

The HCR-20 is a comprehensive set of professional guidelines / risk assessment tool for the assessment and management of violence risk. It focuses on 20 factors:

10 historical	(H)
5 clinical	(C)
5 risk management	(R)

An HCR-20 assessment, which may have been started earlier, was updated by the Gloucestershire team clinical psychologist in February 2012 shortly before the first episode of two days trial leave.
In this assessment MC scored:

- High on historical risk, including being young at first violent incident, relationship instability and substance use problems.
- Fairly low on clinical factors, including lack of insight. There is a yes for the presence of 'unresponsive to treatment' but the wording beneath this appears to contradict this as it says that 'No, he does respond to treatment'. There is also a question mark alongside impulsivity, as this was judged not to be a habitual pattern.
- Two of the five factors under risk management have been ticked (exposure to de-stabilisers and lack of personal support) while the rest have been given a question mark.

This HCR-20 was not fully completed, as noted in the internal investigation. It also appeared to contain some contradictory or ambiguous statements. There was no evidence that other members of the team had contributed to this assessment or that it had been discussed in any depth in a multi-disciplinary team, or used directly to inform the development of a risk management plan. It does not appear to have been shared with Keystones staff.

9.2.3 Multi-agency public protection arrangements (MAPPA) referral

There was no referral at the time of the planning of his discharge to local multi agency public protection arrangements (MAPPA)[23] and it appears that this was not considered. The internal investigation reviewed this and concluded that, although a MAPPA referral should have been made, it would have made no difference to the discharge planning. The reasons for this

[23] Multi Agency Public Protection Arrangements (MAPPA), are a statutory set of arrangements operated by criminal justice and social care agencies to protect the public and reduce the serious re-offending behaviour of violent and sexual offenders. MAPPA support the assessment and management of risks and bring together the police, probation and prison services, and other services which are involved in the care or management of such offenders.

were that MC was being cared for by a single agency (the Trust) and it was believed that a referral would not be discussed in a multi-agency meeting but rather would be kept on file. The internal investigation has recommended that MAPPA referrals should be made for most if not all Fromeside service users in future.

9.2.4 Comment

'The basis of all violence risk assessment is that past behaviour is the best guide to future behaviour. It follows that the most important part of risk assessment is a careful history of previous violent behaviour and the circumstances in which it occurred.'[24]

In our view the clinical psychologist was the most appropriate member of the team to start completing this risk assessment but that it would have been even more valuable if it had been discussed and further developed in a multi-disciplinary team discussion. The Royal College of Psychiatrists' scoping group report noted that it should not be used except by practitioners specifically trained in its use, as a rigorous approach needs to be taken to define and recognise risk factors.

Further scrutiny of the material in the HCR-20 could have led to a more detailed analysis of previous violence, to identify any antecedents or possible preventative factors.

It would have been impossible to predict that he would act so violently with such tragic consequences, or to predict when such an incident could happen. However, based upon his history and the sudden onset of his aggressive impulses it was predictable that he would be violent to some degree in the future. It could be argued that there was too little focus on his impulsivity, which appears to have been a feature of many of his violent or aggressive episodes. However it was noted by the team that there were sometimes years between his impulsive violent acts, and that in the periods between impulsive acts there were conflicts and confrontations which he had dealt with without becoming violent.

We agree with the MAPPA recommendation in the internal investigation. We believe that the very act of pulling together the information for such a referral can add to the team's understanding of the person they are caring for and

[24] Royal College of Psychiatrists (2008) Rethinking risk to others in mental health services. Final report of a scoping group. p23.

help to identify connections or patterns in someone's behaviour which could be overlooked otherwise. Further, in our view it was not necessarily the case that MC's care would continue to be managed by a single agency as the accommodation provider, Keystones, was also to be involved in the management of risk as part of his overall care. This change in his care should have triggered consideration and recording of the appropriateness of level 2 MAPP arrangements.

9.2.5 Recommendations

3. The Trust should ensure that, in forensic services, there is a multi-disciplinary discussion and agreement on individual, evidence-based risk assessment, including static, dynamic and personality factors, and a clear link between risk assessment and risk management.

4. The Trust should ensure that there is very careful history taking on previous risk behaviour and attempts to identify antecedents.

5. The Trust should ensure that all forensic patients are considered for referral to the local MAPPA process, and the decision, and reasons for it, recorded in the patient's records. (This practice has already been implemented.)

9.3 Fire-setting assessment

9.3.1 In the light of MC having set fire to some items in his flat prior to his admission to Fromeside a clinical psychologist undertook a very detailed and comprehensive fire setting assessment over a number of weeks. His report was completed in September 2011. In his conclusions the psychologist concluded that MC did not present a high risk of further fire setting, but that he had used it on that occasion to gain containment, as the option of violence was not possible as he was alone at the time. In his view, MC was in a cycle of wanting 'high containment and then wanting low containment', and that, without intervention, it was likely that the containment cycle would continue and that he would re-offend. In his recommendations the psychologist referred to relapse indicators and a relapse questionnaire which could be started in Fromeside and continued after discharge. A further comment in his recommendations related to the level of input that MC would need after discharge. In the opinion of the psychologist MC would not appear to require a high level of input but he would have difficulty in expressing his needs and he would perceive any reduction in service provision as a reduction in containment, hence increasing the risk of anti-social behaviour. He recommended that MC's 'service level input should be maintained long term despite him appearing not to require such a level.'

The report concluded that risk of violence was higher than risk of fire-setting, and that he may seek to move cyclically from high containment to low containment and then to high containment again. It was suggested that warning signs of relapse were a mixture of internal affect and experiences and a few externally observable signs.

9.3.2 Comment

This clinical psychology report was very thorough and contained a great deal of very valuable information, but the report and its recommendations were not fully implemented for risk assessment and discharge planning.

9.3.3 Recommendation

6. The Trust should ensure that, for forensic patients, any specific risk assessment (eg, fire setting) should be integrated with generic risk assessments and discharge plans.

9.4 Relapse indicators

9.4.1 There were discussions in the multi-disciplinary team and with MC himself about relapse indicators and his relapse signature and early, medium and late warning signs of relapse. The factors described as indicators included:

- Poor sleep
- Boredom
- Alcohol use
- Cannabis use
- Feeling lonely or isolated
- Irritability
- Hand washing and cleaning
- Believing that others could read his mind
- Thought broadcasting
- Believing that others were out to get him
- Wanting not be around other people
- Wanting to be in hospital or prison

These were developed into a personalised relapse questionnaire, with a plan for MC to complete this each week and to discuss the results with his named nurse or care co-ordinator. They would then jointly work on a relapse prevention plan.

