REPORT OF THE INDEPENDENT HOMICIDE INVESTIGATION

INTO THE CARE OF PATIENT T

BY

SHROPSHIRE MENTAL HEALTH SERVICES

COMMISSIONED BY THE NHS WEST MIDLANDS

UNDERTAKEN BY DR GEOFF ROBERTS AND MR ROGER HARGREAVES

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1.0 Executive summary

1. ..... The Department of Health issued guidance on 10 May 1994 on the care of mentally disordered patients discharged into the community in the circular HSG (94) 27, LASSL (94) 4. This included guidance on the conduct of external reviews where a patient has been convicted of homicide. This advice was modified in June 2005 and now allows for consideration to be given for a proportionate Independent Investigation and increasing the discretion of the statutory agencies in the format and nature of the independent investigation. This review was carried out in the context of these changes.

2. ..... The independent investigation has been carried out in line with the Terms of Reference issued by the Strategic Health Authority and this report is the result of the review.

3. ..... In May 2006 Patient T was convicted of manslaughter for the killing of his mother on 3 October 2005 at the home which they shared. A plea of diminished responsibility resulting from mental illness was accepted and he was made the subject of a Section 37/41 order under the Mental Health Act 1983. He is currently in a medium secure clinic.

4..... Patient T had a long history of mental health problems. He first came into contact with mental health services in 1989 when he was serving a prison sentence for assault. No definite diagnosis was made until 1996. At this time he was serving another prison sentence for the grievous bodily harm of his mother and actual bodily harm of his father. This conviction was in 1993. After a further conviction for an assault on two prison officers he was assessed by the Forensic Psychiatrist as suffering from a paranoid psychotic illness.

5. ..... Patient T was eventually transferred to Reaside Clinic for treatment and transferred to Shelton Hospital in 1997. After his expected date of release from his prison sentence in January 1997, his detention continued on a notional Section 37 of the Mental Health Act 1983; this being the only legal option available. However, this meant that there were no restrictions on him after the Section 37 expired or was rescinded.

6. ..... After his transfer to Shelton relationships with his parents were restored. The hospital staff came under increasing pressure to allow Patient T to have leave at his parents. This became more so after his father died in 1998. The hospital staff were well aware of the potential for this to have significant risks and their efforts to restrict this are well noted on many occasions in the records.

7. ..... Patient T moved to live in a supported flat in Market Drayton in 2000. This continued until 2002 when there was a fire incident at the flat. He was readmitted on a Section

3 in October 2002, but this was rescinded after four weeks.

8. ..... Despite considerable efforts by his care coordinator to find suitable accommodation, this did not prove possible. The reasons for this and the functioning of the accommodation funding panel are discussed in more detail in the full report.

9. ..... The default whilst waiting for suitable accommodation became that Patient T lived with his mother. His care was carefully monitored during this time. In the latter part of 2004 and early 2005, there were signs of a relapse of his condition which were successfully managed in the community by the consultant psychiatrist, care coordinator and GPs. A feature of this period was the ready and intensive input of all his care workers. The exacerbation was associated with an overuse of procyclidine, a drug used to counter some effects of his depot medication.

10. ..... In August 2005, there appeared to be a further episode of instability which appeared to be successfully monitored and treated.

11. ..... After killing his mother and for the purposes of a court report, Patient T described an overwhelming episode of hearing voices on the day of her death. He stated that he had not informed his mental health workers of this on the day, as he thought he could and would deal with it himself. Sadly, he did not.

12. ..... Following the incident the Trust carried out an Internal Review using the input of a psychiatrist from another Trust. The review eventually reported in June 2006. The review recommendations, although laudable, did not directly relate to or flow from most of the facts of the case. The requirement for independence of the personnel carrying out an internal review has been examined by the independent investigation and an alternative procedure recommended.

13. It is the opinion of the independent investigation that the members of the Community Mental Health Team (CMHT) involved in Patient T's treatment acted appropriately and could not have foreseen or prevented this homicide at the time.

14. ..... The independent investigation benefitted from the input of Patient T's sister to whom we are grateful and would like to express our condolences.

15. ..... The independent investigation has made 7 recommendations in the following areas

Staff training

Patient accommodation and procedures

CPA reviews

Trust internal investigation procedures

16. ..... At the trial the Judge questioned whether Patient T's mother should have been allowed

to make a decision to have her son back at home. The reality of the evidence examined by the independent investigation has shown a complex picture of relationships and co-dependencies between mother and son. The most likely outcome in this case was that Patient T would return to his mother's home, sooner or later, irrespective of the wishes or warnings of the professional staff looking after him. There would have been insufficient legal grounds to prevent this from occurring.

2.0 Terms of Reference

Independent Investigation into the Care and Treatment of Patient T

1. ..... To examine the circumstances and events relating to the treatment and health care of Patient T by the Shropshire County Primary Care NHS Trust, Shropshire's Community Mental Health NHS Trust and organisations where relevant, and in particular the treatment and health care in the period leading up to the incident at 03 October 2005.

2. ..... To identify any systemic or professional problems in the treatment and health care provided to Patient T. For example:
    - Quality of the assessed risk
    - Assessment of risk of potential harm to himself
    - Assessment of risk of potential harm to others

3. ..... To consider the effectiveness of interagency working, including communications between the mental health services, police etc. with particular reference to the sharing of information for the purpose of risk assessment.

4. ..... To review the internal investigations into the care of Patient T already undertaken by the County Primary Care NHS Trust, Shropshire's Community Mental Health Services NHS Trust, any action plans that may be formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal investigation and assess the effectiveness of their implementation.

5. ..... To employ Root Cause Analysis principles and techniques to enable competency for learning to be realised from the investigation.

6. ..... To prepare and produce a report on the above, including any recommendations for future action the panel finds it appropriate to make, for publication by the Strategic Health Authority.

3.0 Chronology of significant events
(Direct quotations from documents are italicised)

Date of Birth 31 August 1959

Personal Development

1. ..... Patient T was born after a normal pregnancy. There was no family history of mental disorder, epilepsy, criminality, violence or substance abuse. He developed asthma at the age of two which continued until he was 14. This led to hospital admission on two occasions.

2. ..... He attended local schools and obtained two CSEs at 16 in English and Social Studies.

3. ..... After leaving school he worked in a number of jobs for short periods. He undertook occasional casual work through the country travelling to pop festivals, hitchhiking and sleeping rough or living in bed and breakfast establishments. From 1987 he was living on unemployment benefit and was financially supported in part by his parents.

4. ..... Patient T formed a relationship with an older woman and they had a daughter who was born in 1980.

Criminal Record

5. ..... Patient T had 21 convictions prior to 1993, mostly for dishonesty or criminal damage and including two convictions for driving with excess alcohol. His convictions included an assault occasioning actual bodily harm in 1982, a more serious Section 20 wounding of a stranger in June 1989 for which he received a prison sentence of 15 months. The victim required plastic surgery.

6. In March 1989 Patient T was examined by a consultant psychiatrist who noted:

'A history of consistent cannabis abuse since age eighteen was gained, and a moderate intake of alcohol and occasional use of LSD. He had difficulty describing himself or his temperament in any way. The consultant psychiatrist did not find evidence of mental illness but felt that Patient T's difficulties in obtaining and maintaining work, relationships, difficulties with his parents and other behaviour may be secondary to a personality disorder which may be exacerbated by chronic cannabis abuse.

Patient T's mother told the consultant that on the night before the offence he had been walking up and down the stairs in the home all night. The following day he stayed in bed until 2pm and she noticed that he was abrupt and irritable. Earlier that day she felt that he was off-hand towards her.'

7. June 1989, the summary of the court reports included:

'Of special note is that it was difficult to discuss the offence with Patient T. Patient T told her that he had left a public house after consuming three pints of beer. A

friend had asked him if he was drunk. This surprised Patient T who went home but mulled over what he perceived to be a perplexing remark, and he returned to the public house to ask his friend what he had meant. Instead he met the victim. Patient T said that the victim addressed him in an accusatory way, saying "hello, can I help you?" Patient T then assaulted the victim who was physically handicapped. The victim sustained a fractured cheekbone and other injuries.

Patient T's mother described her son at that time as having consumed a lot of cannabis, narcotics and alcohol. The Probation Officer described him at her interviews as "remote", "detached", staring fixedly ahead; there was evidence of paranoia in his perception of remarks made initially by his friend and subsequently by the victim.'

8. Patient T was examined by the Prison Medical Officer in May 1989 who concluded that there was no evidence of mental disorder.

Substance use

9. Patient T began to smoke cannabis heavily during his 20s, but stated in 1993 that he stopped doing so in 1988. He had occasionally taken LSD and on one occasion hallucinogenic mushrooms, but denied involvement with cocaine, amphetamine or heroin. He drank alcohol from the age of 17, frequently consuming 15 pints of beer in a public house, which sometimes led to actually memory loss and occasionally aggressive behaviour.

13/3/90	Psychiatrist to GP *'I reviewed Patient T at the out-patient clinic today. I was impressed by how much brisker and alert he was than when I saw him at Shrewsbury Prison. Today I could find nothing to suggest an organic disorder and can only conclude that he had previously been in a state of chronic cannabis intoxication. He is now feeling a good deal better than when he consulted you and does not therefore wish to have a CT head scan.I think this is a reasonable decision. The only evidence that links cannabis with cerebral atrophy is a study done in Bristol some years ago, which has not been confirmed. In any case even if we were to find that Patient T has minimal cerebral atrophy, it is not going to help in his management.'*
28/11/90	Referral letter by GP *'This gentleman asks if he might see you again. You saw him in out patients in March of this year subsequent I believe to seeing him in Shrewsbury prison. There was a question of drug abuse and a suggestion that he had a CAT scan though this was shelved as he felt better.* *He has been working in Somerset as a plastic moulder but came home because of headaches and disturbance of vision.* *On examination he was normotensive and his fundi were normal. He was however exceedingly vague and slow in thought raising the possibility of continued drug abuse (though he denied this).* *In view of his new symptoms he feels that he ought to have the CAT. scan.'*

22/1/91	Psychiatrist to GP *'Thank you for re-referring Patient T. He complains of headaches but they do not have the characteristics of those associated with intracranial raised pressure. However, in addition, his thinking is very laboured, his speech slightly slurred and his grasp impaired. He could not recognise simple absurdities, and found it very difficult to stick to or follow the point. I cannot say whether these cognitive problems are congenital or acquired, and if acquired, whether through excessive drink or drugs. Although he denies ever taking drugs by injection, I suppose Aids is another remote possibility to be considered if no other organic disorder is found. At all events I think it is worth doing a CT scan (normal) and I am therefore arranging it.'*
14/6/91	Psychiatrist to GP *'Thank you for your letter about Patient T. As you know he turned up at the out-patient clinic without an appointment. Regrettably, I did not have enough time to assess him fully. Nevertheless, in view of the odd attacks he describes, I am arranging for an EEG to exclude the possibility of a temporal lobe focus. He describes seeing apparitions and then shaking violently. However, getting a more accurate account of these episodes is extremely difficult because he tends to wander off in a discursive way which is very difficult to follow. He certainly gives the impression of a man with limited intellectual faculties, although his CT scan was normal.* *I will review him when the result of the EEG is available. (Normal)'*

10. July 1991. At Glastonbury Magistrates Court: convicted of the assault of a stranger. He was fined £100 and ordered to pay £75 compensation. A probation report prepared for the trial in 1993 states that Patient T's account of this was that he was living rough in the area, looking for work, and he saw a local man looking at him. Patient T then confronted the man, asked him what he was doing and hit him three times.

