Independent Investigation into SUI 2006/8119

Final Report

November 2009

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This independent investigation was commissioned by NHS Yorkshire and the Humber in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.

This requires an independent investigation of the care and services offered to mental health service users involved in incidents of homicide where they have had contact with mental health services in the six months prior to the incident, and replaces the paragraphs in "HSG (94)27" which previously gave guidance on the conduct of such enquiries.

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Acknowledgements
The Investigation Team wishes to thank:

- Mr D, a victim of the MHSU incident, and his wife. Mr D is further referred to in this report as V2,
- Mr NP, son of the deceased, Mr P. Mr P is further referred to in this report as V1,
- the Metropolitan Police,
- staff at South West Yorkshire Partnership NHS Foundation Trust, (formerly known as South West Yorkshire Mental Health Trust and referred to as SWYMHT in this report)
- the MHSU,
- Refugee and Migrant Justice, Leeds, and
- staff at the high secure special hospital caring for the MHSU
- the Home Office
- the mental health division, Department of Health.

who all assisted in the completion of the investigation conducted.

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EXECUTIVE SUMMARY

Intention

This report sets out the findings of the Independent Investigation Team (IIT) regarding the care and management of the mental health service user, herewith referred to as the "MHSU", by South West Yorkshire Mental Health Trust, now, South West Yorkshire Partnership NHS Foundation Trust. The organisation is referred to as SWYMHT throughout this report. (SWYMHT). The MHSU attacked eight individuals near Heathrow Airport on 24 November 2006. The attacks were unprovoked and had particularly tragic consequences for two victims (V1 and V2). V1 died and V2 was left with lifelong brain injury.

Purpose

The terms of reference for the team were:

- to undertake an analysis of the MHSU's mental health clinical records and to identify any significant care management concerns that would require further independent investigation;
- to examine the care and treatment the service user was receiving at the time of the incident and to comment on: its suitability, the extent to which it corresponded with local and statutory obligations, the adequacy of the risk assessment, the interface and communication with other statutory and non-statutory agencies, the exercise of professional judgment and the service users' engagement with the mental health service; and
- to make recommendations.

In addition to the above the IIT agreed with the Strategic Health Authority that it would comment on the predictability and potential preventability of the incident. This was an issue of importance to the families of V1 and V2.

Outline of the review process

The team conducted:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A critical appraisal of the Trust's internal investigation report.
- Interviews with staff working in the Trust's Assertive Outreach Team (AOT).
- Review of key policies and procedures.
- Meetings and/or discussions with the Metropolitan Police, Refugee and Migrant Justice and the family of one of the victims.

Main conclusions

The IIT concludes that:

- For the most part the care and management of the MHSU was reasonable. The AOT had regular weekly contact with the MHSU, with some short periods of fortnightly contact. It also provided appropriate support to the MHSU when he was stressed or needed assertive follow-up.
- Medications management for the MHSU was reasonable. In 2005 and 2006 it is difficult to see how the AOT could have managed the MHSU's medications differently. If he was a patient of any AOT today one would strongly consider placing him on a Community Treatment Order.
- There is one instance in May 2006 where a member of the medical staff requested twice-weekly visits for the MHSU because he appeared to be showing signs of early relapse. These enhanced contact visits did not occur and there is no adequate explanation for this. For the four weeks between this instruction and the subsequent outpatient appointment, where the MHSU was again considered to be in remission, his care management fell below the standards expected of an AOT and the purpose of him being with the AOT was thwarted.
- On 6 November 2006, the MHSU self presented and was assessed, and as a result the plan was to continue with weekly contacts. Because of the nature of the MHSU's stressors at the time, he should have received enhanced contact at least twice a week after 6 November. That no such decision was taken is the collective responsibility of AOT and not any individual practitioner.
- Following assessment on 6 November and then subsequently on 8 November, there should have been a clearly agreed plan for what action was to be taken if the MHSU could not be contacted.
- Although the AOT did have contact with the MHSU on 6, 8, 13, 15, and 17 November, only two of these contacts constituted a face-to-face assessment. On 22 November, the MHSU was not contactable by telephone as had been planned. There should have been assertive follow up of this, but there was none.
- The discovered during its attendance at New Scotland Yard that there was the facility for the MHSU's AOT to have core information about the MHSU entered on to the Police National Computer (PNC) as part of its risk management plan. Although it was part of the AOT's plan to notify the police if the MHSU went absent without leave (AWOL), proactive logging of his details on to the PNC and what actions were recommended if the MHSU were to attend at an airport without money, identification, or a means of boarding an aeroplane were not. The main reasons for this were as follows:

- The AOT believed that the police records would already show that the MHSU had a history of attending at airports when unwell as this had occurred in 2002, 2003, and 2005. On all occasions the MHSU had come to the attention of the police. The AOT did not know that the trespass offences are not criminal offences and therefore should not generate a record on the PNC[1].
- Although this AOT was clearly willing to share information with the police the team, as with many other health teams, would not usually share information in advance of there being a developing or actual concern because of perceived risk of breaching the Data Protection Act.

  This concern around the Data Protection Act, as an impediment to proactive and prudent information sharing with agencies such as the police, is not unique to the MHSU's AOT.

With regards to the predictability of the MHSU's attack on members of the public the IIT do not believe that it was predictable that he would present a high and immediate risk to the public. It was however predictable that if he relapsed he may make his way to an airport, attract attention and possibly put himself at risk.

With regards to preventability had information about the MHSU and his known behaviour of attending at airports, when in relapse, been entered onto the PNC and had the police been aware of the MHSU's change of name in 2006 then the police officer, who asked for a check of the MHSU's name on the PNC on 24 November 2006, could have been given information about him that would have better informed his decision making that day. Under these circumstances it is reasonable to suggest that there was the opportunity for incident prevention.

This being said the MHSU's consent would have been required for the AOT to have been able to share information with the police in advance of there being serious concern about him. The reason for this is there was nothing in the MHSU's history to suggest that he posed a serious risk of harm to the general public. Had the MHSU withheld his consent for this the AOT would have had to consider very carefully whether his 'best interests' outweighed its duty of confidentiality, and the lawfulness of any information exchange made without the MHSU's consent. The IIT cannot guess at what may have happened if the AOT had asked the MHSU for consent. What the IIT can say is that the information it gathered suggests that it would not be common place for information sharing to occur so proactively where there is no emerging or immediate cause for concern, and where there is no known risk to the public.

[1] It would not be reasonable to expect mental health professionals to be aware of this.

One of the reasons for this seems to be a lack of understanding of the Data Protection Act and mental health staff's anxiety about being in breach of this.

As noted on page 58 of this report, on 9 September 2009 the Department of Health issued up-to-date guidance to mental health trusts entitled "Information Sharing and Mental Health – Guidance to Support Information Sharing by Mental Health Trusts"[2] This guidance states:

"A reluctance to share information because of fear, or uncertainty, about the law or the lack of suitable arrangements to do so has been a feature of some public services in recent years and a factor in numerous accounts of untoward incidents, including homicides. A natural reaction to uncertainty is to take what appears to be the least risky option and, for information sharing, that can often mean doing nothing – and that may be the worst outcome for the individual and others."

The DH guidance is, in the opinion of the IIT essential reading for all community based mental health practitioners.

Could anything else have prevented the incident?
The IIT does not believe so. Although aspects of the MHSU's care could have been managed differently one cannot say that the following would have prevented the incident:

- Enhanced contact with the MHSU by the AOT between 8 and 22 November.
- Implementation of assertive tracking of the MHSU on 22 / 23 November.
- Notification to the police of the MHSU's change of name in the summer of 2006.