The proposed strategies to be incorporated into a relapse prevention plan included the following:

- Working on a sleep hygiene plan
- Phoning people who could give support
- Talking to others about alternative solutions to problems
- Engaging in activities
- Destroying alcohol and drugs
- Psychiatric review
- Increase in contact with care co-ordinator
- Consideration of admission.

Cannabis use was identified as one of his risk triggers. During most of his stay in Fromeside he told staff that he understood the risk and would keep away from all illicit drugs. However once he was going out on leave he told the PCR meeting that cannabis was not a problem for him.

9.4.2 Comment

It is notable that most of these relapse indictors are internal and not observable by others. They would therefore require a degree of insight and, to gain help, the ability to be able to describe them to others. There was little evidence that MC was able to do this.

His episodes of violence in the past appear to have come 'out of the blue' and were not preceded by observable phenomena.

For these reasons the concept of relapse prevention by monitoring early warning signs and a relapse signature would be less useful than for many other service users.

Similarly, the relapse prevention strategies may not have been totally appropriate for MC. He consistently told staff during the twelve months prior to his discharge that he felt all right and that, although he believed others could read his thoughts this did not bother him. He was also assessed by the team to be settled and to be making good progress. He had a pattern in the past of denying any psychotic thoughts or feelings immediately after any incident, but later would say that he had believed that the person he had assaulted had been reading his thoughts. In these circumstances it is doubtful that he would have been able to act on any awareness of early warning signs or to engage in discussions about them.

MC also may have behaved very differently in different settings, appearing settled and quite well when in hospital, but appearing quite different when in a less contained community setting.

We were told by one member of staff that he would now not necessarily be able to identify any objective signs of an imminent violent incident, but that before the homicide he would have believed it was possible. MC's care plan stressed to Fromeside and Keystones staff that assessing his mental state or any signs of relapse had to be a proactive process with staff seeking out his views and feelings as he would so seldom volunteer anything about his thoughts or feelings.

However in his history of physical and verbal aggression there were no prior reports of externally observable signs of relapse. Nor were there self reports of his deteriorating mental health. There was no verification of the validity of these signs as indicators of relapse; that is, it does not appear that they are based upon reports or observations of any signs or symptoms prior to any other violent incident.

9.4.3 Recommendations

7. The Trust should ensure that relapse indicators, questionnaires and prevention strategies are agreed and reinforced by the whole multi-disciplinary team.

8. The Trust should ensure that any relapse tools are rigorously tested for validity for the individual patient by examining historical risk behaviour and also reviewing the efficacy of prevention strategies in further situations which could generate frustration or aggression.

9.5 Leave of absence

9.5.1 MC's three periods of leave at Keystones were authorised under section 17 of the Mental Health Act. There was a section 17 leave of absence form for each of these periods which set out some conditions. These included no drugs or alcohol and to abide by the rules set out by Keystones staff. The form did not stipulate whether he could travel outside Bristol, although our impression was that staff considered that that would not be an expectation. It appears that Keystones staff were not given copies of the section 17 leave forms, although they assured us that they were fully aware of the conditions set out in them. Following MC's two trips to Newport to see his brother, he told Trust staff that he had smoked cannabis and this was confirmed by drug screening.

The team CFN told Keystones staff that he was returning MC to the ward because of his cannabis use and his trip to Newport. We have been told by Keystones staff that they cannot recall whether they were at the time aware of his second trip to Newport and they may have thought that the CFN was referring to the first trip. Keystones confirmed that they had been asked by Fromeside staff, after the trips to Newport, whether they were happy to continue with the trial period and they said that they were. They were unable to say whether it would have made a difference to their decision about continuing the trial period if they had known that he had travelled to Newport twice.

The CFN talked to MC about his trips to Newport and told him that if he wished to go he should discuss it with the team and they would talk it through with him and would not necessarily rule it out. In the PCR meeting on 13 March 2012 the team gave active consideration to the possibility that MC was attempting to sabotage the placement and to seek greater containment. It was also reported that he was cleaning the kitchen a lot - a possible relapse indicator - but MC did not think it was of any significance. Through further discussions including with MC the team decided not to abandon the referral to this placement but to work from information about his symptoms and his mental health. It was agreed to extend his leave of absence rather than move more quickly to discharge and a community treatment order. It appears that the Fromeside team and the Keystones team believed that Keystones was an appropriate placement which matched MC's needs and wishes.

The CFN and MC's care co-ordinator had planned to meet in the two weeks following the homicide to finalise and record the complex and comprehensive care plan for MC's follow up care (which was already in place but not fully recorded as a care plan). This plan included community team follow-up (including appointments with his new responsible clinician), clinical psychologist sessions, contact and input from the CFN and care co-ordinator themselves and Keystones and community activities.

Keystones staff have commented that in their years of experience they had never been party to such a comprehensive and supportive discharge package as the one designed for MC by the Fromeside team. Keystones also felt that their team was well supported by the Fromeside team.

9.5.2 Comment

The Trust does not have a policy or guidelines on section 17 leave of absence; instead staff are expected to follow legal requirements. However, the development and annual review of a policy on leave of absence, including section 17 leave, is one of the quality principles in the Best Practice Guidance[25].

It may have been worth considering, in the light of his quite rapid move through Fromeside, and his flouting of the conditions of his section 17 leave, negotiating some further conditions with MC prior to his discharge from Fromeside. For example, he could have been allowed to go to Newport, under the conditions of his section 17 leave, if he were to let his care co-ordinator have some prior contact with his brother or his father.

Alternatively, if it was deemed to be counter-therapeutic for him to visit Newport, he could have been asked to agree for Keystones security to check that he was in the house at night (although this would have been an unusual requirement and could have been disruptive for him and other residents), or he could have been asked to participate in certain relevant therapeutic groups at Fromeside or at Keystones.

With the benefit of hindsight it may have been inappropriate to move direct from a medium secure facility to a shared house in the community. It is not clear whether the team considered a period of time in a step down specialist forensic unit as an alternative. Keystones provides approximately ten hours of staff time per week and no staff overnight or at weekends (apart from two short drop-in visits per day). However it would have been possible to arrange some timetabled staff time for MC over the weekend either from Keystones staff or from the Trust, but there is no evidence that this was considered by the Fromeside team, possibly because of his relatively limited use of opportunities to talk to staff in the hospital. Weekends can often be particularly difficult times for service users in the community, when there are fewer staff available, few if any organised activities, and a perception that other people are having time off, relaxing and enjoying themselves.

[25] DH (2007) Best Practice Guidance: Specification for adult medium-secure services.

The pack of reports provided to Keystones by the Fromeside team reported that he had 'clear relapse indicators' and in a separate part of the pack it was reported that the risk of him being a great risk to staff and/or the community was 4 on a scale of 1 (low) to 5 (high). This was scored at 4 'because of past history and arson however the number of incidents in the last seven years is very low (3) with clear indicators and patterns'. However, we believe that this is only partially accurate.