7/10/91	Referral by GP *'I am sorry that Patient T did not keep his last out patient appointment. His mother is still very concerned that there is something drastically wrong with him. He denies having taken drugs for well over two years. He feels himself to be possessed by an evil spirit which he said entered his body about two and a half years ago when he was sleeping rough in a barn in Somerset. This spirit talks to him particularly at meals and at times controls his breathing.* *He seems to have read widely about what it might be using the word incubus to describe the spirit; perhaps this is part of the problem. He had wondered about consulting a medium to see if they could help. He has already discussed his symptoms with a local clergyman who didn't feel able to offer any further advice* *He didn't seem particularly keen to see you again I wondered whether the symptoms I have described might fit with early schizophrenia. Do you know of any other agency that might be able to help him?'*
10/10/91	Psychiatrist to GP *'Many thanks for your letter about Patient T. You will know from earlier*

	correspondence that there is no evidence of cerebral atrophy or epilepsy. I agree that the symptoms you mention raise the possibility of schizophrenia. However a diagnosis of schizophrenia usually leads to long-term, perhaps even life-long treatment with powerful drugs and therefore requires a reasonable' degree of certainty. That degree of certainty is difficult to establish in Patient T who has abused drugs and alcohol and was almost certainly using drugs when he had the original psychotic experience. *I know of no agency that might be able to help, but I would be happy to review him if he gave an undertaking to keep an appointment.'*
27/5/92	Psychiatrist to GP *'Thank you for asking me to see Patient T at home, which I did last Thursday. My findings were very much as on previous occasions. Although Patient T might have been diagnosed twenty years ago as schizophrenic, these days the concept has been made more stringent and he does not really satisfy the criteria. In particular I have never been able to elicit any first rank symptoms.* *Clinically, Patient T gives the impression of being mildly brain damaged. Although he is able to cope with simple tests of cognitive function well, in fact quite speedily and accurately, his higher mental functions are limited, and I suspect impaired. He seems to have virtually no capacity for abstract thought, his judgement is very poor, he finds it difficult to tolerate frustration, and his attitude and outlook is strikingly immature.* *Of all these difficulties the one that causes the most concern is the intolerance of frustration. If Patient T encounters any difficulties, criticism or frustration, he loses his temper and becomes restless, angry and over-talkative, a state which may last for a day or so before he calms down.* *I have always suspected that the drugs he has taken for so many years have induced a minor degree of brain damage. This is the only way I can account for the clinical picture which does not fit with schizophrenia as I have mentioned, and is certainly not part of an affective illness. You will know that his EEG showed nothing to suggest a temporal lobe epilepsy. It would be useful to assess his cognitive function but unfortunately the psychology service no longer do this. In many ways Patient T's mental state would fit with continuing drug taking but, as you know, he denies this.* *The aggressive outbursts are the most serious consequence of his disorder and I am therefore asking the community psychiatric nurse to give him a test dose of Clopixol 100 mg im, followed in a week's time by 200 mg every fortnight. Patient T has, of course, agreed to this, and I hope that the calming influence of Clopixol will cause the aggressive outbursts to abate. When he is calmer I will explore with the manager the possibility of his attending the day centre. Should he develop any extra-pyramidal effects, he may need Procyclidine 5 mg or even tds.'*
7/7/92	CPN to GP *'I visited Patient T on the 2 June 1992 and administered a test dose of Clopixol 100 mg IM. I have then visited the following week to assess how he had been and whether there were any side-effects. I was met by Patient T's mother who said that Patient T had gone out jogging and didn't know I was visiting at that time but hadn't stayed. Father had decided to go after Patient T and I agreed to visit 30 minutes later, but this time Patient T was at home and*

	he appeared "uptight". He said the injection had worked he had felt much better but had no intention of having any more injections. Father tried to talk Patient T into having the depot also without any results. We discussed about Patient T possibly attending the GPs surgery for the depot and he reluctantly said that he would think about this but I suspect he will not bother. I have talked with Patient T about further visits but he declined these. He did agree to keep his outpatients appointment with Dr Myers. If Patient T agrees to have the depot in future and we would be happy to be involved at this time he is very reluctant even to have visits. In fact he told me that he didn't want me to visit any more.'
15/7/92	Psychiatrist to GP *'Patient T failed to keep his outpatients appointment to see me yesterday. He will know that he has also refused Clopixol injections so he has effectively terminated all informal psychiatric management.'*

11. July 1993 He had a court appearance for assault on both parents, regarded as the index offence in contact with mental health services

12. He was convicted of S18 Grievous Bodily Harm and sentenced to 5 years imprisonment for the attack on his mother and convicted of S20 Actual Bodily Harm and sentenced to 3 years imprisonment concurrently for the assault on his father.

13. The letter from his solicitors to a consultant forensic psychiatrist prior to the trial agrees with the suggestion made by patient T's father that his personality had changed over the last five years since 1988. A psychiatric report prepared by a forensic psychiatrist concluded that Patient T was fit to plead, that he did not suffer any mental disorder other than an unusual personality, and that he could not make a specific psychiatric recommendation in this case. Importantly, the psychiatrist stated that if the court were to consider non-custodial disposal, then it would be important that Patient T does not stay again in his parents' home, except for visits for a few hours.

14. Patient T's description of the circumstances of the offences were later stated in a medical report as:
'Patient T explained that he and his parents have lived in the same house for some time, and there was some pressure and tension at home because both parents are retired, and perhaps a little forgetful. He said he would often get on well with his parents, working with his father in the shed, or talking to his mother about her past. However, there were occasional rows, and his father would lose his temper inappropriately. Minor issues such as burning toast have triggered these, and on that particular occasion, one week before the alleged offence, his father told him to leave the house at 10:00 pm on Saturday. Patient T simply declined to do this. In general he felt that his parents had been inappropriately critical and he commented "I'd just simply had enough of their funnies".
On the material day, when his mother unexpectedly referred to his behaviour "unless you stop these evil things," he took offence feeling that she was in a domineering mood.

He then went into the living room, picked up the telephone when it rang as he was expecting a call, his father called out sharply that he should put the 'phone down. He then walked back into the kitchen, and in order to let his mother know that she could no longer push him around, he began to spank her on the backside, although not violently by his account. When his father came into the kitchen he "freaked out" and punched his father forcibly. He then went into the living room followed by his father, and proceeded to hit his father on the head with a wooden ashtray, rendering him momentarily dizzy. His father lost a tooth and required ten stitches to his head, and received a variety of bruises. When his mother came into the living room he also hit her with the ashtray, so seriously that she received a fracture of the skull in the region of the eye, requiring some time in hospital and endangering her eyesight.'

15. May 1994 Following an assault on two prison officers at HMP Stafford, Patient T was convicted of Actual Bodily Harm, Section 47. He was sentenced to six months imprisonment on each charge to run concurrently. A probation service report prepared in connection with the offences expressed concerns about Patient T's paranoid expressed beliefs.

16. The report by the Probation Officer in respect of these assaults stated:
'During this prison sentence I have visited Patient T on three occasions and on each have recorded his detachment and unusual behaviour, on one occasion dropping to his knees to pray; thus interviews have been generally unproductive, other than to confirm my concerns regarding his behaviour and risk of further offending.'

17. During 1994-5 it became apparent that Patient T was suffering from a paranoid psychotic illness for which he received antipsychotic medication. He was assessed by psychiatrists on a number of occasions. He was initially treated in the prison hospital wing. He was latterly seen and assessed by members of the Forensic Team at the local Medium Secure Unit, Reaside Clinic and it was considered necessary to transfer him for further treatment. Hyper-religiosity and what was described as a bizarre pre-occupation with parables, auditory hallucinations and flattening of affect were a feature of the illness when assessed by a Senior Registrar for the purposes of a parole board review in February 1996.

18. 22/5/96 Patient T was transferred from HMP Birmingham to Reaside on a Section 47/49 prison to hospital order. He was treated with a depot antipsychotic. At the time of his earliest date of release from his sentence in January 1997, he was placed on a notional S37. This is a section of the Mental Health Act which gives similar safeguards as a Section 3 for patients who have not been through the Court system and been convicted of an offence, i.e. he could be discharged by a Mental Health Review Tribunal (MHRT) and could not be made subject to conditions on discharge..

19. He was diagnosed with schizophrenia. He was continued on medication of a depot antipsychotic, pipothiazine weekly and procyclidine 5 mg. twice daily, as required.

13/3/97	Risk assessment completed by Keyworker Patient T described the assault on his mother as an impetuous event and that he hit her with an ash tray. He did not mention the assault on his father. *'Opinion* *Patient T seems to have ambivalent feelings about the future placement and said he will go where the doctors wanted him to go.* *Although Patient T is compliant with prescribed medication whilst formally detained in hospital, there is some concern that he may not continue to accept it if he becomes informal. Patient T has not appeared to have deteriorated in his mental state but does seem to lack insight into reasons why he is currently in hospital. Also any possible risk to his mother needs to be explored further.'*

20. At Reaside with active treatment Patient T improved. By April 1997, he was considered to have improved sufficiently to be considered for a move to a less secure environment at his local hospital. There was some delay in a bed becoming available and the move did not take place until August when he was transferred to Oak Ward at Shelton Hospital.

21. He absconded from Reaside on one occasion in April 1997 and was found to have returned to his mother's house. Patient T's version of events was that he had been apprehended by the police in the vicinity of his mother's house and that the police had asked whether he wanted to see his mother prior to being returned to Reaside. However, his mother telephoned the unit later that evening at which time her manner was described as very distressed.