The reason the IIT does not believe that the points cited above would have prevented this incident are as follows:

- The MHSU's sudden and unpredictable past relapses. This was a service user who could present as well and then rapidly relapse without any warning at all. In November 2006 the AOT identified no clear signs of early relapse in the MHSU.
- Even had the AOT instituted efforts to follow up the MHSU on 22 November it is unlikely that this would have occurred until the following day, or even the day after, given the team's relative lack of concern about his relapse risk at the time.
- Even had the AOT advised the police of the MHSU's name change there was nothing on the PNC that would have alerted the police

[2] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104948.pdf

officer at Heathrow Airport of the need for the MHSU to be taken to a place of safety. [3]

The families of V1 and V2 were particularly interested in preventability based on the police knowing the MHSU's real name at the time of the incident, and whether a change is required as to how we in the UK are enabled to change our name by deed poll. The IIT is aware, from information exchanged between the wife of V2 and the Home Office that in the near future there are plans for biometric testing to be available across all police forces and this will more frequently be used to assist in the identification of individuals. Technology is now available to enable this to occur without requiring an individual to attend at a police station. This technology will mitigate against any perceived weakness in the system of deed poll as fingerprint recognition is a far more reliable approach. It is important to note that even had biometric tools been available to the police at Heathrow Airport on 24 November 2006 it is highly unlikely that their actions would have differed because there was, at the time, no information on the PNC to alert them to the fact that the MHSU had a serious mental health illness and had a history of attending at airports when acutely unwell.

The key therefore to preventability of future incidents in similar circumstances, in the opinion of the IIT, is a greater degree of information sharing between the police and the mental health services that is supported by national policy and clear operational systems for how to, and with whom, information needs to be communicated so that it finds its way on to the PNC in a timely manner.

Recommendations

Unusually for this type of investigation, the IIT has no specific recommendations for SWYMHT or the MHSU's AOT. We were impressed by the developments in systems and processes within this AOT that have continued since 2006. The AOT has good leadership in both its consultant psychiatrist and its team leader. For this team this case has already resulted in more proactive information sharing with the police and the development of solid relationships with the local vulnerable person's officer and the police liaison officer. This now needs to be achieved across all mental health community based services.

The IIT has four recommendations, which it believes need to be addressed nationally. It does however ask Yorkshire and the Humber SHA to communicate the recommendations to other SHA mental health leads so that local consideration can be given to recommendations one, two, and four.

The management team at SWYMHT are also asked to ensure that all of its community based services are cognisant of the key findings and

[3] Note: The offences that the MHSU had been involved in preceeding November 2006 were not of a criminal nature and he should not have had a PNC record at all as a result of these.

recommendations of this report and that it double checks its own systems and polices against the principles espoused in recommendations one and two.

Recommendation 1: information sharing

It has been requested that the National Patient Safety Agency work with the Department of Health to ensure that it's recent information sharing guidance[4] is translated into clear workable operational policies in individual mental health trusts. The message that needs to be underlined is that in all circumstances where there is benefit to the service user in sharing information with other agencies, such as the police, third sector agencies and probation, then all reasonable efforts should be made to obtain the consent of the service user to do so. In circumstances where the service user withholds consent, or obtaining consent is not possible, the healthcare team must then consider the risk to the service user and the wider public of not sharing the information. The issues considered and the output of this consideration must be documented in the service user's clinical record and risk management plan. Furthermore the professionals should seek advice from:

- the Trust's Caldicott Guardian,
- the vulnerable persons officer,
- the police liaison officer,

where appropriate, particularly if there is any uncertainty whatsoever as to the most reasonable course of action to take, i.e. 'to share' or 'not to share'.

In this case the AOT did not tell other agencies that the MHSU had changed his name by deed poll because of concerns around client confidentiality. Furthermore it did not proactively engage with the police in the risk and contingency planning for the service user because of similar concerns. These concerns are commonplace amongst mental health professionals. However, to have shared information with the police in this case would have undeniably been in the MHSU's best interests. In this case, lack of clarity about when it is acceptable and not acceptable to share information without consent contributed to a lack of opportunity for incident prevention.

Recommendation 2: information sharing and the police national computer

It was the working assumption of the Assertive Outreach Team caring for the MHSU that if he was 'picked up' at an airport without any money, identification, or tickets to board a plane, then he would be taken to a place of safety and mental health services would therefore become immediately involved with him. This is what had occurred on two of the previous three occasions he had attended at an international airport. The AOT believed that because the MHSU had been arrested by the police before that there would

[4] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104948.pdf

automatically be a record on the Police National Computer (PNC) about him and the circumstances of his arrests. Unfortunately this was not the case.

Trespass is not a criminal offence and therefore does not generate a PNC record.

The PNC does however have the facility to record core information about service users about whom the mental health services have significant concerns if they go 'absent without leave' (AWOL), or fall out of contact with the services. Furthermore the PNC can accommodate instructions on what actions to take, and who to contact, should the service user be stopped by the police in 'identified circumstances' and a check made against their identity. A service user does not have to have to have any previous criminal record for this facility to be utilised.

An ad hoc survey of a small number of mental health professionals revealed that about 50% were unaware that the PNC could be used positively as part of the risk management planning for a service user. It also revealed that 100% of those professionals approached believed that if a person arrested for any reason a PNC record would be generated and that the circumstances of the arrest would also be recorded. The responses received also suggested that the bar is set quite high when it comes to sharing information with other agencies because professionals are anxious of being in breach of the Data Protection Act. (See recommendation 1.)

In this case had important information about the MHSU been entered onto the PNC in advance of the incident, as part of a proactive risk management and contingency plan, then this incident in all probability would have been prevented.

Because of the numbers of victims as a result of this incident, and its potential preventability, it is essential that all mental health professionals are aware:

- Of the importance of proactive information sharing with other agencies where to do so enhances the safety of the service user and/or the safety of the public, even if the service user withholds consent.
- Of the optimal times to address the issue of information sharing and the obtaining of consent with a service user. For example after a relapse and in the early period of wellness.
- Of the practical measures professionals can take to determine whether the information sharing is lawful if a service user refuses consent, or is unable to give consent (i.e. liaison with the Caldicott Guardian, the Trust's vulnerable person's officer and the police liaison officer – essentially reasoning it out with others).
- Of the scope of the PNC for logging the details of service users who are known to go AWOL when unwell and place themselves in high

risk situations (e.g. vulnerable or dangerous situations), and/or pose a potential serious risk of harm to others. And the absolute acceptability of this where the mental health professional(s) believe that to add a service user to the PNC will enhance the risk management plan and therefore the safety and well being of the service user.

To achieve the above it is essential that training workshops on data protection, clinical risk assessment (as it pertains to service users) and local and national guidance documents and policy on information sharing ensure that the above messages are incorporated and that staff do not have an ungrounded fear of information sharing that is detrimental to the delivery of safe and effective care.

To ensure that this very important issue, in particular the scope of the PNC to support effective risk management planning, receives the attention it needs, the Director of Patient Care and Partnerships/Chief Nurse for NHS Yorkshire and the Humber is asked to bring this recommendation to the attention of the Chief Nursing Officer for the NHS and the NHS Medical Director so that an effective risk reduction solution can be generated, working with relevant partners such as the police and the Information Commissioner's Office.

Recommendation 3: occupational therapists and medicines management

One of the relapse triggers for the MHSU was medication non-compliance and on numerous occasions staff underlined for the MHSU the absolute importance of taking his medication. However, at some times the MHSU took only very low doses of his medication and his care coordinator, an occupational therapist (OT), and other non-medical staff were not sufficiently aware that this posed an inherent risk of relapse.