There had been more than three incidents in the previous seven years:

- August 2004 serious unprovoked assault on another male service user in Fromeside (this was just outside the seven years, but was significant in his risk history).
- June 2005 MC assaulted another patient at Broadmoor, hitting him around the head with a metal cup and punching him in the face.
- 5 March 2011 setting fire to items in his flat
- 7 March 2011 assault on nurse in Greyfriars by throwing a plant
- 11 March 2011 assault on nurse in Fromeside the day after admission

Further, it is not the case, in our judgement, that there were clear, discernible indicators and patterns to these incidents, other than MC's reports after some incidents that he felt others could read his thoughts.

Although he had not breached any condition on travel outside Bristol, MC had breached the condition about not taking any non-prescription drugs, and as a result of this had breached both the spirit and the letter of his section 17 leave. This breaching of his leave conditions may have been significant irrespective of whether the cannabis affected him psychologically.

MC's two trips to Newport were discussed by the team with MC in the PCR meeting on 13 March 2012. As it was not clear whether Keystones were aware that he had travelled to Newport twice, the involvement of Keystones staff in this meeting would have been particularly appropriate and useful.

The plan to extend his leave would have enabled the team to bring him back into hospital more easily than if he was on a community treatment order (CTO)[26]. However on a day-to-day basis it would have made no difference to MC's time at Keystones and it may have appeared to him that there were no consequences to his breaching the rules of his leave.

[26] A patient's responsible clinician may apply under the Mental Health Act for supervised community treatment (SCT) under the conditions of a community treatment order. The purpose of SCT is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to help to prevent relapse. (Mental Health Act Code of Practice, para 25.2).

9.5.3 Recommendations

9. The Trust should develop good practice guidance on leave of absence under section 17 of the Mental Health Act, which should, amongst other elements, require responsible clinicians to set out clear criteria and conditions for such leave.

10. The Trust should ensure that in any multi-disciplinary review of issues arising from a forensic patient's leave of absence, the patient's placement is fully informed and fully involved in the discussion.

9.6 Discharge planning

9.6.1 Discussions about discharge appear to have started in June 2011 when MC first talked about a future placement and began the first phase of self-medication. There were then further discussions in October 2011 when he expressed a wish to remain in Bristol rather than go back to Cheltenham.

The referral was made to Keystones on 22 November 2011 by the team community forensic nurse. The following documents were enclosed with the referral:

- self-completed questionnaires on alcohol, drug misuse and anger management
- information on MC's relapse signature and relapse questionnaire
- his consultant's report for the Mental Health Review Tribunal, dated 4 March 2011
- the clinical psychologist's fire-setting assessment, dated 16 September 2011
- care plan dated 15 November 2011

It appears that there was no detailed risk assessment or risk management plan provided to Keystones at that time or later. However some of the above documents, particularly the Mental Health Review Tribunal report, the fire-setting assessment and MC's self-completed questionnaires, contained detailed information about MC's forensic and drug and alcohol history and therefore previous risk behaviour. The large amount of information in the documents sent to Keystones was distilled into their own Care and Risk Overview.

Keystones staff have reported that when MC was first referred to them they understood that he was a settled, quiet service user, and their impression at that time was that he might need variable levels of support when feeling stressed or vulnerable, rather than containment. His historical offending history scored highly but current risk (based on the previous 12 months) scored low. On this basis they agreed to take him on a trial basis. In subsequent discussions Keystones staff have been unable to say whether they would have refused to take him if they had seen a more comprehensive, contemporary risk assessment, as they believe much of the information was contained in other documents. On the basis of the information provided to them MC met their eligibility criteria. They have stated that they have quite frequently turned down Fromeside referrals and that they generally have arrived at their decisions to accept someone for a trial based on documentary information, the patient's own motivation and their recent behaviour.

In January 2012 a comprehensive discharge plan involving a number of members of the Fromeside multi-disciplinary team was developed. This plan covered:

- transition from hospital into community
- mental health
- leave
- rights
- self medication

All sections of this discharge plan were signed by MC. It appears that this plan was not shared with Keystones and it does not appear in the Keystones documents now held by the police.

Although comprehensive the discharge plan had not been given a chance to become well-established prior to MC's extended leave. He had enrolled on a volunteering scheme and had been attending yoga classes in the community, but neither of these appears to have become embedded into his routine and it seems that he did not continue with these during his short stay at Keystones.

Although certain documents appear not to have been shared there is evidence of sound and comprehensive collaboration and information exchange between the Fromeside team and the Keystones team. Their accounts of MC's referral and time at Keystones were totally consistent.

9.6.2 Comment

The basic package of care for any new admission to Keystones is for approximately ten hours of care per week, which may be one-to-one or in groups. We were told that in practice it can be significantly higher than this, depending on a resident's involvement in activities and groups. It also tends to be higher in the Filton Avenue house as that is where staff are based between 10am and 6pm, Monday to Friday, with on call arrangements 24 hours a day, and a staff member dropping in briefly at weekends. MC has confirmed that he saw and spent time with a number of members of staff and that there was significantly more support at Keystones than there was in his placement in Cheltenham two years earlier. We understand that it would have been possible to commission one-to-one weekend contact for MC for a number of weeks at the beginning of his placement. However, as already discussed, there is no evidence that this was considered by the Fromeside team, possibly because of his relatively limited use of opportunities to talk to staff in the hospital, and his reports when he did talk to staff that everything was fine.

Although several of those involved in MC's care have told us that they do not think that the pace of his discharge was too swift, our view was that there would have been benefits in slowing down his discharge and more fully checking progress at every stage.

We are concerned that the risk assessment documentation does not appear to have been shared with the Keystones team. As stated in the Trust's policy, ratified later in 2012:

Risk assessment will not prevent or eliminate all untoward outcomes, but it will make these less likely, but it is meaningless unless it is communicated effectively within and between teams, services, professionals, service users and carers.

Effective engagement and communication with and between the service user, their carer(s), other professionals and agencies, underpins all risk assessment and management.[27]

We have also considered whether the referral to Keystones was appropriate in the light of the judgement in the case of the Health and Safety Executive v Hertfordshire Partnership NHS Trust[28]. In that judgement it was deemed that the placement was not appropriate and, amongst other factors, staff were not experienced, trained or skilled in the care of such residents. However that was not the case with Keystones where there had been a history of a number of successful placements from Fromeside and where staff appeared to be appropriately trained and supervised.