13/6/97	Reaside RMO to hospital managers *'Patient T is a thirty-seven year old, single man who has been an in-patient at the Reaside Clinic since 22nd May 1996. He was transferred from HMP Birmingham as there were concerns with regard to his mental health. He has a past psychiatric history dating back to 1989.* *Although the positive symptoms of his illness have come under control with his medication, he remains insightless into his illness. He does not see the need for medication although he is willing to take it. He remains disabled by the negative features, (for example avolition, poor self care, and apathy) of his illness.* *It is appropriate that he continues to be detained under a Notional Section 37 of the Mental Health Act 1983 for his own health and for the safety of others.'*

22. A social worker assessment was carried out in June 1997 at patient T's parents' house. His mother was present. Although somewhat ambivalent about her son's

move to Shelton, it was reported that on balance she would go along with them if they helped her son. *'She only wants the best for him.'* The re-establishment of a relationship with his father was also noted.

23. Patient T was admitted to Oak Ward on 4 August 1997 and by 13 August his urine tested positive for .Cannabinoids. On 14 August he was given Section 17 leave from the hospital and he started spending an increasing amount of time at his parents. His parents visited Patient T at Shelton regularly from the time of his admission. They also brought Patient T's daughter. In September 1997 his mother was asking for the periods of leave to be increased, although the RMO at the time did continue to limit the time he spent at his parents. His depot medication and procyclidine were continued. He spent Christmas on overnight leave with his family.

24. On 6 November 1997 both parents were interviewed by Patient T's RMO. The entry reads:
'During the interview it became quite evident that his mother had forgiven what had happened in the past and would very much like to continue their relationship, previous to the incident; which was a very loving one. There still appears to be an element of friction between father and son though. They would like Patient T to come and visit them, with an emphasis on this becoming regular.'

The continuing attempts by staff to develop Patient T's independence against a background of the family's natural pressure to include him, is typified in the case entry dated 29 November 1997. This reads:
'Patient T's mother rang up to see if Patient T could go home next Wednesday. I mentioned that this would not be suitable in the light of previous discussions between the RMO and family. It is important that Patient T fosters independence, and if the family begin to see Patient T very regularly, there is a possibility Patient T may only see the family home as being his future.'

25. This tension and continuing visits by the parents are recorded throughout Patient T's hospital stay. The need to include the family in discharge planning is included in a Care Plan of 25 September 1997.

26. In January 1998 Patient T was transferred to Beech Ward. By this stage his family were under the impression he would have increasing leave and his Section 17 leave documentation was amended accordingly. However, the records clearly refer to the RMO firmly expressing the view that Patient T required a structured work and living environment in the long term. This was a recurring theme of care plans in March, April and May 1998.

27. In May 1998, Patient T's father became seriously ill and required prolonged hospital treatment. The records describe an increasing amount of time spent on leave at home with his mother and also in the company of his sister. In June Patient T was noted to be spending most of his days at his father's bedside.

28. In July 1998, the care plan entry reads:
'Patient T's father has now been moved to Whitchurch Hospital and Patient T is spending his days' leave visiting him. His sister also picks him up at weekends to take him to the hospital. The one positive thing about his father's illness is that it has drawn Patient T and his sister closer together.
My concern is what happens if his father dies. His mother seems to continually want the company of Patient T, which in ways is understandable. But I feel that there is a danger she definitely wants Patient T to come and live with her. She rarely listens to what staff say, including the dangers of Patient T living with her; and the RMO will have to be very strict with patient T's mother and make sure that one of the conditions of Patient T's future discharge is that Patient T has restricted access to his mother. Another consideration is how will Patient T react when his father dies.'

29. On 16/9/98 Patient T was transferred to West Bank Ward for rehabilitation following an introductory period over six weeks. A part of the purpose of this was to keep some distance between Patient T and his family to encourage Patient T develop to some independence, as well as to enable him to develop his social skills which it was considered may increase his confidence.

30. Patient T's father died in October 1998 and the records describe his difficulty in expressing his feelings about this for some time. He spent a period of leave at home at the time of the funeral. The records show increasing and regular periods of leave at home with his mother during 1999.

31. It is against this demonstrable very strong bond between mother and son that the subsequent history emerged and the likely inevitability of his living with her in the family home. There were no sanctions in place or available to prevent this. By July 2001 Patient T described himself as his mother's carer. Guardianship could have been considered at any point. However, there is little reason to consider it would have altered the outcome. There was no sanction for non-compliance, other than admission; it would be difficult to justify to a MHRT in view of the permitted leave at his mothers and could only be used if there were somewhere for him to live, other than hospital.

32. In August 2000 the rehabilitation had progressed to the stage of considering supervised accommodation in a flat in Market Drayton. He was self-medicating by this time.

11/9/00	Review *'Patient T is currently a patient at West Bank, continues to make significant progress. He attends Second Chance, literary scheme in Shrewsbury, Abbey Works on a Friday and spends weekends at home with his mother in Whitchurch.* *Present medication* *Thioridazine 100 mg* *Pipothiazine 30 mg injection-weekly* *Procyclidine 5 mg'*

3/10/00	Signed tenancy agreement with Trident Housing for flat in Market Drayton
30/12/00	Review *'Patient T is to start having a weekly overnight leave to his flat in the New Year. Recently in ward round it was determined that Patient T would remain on his section 37 (as it was up for renewal) while he made the transition into the community on the understanding that as soon as he had made a successful transition, the section would be revoked. However, I understand from a phone call I received from the consultant's secretary just prior to the Christmas holiday that Patient T's section is now going to be allowed to lapse as opposed to being renewed.'*
17/1/01	Nursing record *'Patient T has had overnight leave to his flat, as planned. Mentally stable on return to the Ward. Patient T reports that leave was a great success. No problems identified by either Patient T or myself.'*
18/1/01	Nurse's report for a Mental Health Act Manager meeting *'It has been planned with Patient T that he will have a 'staged' discharge- increasing his periods and duration of leave leading to eventual discharge. The timeframe for all this will largely be dependent upon how Patient T tolerates this process and allowing for the identification of any actual or potential difficulties.* *Patient T feels he is ready to live independently, whilst recognizing that he will require support, particularly as he makes the transition from a hospital environment to community living. When questioned, Patient T does not express any concerns or worries about his future.* *It is intended that Patient T will still continue to visit his mother on discharge, much as he does now. Patient T has a close relationship with his mother and they appear to have a mutually dependent relationship. Since the death of Patient T's father in October 1998, Patient T has become an essential part of his mother's support network. Patient T is also re-establishing regular contact with his adult daughter, which is proving rewarding for him.'*
Feb-July 01	Periods of leave to the flat were gradually increased.
5/3/01	Discharged from his S 37 by the Mental Health Review Tribunal who considered Patient T had progressed sufficiently as not to need compulsory detention.
10 July 2001	Patient T was reported missing from his flat. The Trident work alerted West Bank and the care coordinator who alerted the police. Patient T was found in the Bristol area and collected by West Bank staff. Mother informed West Bank of his whereabouts.

33. In June and July 2001 the care plan included a structured approach to discharge with Patient T attending various activities in the community centred around his living in the supervised accommodation, or alternatively at his mothers. A referral to the Assertive Outreach Team by the care coordinator on 11 August 2001. A discussion with the ward nurse on 17 August records that Patient T saw his role towards his mother as *'(?carer)'* and that he appeared to be getting used to a change of role with her.

34. On 5 September 2001 Patient T was discharged to the Trident Supported Flat, Market Drayton. A full discharge letter was sent by the staff grade psychiatrist to the new GP on 13 September 2001. At the same time a copy was sent to the Assertive Outreach Team, but Patient T was not considered to fit the criteria of their service.

35. In 2001 the substantive consultant psychiatrist for the area moved and in the period between 2001 and 2004 there were several different locum consultants who provided medical cover. This gave rise to a loss of continuity in the medical cover and which was recognised by the internal review. The review recommended that a non-consultant career grade doctor should be appointed for each locality. This has been achieved and is commended.

4/2/02	Care coordination Review *'Enhanced CPA* *Since his discharge from West Bank hospital in September 2001 Patient T has not attended day services, Abbey works on a regular basis. He has been spending less and less time at his Market Drayton flat. He has complied with his medication and he attends base services on Wednesday to receive his depot injections.* *Care plan to be reviewed in three months* *Patient T to increase his stake at his market Drayton residence.* *Patient T to be engaged with services on Mondays Wednesdays and Abbey works on Fridays* *Present medication and treatment* *Piportil 50 mg Im weekly* *Procyclidine 5 mg daily* *Chlorpromazine 40 mg nocté* *Management plan: reduce Piportil to 40 mg weekly'*

36. At a meeting with his social worker on 4 July Patient T informed him that he had been on a Section 37 and was in a controlled environment. He now stated that he did not have to do as he was told. He was informed that to make progress and develop he must spend time at his flat. Patient T was given notice that unless he spent more time at his flat, his tenancy would be terminated. On 16 September the social worker was informed by the housing trust that Patient T had gone missing from his flat. He had been in breach of his tenancy agreement due to the large amount of time he was spending at his mother's home.

37. There was an allegation that he had set fire to the flat, although this was subsequently denied by Patient T and not pursued by the police after investigations had taken place. By the 19 September the locks on the flat had been changed and Patient T's belongings removed.

38. On 2 October 2002, Patient T returned to his mother's house. She telephoned the police and Patient T was removed to the police station under a place of

safety S136 of the Mental Health Act. Patient T was assessed for compulsory admission and was admitted to Shelton Hospital on S3.

39. Patient T settled very quickly on the ward on his previous medication. He had missed two doses of his depot medication prior to the fire incident and it was thought that this had precipitated his relapse. By the ward round on 29 October his condition appeared stable, he was compliant with medication and willing to stay in hospital as a voluntary patient. It was thought inappropriate for the S3 to be continued and he was therefore discharged, but on the understanding he would remain in hospital. A forensic opinion was considered at that time, but the consultant decided that it should not be pursued.

40. He remained in hospital and continued to progress. His medication remained Piportil 100 mg. weekly, procyclidine 5 mg daily and chlorpromazine 40 mg nocté. During his stay he continued to have periods of leave at his mother's house.

41. An application was made to accommodate Patient T at the Elms House unit in December 2002, but was not pursued by the unit because there were no vacancies at that time. There were also no vacancies at the West Bank unit.