Discussions between the IIT and the OT identified a potential professional conflict between the guidance provided by the College of Occupational Therapists (COT) to its members about medicines management and the role and responsibility of a care coordinator. It was the OT's understanding, in 2005, that the College advised that OT's did not need to have any knowledge about medicines. However, with the evolution of New Ways of Working[5] in mental health, in the opinion of the IIT, that a care coordinator, regardless of his/her professional background, does need to have at least a basic understanding of the medicines their clients are on and the usual dose range of these.

Clearly it would be unreasonable for an OT to take responsibility for complex medicines management. However it should be within their capability to be

[5] Mental Health: New Ways of Working for Everyone Department of Health May 2007

informed about the medications prescribed for clients for whom they are care coordinator. Guidance issued by the COT to its members in September 2008 makes clear the responsibility for an OT to ensure that he/she has the competencies to fulfil their job role. For a care coordinator this must include a basic knowledge of common mental health medications, the normal dosage and common side effects.

It is recommended that the allied health professionals (AHP) lead in the Directorate of Patient Care and Partnerships at NHS Yorkshire and the Humber and the SWYMHT OT liaise with the COT on the matter of what skills and competencies are required by OTs who are care coordinators for service users. The COT should take an active role in working with relevant partners in defining these core competencies, especially as they relate to medicines management, for the sake of consistency nationally.

Recommendation 4: Client Focused Risk Management Training and Risk Assessment

This investigation highlighted two issues which need to be addressed in client-focused risk assessment training delivered in all mental health trusts and in documented risk assessments.

The first is the concept of 'risk vulnerability', a concept that was not well understood by all members of the MHSU's care team. Furthermore it does not appear to be routinely included in risk assessment training. In the case of the MHSU, situational stress increased his risk vulnerability but was not a 'relapse indicator' per se. The lack of appreciation of this concept did adversely affect the risk management plan agreed within his care team.

The second is staff's awareness of the risks posed by service users engaged in sports such as karate, kick boxing, boxing, kung fu etc. When individuals become competent in any of these sports their hands and feet are considered to be dangerous weapons. For some of these sports such as kick boxing, it does not take long for some degree of competency to be achieved as this case highlights. It is essential that mental health professionals' awareness of this is enhanced as it has real implications within the process of risk assessment, and the documentation of identified risk, especially where service users are prone to relapse and to hit out with their hands and feet.
It is therefore recommended that the Adult Services Lead for NHS Yorkshire and the Humber liaise with the chairs of the national Mental Health and Learning Disability Nurse Directors' and Leads' Forum and national Mental Health Medical Directors' Forum respectively, so that this case can be used for learning lessons nationally. The appropriateness of incorporating the issue of (i) risk vulnerability and (ii) awareness of risks associated with martial arts and other contact sports, such as boxing, into risk training programmes shall be considered by these fora. Consideration should also be given to liaising with the Royal College of Psychiatrists.

1.0 BACKGROUND

On 24 November 2006 the MHSU attacked eight people on a perimeter road near Heathrow Airport. He did not have a weapon; he only used his feet and hands. The attacks caused one individual's death, a lifelong brain injury to another and minor to moderate injuries to six other people. At the time the MHSU was a service user of South West Yorkshire Mental Health Trust (SWYMHT).

Following his arrest at the scene the MHSU was transferred to a high secure special hospital. He was subsequently convicted and sentenced on 23 July 2007 at the Central Criminal Court. He was sentenced to indefinite detention at a high secure special hospital, with review of his treatment. The Judge recommended he be deported if he were ever suitable for release.

NHS Yorkshire and the Humber, SWYMHT and the IIT were all committed to establishing:

- what, if anything, could have been done (in terms of mental health management by SWYMHT) to avert the incident; and
- what can be done to prevent a similar incident occurring in future.

Overview of the MHSU's care and management by SWYMHT

7 October 2001: The MHSU had his first contact with mental health services. He was assessed by staff employed by Leeds Mental Health Trust at Weetwood Police Station at the request of the police surgeon. A Mental Health Act (MHA) assessment was undertaken. It was noted at this assessment that the MHSU went by a number of names: Saad, Saad Al-Jesere and Laidi.[6] This initial assessment revealed religious delusions and the need for a further period of assessment. The MHSU was therefore sectioned under section 2 of the MHA and admitted to a psychiatric inpatient unit in Leeds.

October – November 2001: the MHSU was transferred to Halifax inpatient services on 11 October 2001.

26 November 2001: at the end of this admission the clinical opinion was that the MHSU had suffered an acute psychotic episode. He was therefore

[6] The name used for the purposes of his asylum seeker's status, and his subsequent application for extended residency in England, was Saad Bo Jasere. This was the name that would have appeared on his passport had he been provided with this prior to his name change by deed poll in 2006.

discharged on standard Care Programme Approach (CPA) with follow up in outpatients by his consultant psychiatrist (CP1).

7 December 2001: The MHSU was fully discharged from mental health services.

23 October 2002: following a period of no contact with mental health services, the MHSU was admitted to an inpatient facility. The precipitating incident was his attendance at Bradford International Airport, trying to board a plane to Rome. He claimed to have a message for the Pope.

During this admission the MHSU was violent and aggressive to a number of staff, and patients. He:

- punched a fellow patient in the eye,
- bit a female member of staff, and
- punched another member of the female staff in the face (she was badly hurt and had time off work as a result).

Clopixol Acuphase (an injectable antipsychotic drug) was given with little impact on his mental state. Staff no longer felt that he could be safely managed in an open ward environment. He was therefore referred to the forensic service for an assessment, the outcome of which was:

- That the MHSU did not present a continuing high risk to others. The MHSU was noted to have been remorseful, was able to explain why he attacked the nursing staff but not the patient, was willing to take his medication, provided an accurate history of his past circumstance and family background, and his attitude and demeanour were appropriate. He had no animosity towards anyone of other religions to himself, or urges to harm others.
- The forensic consultant noted that the trigger for his attack on the staff was that when they approached him to give the Acuphase he thought it was to kill his Muslim beliefs[7].
- That the MHSU could be managed on an open ward but advised rationalisation of his treatment regime and commencement of a Section 17 leave[8] programme.
- That work to improve the MHSU's insight was required, possibly with the assistance of an interpreter. Although the MHSU's English was reasonable it is noted that at times he struggled with questions.

[7] The social worker assigned to the MHSU in 2002 notes in her records that he was fearful of needles and avoided contact with them where ever possible, including the avoidance of having his blood taken to monitor the serum levels of his medication.

[8] Section 17 of the Mental Health Act (1983) allows a responsible medical officer (RMO) to grant a detained patient under their care permission to leave the premises of the hospital where they are liable to be detained.

- It was recommended that the MHSU needed prolonged aftercare on enhanced CPA.
- If the MHSU were to behave violently again, in the context of further future relapse, he would benefit from rapid access to psychiatric intensive care (PICU) for short term containment to effect treatment.

17 December 2002: The MHSU was discharged from the mental health inpatient ward.

18 December 2002 – 18 July 2003: The MHSU was successfully managed in the community. The overriding issue for him was medication compliance. There were no episodes of violence and aggression.

19 July 2003 – 20 July 2003: The MHSU was admitted to Hillingdon Hospital under the MHA following his arrest at Heathrow airport trying to get a flight to Tunisia without a passport. He was quickly transferred back to SWYMHT.

The MHSU's presentation was not dissimilar to his presentation in 2001. He was changeable in affect, he had poor insight into his mental health state, and medication acceptance was problematic. He absconded from the inpatient unit on 14 August and was returned by the police on 16 August.