The Keystones team have undertaken their own review and identification of lessons to be learnt from this tragedy. The service has revised its referral guidelines and procedure, strengthened house rules (including being specific about not allowing offensive weapons), installed CCTV cameras in entrance halls, and made changes to a number of policies including action to be taken in the event of illicit drug use. Prior to the homicide the Keystones licence agreement specified in two places that offensive weapons or other offensive goods were prohibited. This agreement and the house rules were discussed with, and signed by, MC. As the organisation has pointed out, Keystones residents live in the community in supported accommodation, not a secure setting. Keystones staff do not, and cannot legally, search residents' rooms. However they will often help residents to clean their rooms and will take that opportunity to observe behaviour and the environment.

The developments at Keystones have been shared with the local authority safeguarding team. Bristol City Council undertook a series of safeguarding

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[27] *Avon and Wiltshire Partnership NHS Trust (Nov 2012) Care Programme Approach – Clinical Risk Assessment and Management Procedure*

[28] *Hertfordshire Partnership NHS Trust was criticised and fined for placing a potentially violent patient into a care home where staff were not trained or equipped to provide the appropriate care. The patient stabbed and killed a care worker.* http://www.mills-reeve.com/files/Publication/7f6b48f9-28ec-4cf4-8634-1010bf331ad1/Presentation/PublicationAttachment/662ecc63-ed0a-4ced-a0e6-f9046511f2fd/Hertfordshire%20Partnership%20Trusts%20conviction%20-%20July%202012.pdf

strategy meetings after the homicide, and it is clear that Keystones and the Trust co-operated fully with these meetings.

9.6.3 Recommendations

11. The Trust should ensure that all pertinent information including evidence-based risk assessments should be shared with the organisation to which a forensic patient is being discharged.

12. The Trust should ensure that for forensic patients discharge plans should be phased in over several weeks so that the plan and routine for life in the community is firmly embedded prior to actual discharge. This should include awareness of and planning for the seven days of the week and 24 hours in each day.

10. CARE AND SERVICE DELIVERY ISSUES AND CONTRIBUTORY FACTORS

The independent investigation did not find any problems which were solely to do with care or service delivery. Rather we identified two delivery issues which were influenced by a combination of care and service contributory, but not causal, factors. These are:

Risk assessment and relapse prevention
Contributory factors

- Lack of a clear, collaborative multi-disciplinary process for risk assessment
- Lack of clarity on the use of risk assessment to inform care planning
- No process to test relapse prevention planning in ward or community setting
- The need for greater integration of inpatient nursing staff into multi-disciplinary team meetings and discussions

Section 17 leave and discharge planning
Contributory factors

- Lack of referral to MAPPA
- The need for strengthened communication between the Trust and partner organisations
- No Leave of Absence policy or guidelines in the Trust

These care and service delivery issues are reflected in this report's recommendations.

11. AVON AND WILTSHIRE PARTNERSHIP TRUST'S INTERNAL INVESTIGATION

Summary

The internal investigation was conducted within a few weeks of the incident by the lead nurse for risk management and the consultant clinical psychologist for the drug and alcohol service. The team also had some input from a consultant forensic psychiatrist from a different trust towards the end of their investigation. The team took statements from and interviewed a large number of people who were involved in MC's care. They also scrutinised psychiatric records and polices. The team met GN's adoptive parents, but not other members of his family, on the advice of police liaison officers. They did not meet MC or any members of his family.

The investigation appears to have used a systematic process drawing upon root cause analysis, and identified three care delivery problems (CDPs) as possible contributory factors in this tragic event. They did not identify any service delivery problems. The care delivery problems were:

Care Delivery Problem 1: Risk assessment documentation was incomplete.

Some fields on the HCR-20 were not completed. Other fields contained summarised, factual and accurate information. However, not enough detail was provided to allow it to be used as a stand-alone risk assessment document. As a result, the HCR-20 could not adequately contribute to risk management and care planning.

The HCR-20 lacked details of the author or date of completion, and there was no review date.

The HCR-20 was not reviewed at the point of transition from inpatient to community care, nor within an identified time frame.

The HCR-20 and the two section 17 leave forms issued whilst MC was on leave from Fromeside did not specify any restrictions in relation to whether he could travel outside of the Bristol area.

Mr MC had an extensive history of violence which far outweighed his history of fire setting. More attention was given to fire-setting than to the violence risk assessment.

The HCR-20 did not include more subtle qualitative risk enhancing factors, which taken together, might indicate a need for increased concern.

Mr MC's long history of contact with psychiatric services and previous medium security and high security placements were not incorporated into the HCR-20.

Care Delivery Problem 2: Whilst a thorough and comprehensive transfer plan had been made by the Team for MC's transition from a medium security hospital to the community, the care plan which included the crisis and contingency plan, lacked adequate detail.

The care plan was not contemporaneous.

An updated care plan was not produced at the Section 117 meeting or in a CPA review prior to the start of the transition of care to community.

The care plan that was in place at the time of his transition was adapted from his inpatient care, and therefore it did not adequately represent the package of care agreed at the Section 117 meeting.

The care plan failed to provide explicit contingency arrangements in the event of increasing risk or relapse indicators becoming apparent. A fully completed HCR-20 would have assisted in the development of a comprehensive crisis and contingency plan.

Staff may lack understanding of how to use the care plan, care plan library and associated documentation on RiO. Mr MC's care plan contained a number of contradictory start and stop dates for interventions.

The lack of a detailed and explicit contingency plan may have resulted in ward staff failing to appreciate the possible urgency and need to rapidly escalate the concerns of the community nurse to a member of the Gloucester sector team or the Unit Nurse in Charge

The AWOL section of the care plan attempted to explain that in the event of Mr MC going absent without leave that he may attempt to visit his brother in Newport. However, the language used may have led Mr MC or staff to believe that he was allowed to visit his brother in Newport.

Care Delivery Problem 3: The RiO risk assessment and core assessment did not adequately reflect that Mr MC had been convicted of a MAPPA eligible offence. Consequently, Avon and Somerset MAPPA were not informed when Mr MC commenced leave and his discharge was planned.

Interpreting MAPPA National guidance was highly complex and time consuming.

Advice on the Trust Intranet did not clarify how to identify eligible MAPPA offences.

Trust Information Sharing guidelines were unclear about when and how MAPPA should be advised of admission, starting leave, changes to risk and discharge.

A MAPPA G form was not completed when MC started leave, nor when discharge was planned. The MAPPA G form is intended to be used to inform local police of service users in mental health services (including those who are detained or conditionally discharged) who may meet the MAPPA criteria or who present a significant risk of committing violent or sexual offences. It is also used for updating and informing the police of any significant risk changes.

There was no system within the Gloucester Sector Team at Fromeside for the completion of MAPPA G forms.

Guidance had not been issued to staff to clarify how and in what circumstances the MAPPA Y/N marker on the RiO risk assessment should be used.

Guidance had not been issued to clinicians to indicate where information about MAPPA should be stored on RiO.