42. In February 2003, it was decided at a ward round to ask the Reaside clinic for advice on the future accommodation needs for Patient T. A Forensic Specialist Registrar attended and prepared the following advice with the support and supervision of his consultant:

3 April 2003 Opinion by Forensic SpR from Reaside

'Impression

Patient T suffers from chronic schizophrenia and his positive symptoms appear to be relatively well-controlled present on present medication although he does display some negative symptoms of the illness. He lacks insight believing that he does not have a mental illness or that he requires medication. He is, however, willing to continue to comply with his depot medication.

It is difficult to comment on his risk with regard to fire setting in view of the fact that the investigation into it by the police has not been completed. At the time of the incident it would appear that his mood may have been elevated and he may have been more likely to act in a disinhibited manner.

It would appear he has not exhibited any aggression over the past few years but this will need to be closely monitored whilst in the community.

In my view, Patient T will require continued supervision when his discharge from hospital occurs and would probably be best placed in supervised accommodation, which is staffed at 24 hours per day. This would allow for closer monitoring of his mental state and behaviour. If there is a deterioration in his mental state, in particular if he experiences any psychotic symptoms or there is an alteration in his mood, there should be a low threshold for readmitting him into hospital. In addition, it would be easier to monitor his use of any illicit substances if he was in a supervised setting.

His current medication, Piportil 100 mg every two weeks, appears to be controlling his psychotic symptoms and I would suggest he continues with this.
I would be grateful if you could let me know the outcome of the investigation into the fire as it would be easier to comment on his risk once the investigation has been completed.'

43. This report was discussed in the consultant ward round on 13 May 2003. The recommendation for 24 hour supervised accommodation was accepted and the social worker asked to make inquiries on the availability of suitable accommodation.

44. This was acted on and the social worker met up with Patient T on 9 June to discuss his accommodation wishes:
9 June 2003 Social worker record
'I collected information on Care Standards Offices in the West Midlands and North West Regions.
I met Patient T at Day Services. He specified that he did not and would not consider accommodation in the Telford, Inner West Midlands and South Shropshire and further afield.
He would consider Shrewsbury, Staffordshire (not South Staffordshire) and Cheshire.
I requested information from Shropshire, Cheshire and Staffordshire Care Standards on residential accommodation.'

45. On 14 June, the social worker recorded his efforts to find suitable accommodation. In total he telephoned 23 providers; 8 in Staffordshire, 7 in Shropshire, 4 in Telford and 4 in Cheshire. All but 2 potential placements were either not suitable or had no vacancies. Application forms were requested from a placement in Shropshire and one in Cheshire. An application was also made to the Richmond Fellowship which operates potentially suitable accommodation. No further progress was made at this time with the fire history causing particular problems.

31/8/03	Care co-ordination transfer summary due to the Care Co-ordinator leaving the CMHT *'From the start of 2002 to August 2002 Patient T only came for his depot injection. Two incidents occurred where Patient T went missing. The first was when Patient T had hitchhiked to Bristol and was then caught by British transport police who alerted the West Bank hospital who collected him. The latter was when there was a fire incident at his flat. He needed to be interviewed by the police. Patient T stated he went to the pub, left his front door open by mistake. Upon his return he saw the police and fire engines. He panicked and caught the bus to London. He was reported to the police as a missing person. He slept rough whilst he was there.* *He returned to his mother's home two weeks later and was arrested by the police under section 136 of the MHA1983. He was placed on and Buildwas Ward under section 3. He settled on the Ward on medication and resumed daycare at Market Drayton. He has also been on home leave and to his*

	mother's home over the weekend. The police did not process the charges as evidence was circumstantial and he was treated in hospital. He was assessed by forensic services at Reaside clinic who recommended that he would need low level 24-hour residential establishment with the aim for him to ensure that his mental health is monitored and that he could be rehabilitated to independent living. *Reasons for transfer:* *Care coordinator leaving the NES CMHT'*

46. .... The continuing efforts of Patient T's new care co-ordinator to obtain suitable accommodation and funding for the accommodation from the joint funding panel are well documented and described as follows:

'1 August 2003 - Hereford placement identified
5 August - Trimark placement in Liverpool identified.
12 August - Trimark visit Patient T on ward to discuss project and carry out assessment
18 August - visited Hereford placement with Patient T, Patient T states does not wish to go to placement, too much like West Bank - previous placement
27 August - referral to Trimark formally made
2 September - Entry that funding panel aware of Patient T.
12 September - Locality Manager, contacts me to discuss Trimark placement, feels placement cost too high but advised me to take to the funding panel
15 September - Funding Panel - unfortunately unable to attend due to having to attend Mental Health Act Assessment as on call ASW, colleague, from team goes on my behalf, panel have already have pro-forma and information from Trimark (copies in correspondence section of file). Advised by colleague that in principle they are agreeing to placement but want to know more about Trimark's registration status
16 September - provide information to Locality Manager, regarding Trimark's registration status, agree's will share with other Funding Panel members. Also asks me about continuing care monies and if appropriate - I suggest I did not believe so as Patient T has no nursing needs, needs identified are care based in my opinion.
29 September - Funding Panel - Team Manager, discusses Patient T's case again within Funding Panel following letter sent by myself with further information about the placement as I am on annual leave
6 October- informed by Team Manager, on return from leave that Funding Panel have suggested looking at the Elms, Rehabilitation Unit similar to West Bank for Patient T, as a place has now become vacant there. In my absence informal visit/assessment been arranged to see Patient T on ward by Elms staff. Not been discussed with Patient T. Was due to visit Trimark placement on same day, so this is cancelled. I expressed my concern about Elms, as same as West Bank, where Patient T was discharged from, and he has already expressed opinion to not want to go to place again like West Bank, also concerned that it has not been discussed with Patient T. I phoned Patient T to discuss, he says does not want to go to Elms, so assessment visit by Elms cancelled and I agree to go back to funding panel to discuss as care co-ordinator on 13 October.
13 October - unfortunately again cannot attend funding panel due to having to attend mental health act assessment as on call ASW, Team Manager, attends on my behalf, Funding Panel now requesting that Trimark placement needs to also be funded jointed by continuing care money and request nursing assessment.
15 October - Nursing assessment completed by CMHT manager, Funding Panel agree funding

of placement with Trimark
29 October - Visit Trimark project in Liverpool with Patient T. Following visit Patient T not sure if now wants to go, agrees to have think about it.
31 October - Patient T informs me does not want to go to Liverpool.
13 November - identify possible placement in Wales
14 November - discuss placement in Wales with Team Manager, as cost of placement more expensive than Trimark, suggested may be too expensive. Also discuss if need for 24 hour care at this point and other options, agree to discuss with Patient T and look at options in Shropshire area for supporting people.'

47. ..... The operation of the funding panel is discussed below. (paragraphs 78 -83)

48. In December 2003 the care coordinator prepared a very detailed report to support Patient T's application for accommodation with support which acknowledged his entitlement to Local Authority funded Section 117 aftercare. This was a very thorough review of events to that date. The care coordinator stated that Patient T did not want to live with his mother full-time and that this would, in her opinion, be appropriate in the long term.

20/1/04	Formally Discharged from Shelton Hospital *'Medication* *Piportil 100 milligrams fortnightly* *Accommodation needs to be located and secured for Patient T to provide for his needs and then a support package from MACA or Supporting People whilst waiting for accommodation Patient T will reside temporarily at his mother's house* *13 April 2004 Care co-ordination review meeting. Enhanced CPA and section 117* *Patient T is currently still living with his mother, as no appropriate housing has been allocated as yet, both Patient T and Patient T's mother happy with this arrangement until permanent housing is found. Temporary accommodation was offered by North Shropshire District Council in Whitchurch. However, Patient T wants to wait for permanent accommodation to be offered as he does not want to move twice.* *Patient T has made housing applications to North Shropshire District Council, Oswestry Borough Council and also with the Bromford supporting housing project in Shrewsbury* *Patient T has been reviewed in the outpatients twice since January.'*
12/5/04	Care co-ordination review *'Unmet needs* *Lack of available housing in the North Shropshire area* *Lack of support housing projects in Shropshire area'*
18/8/04	Care coordination review- care coordinator *'Patient T's mother, should be kept informed of any changes or concerns regarding Patient T's mental health as previously she has been physically assaulted by Patient T when unwell. Patient T has also disappeared when experiencing a relapse of his mental health, if this happens, the police, his*

	mother, and/or other mental health services should be informed as soon as possible due to his vulnerability and previous risk to others.'
14/9/04	Consultant to GP *'I reviewed Patient T in clinic on 13th August 2004. He had appeared physically unwell the day before and therefore a depot had not been given. He described himself as feeling sluggish, stiff in his joints like having a toothache with difficulty getting going and poor energy. He has noticed this over the past 6 weeks and it is particular worse about 4 days after his depot. On a couple of occasions he has taken a larger amount of Procyclidine which has helped. On direct questioning he has occasional indigestion and has had some watery diarrhoea over the last couple of days otherwise he feels he is physically fit and his mental health he reports as being fine at present.* *On examination he had cogwheel rigidity of his elbows with mild tremor and akathisia. I feel that he has extra pyramidal side effects and akathisia secondary to his depot. We discussed at great length the pros and cons of reducing his depot but I am happy to reduce it to 80 mg every two weeks and to increase his Procyclidine to 5 mg three times a day.* *I believe that he is due to see you with regard to a repeat prescription in the near future. I think it would be well worth checking his bloods and his urine for general screening as there is a strong family history of diabetes, his father died young and he is smoking heavily at present.* *He remains under weekly review by the CMHT and I will review him in between 4-6 weeks depending on the effect of the reduction.'*
30/9/04	Consultant to GP *'I reviewed Patient T on 6 September 2004. As you are aware he had had some problems with extra pyramidal side effects and akathisia. We reduced his Piportil to 80 mg two weekly and he increased his Procylidine to 5 mg three times a day. With this combination he did seem to improve, no abnormal movements and no return of psychotic symptoms with him describing himself as being brilliant. Unfortunately he ran out of his Procyclidine over the weekend and he reports that there was an increase in tremors in his arms and legs, the aching feeling in his limbs and pacing about.* *In clinic he again looked like he had akathisia and was quite rigid in his upper limbs although neither were as bad as I saw last month. His mental state was very good with him appearing more communicative and brighter in mood.* *I gave him a prescription for Procyclidine 15 mg a day for 2 weeks as I understand he is due to pick up a repeat prescription from you at that point. He should continue the depot at the current dose and I have arranged to review him again in 6 weeks' time.'*
10/11/04	Consultant to GP *'I reviewed Patient T in clinic on 25`h October 2004. He tells me that he has not been too bad recently. He has been out and about more often, shopping, taking walks and going out with members of the CMHT. He is living with his mother at present but is going to look at some independent accommodation in Oswestry over the next month. He reports good mood, sleep, appetite and no psychotic symptoms.* *He continues on his depot 80 mg of Piportil 2 weekly. His akathisia has*

	stopped since the dose has been reduced but he continues to have extra pyramidal side effects of stiffness and tremor. He has been using his procyclidine above the prescribed dose of 5 mg tds on occasion, however on examination today he does have cog wheeling particularly on the right. *We will continue on his depot at 80 mg but he can use up to 30 mg of procyclidine a day in divided doses. I have arranged to see him in clinic in 6 weeks' time.'*
25/11/04	Consultant to GP *'I reviewed Patient T in clinic on 15`h November 2004. He is doing well at present. He remains at his mother's but is due to look at some accommodation in Oswestry next week. Although there have been no problems staying with mother he is still keen to move on. At the moment he describes his mood as okay, he has no overt psychotic symptoms, is not abusing illicit substances and is keeping his alcohol intake to a minimum. He is pleased with the reduction in his depot medication and feels that the side effects are now under control. He no longer has any toothachy feelings (akathisia) and seems to be managing the extra pyramidal effects with 15 mg of procyclidine a day.* *I would like him to continue with his current treatment plan and have arranged to see him in 6-8 weeks' time.'*