Acuphase had been prescribed for the MHSU on 11 August but he did not want to accept this, he subsequently did accept this after he was returned to the ward. During this admission there was no evidence of violence and aggression.

The medical records suggest that there was a dramatic improvement in the MHSU's mental state after the administration of Acuphase and he very soon started to display some degree of insight.

Section 17 leave was commenced soon after the MHSU's return to the ward and this was used appropriately.

1 September 2003: there was a Section 117 pre-discharge meeting.
The plan was to:

- refer the MHSU to the assertive outreach team (AOT);
- continue with prescribed medications;
- discharge the MHSU on enhanced CPA;
- reduce olanzapine to 7.5mg nocte;
- carbamazepine levels to be monitored (the MHSU would not take lithium); and
- outpatient appointment (OPA) in three weeks.

25 September 2003 – 6 July 2005: The MHSU was managed in the community. Apart from frequent negotiation regarding the dosage of his medication this period was relatively uneventful.

6 July 2005: The MHSU was arrested at Manchester Airport trying to board a plane without a passport. He was subsequently bailed the same day and he made his way back to his home town and presented himself at the local outpatient clinic. It was clear to those present that he was becoming unwell. He lashed out at his previous care coordinator, punching him. The police were called so that the MHSU could be taken to a place of safety. He went peacefully with the police. He was assessed under the MHA in the police cells and then transferred to a privately managed psychiatric intensive care unit (PICU), as there were no PICU beds available within SWYMHT at the time.

8 July – 6 September 2005: the MHSU was managed in a PICU environment. The records show that he was challenging to manage for a substantial period of time. There were outbursts of aggression and violence, similar to that displayed on the SWYMHT inpatient facility in 2003. The PICU records reveal that the MHSU's mental health state remarkably improved after the commencement of sodium valproate.

He was discharged back to SWYMHT on:

- olanzapine Velotabs; and
- sodium valproate syrup.

Lorazepam had been discontinued.

7 September 2005: The MHSU was returned to his local inpatient facility from PICU.

14 September 2005: the detention of the MHSU under Section 3 of the MHA was revoked.

15 September 2005: The MHSU was discharged.

19 September – 8 May 2006: The MHSU was followed up on a weekly basis by the assertive outreach team (AOT).

8 May 2006: the MHSU was assessed in outpatients by an associate specialist who had cared for him before. The associate specialist detected some early signs of relapse in the MHSU and requested that the frequency of contact was increased to twice a week with further outpatient follow up in two weeks' time.

9 May – 26 June 2006: contact with the MHSU continued on a weekly basis. The outpatient appointment on 26 June revealed that the MHSU was again in remission from his illness and that the previously noted early signs of relapse had receded.

4 July 2006: the records note that the MHSU had stopped taking his sodium valproate. Following discussion with his care coordinator he agreed to commence carbamazepine and to continue with olanzapine.

4 July – mid October 2006: community based care continued.

25 October 2006: the MHSU was noted to have passed his British citizenship examination.

6 November 2006: the MHSU self-presented at outpatients requesting assessment. He was very anxious about his passport application and had

experienced some difficulty with the first solicitor he contacted. The specialist registrar (SpR) on duty for AOT assessed the MHSU. No obvious signs of relapse were identified but because he was stressed, and because the MHSU was known to relapse suddenly and quickly, the SpR recorded that it would be prudent to "keep a close eye on him".

8 November 2006: The internal investigation report notes that the MHSU did attend for assessment on this day and was seen by one of the AOT social workers. There is no record of the assessment as the social worker apparently became unwell and went home before making a record of this.

13 November 2006: There was telephone contact with the MHSU as he was not available for his planned home visit on this day. The visit was rearranged for 17 November.

17 November 2006: The MHSU was visited at home by a locum social worker. The visit was planned for 45 minutes, but the MHSU had plans and could only accommodate 20 minutes. The assessment of the social worker was that there were no signs of emerging hypomania and that the MHSU was welcoming and appeared well mentally. His anxiety levels were not considered notable.

22 November 2006: A Community Psychiatric Nurse working with AOT attempted to contact the MHSU by telephone. The MHSU did not answer his phones.

24 November 2006: In the early hours of the morning the MHSU was challenged by one of the Heathrow Airport police regarding a bar of chocolate he had taken from a shelf in a cafe but had not paid for. The information provided by the Metropolitan Police revealed that at this time the MHSU was very polite, was smiling, and put the chocolate bar back when challenged. There was nothing in his behaviour that was aggressive in any way. If anything the MHSU was notably polite. The police officer did check the MHSU's name on the PNC, as is routine procedure, but this revealed no information.[9]

24 November 2006: the MHSU was arrested on a perimeter road outside Heathrow airport following the serious incident.

Other issues of relevance

Ramadan

As an IIT we researched any connection between the timings of the MHSU's relapses and Ramadan. Having looked at the dates for Ramadan between 2002 – 2005 there is no correlation between the MHSU's relapses and this religious festival.

[9] The reason no information was revealed was that the MHSU had changed his name in mid 2006 and had not notified the police of this. Currently the weight of responsibility for notification to the police regarding change of name if one has any previous record rests with the individual changing their name.

The change of name effected by deed poll

In May or June 2006, the MHSU changed his name back to what the IIT understands is his birth name. An issue for the families affected by the incident was how the MHSU could have changed his name without essential agencies such as the police being made aware. The situation in 2006, and the situation today, is that the onus is on the individual changing their name to make sure that all relevant agencies are made aware of it.

At the time the MHSU proceeded with his name change he was no longer a client of Refugee and Migrant Justice (formerly known the Refugee Legal Centre). Had he been a client this centre would have notified the authorities of his name change. The mental health team did not do this because it was concerned about breaches of confidentiality.[10]

At the time the MHSU changed his name, the mental health service was unaware of the MHSU's true nationality. All believed him to be Iraqi which is what was stated for his asylum seeker's status. He was in fact Tunisian. When he changed his name in 2006 he changed it back to his birth name, not the name he assumed to support his claim to have come from Iraq. This information only became known to the SWYMHT AOT in August 2008 when a specialist registrar (SpR2) attended a CPA meeting at the high secure hospital currently caring for the MHSU.

Please go to appendix 1 page 76 for a more detailed chronology of the MHSU's contacts with the mental health services provided by SWYMHT.

[10] The issue of police notification was much debated within the Investigation Team. On balance the Investigation Team believes that it would have been reasonable for AOT to have advised the police of the MHSU's name change, in relation to achieving a robust risk management plan that was in the MHSU's best clinical interests. However the Investigation Team does not believe that it is reasonable to have expected the AOT to have notified the police of the MHSU's name change per se. In the UK it is the responsibility of the individual who has changed their name to notify all relevant authorities of this. The system of deed poll relies on this notification occurring by default when individuals apply for a new driving licence or passport.

2.0 TERMS OF REFERENCE

The terms of reference for this Independent Investigation, set by Yorkshire and the Humber Strategic Health Authority (the SHA) in consultation with South West Yorkshire Mental Health Trust (SWYMHT) and Calderdale PCT (PCT) were as follows.

To examine:

- The care and treatment the service user was receiving at the time of the incident (including that from non-NHS providers e.g. voluntary/private sector if appropriate) in view of what was known of the service user's history and assessed health and social care needs, including:
  - the suitability of that care and treatment;
  - whether the specific care needs of the patient, in terms of ethnicity and status, were identified and whether this had any impact on care;
  - the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies;
  - the adequacy of risk assessment, identification of relapse predictors, care planning and their use in practice;
  - the exercise of professional judgment and clinical decision-making including delivery of management and clinical supervision;
  - the interface, communication and joint working between all those involved in providing health and social care, in order to meet the service user's mental and physical health needs, (including the relationship with police and other services); and
  - the extent of services' engagement with carers, the impact of this, where applicable, and the extent of support for the service user's social wellbeing.
- The quality of the internal investigation and review, including the relevance of the recommendations, and progress made by the Trust to improve systems following the incident.