The team went on to consider whether the incident could still have happened if the contributory factors had not occurred. They concluded that, although some of the records lacked detail, the actual care provided appeared to have been comprehensive and thorough. In their view more comprehensive and detailed documentation would not have, in itself, changed the outcome.

Lessons learned from the internal investigation

1. On reviewing the care provided to Mr MC by AWP, the internal investigating team's opinion was that the decision to move Mr MC from secure care into community accommodation was a reasonable course of action given that his mental health was stable, he was fully compliant with treatment, he was self-medicating, he had much improved daytime structure, he was placed with an experienced provider in stable accommodation and he had a comprehensive after-care plan which included a high level of ongoing support and monitoring by AWP.

   Whilst Mr MC was still exhibiting thought broadcast, his mental state was stable and it is not uncommon for individuals who continue to hold residual psychotic symptoms to be discharged on condition that there is a comprehensive aftercare package to maintain monitoring, supervision and treatment needs. This was clearly addressed in this case. This is additionally consistent with the recovery model, therapeutic risk taking and aiming for his ongoing management in the least restrictive environment. It is worthy of note that the alternative of him remaining in hospital is of course associated with other risks such as damaging therapeutic rapport which could alienate him and paradoxically heighten risk. This is an extremely difficult balancing act which clinicians are faced with on a day-to-day basis.

   It is our opinion (the opinion of the Trust's internal investigation team) that, given Mr MC's lack of recent violence and stable mental state, that if Mr

MC had applied for a Mental Health Tribunal, that he may have been discharged from the Mental Health Act.

2. Mr MC's section 17 leave was suspended and reviewed following his trip to Wales and his use of cannabis. After a period of observation and review of MC's mental health, a decision was made to extend the period of leave to allow for a longer trial period at Keystones. It would have been helpful at this point if more detailed consideration had been given to the potential pros and cons of MC visiting his brother and if there had been specific instructions on the S17 leave form as to the conditions of leave in relation to use of drugs and travel outside of the Bristol area. Staff generally considered that contact with his brother was positive and to be encouraged. It would have been helpful if staff had taken the opportunity to contact the brother following MC's first visit to him whilst on leave (with MC's permission), as he may have been able to shed further light on MC in and around this time period.

3. The HCR-20 is a pivotal document for considering and planning the risks in relation to violent service users. A member of staff trained in the use of the HCR-20 should be identified to lead the process of completion of this document, with the remainder of the team coming together to ensure that it is completed as comprehensively and as accurately as possible. This document should be used to guide and inform the care plan and risk management plans.

4. Section 117 planning should be undertaken within the CPA process and a care plan should be produced that utilises risk information from the HCR-20.

5. There were conflicting records of Mr MC's mental state on record. Some notes refer to Mr MC chronically exhibiting signs of psychosis (and particularly the delusional belief that others can read his thoughts or are interfering with his mind which psycho pathologically would be construed as thought broadcasting/thought alienation/passivity). Other notes say there is "no evidence of psychosis". It is known that Mr MC sometimes hid his symptoms. However, he also talked about them when asked. Care should be taken by members of the multi-disciplinary team to ensure that where a thorough mental state examination has not been undertaken and a subjective assessment of mental state is being made that the means of assessment are indicated.

6. Although it is outside of the control of the authors of this report, we believe that charges should not have been dropped in relation to the incidents of arson and assault occasioned by Mr MC. It is possible that the charges being dropped reinforced Mr MC's antisocial behaviour due to a lack of consequence and made risk assessment more difficult.

7. The local procedure for dealing with enquiries in relation to service users on section 17 leave is contained in the Forensic Liaison team out of hours contact procedure. The procedure is unclear.

8. Initials of staff members attending PCR were recorded on RiO on occasions, making identification of individuals open to error.

9. The time that visits/events occurred was unclear from RiO – Progress notes only gave the date and time that the entries were made, and not the actual date and time of events.

Recommendations from the Trust's internal investigation

Recommendations already addressed:

1. MAPPA G forms are now routinely completed in the Gloucester sector team at Fromeside for all service users prior to leave and/or discharge.

SBU[29] Recommendations

1. The SBU should audit the quality of HCR-20 documentation against best practice guidelines.
2. A new RiO Care Plan should be developed after each CPA meeting, and include specific contingency arrangements in the event of increasing risk or relapse indicators becoming apparent.
3. Responsible Clinicians to ensure that explicit instructions are provided on the section 17 leave form in relation to the specific conditions of leave.
4. Planning for Section 117 should take place within a CPA meeting.
5. Staff should actively involve family members and concerned others in relation to care planning and risk management.
6. The procedure for dealing with enquiries in relation to service users on leave, both within and outside of working hours, should be reviewed. The guidance should be clear and unambiguous in ensuring a consistent and proportionate response.
7. All locality teams in Fromeside should review their practice in relation to the implementation of MAPPA and the completion of MAPPA G forms.
8. The names and roles of all staff need to be recorded in full on all RiO entries.
9. The RiO records need to clearly specify the date and time of the actual event/visit, as well as the date and time of entry.

Trust Recommendations

1. The Trust should review the draft MAPPA Policy, any associated procedures and guidance to ensure that documents:-

[29] In 2012 the Trust had a number of Strategic Business Units (SBUs). These have now been replaced by management areas coinciding with local authority boundaries.

a. Are clear about when and how clinical staff should request an offending history,
b. Provide clinical staff with a clear explanation of how to identify eligible offences,
c. Are explicitly clear about when and how communication is to take place with MAPPA,

2. The Trust should consider updating its' Rio Wiki guide to:-
   a. Explain the circumstances under which the MAPPA Y/N fields are to be marked as "Y" on Rio.
   b. Include an explanation of where to capture MAPPA information on Rio

11.1 Comment on the internal investigation from the independent investigation

The independent investigation has reviewed the internal investigation guided by the NPSA toolkit[30]. We also interviewed one of the two main authors of the report and found that the investigation had followed due process, and their evidence gathering had been thorough, comprehensive and systematic. They had considered many of the themes which we also pursued and arrived at very similar conclusions in a number of areas. These had not always been reflected in the findings which in our opinion focused on record-keeping, paperwork and documentation and did not sufficiently reflect the practice issues, some of which they had explored in discussions. It was unfortunate that there was no forensic specialist input to the investigation until the process was nearing completion.

There was some significant involvement of Keystones staff in the internal investigation and it was clear that Fromeside and Keystones had worked closely together. However we believe that the investigation may have been further strengthened by greater involvement of Keystones staff in the review, for example: a Keystones director joining the review team for part of the process; sharing of Keystones records; or interviews with one or two additional members of Keystones staff.

We are in full accord with all the Trust's identified Care Delivery Problems and their contributory factors and with the recommendations and lessons to be learnt.