49. Regular visits by the CMHT to Patient T continued and he received his depot medication, as prescribed. He continued to live at his mother's house and spent Christmas with her. There was an argument between Patient T and his mother over the Christmas meal which ended with the statement that he intended to have his own place to live. This was discussed with the co-worker during a visit on 30 December and Patient T's care plan included monitoring for signs of relapse, to discuss with the consultant side effects of medication and to continue with weekly visits.

50. On 13 January 2005, Patient T's mother rang the care coordinator expressing concern about her son's recent behaviour. He had been ignoring her and had developed a change in his sleeping pattern. She refused permission for this to be discussed with her son. The care coordinator visited, but Patient T was out. His mother was reluctant to let him know that the care coordinator had visited.

51. On 10 February Patient T telephoned the consultant to inform her that he had run out of procyclidine and had been unable to obtain another script. The consultant considered that he may be misusing the procyclidine, but refused to issue another prescription. This information was passed to the care coordinator.

52. Over the weekend of 12-13 February Patient T had been out drinking, had been violently sick and hostile towards his mother. His mother telephoned the CMHT on Monday 14 February to inform her. He was visited by the co-worker who assessed him. She considered his mental state to have deteriorated as a result of alcohol and procyclidine misuse. She discussed this with the consultant who asked her to discuss informal admission with Patient T. Patient T refused

admission, but did agree to see his GP that day to obtain a prescription for procyclidine. He was seen by the GP that day. The GP made no reference to a need for admission.

14/2/05	Hand written letter, Consultant to GP *'I have spoken to Patient T, who would be able to get up to the surgery, if that would help.* *To reiterate medication, I suggest:* *procyclidine 10 mg TES* *Temazepam 10 mg* *for seven days only. I will look into alternatives for the procyclidine.'*
14/2/05	Seen by GP *'Taking the excess procyclidine. ? 12/day - up to 7 at a time. Phone and fax advice from consultant is 10 mg tds. Temazepam 10 mg nocté seven only. She is due to see later week'*
15/2/05	Consultant to GP *'I reviewed Patient T in clinic on 17`h January 2005. He continues to live with his mother at present and he reports that this is going well with no problems. Although he is not in any rush to move out he has had a letter from a housing association in Oswestry and will continue to pursue the idea of settling over there.* *He reports that he is getting out and about more at the moment, going for walks everyday, keeping away from the "demon drink" and not using any illicit substances. He states his mood is good, he is sleeping from 10 o'clock at night until about 6 am. He is eating well. He denies any hallucinations or psychotic beliefs. He remains on depot Piportil 80 mg two weekly. He denies any current side effects but continues to use procyclidine periodically. He tells me he takes none some days and up to 5 tablets other days.* *Objectively he appeared well, he was calm with no evidence of akathisia or extra pyramidal side effects. There was a good level of communication and no evidence of thought disorder or psychosis. I have advised him that he would be better off taking a smaller close of the procyclidine everyday and he is agreeable to continue on his depot at the current level. He is seen weekly by the CMHT and is happy to continue doing so. I have arranged to see him in clinic in 8 weeks' time.'*
16/2/05 (letter to GP 21/2/05)	*Hand written letter, Consultant to GP* *'I met with Patient T on 16-2-05. We have agreed for him to continue procyclidine at 20 mg per day (either 5 mg QDS or 10 mg TD). It may help to give him only a limited supply at a time. If there are any problems with this, please let me know.'*
19/2/05	Seen by GP *'Managing on cue DS procyclidine. Avoiding alcohol. .Tremor ++ Continue pro tem.'*
23/2/05	Home visit by co-worker *'Patient T appeared appropriate and pleasant. No aggression exhibited or paranoid thoughts. Discussed recent behaviour. Patient T says he realises he shouldn't drink 7 pints, that he should only have 2 pints. Patient T said he had*

	been to see the consultant and they had discussed how he had been. Patient T still waiting to move to Oswestry…. Depot medication given.'
2/3/05	Care coordination review by Patient T, care coordinator, co-worker, consultant and mother *'Current progress and outcomes* *Since Patient T's last review took place in August 2004 he has continued to live at his mother's home and has had no further hospital admissions. Over the past six months Patient T's mental health has remained relatively stable, however, there has been some concern over his overuse of his procyclidine at times, which has caused him to present as more elated in mood and his mother has reported him being more restless. Recently Patient T also had a weekend where he drank a substantial amount of alcohol, in addition to having no procyclidine, this had an impact on his mental health and presentation. Patient T became very restless, agitated and was not sleeping and was irritable towards his mother and one of his workers. Patient T was seen by the consultant urgently and his GP and was prescribed a course of temazepam to help him sleep which appeared to help stabilise his mental health again. Patient T has now recognized that he needs to ensure his alcohol intake is limited due to the impact on his mental health and take his medication has prescribed.* *Patient T has continued to meet all of his appointments with workers on a weekly basis and has attended all his outpatient appointments with the consultant. He continues to mainly use these appointments to discuss his mental health, how he has been using his time and looking at any ongoing issues such as his relationship with his mother, medication, housing and financial issues.* *Despite housing applications with Oswestry Borough Council and equity housing for the Oswestry Street area, and regularly contacting private letting agencies, Patient T has had no success in securing accommodation in the Oswestry area. We have discussed extending the area Patient T would like to live in, Patient T does not want consider any other area. Therefore, until accommodation is secured Patient T is continuing to live with his mum.* The Assessment continued: ***6. Specific signs of relapse:*** *It has been assessed via the risk assessment and in discussions with Patient T that many of his previous relapses in his mental health have been following him overusing alcohol and/or misusing illicit drugs. Also of note one of his relapses was following a reduction of his medication. Specific signs of relapse have been assessed as;* *• Becoming more talkative* *• Becoming agitated and restless* *• Being more irritable in his mood and feeling stressed'* *• Sleep pattern changing — not being able to sleep* *• Acting more 'sly', not being as open with workers and his family* *• Increase in activity — starting to go jogging for example* *• Describing distorted perceptions — being out of touch with reality, feelings colours, plants, furniture etc changing and/or different*

	** Previously it has always been Patient T's mother who has been the first to notice that Patient T is becoming unwell, therefore, if she contacts services this is a good indication that Patient T's mental health may be deteriorating.* ***7. What actions could be taken in the event of a relapse or disengagement:*** *The following actions should be taken in the number order given if possible;* *Care Coordinator/Co-worker to discuss with Patient T any changes in his presentation to check if there has been any overuse of alcohol, misuse of illicit drugs or his prescribed medication to determine possible cause of deterioration.* *Urgent psychiatric review to be organised with Consultant Psychiatrist to review medication and presentation.* *Increase in CMHT home appointments and possible involvement of the crisis intervention team should be considered to support Patient T's mother supporting him at home.* *However, hospital admission will need to be considered if deterioration is continuing. This should be discussed with Patient T and if possible admission should be on informal basis, but if risk to self or others increasing then an assessment under the Mental Health Act 1983 should be organised.* ** Patient T's mother, should be kept informed of any changes or concerns regarding Patient T's mental health, as previously she has been physically assaulted by Patient T when unwell. Patient T has also disappeared when experiencing a relapse in his mental health and gone to London. If Patient T does go missing his family, the police and/or other mental health services should be informed as soon as possible due to Patient T's vulnerability and previous risk to others.* *Previous strategies which have been successful include:* *• Recently (Feb 2005) actions 1 and 2 above helped to avoid a relapse resulting in hospital admission or risk to others. Patient T was seen by his Co-worker, an urgent psychiatric review was organised and a course of temazapam introduced to help Patient T sleep, and Patient T's mother was liaised with throughout the episode.* *• Prior to Patient T's recent deterioration the only other strategy used has been admission into hospital detained under the Mental Health Act 1983.* *9.* ***The person to whom the service user is most responsive:*** *Patient T's mother*
2/3/05	Risk assessment review senior social worker/care coordinator *'Patient T has not misused alcohol or any illicit substances since February 2005.* *Patient T has recently been misusing his procyclidine times to induce a high and buzz. His family have noticed a change in his presentation at these times, with Patient T becoming more irritable and restless.* *Patient T is a risk to others remains a concern when/if he experiences a relapse of his mental health.* *Any other new risk identified:* *overuse of procyclidine* *recent misuse of alcohol (February 2005).'*

21/3/05	Seen by GP. *'Feels a bit more calm, less shaky. Continue procyclidine.'*
7/6/05	Consultant to GP *'I reviewed Patient T in clinic on 16th May 2005. Things seem to have settled down significantly since I last saw him. He is taking Procyclidine 5 mg qds regularly and neither abusing this nor getting overt akathisia or EPS. He is still living with mum and describes them getting on pretty well at the moment but he is due to go and look at some possible private properties in Oswestry next month. He reports his mental state as being stable with good mood, no abnormalities in sleep and appetite, denies any psychotic symptoms and none evident on examination. He is not drinking alcohol at the moment and strenuously denies any use of illicit substances. Objectively he appeared well and humorous.* *I would like him to continue with his Proportil 80 rng two weekly and Procylidine 5 mg qds. He is thinking about attending a Healthy Living group at the Day Centre and continues to have weekly contact either with Care co-ordinator or co-worker from the team. I have arranged to see him in clinic in 3 months' time.'*
5/7/05	Risk assessment review/update Care coordinator *'Patient T has not misused alcohol or any illicit substances since February 2005.* *Patient T and his mother, have decided that Patient T will now permanently reside with her. Patient T's mother happy for Patient T to live there.* *Patient T continues to misused his procyclidine at times.* New management plan *Patient T to continue to have weekly contact with the CMHT* *Patient T to collect prescriptions for his procyclidine every 2 weeks from his GP* *Patient T's care plan (see CPA review dated 2/3/05 to continue)* *Patient T 's mother (carer) to continue to be offered support/advice as needed'*
3/8/05	Telephone call with consultant to GP – GP record *'Consultant reports increased problems shaking a lot more today (just had depot). Thinks that this may need to be slowly decreased. Recommends increase to two tds procyclidine for a week.'*

53. This call was made in response to a conversation between the care coordinator and consultant in which increasing problems of extra-pyramidal side effects of the depot medication were described. The procyclidine was increased.