  Note: The IIT's assessment and feedback to SWYMHT on its internal investigation is not included in this report. The reason for this

is that a decision was made at an early stage that because of the severity of the incident, the MHSU's care and management would be reviewed as though an internal investigation had never been undertaken. However, it must be noted that the internal investigation commissioned by SWYMHT was fulsome and searching. The resulting report was also thorough and detailed.

To identify:

- Learning points for improving systems and services.
- Developments in services since the user's engagement with mental health services, and action taken since the incident.

To make realistic recommendations for action to address the identified learning points to improve systems and services across agencies.

To report these findings and recommendations to the board of NHS Yorkshire and the Humber.

3.0 CONTACT WITH THE FAMILIES OF THE VICTIMS

This incident was unique in that the number of individuals directly affected by it was far greater than is usually the case. Of the eight persons attacked two were more seriously injured than the others. One was mortally wounded (V1) and one was left brain damaged for life (V2).

It is notable that the Chief Executive and Medical Director of SWYMHT met the family of V2 in the aftermath of the incident and they remain open to continuing dialogue with this family and the family of V1. There were initially arrangements in place to meet with the family of V1 but in the event this meeting did not occur.

At a very early stage in the independent investigation process the IIT made contact with the wife of V2, who happened to have maintained contact with the family of V1. A meeting was planned with both families to take place on 27 December 2008. In the event the son of V1 was not able to attend and an agreement was made to meet with him on completion of the investigation.

The meeting with V2 and his wife did occur on 27 December. Contact with V2 and his wife continued throughout the investigation process by telephone and email.

The issues of greatest importance to the son of V1, and V2 and his wife were:

- How the MHSU managed to change his name by deed poll in 2006 without the police being made aware of this.
- Whether there was anything the mental health services should have done that would have prevented, or reduced the risk of, the incident that occurred.
- Whether the police could have, or should have done anything differently.

With the assistance of the Metropolitan Police the IIT wrote to all remaining individuals (six in total) attacked by the MHSU offering them the opportunity to meet with the IIT. In five instances no response to these letters was received and in one the letter was returned as ‘person unknown at this address’.

On completion of the investigation V2 and the son of V1 were again contacted and arrangements were made to take them through the findings and recommendations of the investigation. Both families received further communication from the IIT after it found out from Scotland Yard, after the supervised reading of the draft investigation report, that there is the facility on the PNC to proactively record information about mental health service users, and others, who in defined circumstances present a significant risk to themselves or others.

4.0 FINDINGS OF THE INVESTIGATION

As a result of its review of the care and management provided to the MHSU by his AOT the IIT is able to report that, for the majority of his contacts with the services provided by SWYMHT, the MHSU's management was of a reasonable standard.

There are a number of aspects of his care and treatment/management about which positive feedback to the mental health services needs to be conveyed, and this is presented on page 24, section 4.1 of this report.

In evidencing a critical analysis of the MHSU's care and management, the IIT set out to provide answers to the following questions. The findings of the IIT in relation to each of these are presented in sections 4.2 to 4.4 (pages 26 to 61)[11]. The questions covered in these sections are:

- Does the analysis of the MHSU's clinical records and interview notes evidence that:
  - the professionals who cared for him between 2001 and 2006 had a grounded appreciation of his risks?
  - the risk management of the MHSU appropriate?
  - there were timely and reasonable risk assessments undertaken by the AOT in relation to this MHSU?
- In the weeks leading to the incident on 24 November, was the Assertive Outreach Team's management of the MHSU appropriate?
- Was the medication management of the MHSU appropriate?

In addition to the above the IIT sought to be able to provide a response to the following:

- Does the IIT believe that the acts of aggression displayed by the MHSU in November 2006 were predictable?
- Does the IIT believe that the incident involving the MHSU in November 2006 was preventable, by virtue of any change in his mental health management, or any other factor even if outside the control of specialist mental health services?

Before proceeding to detail the IIT's findings in sections 4.2 – 4.4, the following positive feedback to the local AOT is presented.

[11] The data included in these sections also addresses the terms of reference of this investigation.

Section 4.1 Positive feedback

In almost all retrospective analyses of the care and management of mental health service users involved in a serious incident, it is possible to identify aspects of the care and management that could have been better. However it is also important to acknowledge good care and management.

In the case of the MHSU, it is clear that he received excellent social support from all staff who cared for him in the community. Staff were very mindful that he did get stressed, and they took measures to try and reassure him and assist him in reducing his stressors as far as was reasonably possible.

It is also notable that the AOT had a good culture of communication, meeting every morning and evening to share important information about their clients. This evidenced recognition of the need for consistent communication, with a 'whole team' approach to care and management.

The following represents a selection of the good practice displayed by those staff engaged in the care and management of the MHSU. It is not exhaustive but the IIT believes it highlights that there were many positive aspects of the MHSU's care and management, and also some notably positive operational practices by the AOT.

- October 2001: on transfer to SWYMHT, screening for illicit substances occurred.
- Staff utilised the services of an Arabic-speaking interpreter in 2001.
- The MHSU was referred for a forensic assessment in November 2002, following an escalation in his violence and aggression towards other patients and staff.
- In January 2003 there is clear evidence that the MHSU's first care coordinator (CC1) tried to work assertively with him. This was when the MHSU was a patient of the community mental health team and not the AOT.
- Between April 2003 and November 2006 the quality of correspondence between the medical staff and the MHSU's GP was of a good standard. Management plans were clearly documented and the service user's risk status, both past and current, was clearly tabulated.
- There is clear evidence that CC2 maintained contact with the PICU provider between July and September 2005. Furthermore this individual attended for the discharge planning of the MHSU. This represents good practice.

- The information provided by the PICU provider on 20 September 2005 to the mental health services provided by SWYMHT was of good quality.
- In September 2005 there was a clear awareness within AOT that proactive relapse signature work was required for and with the MHSU. Although there is little detail as to the substance of this within the MHSU's records, the IIT is satisfied that this work was commenced by CC3 in 2006, and that she worked with him using a booklet that was provided for him to keep. That this work was progressing was independently validated by CP3.
- The AOT records evidence that CC1 and CC2 assertively tracked the MHSU if he did not attend outpatients or was not available for planned contact visits. An example of this is on 6 October 2005, where the progress notes show that CC2 went to considerable lengths to locate the MHSU. At this stage he was not displaying risk symptoms but he was under stress in relation to his pending court case following the Manchester Airport incident in July.
- The MHSU was well supported by AOT staff in the period leading up to and during the court hearing in relation to the Manchester Airport incident.
- In March 2006 AOT staff were responsive to the MHSU's expressed need to be up in the morning for college. His medication regime did cause difficulties with this, but AOT staff undertook to phone him in the morning to enable him to be up in time.
- In May 2006 there was an appropriate response to emerging signs of hypomania in the MHSU. The assessing associate specialist requested an increase in contact with the MHSU from once to twice a week. Medications were also increased.

With regards to operational issues, in 2004 when CC3 joined AOT as team leader, a much more robust system was implemented in relation to medicines management for AOT clients.

Also in 2004 when CP3 joined AOT, there was a marked improvement in the standard and structure of clinical correspondence with GPs. Furthermore this consultant psychiatrist instigated a structured system of clinical review for all AOT clients and personally under took to assess all new referrals to the team.