The Trust's action plan

We have also reviewed the Fromeside action plan developed to address the recommendations (appendix 2). Of the twelve action points it appears that all but two had been completed by June 2013, the exceptions being:

Action point 1
The SBU should audit the quality of HCR-20 documentation against best practice guidelines. It is reported that an audit will take place following the development of standards.

Action point 7
The procedure for dealing with enquiries in relation to service users on leave, both within and outside of working hours, should be reviewed. The guidance should be clear and unambiguous in ensuring a consistent and proportionate response. This was to be addressed through policy/guideline development.

[30] *National Patient Safety Agency. RCA Investigation Evaluation Checklist.*

Recommendation

13. The Trust should ensure that any future internal investigation of a serious incident should, where appropriate and possible, be undertaken as fully as possible in partnership with other involved agencies, and with the involvement of families.

11.2 Comment on the Trust's communication and support for GN's family

We understand that there was some early contact by the Trust with GN's family and they were invited to contribute to the investigation. In addition, senior members of Trust staff met them to discuss the report. It appears that there was no further contact after that meeting, although it was stated in the internal investigation that the Trust's representatives intended to maintain contact.

12. LESSONS TO BE LEARNT AND RECOMMENDATIONS

The Scoping Group of the Royal College of Psychiatrists observed that:

'Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour.'[31]

In our judgement it was predictable that there would be some violent episode at some point following MC's move out of medium secure care, but the timing, nature and severity of this violence was not predictable. To have prevented any serious violence MC would most likely have had to remain for a much longer period or even indefinitely in some form of secure care, and it is unlikely that that would be deemed to be lawful. A somewhat longer pathway within medium secure care or an alternative more highly staffed placement on discharge from Fromeside may have reduced the possibility of such a serious violent incident, but that is judged with the benefit of hindsight.

Therefore this tragic event was neither predictable (in the nature and seriousness of the event) nor preventable.

This view appears to be supported by the judge's summing up in court.

> The judge said: "In my judgement you are particularly dangerous because it can appear to professionals that your mental health is such that you can live in the community, whereas, as this tragic case demonstrates, your behaviour is unpredictable... I am wholly satisfied that you are a significant risk to the public of serious harm... You will not be considered for release whilst it is their thought that you might represent a danger to the public. You will only be released when the authorities are satisfied that any such risk has evaporated." [32]

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[31] Royal College of Psychiatrists (2008) Rethinking risk to others in mental health services. Final report of a scoping group. p23.

[32] The Law Pages website. http://www.thelawpages.com/court-cases/Marc-Carter-10166-1.law

12.1 Recommendations

The independent investigation fully endorses the recommendations of the internal investigation and, with the exception of recommendations on section 17 leave and MAPPA, we have not repeated them in our recommendations. The following are the recommendations arising from this independent review.

1. The Trust should ensure that each new or re-admission to the medium secure unit has a full and comprehensive multi-disciplinary mental health assessment, informed but not dictated, by his/her history. This assessment would lead to a detailed care plan owned by all professionals involved.
2. The Trust should ensure that forensic multi-disciplinary inpatient teams work more closely with inpatient nursing staff.
3. The Trust should ensure that, in forensic services, there is a multi-disciplinary discussion and agreement on individual, evidence-based risk assessment, including static, dynamic and personality factors, and a clear link between risk assessment and risk management.
4. The Trust should ensure that there is very careful history taking on previous risk behaviour and attempts to identify antecedents.
5. The Trust should ensure that all forensic patients are considered for referral to the local MAPPA process, and the decision, and reasons for it, recorded in the patient's records. (This practice has already been implemented.)
6. The Trust should ensure that, for forensic patients, any specific risk assessment (eg, fire setting) should be integrated with generic risk assessments and discharge plans.
7. The Trust should ensure that relapse indicators, questionnaires and prevention strategies are agreed and reinforced by the whole multi-disciplinary team.
8. The Trust should ensure that any relapse tools are rigorously tested for validity for the individual patient by examining historical risk behaviour and also reviewing the efficacy of prevention strategies in further situations which could generate frustration or aggression.
9. The Trust should develop good practice guidance on leave of absence under section 17 of the Mental Health Act, which should, amongst other elements, require responsible clinicians to set out clear criteria and conditions for such leave.
10. The Trust should ensure that in any multi-disciplinary review of issues arising from a forensic patient's leave of absence the patient's placement is fully informed and fully involved in the discussion.
11. The Trust should ensure that all pertinent information including evidence-based risk assessments is shared with the organisation to which a forensic patient is being discharged.
12. The Trust should ensure that, for forensic patients, discharge plans (including meaningful use of time) are fully established, implemented and tested prior to trial leave and discharge, so that the plan and routine for life in the community is firmly embedded prior to actual discharge. This should include awareness of and planning for the seven days of the week and 24 hours in each day.
13. The Trust should ensure that any future internal investigation of a serious incident should, where appropriate and possible, be undertaken as fully as possible in partnership with other involved agencies, and with the involvement of families.

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APPENDIX 1
Chronology of MC's care from March 2011 to March 2012

This chronology has been drawn up from medical records and records from Keystones.

10/3/11	Admitted to Bradley Brook (Fromeside) from Greyfriars Hospital, on section 3. Had been admitted to Greyfriars after setting fire to property in his flat, which he believed was broadcasting his thoughts. In Greyfriars he had damaged a microwave oven and thrown a plant at a staff member, resulting in him being taken into police custody and from there to Fromeside. Said that he preferred Fromeside to Broadmoor as possible to smoke at Fromeside. Core assessment completed.
11/3/11	Punched a female member of nursing staff after making a request to go into garden for a cigarette at 6.45 am and having this request refused. Restrained and given medication.
12/3/11	RiO risk assessment commenced by member of ward nursing staff, and dated as completed on 23/3/11
	There followed a period of being fairly settled, although sometimes a bit 'edgy' and slightly suspicious, but generally 'warm' with good eye contact. It was thought by the team that the assault may have been instrumental or result of odd/psychotic phenomena. He reported that he felt better in hospital.
15/3/11	At Patient Care Review (PCR) Dr Z said that MC probably had paranoid schizophrenia and may also have a personality disorder.
16/3/11	Social worker talks to MC about making contact with his father (who was his nearest relative under the MHA) and asks if she can speak to him. MC says he will think about it and let her know in PCR meeting next week.
23/3/11	His father phoned the ward and then phoned MC on payphone.
24/3/11	Dr Z meeting with MC. Dr Z concluded that MC was 'feeling safe in a secure and structured environment and bizarre thoughts may be better controlled here as limited access to illicit drugs'.
27/3/11	Told staff that he is sometimes frustrated by other patients, and that he would like to live in Bristol when discharged.
	Some engagement with OT over coming weeks. He would attend some groups but not join in, preferring to observe. Diazepam gradually reduced.
30/3/11	MC tells social worker that she could phone his father if she wishes, but he would not want to discuss things with her.
5/4/11	Social circumstances report written by forensic social worker for first tier tribunal. She has spoken to MC's father who had been happy to speak to her. He told her that he thought that MC had 'gone downhill very fast' when he got his own tenancy, he felt that MC had been depressed and struggled with his very small flat in Cheltenham and that he was institutionalised. MC's father did not wish to become involved as nearest relative, but would 'leave it to the professionals'. In this report the social worker also noted that MC 'had no children as far as I am aware'.