54. Home visits to Patient T were carried out by members of the CMHT on 14/7/05, 20/7, 25/7, 27/7, 3/8, 10/8, 15/8, 25/8, 7/9. His Procyclidine was increased from 20 mg to 30 mg from 15 August. On 12/8/05 a letter sent to Patient T informing him that his usual care worker was on sick leave and to contact the CMHT as necessary.

15/8/05	Handwritten letter consultant to GP *'Please could you continue Patient T on procyclidine 10 mg three times a day. He has very marked extrapyramidal side-effects at the moment; we plan to decrease the depot in the longer term.'*
22/8/05	Seen by consultant *'says doing well…* *Going out more..* *Getting on well with mum..* *Says still keen to move to Oswestry – just waiting until care coordinator is back.* *See 3/12'* The letter to the GP from this visit was not sent until 15 September due to a lack of secretarial cover.
26/8/05	GP record entry *'Further request procyclidine last issued 50/8/05-mum threw on fire. Telephone to Patient T's mother confirmed. ? Dosette box.'*
15/9/05	Consultant to GP *'I reviewed this gentleman with schizophrenia in clinic on 22 August '2005. He tells me he has been doing well since his last review. He is going out more, for example, visiting his sister, going out for Sunday lunch, taking his mum shopping and is doing more around the house. He denies any positive symptoms of his psychosis and actually talked very openly about previous symptoms today. Generally his sleep and appetite have been good and he has been steering clear of alcohol and drugs.* *The main problem there has been since our last review is increasing side effects from his depot. He has episodes of increasing salivation, shakes, stiffness in his arms and legs and akathisia; this often happens for a run of 2 or 3 days, a few days after having had his depot. If he has enough Procyclidine at home he increases the dose and this generally manages things. Since the side effects were observed by his care coordinator on a home visit we had arranged for Patient T to be having Procyclidine 30 mg a day in divided doses. He has found that having taken this amount consistently he has had no further side effects.* *Objectively today I found him relaxed, he denied any current positive symptoms and his frank discussion of previous symptoms would indicate that he is well at the moment. His mood was euthymic. On examination he had cogwheel rigidity at both elbows and slightly at both wrists and a positive glabellar tap. There was no evidence of tremor or stiffness in his legs. I do feel that Patient T is genuinely having extra pyramidal side effects to his depot, Piportil, and why this has increased over the years is unclear. He was very reluctant to consider the decrease in depot fearing that he would become unwell again. Since the 30 mg of Procyclidine is holding his side effects at the moment we did not pursue changing anticholinergic, however I have made it very clear to him that any increase in side effects we will have to make a change. This would be to decrease the depot, to change the depot, to consider Clozaril or to change the anticholinergic. I would be reluctant to continue increasing the dose of Procyclidine further but I am happy for him to remain on 30 mg day. I have arranged to review him in clinic in 3 months' time*

	but would be happy to see him if there were problems earlier.'
26/9/05	Home visit by co-worker *'Patient T in good humour, missed the first healthy lifestyle group and attended the end of the second one. Patient T was amazed that he weighed almost 18 stone, he said he had started to diet before but had more incentive now.* *Discussed his use of procyclidine says he finds it better to get a weekly prescription as it means he only goes without for one day, states he takes extra because it makes him feel "normal". Patient T's auntie arrived when we were discussing this, we'll talk to Patient T again next visit. Interaction with his auntie was appropriate discussing other family members.* *Have not discussed with Patient T myself taking over as care coordinator, need to talk to present care coordinator as to how to approach the subject. CPN administered depot medication 23/9/05.* *Plan: next visit and injection 6/10/05.'*

55. Patient T attended the Healthy Living Group on 21 and 28 September. On 28 September he was noted to be in good humour and stayed to wash up mugs after the group.

28/9/05	Co-worker note '*Telephone call from Patient T's mother who spoke to CPN expressing some concern about Patient T , said that she thinks he was a little aggressive this morning, muttered under his breath "bitch" so Patient T's mother went to bed. At time of ringing Patient T was on his way to the healthy living group. She reports he still runs her around if she needs to go somewhere, back in his car, didn't give further details on this. She says he is taking too much procyclidine and needs to do something as he is "stuck in a rut". Patient T's mother states he needs a regular social worker. Seeing someone weekly.* *CPN explained she is running the healthy lifestyle group this morning and she would monitor Patient T's mental state during this. '*
28/9/05	Co-worker note *'Patient T's mother also reported Patient T is up at 5 a.m. every morning, Patient T had informed me of this on our last visit, but said he goes back to bed after a couple of hours and sleeps again until 8 a.m. Depending on what he is doing that day he may go back to bed again for a few hours later in the morning, getting up at lunchtime.'*
28/9/05	Co-worker note *'Patient T attended the group; report from the nurse was that Patient T participated in the discussion and activities appropriately. On occasion may have had what could be described as a sarcastic comment. Difficult to ascertain if this is Patient T's personality relapse in his mental state. Continue as planned to visit Patient T next week.'*
3/10/05	Note by Care co-ordinator *'Telephone call to Patient T, Patient T's mother answered, stated concerned about Patient T, used all his procyclidine again, not due until Wednesday 5/10/05. Advised Patient T needs to take responsibility for ensuring he uses*

	his procyclidine appropriately, but will discuss with him. Patient T's mother went on to say having lots of problems at the moment, as daughter having a problem, husband has left: supporting her. Patient T not being understanding. Asked Patient T's mother if we can offer her support at the moment-said no thank you. Spoke to Patient T, said doing okay. Doesn't want me to visit this Wednesday agreed appointment 10/10/05 at 2 p.m.'

56. On 3 October 2005 Patient T killed his mother by hitting her on the head with a heavy weapon inflicting multiple injuries. He left their house and went out in his car in which he had a road traffic collision. He was taken to Leighton Hospital for treatment. He was later arrested.

4.0 Analysis of Care and Treatment

57. After fully considering the documentation and hearing the oral evidence, the independent investigation have concluded that the incident itself could not have been predicted by any of the staff involved in the care of patient T at that time. Throughout his community contact with the mental health services he was placed appropriately on the Enhanced level of the Care Programme Approach (CPA).

58. The internal review considered at some length similar issues raised by the terms of reference of the independent investigation. The independent investigation will therefore use the format and discussion of the internal investigation for this commentary. Matters relating to the terms of reference of the independent investigation are included with these points to simplify the presentation.

Terms of reference of the independent investigation.

1. To examine the circumstances and events relating to the treatment and health care of Patient T by the Shropshire County Primary Care NHS Trust, Shropshire's Community Mental Health NHS Trust and organisations where relevant, and in particular the treatment and health care in the period leading up to the incident at 03 October 2005.

2. To identify any systemic or professional problems in the treatment and health care provided to Patient T. For example:

    - Quality of the assessed risk

    - Assessment of risk of potential harm to himself Assessment of risk of potential harm to others

3. To consider the effectiveness of interagency working, including communications between the mental health services, police etc. with particular reference to the sharing of information for the purpose of risk assessment.

4. To review the internal investigations into the care of Patient T already undertaken by the County Primary Care NHS Trust, Shropshire's Community Mental Health Services NHS Trust, any action plans that may be formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal investigation and assess the effectiveness of their implementation.

5. To employ Root Cause Analysis principles and techniques to enable competency for learning to be realised from the investigation.

The internal response to the incident

59. An incident report form was completed by the team manager on 4 October 2005 and submitted to the clinical director. The clinical director informed the director of mental health and learning disability services on the same day and forwarded an initial briefing note.

60. A divisional scoping review, dated the 17 October 2005, recommended that a full root cause analysis should be performed with external advice as soon as the legal process allows. It was noted that this would be in addition to any external review process by the Strategic Health Authority. No immediate necessary actions within the adult division had been identified.

61. A multi-agency homicide review meeting, including a police representative, was held on the 28th of November 2005.

62. A letter was sent by the Director of Mental Health and Learning Disability Services to the sister of patient T on the 3 January 2006. This was to express his condolences and also to provide information on the review being undertaken by the PCT. The sister was invited to contribute to the internal review, either orally or in writing. This was good practice.

63. ..... A further homicide review meeting was held on the 11th of January 2006. The terms of reference for the internal review were drawn up by the Director of the service on the 19 January 2006. These were:

- The participants were to be an independent consultant psychiatrist with investigation experience, the clinical director of adult mental health, a consultant psychiatrist end the nurse consultant.
- The internal investigation will formally report its findings to the Chief Executive and the independent investigation, when this has been commissioned by the Shropshire and Staffordshire Strategic Health Authority.
- The internal investigation will set out the facts and dates and responsibilities of the trust in the history of their involvement with patient T.
- The internal investigation will use the methodology of root cause analysis to investigate any care delivery or service delivery issues.
- Particular attention will be paid to the use of care coordination and risk management policies.
- The internal investigation will determine whether as a result of this investigation, any immediate change to trust policies and procedures should be recommended.

64. ..... The following staff were interviewed as part of the internal review:

The Medical Director (by telephone call)
Consultant forensic psychiatrist, Reaside clinic, (by telephone call)
General practitioner, (by telephone call)

Consultant psychiatrist from 1998
Consultant psychiatrist from June 2003 until the incidents
Day services nurse at the time of the incident
Co-worker
Co-worker due to become care coordinator
The approved social worker who was care coordinator at the time of the incident.