The remainder of this section addresses the critical questions detailed above.

Section 4.2 Does the analysis of the MHSU's clinical records and interview notes evidence that:

- **the professionals who cared for him between 2001 and 2006 had a grounded appreciation of his risks?**
- **appropriate risk assessments were undertaken in relation to the MHSU between 2001 and 2006, and that there were appropriate associated risk relapse and prevention plans?**

4.2.1 Did the professionals who cared for him between 2001 and 2006 have a grounded appreciation of his risks?

The Trust's own internal investigation report suggested that the AOT team had a narrow perspective of the MHSU's risks, and in particular his level of dangerousness. In light of the incident that occurred, ensuring that the IIT had a grounded appreciation of staff perspectives was therefore very important, especially as the involved staff had been disappointed to read this finding in the internal investigation report. There was a sense amongst AOT team members that the internal investigation team had taken an overly forensic perspective in relation to its criticism of their risk analysis. Although the AOT accepts that in the assessment of client risk, taking a more forensic approach is necessary with the type of clients to which an AOT provides a service, it does not believe that care and treatment plans can be formulated forensically. The main reason for this is that care is almost exclusively managed in the community and not in an inpatient setting. Risk taking is therefore integral to its work. The skill for the AOT is in identifying those clients who should be in a forensic setting and not an AOT care setting. The Investigation Team agrees that applying a forensic approach to the assessment of risk in assertive outreach is prudent.

Following the IIT's analysis of the clinical records, and the interviews conducted with staff working in the AOT who cared for the MHSU, it is very clear that collectively the staff had a huge body of knowledge about his risk factors and risk presentation. The collective risk factors cited, and detailed in the clinical records, were:

- religious delusions;
- attendance at airports trying to get home to see his family;
- attacking others during the process of enforced mental health treatment;
- unprovoked attacks on staff and other in-patients;
- medication non compliance;
- low mood;
- anxiety and situational stress; and
- that when he showed any of his relapse indicators, the risk of rapid deterioration was present.

However the knowledge and risk perspective held by individual staff members varied considerably. This variation was most noticeable between those staff

who had had contact with the MHSU between 2002 and 2005 and had experienced his relapse first hand, and those who had their main contact with him after September 2005 and thus had not seen him relapse.

The aspects of risk that were not so well understood by the latter group were those associated with:

- mood elevation;
- situational stress; and
- the giving of injections by force and the aggressive response this provoked in the MHSU (although the MHSU's care coordinator from 2005 – 2006, CC3, did understand this).

In addition to these, none of the staff, whether they had experienced his relapses first hand or not, appreciated the increased risks associated with the MHSU taking an interest in kickboxing, indeed some staff were completely unaware that he had ever engaged in this sport. This was a service user who used his hands as weapons when violent and aggressive in inpatient settings.

Furthermore even though the MHSU had made a number of unprovoked attacks on fellow inpatients (and on one occasion a member of staff), not one member of staff having contact with him after September 2005 recalled these episodes. CC2, who did recall these attacks, did not attach the same significance to them as the attacks on staff, some of which she believed could have been avoided with better management of the situation. Both CP1 and the associate specialist said if they had been aware of the MHSU's interest in kickboxing, it would have been of concern to them. The associate specialist particularly remembered the MHSU's unprovoked attacks on fellow patients.

For staff involved in the care and management of the MHSU between September 2005 and November 2006, their predominant perspective was that the MHSU attacked inpatient staff only when they were trying to administer compulsory treatment to him such as Clopixol Acuphase[12].

The reasons why there was a lack of comprehensive understanding about these issues are presented below.

Team factors

It was, and is, the practice of this AOT to take a team-based approach to care. This means that although a service user may be assigned a care coordinator, in general a number of team members will have contact with him/her. This means that a breadth of knowledge about the service user will be spread across the team and not invested in any one individual[13]. However, there was a considerable body of knowledge about the MHSU invested in CC2. CC2 had

[12] Clopixol Acuphase is used by injection for rapid tranquilisation.

[13] This is usual practice for an AOT

been closely involved with him during two of his relapses, including the occasion he was admitted to the psychiatric intensive care unit at the medium secure facility in Darlington. When this individual left the AOT in December 2005, there was no-one who had anything like this depth of knowledge or sensitivity to the MHSU's risk and relapse factors.

The associate specialist working in AOT in 2005, who had also previously cared for the MHSU as an in-patient in 2003, said: "He [*the MHSU]* may have been under-prioritised in view of others on the caseload." This doctor felt that because the AOT team, at the end of 2005 and in early 2006, did not have any collective personal historical experience[14] of the MHSU, they may not have fully appreciated the huge gulf between the MHSU well and the MHSU unwell. The associate specialist, however, had this first-hand experience and consequently believed the MHSU to be a medium risk of harm to others and always at risk of relapse. He was in retrospect correct.

The impression of the IIT, which was confirmed by the current team leader for this AOT, was that there had been a 'loss of memory' in the team when CC2 left. This individual advised the IIT that CC2 was the only team member who had experienced the MHSU in relapse and had substantive knowledge about him. She also saw him more than any other team member and it is not ideal for such in-depth knowledge to be invested in one team member. This loss of memory from a team is something that all community and in-patient teams have to grapple with.

Task factors[15]

It was the routine practice of this AOT to meet every morning and evening to share significant information about the service users on the AOT caseload. The morning meetings were mainly focused on workload and work distribution for the day. The evening meeting was focused on any emerging issues of concern that all team members needed to be aware of. There was a weekly Wednesday meeting where service users were discussed in more depth, especially 'code red' service users (those of most concern). The MHSU would not have constituted a 'code red' service user as, when he was well, he was reasonably well motivated and engaged with the team. He would meet with them and said he wanted to integrate with Western society and work. One of the support workers the IIT met with said he "would not be in the top five

[14] The team leader (CC3) for the AOT at this time recalls that they did have a newly appointed community psychiatric nurse who had knowledge of the MHSU when he was an inpatient following some of his previous relapses. It was her intention to appoint this individual as the MHSU'S care coordinator once he had been properly inducted and gained some community experience with a small caseload of service users. At the time of the incident she was in the process of making this member of staff the MHSU's care coordinator.

[15] Task factors are those associated with specific activities such as care planning, risk assessment, and handover of care between care coordinators - essentially any activity that is guided by organisational policy and procedure.

clients of concern. The top 15-20 but not the top 5". This sentiment was echoed by all staff[16].

The IIT believes that there was an over-reliance on information exchange at these handovers. There appears to have been a belief that participants would interpret the information in the way the information giver expected. Some of this over-reliance is understandable given the frequency of meetings and the professed open communication about individual service user risks between team members. That information exchange may not have been working as expected is evidenced by CC2's reaction to the news that her colleagues did not share her risk appreciation of the MHSU. She was nonplussed that her colleagues did not appreciate situational stressors as a significant relapse trigger for the MHSU, as she believed that she had continually spoken of these. She wondered whether her colleagues had been listening. The IIT does not believe that the 'loss of memory' was as a result of team members not listening.

In the case of the MHSU, there was no formalised handover between the outgoing care coordinator (CC2) and the new care coordinator (CC3) in late 2005. Although CC2 initially disputed this, there is no documentary evidence of a formal care coordinator to care coordinator handover when CC2 left AOT. There was certainly no joint visit by CC2 and CC3 to the MHSU's home. CC3 informed the IIT that the main reason for the lack of handover of care was the fact that the AOT was very short staffed at the time, and that the service users assigned to CC2 needed to be handed to other team members rapidly. This situation was compounded by the fact that CC2 left the team quite quickly after her successful appointment to another post. All interviewees said that the AOT was under-establishment with its staffing and skill mix.