27/4/11	MC tells staff that he is increasingly frustrated by another patient who 'keeps on at him'. Tells staff he feels like assaulting him.
3/5/11	In PCR says he would like to move to Avon ward and to stop diazepam.
5/5/11	Court appearance. Outcome is for him to continue on his section and treatment plan.
10/5/11	It was confirmed in patient care review notes that he is on a notional section 37[33], hospital order. Reported that he is 'doing well'.
15/5/11	Assessed by Avon ward staff and accepted.
18/5/11	Transferred to Avon ward
	Attended individual relaxation classes. Gradually allowed unescorted ground leave and began to express interest in therapy groups.
24/5/11	In PCR meeting he appeared a little more anxious. No hallucinations, but said that he still believed people could read his thoughts. 50% sure that this was result of mental illness. Escorted ground and community leave started.
31/5/11	CPA meeting, discussed future placement, support, drugs, relapse prevention, fire setting work
13/6/11	Attended first Positive Futures group.
20/6/11	Started first phase of self medication regime.
21/6/11	In PCR meeting agreed could start unescorted ground leave
1/7/11	Received letter from landlord telling him that he wanted him to relinquish his tenancy in Cheltenham. Happy to do so and asked for his Cheltenham CPN to collect his property.
5/7/11	Some tension between patients re MC listening to music on the television while others wished to watch a different channel. Still reporting that others could read his thoughts but he was 'not bothered by this'.
15/7/11	Took part in Explore Bristol group, visiting a museum and travelling by bus.
20/7/11	First of five sessions for fire setting assessment with trainee clinical psychologist (who was fully qualified by time of incident).
25/7/11	MC informed his named nurse that he had been told that police would not pursue charges against him re assault on Fromeside nurse.
26/7/11	Session with named nurse. He said he felt very positive and that he was not going to touch drugs again and had no urge for alcohol. Also said that he realised he needed to be tolerant of others and not behave aggressively.
2/8/11	Altercation between MC and another patient over what they were watching on the television.
8/8/11	Discussion with named nurse. MC felt the incident over the TV with another patient was entirely the other service user's fault.
16/8/11	PCR meeting. Engaging well, no new problems, on stage 2 of self medication. Appeared to be very well.
22/8/11	Discussion between MC and clinical psychologist who was completing fire setting report.
30/8/11	Fire setting report discussed in PCR. The assessment suggested that he remained at risk of actions which would allow him to achieve containment in

[33] The term refers to a patient who is treated as if subject to a hospital order under s37 of the Mental Health Act

	hospital and that this has implications for placement and discharge.
9/9/11	Meeting between MC and clinical psychologist. Psychologist's formulation included suggestion that he was in a cycle of seeking high and then low containment. He appeared to agree with this.
13/9/11	Granted unescorted leave for 4 hours twice a week.
15/9/11	First yoga class in the community using unescorted leave. Successful trip
29/9/11	Fire setting report recommended problem solving group and work on relapse prevention. Proposed that he should not have any reduction in support on discharge. Also agreed for an increase in unescorted leave.
4/10/11	Discussion between social worker and MC. He may not be eligible for housing in Bristol and may have to go back to Gloucestershire. He would prefer Bristol as it is bigger.
10/10/11	One-to-one with named nurse. He said he was determined not to come back into hospital again and would keep away from drugs.
8/11/11	Told that he would need to apply to private housing provider. Started stage 3 of self medication.
15/11/11	CPA review. Housing and discharge planning discussed. Team agreed that HCR-20 should be completed.
22/11/11	Referral to Keystones. The following documents were enclosed with the referral: • Self-completed questionnaires on alcohol, drug misuse and anger management • information on MC's relapse signature and relapse questionnaire • his consultant's report for the Mental Health Review Tribunal, dated 4/3/11 • the clinical psychologist's fire-setting assessment, dated 16/9/11 • care plan dated 15/11/11
5/12/11	Assessed by Siston ward staff and accepted
16/12/11	Keystones confirmed that happy to progress to next stage, i.e. informal visit
18/12/11	Several incidents of raised voices between MC and another patient over use of television
23/12/11	Visited Keystones with forensic community nurse. Said that he liked the accommodation and would like to take the vacancy.
3/1/12	In PCR meeting agreed that 9-5 support would be enough as he had had much less in Cheltenham prior to the fire setting. To start stage 4 of self medication.
6/1/12	Moved to Siston ward
15/1/12	Care plan developed covering: transition from hospital into community, mental health, leave, rights and self medication. All signed by MC.
17/1/12	Plans for MC to have care co-ordinator in North Bristol CMHT. He would be on a community treatment order (CTO) once discharged.
23/1/12	Minor incident involving television between MC and another patient. Staff talked about this with MC but he became upset and left the room, banging the door. He later apologised to staff for his behaviour and said he had no issues with other patient.
3/2/12	HCR-20 updated by clinical psychologist.
7/2/12	Attended Fareshare voluntary scheme to register as volunteer. Intended to continue with this once discharged.