65. A draft report was prepared was distributed at a further homicide review meeting on 6 June 2006.

66. An important point which has been made repeatedly to the independent investigation was that not all the people interviewed received a copy of the draft report to comment upon accuracy prior to the report being released. They not unreasonably interpreted some of the recommendations as being critical of their actions, but without the remedy of being able to comment before the document was circulated. It is the view of the independent investigation that this was unreasonable and it recommends that in any future investigation staff contributing should be given the opportunity to comment on the accuracy of their involvement.

Recommendation: that staff contributing to internal reviews should be given the opportunity to comment upon the accuracy of any report before it is more widely distributed.

67. The internal review report was considered at the trust and governance committee on 4 July 2006. Review dates for the implementation of the internal investigation recommendations were set for November 2006 and January 2007. These procedures enabled the Trust to discharge its statutory responsibilities.

68. The independent investigation has a number of concerns about the content of the internal review report. For ease of reference these are commented upon under the headings used in the internal review. Matters relating to the terms of reference are included.

Medical Cover (Service Delivery problems)

69. The internal review indicated that Patient T had 11 different consultants involved in his care between 1997 and 2003. A number of these locum consultants were employed through locum agencies. The internal review recommended that the medical director should formalise induction processes for all future locum consultant staff. It also recommended that the trust employs an associate specialist to work in each CMHT to assist with continuity of care. This improvement in medical staffing has been commended in the chronology of this report. However, induction training should not be limited to locum staff, but should also apply to all newly appointed medical and other staff.

Recommendation: that all staff should receive appropriate induction training.

The use of the Mental Health Act (Care Delivery Problems)

70. The internal review states that the Section 37 was eventually rescinded by a Mental Health Review Tribunal in March 2003. This was in fact carried out in March 2001. The internal review speculates that had patient T's mental illness been recognised earlier (prior to the index offence in 1993), it is possible that he may have been originally sentenced to Section 37/41 of the 1983 Mental Health Act. The internal review team correctly state that this would have given the advantage of a conditional discharge to the community allowing conditions of where Patient T should live, as well as making him comply with ongoing treatment in the community. However, all these matters are purely speculative. Mental health issues formed no part in his defence nor the disposal considerations of the index offence, despite Patient T being examined by a consultant Forensic Psychiatrist. Patient T was transferred to the Reaside Clinic on a Section 47/49 after his mental health was noticed to be affected and required a specialist inpatient environment in 1996. A Section 37/41 could not be imposed outside the court system and any discussion of it by the internal review can only be based on the benefit of hindsight.

71. The Forensic Specialist Registrar who gave the opinion in April 2003 stated that a low threshold should be applied to a decision to admit Patient T on a compulsory basis. However, where a patient is not subject to a conditional discharge, which includes a power to recall the professionals assessing for possible compulsory admission, assessing professionals have to apply the same threshold for compulsory admission as for any other patient.

72. The internal review was critical of the decision to rescind the section 3 on 29 October 2002. The independent investigation notes the concerns of the internal review team, but has little doubt, given his levels of co-operation, that an application to the MHRT for discharge would have been successful long before his eventual discharge from hospital months later. It is correct that any considerations for supervised discharge or guardianship ended at the time the section 3 was rescinded. However, Patient T showed compliance with medication and ready engagement with services following discharge from hospital. Supervised discharge under section 25 of the Mental Health Act, or Guardianship, would have been unlikely to withstand a legal challenge in Patient T's circumstances.

73. The internal investigation recommended that further training should be given in respect of consent to treatment, use of supervised discharge orders, guardianship and the new case law on extended section 17 leave. It also stated

that the trust was drafting a policy on the use of extended section 17 leave to take into account new case law. This is to be commended.

The process of finding Patient T suitable accommodation

74. The trust consultant involved with the review was noted as having treated Patient T in 1997 and 1998. In the discussion of the process for finding Patient T suitable accommodation, the review report states *"by the middle of November 2002, Patient T was already going on planned leaves to his mother's address."*

75. In fact, Patient T started planned section 17 leaves from the Ward in 1997 whilst under that consultant's care. These periods were extended over time. It is clear from the records that the ward staff made every effort to make clear the boundaries to limit the time spent at his mothers to both Patient T and his mother.

76. By November 2002 Patient T was regularly spending time, including overnight periods, at his mother's house. It had become a well established practice. This pattern continued.

77. The internal review regarded the increasing amounts of time that Patient T spent at his mother's to be an indicator of "drift" in his care. It is the view of the independent investigation that, rather than "drift", this was an understandable and natural consequence of a number of factors:

- .... The early pattern of section 17 leave was to his parents, and latterly his mother's, following his father's death, was stated to be for re-establishing family ties. That is a very reasonable aim, but in reality between 1997- 2000 there was nowhere else that Patient T could reasonably expected to spend his leave away from the hospital.
- In 1998 Patient T's father died. The case notes clearly document the change that this meant for his relationship with his mother. There was a co-dependency between them which, without the benefit of section 41 restrictions on accommodation and place of living, meant that the clinical staff involved would be unlikely to usurp this. This is clearly demonstrated in the chronology.
- Re-establishing family ties is a central part of rehabilitation practice.

78. The very extensive efforts made by the two care coordinators involved in Patient T's treatment in 2003 to obtain suitable alternative accommodation are recorded in the chronology of the report. In the case for funding for Patient T at Trimark, the care coordinator had to arrange to present to the funding panel on three occasions over a two-month period. Unfortunately, due to having to undertake urgent Mental Health Act assessments on two occasions as required in her role of duty social worker and once on leave, the care coordinator was not able to attend herself.

However, her carefully prepared documentation present in the records indicate that she made every effort to research and support her client's case.

79. There is mention in the internal review that there were no records of the funding panel decisions to allow consideration of the process. No further reference is made of this. It is the view of the independent investigation that this was a significant omission. It was misleading and gives the potential impression that the lack of records was due to a failure on the part of the care coordinator. Such an impression would be incorrect.

80. The failure to retain records was not that of the care coordinator, but rather that of the panel. The failure to keep records not only indicated that the funding panel could not demonstrate it was working efficiently or effectively, but also at that time it could not fulfil the requirements of compliance with financial audit standards. The independent investigation was informed that any notes of meetings were shredded at some stage.

81. The funding panel in 2003 comprised the three locality managers of the mental health services. The panel operated without a chair or defined quorum and the independent investigation was given to understand that attendance of the locality managers was variable with sometimes only one being present.

82. The independent investigation was informed that the care coordinator would usually present a case to the funding panel which would be agreed, not agreed or deferred for consideration of further information. Although the independent investigation was told that there was an appeals process, this was in fact by way of a further request to the panel for reconsideration, rather than an appeal to a separate and higher body.

83. In 2005, with appointment of a new Mental Health Service Commissioner at the PCT, a written procedure for the presentation of cases to the funding panel was introduced. This fact that there is now a written procedure is commended, but the independent investigation recommends that the PCT, Mental Health Trust and the Local Authority agree that it meets their statutory obligations for funding and audit purposes.

Recommendation: that the PCT, Trust and Local Authority agree an operating procedure for the funding panel which is equitable and meets their statutory requirements.

84. In Patient T's case, the request for funding for the Trimark placing in Liverpool was deferred three times and on the third occasion alternative accommodation suggested by a locality manager and which was turned down by Patient T. This was

perhaps unsurprising as he thought he was familiar with the environment being offered at the Elms from his visit at the time of his inpatient treatment.

85. It is clear that the care coordinator continued to try and find suitable placements. However, these were likely to be difficult to obtain in county due to Patient T's involvement with the alleged fire incident at his flat. In July 2005 Patient T informed his care coordinator that he and his mother had decided that they would continue to live together. However, this contrasted with Patient T's statement to the consultant in August that he was still waiting to hear about accommodation in Oswestry.

86. Many informed witnesses told the independent investigation of the difficulties in obtaining suitable accommodation in county for patients with the characteristics of Patient T. It is recommended that there is a review of the profiles of patients requiring supported and specialised accommodation to minimise delays in placement in the future.

Recommendation: that there is a joint health and local authority review of the profiles of the numbers of patients requiring supported and specialised accommodation to identify resources and minimise delays in placement in the future.

87. The internal review stated that action has now been taken to ensure that the decisions on applications to the funding panel are on file and filed in the notes. It also recommended that early specialist forensic opinion is when there is a significant forensic component present. The implementation of a specialist forensic team within the Trust should now allow this to occur.

88. Also, the multi-agency public protection arrangements (the MAPPA) arrangements which have now been introduced and are now in place would mean that Patient T would be subject to much closer forensic supervision. It is likely that he would have been considered a category 2 offender for these purposes.

Relapse signatures not being sufficiently linked into Risk Management and day to day care plans (Care Delivery and Service Delivery Problems)

89. The internal review report commented that:

'the clinical team had a clear and documented relapse signature profile and had up to date, well documented risk assessment and management documentation, as well as care co-ordination plans. A care coordination review was due to be held on 31 August 2005, but did not occur due to staff sickness. Apart from this occurrence, the documentation was of good quality and completed in accordance with the Trust Standards.'

90. The independent investigation agrees with this view. A notable feature of this investigation has been the high standard of the written clinical records.

91. The internal review is critical of the clinical team's handling of events between Christmas 2004 and February 2005. It is the view of the independent investigation that this criticism is not well founded. There is no doubt that Patient T demonstrated problems with his mental health during this time. However, the stated risk management plan was followed and the symptoms and the episode successfully managed in the community by the clinical team, including the case workers, consultant and the GP. In the view of the independent investigation a Mental Health Act assessment at that time would have been unlikely to result in compulsory admission.

92. Particular reference was made in the internal review to Patient T's well-documented and long-standing problem of using too much of his procyclidine medicine. The GP records would have indicated the extent of at the usage of procyclidine by Patient T. A printout obtained of prescriptions by the GP for the independent investigation showed over usage of procyclidine by Patient T in February and in August 2005.

93. This information could have been made available for the clinical team, had it been requested. Professionals monitoring compliance with medication is important for patients with mental health problems. It is recommended by the independent investigation that printouts of medication prescribing should be obtained from the GP for use at Care Programme Approach reviews.

Recommendation: that GP medication prescribing records be obtained by care coordinators for use at Care Programme Approach reviews.

94. The internal review states:
'Given the known relapse factors, the understood risk of violence to others, and the relapse observed 7 months earlier, the Review Team felt that the events of 28 September and 3 October were probably signs of a further relapse in Patient T's mental state and were again not acted assertively upon.'