Communication/documentation factors

The IIT focused particularly on the documented risk assessments, and risk management and relapse prevention plans, in its assessment of documentation. It is the risk documentation that quickly informs team members about salient features of a service user's risk presentation, the measures to be taken when relapse indicators are emerging or suspected, and when a service user is in full-blown relapse.

In the case of the MHSU the documentation of the risk assessments and also the risk management and relapse prevention plans was disappointing, in relation to the depth of information recorded, and also in the lack of any structured and auditable risk management and relapse prevention plans.

[16] It is important to remember that all AOT clients are considered to be higher risk than Community Mental Health Team clients. The reasons for this will range from a tendency to disengage from mental health services through to behavioural issues that puts the service user or others at risk. This MHSU was not considered to be a high risk of violence in the community because he displayed no such behaviour in the community.

Specifically:

- The risk assessment form design used in SWYMHT at the time, although comprehensive in the areas of risk it asked to be considered, utilised a tick-box style. This meant that even where it was identified that there were current or past risk behaviours there was no specific detail recorded about these. For example it was noted on every risk assessment that the MHSU had a historical risk of causing harm to others. However no information was documented on any risk assessment about the context or consequences of this. Therefore staff understanding was based on what they heard, and the information they retained. This may be why many staff did not appreciate that the MHSU made unprovoked attacks on individuals as well as provoked attacks on staff.

- On no occasion could the IIT identify a clearly documented risk management plan which addressed actions to take if there were suspected or identified relapse triggers, or vulnerability indicators, as well as the actions to take if the MHSU was considered to be 'in relapse'.

The issue of whether or not appropriate risk assessments were undertaken with the MHSU is more fully addressed in Section 4.2.2 page 38 of this report.

Organisational factors

From the inception of the AOT until 2004, there was no dedicated consultant psychiatric cover. Therefore, there were no established systems and processes for in-depth individual case reviews. Indeed when a consultant psychiatrist (CP3) was appointed to the AOT, she found that no in-depth case reviews had occurred at all. She believes that this was largely due to the fact that the AOT had been provided with medical cover by consultants working in adult psychiatry, who made themselves available on an as-needed basis and for outpatient follow up. There was a general acceptance that AOT was a nurse-led service and that it would obtain medical input on an as-needed basis.

When CP3 took up her post she instigated a system of regular case reviews. However because of the volume of service users, and because the process needed to be implemented from scratch, cases had to be prioritised with the most concerning service users being reviewed first. Excluding the extensive preparation time that was required, each case review took between one to one-and-a-half hours. For a proportion of clients this process was repeated two or three times until CP3 believed that as a team they had a sufficiently detailed understanding of the 'high risk - high complexity' service user. The MHSU was not a priority for this type of review as his presentation had been stable for some time in 2004, and he was not considered to be risky when in remission of his illness. (Note: he did not have his third relapse until July 2005).

It took three years for all AOT service users to have the in-depth case reviews that were commenced in 2004. One of the reasons why this took so long was that CP3 had a number of months of ill health at the end of 2005 – early 2006. During this time the AOT had no dedicated medical cover and it reverted to its previous pre-2004 practice of only calling for medical input where this was required. Consequently the system of detailed case review implemented by CP3 was put on hold. Nevertheless three years to complete this very good initiative was perhaps a little too long.

The reason why the MHSU did not receive a case review upon CP3's return to work was because he was again in remission of his illness, and the information she was consistently receiving from the team was that he was settled and engaging with them appropriately. Again, not inappropriately, he was not deemed to be among those most in need of full clinical review by the team.

Further compounding the speed with which all service users could be reviewed was the fact that the AOT consultant ensured that she personally assessed all new referrals to the team, those recently discharged from hospital and those with a significant forensic history. This represents good practice.

The final factor in the time taken for all AOT service users to receive a review was the fact that CP3 worked on a part-time basis.

Staff understanding of specific risk issues - martial arts

At least one eye-witness account of the way in which the MHSU attacked his victims suggested that he had some military or martial arts training. A perusal of his records revealed that he did spend a short period of time kickboxing early in 2005. Most staff recall him either going to the gym, running, or playing football. The general consensus was that he was fit. A number of staff did recall that the MHSU when violent only used his hands and feet, and on one occasion his teeth. The IIT's case note review confirmed that from his first contact with mental health services in Yorkshire, the MHSU used his hands and feet as his mode of attack. In light of this, and because of the extensive damage caused by the MHSU in November 2006, the IIT wanted to gain an insight into staff understanding. Did they consider hands and feet to be potentially dangerous weapons in individuals who had engaged in activities such as kickboxing, and how did they perceive risk in relation to this MHSU and kickboxing?

What became very clear was that not all staff engaged in face to face contact with the MHSU were aware of him ever having taken up kickboxing, or of the relevance of this to his usage of hands and feet as weapons when mentally unwell. One of the staff interviewed reported: "[*I have*] only a very grey recollection of martial arts and the MHSU … vaguely recall a reference to him kickboxing on the ward in his aggressive outbursts … thought perhaps his

activities were over described … On reflection myself and my colleagues were unaware of this (i.e. kickboxing) and had no knowledge of him attending a club at any stage. The only reference to him kickboxing was on the ward when unwell."

Both of the support workers who had contact with the MHSU were unaware of any connection between the MHSU and martial arts or kickboxing. One of the support workers had never seen any evidence of the practice of martial arts in the MHSU's flat, and the other support worker was adamant that martial arts and the MHSU had never been mentioned.

CP3 was aware of the risks associated with any martial art if an individual is not in control of himself/herself, however she was not as aware as she is now of the link to hands and feet being considered dangerous weapons. CP1 however told the IIT that he would have been very worried if he had known that the MHSU had taken up kickboxing. He reports that he would have wanted to keep an eye on the situation, but more importantly to make sure that the MHSU was taking his lithium. In this doctor's opinion the MHSU was an individual who could relapse at any time without warning.

CC3 told the IIT that: "I believed when unwell and subject to compulsion the MHSU would use his skills as a kickboxer to fight. It is for this reason that I wished to make clear in the risk management plan that this is the means of assault/defence he would utilise to try to reduce any future instances of assault."

Because of the mixed knowledge and perspectives of the AOT, the perspective of a kickboxing club affiliated to the World Association of Kickboxing Organizations was sought. This club advised that if one has natural physical ability and a good level of fitness, one does not have to practise kickboxing for a significant length of time to present a danger to others if out of control and utilising the basic techniques learnt. With regards to the appropriateness of individuals with a mental illness engaging in this sport or any martial art, the perspective shared was as follows:

- It is helpful for an instructor to know if a club member has a significant mental illness so that the good practice issues of restraint and control can be reinforced at all times.
- Health professionals engaged with a service user, if aware of them taking up a martial art, should inform themselves about the nature and the ethos of the club. For example with kickboxing there is a wide spectrum of clubs ranging from competition clubs, clubs where no protective clothing is encouraged and the emphasis is on 'the fight', to clubs where full protective clothing is worn and the ethos is on discipline in training and full contact during sparring is not encouraged. Clearly for individuals with mental illness, one would want to encourage membership of the latter type of club if engagement in this activity is to be beneficial to the service user.

Medication risk
All staff were aware that one of the relapse triggers for this MHSU was medication non-compliance, and it is very apparent from the analysis of his clinical records that on numerous occasions staff underlined for the MHSU the absolute importance of taking his medication. What appears to have been less well understood by non-medical staff was the inherent risk of relapse because of the very low doses of medication the MHSU was taking. Throughout the entirety of his contacts with the AOT, engaging the MHSU with medication was a fine balancing act and staff took the view that it was better that he agreed to take small doses of medication than disengage from the service altogether.