8/2/12	MC participated in psychology group 'getting out, staying out'. Also discussed overnight leave and care plan with named nurse.
9/2/12	New responsible clinician from date of discharge and care co-ordinator confirmed by CMHT manager.
22/2/12-24/2/12	Two days/nights leave to Filton Avenue, Keystones for trial leave. On return journey with community forensic nurse MC told him he had heard from brother that his cancer had returned and he had visited him in Newport and had smoked cannabis. He also said that he had heard that he would need to contribute £53 towards rent out of his £100 per week. (This turned out not to be the case.)
28/2/12	Told PCR meeting that cannabis is not a problem for him. Team agreed to slow down his discharge by using more section 17 leave instead of discharge on CTO on 5/3/12.
29/2/12-2/3/12	Second period of trial leave to Keystones.
2/3/12	On return to Siston ward MC said that leave had gone well. Urine screen positive for cannabis (possibly from admitted cannabis use on 22/2/12) Section 117 meeting, was attended by Cheltenham CPN and Keystones. Agreed discharge plan and further two weeks leave to Keystones. Very comprehensive discharge plan developed, including ten hours of direct support by staff as well as general support available at the house.
5/3/12	Taken to Filton Avenue, Keystones for beginning of 2 weeks leave. Section 17 leave form stated that he is 'to abide by the rules and regulations and guidance of staff there. To be free to leave the house at will but to abide by the rules and regulations. For no alcohol or illicit drugs. '
7/3/12	Keystones visited by CFN. MC was not there but staff said he had been fine.
9/3/12 Friday	Care co-ordinator visited Keystones to give depot medication. MC was just coming back from two days visiting his brother in Newport. Had smoked cannabis (believed by team to be significant relapse trigger). A bit suspicious. Depot given. Keystones staff had not known his whereabouts over past two days. Siston ward informed by phone of situation by care co-ordinator. No record of this telephone call.
12/3/12 Monday	CFN informed ward that he would bring MC back. MC had no evidence or signs of paranoia, appeared relaxed. No signs of delusional thinking or symptoms of mental illness. CFN spent around two hours with MC that afternoon, some of it in a local cafe. He reported that MC was physically and psychologically relaxed and showed no signs of paranoia, had good eye contact and denied any problems. CFN told Keystones staff that he was returning MC to the ward because of his cannabis use and his trip to Newport. We have been told by Keystones staff that they were at the time not aware of his second trip to Newport and thought that CFN was referring to the first trip. MC came back to the ward later that day and said that he was keen to go back to Keystones as his father was visiting him there on Wednesday 14/3/13. Drug screen positive for cannabis and negative for other illicit drugs.
13/3/12 Tuesday	PCR meeting attended by MC. This meeting did not include anyone from Keystones. Reported that he was cleaning the kitchen a lot – a possible relapse indicator, but MC did not think it was of any significance. Agreed that leave could continue and that Dr Z would visit him there. Back to Keystones

	in the afternoon.
15/3/12 Thursday	MC seen at Keystones by Dr Z. All appeared to be well. Dr Z reported that he felt 'somewhat reassured' as MC appeared calm and settled. Leave extended to 2/4/12. Conditions stated 'to abide by the rules and regulations and guidance of staff at Keystones. Not to drink alcohol or use illicit drugs, may have access to broader community'.
17/3/12 Saturday 3.50 pm	MC was watching rugby game on television in Filton Avenue. GN was cooking in kitchen. Both seen and briefly spoken to by Keystones director as she entered the building and went upstairs to office.
4.00 pm	Fire alarm went off, possibly caused by GN cooking in the kitchen. Director came downstairs to turn off the fire alarm but this had already been done by MC.
4.02 pm	Director met visitor at the front door. Did not see either MC or GN at this time.
5.10 pm	Director told about GN being injured by another resident.
	MC was missing from hostel at time of discovery, but went to police station shortly afterwards and was taken into custody. Homicide believed to have been committed using a samurai sword which MC had in his room. Not known how he came to have the sword in the house.
	MC spent 11 nights in Keystones altogether. This included the nights he stayed at his brother's in Newport.

APPENDIX 2
Fromeside action plan to address recommendations

	Recommendation	Action	Who responsible	Audit/Review process	Deadline for completion	Completion information RAG Rating
1	MAPPA G forms should be routinely completed for all eligible service users prior to leave or discharge	MAPPA G forms are completed whenever there is a change in the level of supervision with respect to leave (e.g. granting of escorted community leave or transition from escorted to unescorted leave) or else when somebody is being discharged.	Care Co-ordinator	This is in line with the MAPPA policy and is therefore subject to 3 yearly review in line with Trust Policy.	Complete	
2	The SBU should audit the quality of HCR-20 documentation against best practice guidelines	An audit is not possible where there are no established standards. Instead, a survey of HCR-20 practice to be undertaken initially, to establish current practice and to examine areas of weakness.	All teams. WW and VV are conducting the review and planning the audit.	Survey now complete. Plans to set standards for HCR-20s and to set up an audit process are in progress.	To complete within 6 months (Nov 2013)	
3	A new RiO Care Plan should be developed after each CPA meeting, and include specific contingency arrangements in the event of increasing risk or relapse indicators becoming apparent.	Rio Care Plans to be developed after each CPA	All Teams – All care plans fit under the 7 headings of my shared pathway and in addition the RC generates a written review of the CPA in CPA management on RIO	Forms part of the trust CPA audit.	Complete	

4	Responsible Clinicians to ensure that explicit instructions are provided on the section 17 leave form in relation to the specific conditions of leave.	RC's to be mindful of the need to be specific with respect to locations for leave, including exclusions where appropriate and specifying outer limits of boundaries of leave	All RC's – OO to disseminate.	Forms part of weekly MHA audit – completed by ward staff.	Complete	
5	Planning for Section 117 should take place within a CPA meeting.	117 meetings should always be regarded as CPA's even if they fall without the CPA cycle.	All RC's /Care –Co-ordinators – OO to disseminate.	Forms part of annual CPA audit and regular records audit.	Complete	
6	Staff should actively involve family members and concerned others in relation to care planning and risk management.	Staff to ensure that every time a Service User is given their rights, that staff also complete the 'Information sharing and consent' template on Rio	All Nursing Staff – KK to disseminate	Forms part of the weekly MHA audit	Complete	
7	The procedure for dealing with enquiries in relation to service users on leave, both within and outside of working hours, should be reviewed. The guidance should be clear and unambiguous in ensuring a consistent and proportionate response.	An addition to be made to UNIC policy to address this recommendation by stipulating an escalation process for concerns expressed.	For GG to action	Via ratification in CLG	3 months	
8	All locality teams in Fromeside should review their practice in relation to the implementation of MAPPA and the completion of MAPPA G forms.	See number 1 (above)	As number 1	As number 1	complete	

9	The names and roles of all staff need to be recorded in full on all RiO entries.	Matrons to disseminate to all of Fromeside	All staff – to be disseminated by KK	As per any audit of Rio records	Complete	
10	The RiO records need to clearly specify the date and time of the actual event/visit, as well as the date and time of entry.	Matrons to disseminate to all of Fromeside	All staff – to be disseminated by KK	As per any audit of Rio records	Complete	
11	The Trust should review the draft MAPPA Policy, any associated procedures and guidance to ensure that documents:- a. Are clear about when and how clinical staff should request an offending history, b. Provide clinical staff with a clear explanation of how to identify eligible offences, c. Are explicitly clear about when and how communication is to take place with MAPPA,	KK to discuss with HH requesting that he take it to the Trust Policies Group	HH to address		Complete	

12	The Trust should consider updating its' Rio Wiki guide to:- a. Explain the circumstances under which the MAPPA Y/N fields are to be marked as "Y" on Rio. b. Include an explanation of where to capture MAPPA information on Rio	KK to discuss with HH requesting that he take it to the Trust Policies Group	HH to address		Complete	