95. ..... In the opinion of the Consultant Forensic Psychiatrist, expressed in a report prepared for the trial, she states:

'At the time of the alleged offence he was experiencing an exacerbation of the symptoms of his illness, including auditory hallucinations (voices) and messages from the television. He had not told his psychiatric team about the voices, believing he could cope with them. However, on the day of the alleged offence he deteriorated further and experienced symptoms directly related to the offence. He felt his body being moved by a force, not by himself, which is a symptom of schizophrenia known as passivity phenomenon. He was continuing to hear auditory hallucinations.'

96. However, the CMHT staff acted in accordance with a risk management plan which had been successfully applied earlier in the year. Importantly, Patient T had not informed them of significant symptoms. The key points appear to the independent investigation to be:

- Was the risk management plan satisfactory in the light of known risks? – Yes
- Did the events of Christmas 2004 raise risks which had not been previously identified and which would require the plan to be modified? – No
- Did the staff follow the plan? – Yes

97. The internal review recommended that revised paperwork for risk assessments should be introduced. This has been completed.

Carers assessment and support for Patient T's mother and extended family (Care Delivery Problem)

98. ..... The internal review correctly states that as part of the Care Programme Approach and Care Coordination, the carers' assessment should be offered to every carer for a person on Enhanced CPA. This was offered on several occasions to Patient T's mother and always declined.

99. ..... It is unfortunate that, despite his mother declining the offer of a carers' assessment, a separate assessment of the risk of domestic violence was not carried out. It is appreciated by the independent investigation that this may yet not be routine practice. However, it is recommended that in similar circumstances a risk of domestic violence assessment is carried out with the carer alone.

Recommendation: that a risk of domestic violence assessment should be carried out with carers, without the patient present, where appropriate.

100. Patient T's nephew lived at the home on an intermittent basis. This is not stated in the case records, care plan or risk management plan. Patient T's mother asked for this to be suppressed as the result of potential adverse effects on benefits. There is no indication that this adversely affected any assessment or treatment.

101. The internal review recommended that further training would be implemented for CMHTs which has been completed.

Long Term Risk Management (Care Delivery Problem)

102. The internal review stated:

'The main concern raised by the Review Team was the apparent loss of sight of the long term risk factors. This appeared to be exacerbated by the frequent changes in Consultant Psychiatrist input and the options for accommodation being reduced due to funding decisions, Patient T's declining placements and the lack of local supported accommodation.

The Clinical Team told the Review Team that they kept in mind the Risk Factors from 1993 when Care Planning. However, the Review Team thought that this was more in terms of classical risk factors such as gender, substance misuse, compliance with treatment, rather than the longer term, more overarching risk indicated by a man who had seriously injured both of his parents early on in his history of schizophrenia. When relapse signature patterns were seen, the responding action was not sufficiently assertive.

Consideration was not given to referral to the local Assertive Outreach Team to attempt more assertive community engagement and future planning for employment and independent living.'

103. The independent investigation has commented and made a recommendation on the provision of options for accommodation. There is no evidence that the staff lost sight of the long term risks, insofar as they were understood, or that the changes of consultant were material to the outcome since there was good continuity of the other staff.

104. The internal review recommended that individuals with a history of forensic involvement would be reviewed jointly between the CMHT and the local Forensic Liaison Team and that all CMHTs would review their caseload for potential Assertive Outreach referrals. This is commended as good practice.

Other issues

105. The internal review was concerned that on 28 September a case note entry had been made by one worker on behalf of another. This was considered contrary to Trust practice.

106. The internal review also noted that induction training had not been given to locum consultant staff in the Trust. It recommended that induction should be provided.

107. The internal review also noted issues in respect of consent to treatment where Patient T had signed consent forms whilst being described as having little insight into his illness and need for treatment. It recommended a review of practice. This is commended, particularly with the requirements for training following the introduction of the Mental Capacity Act in October 2007 and the implementation of the Mental Health Act 2007.

Terms of reference of the independent investigation.

- ... **To prepare and produce a report on the above, including any recommendations for future action the panel finds it appropriate to make, for publication by the Strategic Health Authority.**

108. This report and recommendations have been produced after consideration of the case records, policies and interviews with relevant staff involved in Patient T's care and treatment.

109. The internal review process undertaken by the Trust was carried out by a panel of four people, two of whom had either had clinical responsibility for the patient, or had managerial responsibility for the funding panel managers at the relevant times. It is the view of the independent investigation that both of these people had the potential for, or actual real conflict of interests. It is the view of the independent investigation that the internal review did not adequately examine the failings of the funding panel to conduct itself appropriately, nor to explore in any depth the dynamics of the relationships between Patient T and his parents from the time of his admission to the Shelton Hospital in 1997.

110. The conduct of internal reviews has been thoroughly examined in other independent investigation reports and it is recommended that these procedures be adopted. A suggested format for internal reviews recommended in the Michael Abram Investigation is attached at Appendix 4 to this report.

Recommendation: that the Trust internal review process be changed to that recommended in the Michael Abram Investigation.

111. Whilst the nature of the actual assault on Patient T's mother in October 2005 was similar to the one in 1993, the underlying circumstances were different. In October 2005 Patient T was clearly psychotic; in 1993 he almost certainly wasn't, according to the psychiatric examinations at the time and in 1994/5. Although he had a history of both assaults and relapses, there had never been an instance where he had, within a very short time, become both psychotic and violent. The risk management was not therefore based on an assumption that this would happen. That was very reasonable practice. If the event had been reasonably predictable, Patient T should never have been permitted to leave hospital. Clearly, that was never a part of the professional assessments and risk management planning from 1996. The internal review's conclusion appears to be based on an assumption that the homicide was predictable, and/or that the staff could or would have done something different if they had not 'lost sight' of the risks. It is the view of the independent investigation that this conclusion was incorrect.

5.0 Recommendations

Staffing

1. Recommendation: that all staff should receive appropriate induction training. (paragraph 73)

Patient Accommodation and procedures

2. Recommendation: that the PCT, Trust and Local Authority agree an operating procedure for the funding panel which is equitable and meets their statutory requirements. (paragraph 83)

3. Recommendation: that there is a joint health and local authority review of the profiles of the numbers of patients requiring supported and specialised accommodation to identify resources and minimise delays in placement in the future. (paragraph 86)

CPA reviews

4. Recommendation: that GP medication prescribing records be obtained by care coordinators for use at Care Programme Approach reviews. (paragraph 93)

5. Recommendation: that a risk of domestic violence assessment should be carried out with carers, without the patient present, where appropriate. (paragraph 99)

Trust internal investigation procedures

6. Recommendation: that staff contributing to internal reviews should be given the opportunity to comment upon the accuracy of any report before it is more widely distributed. (paragraph 66)

7. Recommendation: that the Trust internal review process be changed to that recommended in the Michael Abram Investigation. (paragraphs 109-110)

Appendix 1 Job titles of people interviewed

Care coordinator 2001 - 2003
Care coordinator 2003 – 2005
Clinical Director
CMHT Team Manager
Consultant Psychiatrist responsible for Patient Ts treatment 1997-1998 and internal review member
Consultant Psychiatrist responsible for Patient Ts treatment in the community 2003 - 2005
Consultant Forensic Psychiatrist Reaside
Co-workers (2)
General Practitioners (2)
Criminal Justice Lead Liaison
Criminal Justice Liaison Nurse Telford
Senior Liaison Criminal Justice Team
Locality managers – funding panel members (2)
Mental Health Services Commissioner 2003
Mental Health Services Commissioner current
Trust Medical Director

Patient T's sister

Appendix 2 Documentation reviewed in the preparation of this report

Shelton Hospital Records 1989 – 2005 (18 volumes)
Reaside Clinic Records 1996-97 and 2005 onwards
GP records

Internal investigation report
Trust management file for investigation

Governance sub-committee terms of reference and minutes

Shelton Section 17 leave policy 1998
CPA policy
Risk Assessment and Management Policy for adults of working age – Joint policy with Local Authority February 2003

Policy and Procedure on the Electronic Framework for Strategies, Policies, Procedures, Protocols and Guidelines
Procedure for non-compliance with treatment

Appendix 3 The authors

Dr Geoff Roberts is an independent investigations consultant and the former Medical Director of the 5 Boroughs Partnership NHS Trust. He is a former lead commissioner of the Mental Health Act Commission. He is an Honorary Senior Lecturer at the University of Central Lancashire and lead examiner in health for the Institute of Risk Management. He is also rated as an expert adviser for the database of the National Policing Improvement Authority and acts as expert adviser to HM Coroners in respect of mental illness associated deaths. Dr Roberts is HM Assistant Deputy Coroner for Cheshire.

Roger Hargreaves is a registered social worker who is an independent consultant specialising in mental health and adult care. He is a former member of the MHAC, has served on 6 previous independent inquiries and was the British Association of Social Workers lead on the 2007 Mental Health Bill.

Both of the panel members are independent of the Services involved in this case and have previously taken part in HSG 94(27) external inquiries.

Appendix 4 Recommendations for the conduct of internal inquiries from the Michael Abram Independent Investigation[1]

'Requirements for an internal investigation

It is the view of the investigation panel that following any serious incident, three distinct processes need to be undertaken as soon as possible.

Firstly, the line manager (for serious incidents an off-line manager) needs to ensure that a thorough first line review is undertaken. Key to the process is the examination of all available evidence, interviews with relevant staff on a personal basis rather than collectively and the preparation of a thorough and accurate chronology of events.

Secondly, the multi-disciplinary team involved in the incident needs to get together to review its management of the case and to draw out any lessons for future practice.

Thirdly, a senior manager (either the Chief Executive or responsible Executive Director) needs to make whatever inquiries are necessary to satisfy himself/herself and the Board that all policies and procedures have been correctly followed, that there has been no misconduct, and that any major weakness in service delivery has been identified and steps taken to rectify them with an action plan identified.
We suggest that the reports from these reviews should then be examined by an Executive Director to assess whether and what sort of more formal review is necessary. We have no doubt that in the majority of cases the multi-disciplinary review format which is reinforced by the participation of a senior manager would suffice, but in the more serious case the next step should be an immediate management investigation with the prime purposes of securing evidence and establishing facts whilst witnesses are available and the events are still fresh in their memory.

Any review following an incident which demonstrates areas requiring attention or action should be followed by the preparation of an action plan which details the action required, the person with responsibility for ensuring that the action occurs, the timescales within which the action should occur, and a sign off mechanism by which the Board can be satisfied that the actions have been completed.

NHS Trusts must be able to demonstrate that they have the ability to investigate, review and implement robust action plans for all but the most serious incidents on their own, if they are to be credible as responsible public bodies and as "learning organisations".'

[1] St Helens and Knowsley Health Authority 2001