Although CC3 told the IIT that she believed the MHSU to be concordant with his medications, she accepts that she did not fully appreciate that the dosages he was on were often sub-therapeutic, or that the dosages were less than the medical staff were really satisfied with. Consequently she believes that she was not as aware as she could have been about the enhanced risk of relapse for the MHSU as a direct result of this. CC3 was aware that the medication dosages the MHSU was taking were the result of “needs must” in order to maintain engagement with him.

The Investigation Team leader (ITL) and CC3 had a detailed discussion about the role of occupational therapists who are care coordinators in relation to medicines management. As a result of this discussion, CC3 agreed to ask the mental health and learning disabilities professional affairs officer at the College of Occupational Therapists to review the briefing provided to OTs working in mental health services about medicines management. The ITL and CC3 agreed that it is not reasonable for OTs to take professional responsibility for medicines management, but that it is reasonable to expect an OT who holds care coordination responsibility for a service user to have informed themselves of the medicines the service user is on, and the usual dose range of these.

Please see section 4.4 page 59 for a more detailed analysis of the medication management of this MHSU

Perceptions of dangerousness
It is very clear to the IIT that none of the AOT team members perceived the MHSU to be a danger to the public. His risk of violence to others was seen as entirely related to his interaction with inpatient staff when they were trying to enforce treatment, or administer medication to sedate or calm him when completely out of control and a danger to himself and/or others.

CC2 told the IIT: “I was very aware that the MHSU could relapse and when he did he was very unwell. I did not believe however that he posed a danger to the public. There was absolutely no evidence to support this at all. Not once in all of his relapses did any violence and aggression occur in a public place. On

each occasion he relapsed he was in a public place and it was only on admission to hospital that he became significantly violent. The most notable example of this is when the MHSU was picked up at Manchester Airport. He was charged and released on bail. He then made his own way to The Dales [outpatient department] and asked to see me. When I arrived I saw immediately that he was unwell and arranged for him to be taken to a place of safety. While he was at The Dales he did lash out at his previous care coordinator CC1, but there was nothing frenzied about his attack, he was though deteriorating rapidly. When the police came the MHSU walked out of the department with them [and] there was no display of aggression at all. It was then that the Mental Health Act assessment occurred and from there he went to a medium secure unit to psychiatric intensive care as there was no bed availability at the Trust."

CP3 told the IIT: "Clearly when ill there was a body of knowledge about how profound his risks were, namely delusional beliefs, he believed that he may be poisoned and intramuscular medication being enforced. His aggressive outbursts at these times could be powerful – intimidating. He posed a significant threat to in-patient staff when unwell. He was extremely menacing. They were all aware of the three occasions when he presented at airports and how that unfolded. When ultimately he arrived on an in-patient ward he was generally very unwell."

However in relation to risks to members of the public, CP3 advised that anyone who has been violent is of increased risk per se. However, looking at the past behaviour of the MHSU there was nothing to specifically raise a public safety risk. All of his violent behaviour was in-inpatient settings and not in public places. As a team they thought that the most likely scenario was that he would go to an airport when becoming unwell, and that as on previous occasions he would be apprehended, or taken to a place of safety where a Mental Health Assessment would occur. There was of course the possibility of other scenarios but this was the most dominant.

The perspective of CP3 was echoed by all interviewees the IIT met with, including those who had contact with him between 2002 and 2005.

Interestingly although staff did not see the MHSU as a public safety risk, they did perceive him to be a potential nuisance risk at airports. CC3 accompanied him to the court hearing on 6 December 2005, following his being arrested and bailed at Manchester Airport in early July 2005, and told the IIT that she had then discussed the situation with the MHSU's solicitor and that they explored what could be done to minimise the risk of the MHSU attending airports again. CC3 wanted to see if a restriction order could be imposed which would have required the conditions of:

- serum monitoring;
- medication compliance;
- no attendance at airports; and
- meeting with the team as required.

The residing magistrate did not impose any restriction order and only imposed a fine on the MHSU. CC3 saw this as a lost opportunity as it would have, in CC3's opinion, given the AOT a lever to involve the police if the MHSU was not available to meet with the AOT when he should be.

Comment by Investigation Team

The IIT agrees with the AOT that the events of 24 November 2006 were not predictable, and that the MHSU's history was not suggestive of someone who posed a serious risk to public safety. However, the IIT does feel that the AOT was overly reliant on the MHSU being picked up and taken to a place of safety before being in the full throes of relapse (i.e. hypomania). The team already had one example of how the MHSU had managed to get from Manchester Airport to The Dales and was rapidly relapsing upon his arrival there. On this occasion staff were mindful of his risks and were careful to keep some distance between them and him. The IIT does believe that the attack that occurred on 24 November could not have been predicted, however it also suggests that the AOT should have considered the scenario of the MHSU relapsing and not being able to make his way to his care team, and/or not being picked up and taken to a place of safety. The consideration of such a scenario may, and only may, have prompted more careful consideration of any potential public safety risk, alongside the risks to the MHSU himself. Even so, the IIT does not believe that it would have entered the consciousness of this AOT, or any other team, that the MHSU would have lashed out at and caused injury to so many individuals as well as causing the death of one of his victims.

Stress vulnerability

The MHSU had some specific stressors in his life. He was an asylum seeker and although he achieved an extension to his temporary residency in July 2005, he did not pass his citizenship exams until 2006. As far as the IIT is aware, citizenship was not granted prior to the incident. However the AOT is mindful that it may not have appreciated the additional stress that 'everyday' stressors could pose for an asylum seeker compared to UK nationals and individuals from the European Union. This being said there is nothing to suggest that the MHSU was not capable of managing his stressors with the support of the AOT. The MHSU's clinical records show that on a good number of occasions between 2004 and 2005 he responded well to AOT's efforts to support him when stressed.

AOT staff told the IIT that although the MHSU did become stressed at times, this always seemed to be transient in nature. In their experience he seemed to take on board reassurances that were provided by the team, and his anxieties generally reduced. The MHSU is reported to have articulated on a number of occasions that his stressors did reduce with the support of the team**.** Staff reported that sometimes simple discussion with the MHSU about his worries was sufficient to bring his anxiety or stress levels to a level that he could manage; at other times he required additional medical input and would usually

accept an appointment with one of the medical team to achieve this. At such times adjustments might be made to his medication if the MHSU was agreeable to this.

The current team leader for the AOT recalled that the MHSU demonstrated by his attending the AOT in a stressed state and seeking help that he could respond appropriately negating the need for further follow up unless there were other indicators that prompted this.

The above however does not reflect the perspective of the CC2. She told the IIT that in situations of stress vulnerability such as sitting exams, applying for a passport, or seeking citizenship she would have watched the MHSU "like a hawk". This individual was able to evidence that in similar situations she did assertively track the MHSU and maintain contact with him on a daily basis if needs be, until she was satisfied that he was managing his stress and not entering the early stages of relapse. She told the IIT that she was very mindful that the most effective tool she had for managing a relapse situation was close monitoring of the MHSU, given his reluctance to take any therapeutic dose of medication.

Comment by Investigation Team

The issue of stress vulnerability is a difficult one. The IIT has a sense that the AOT team members between September 2005 and November 2006 held a perspective about the MHSU's risk vulnerability that was too narrow. On more than one occasion, and as late as 2006, the MHSU volunteered that stress was a relapse precursor for him. However, the IIT can understand how the AOT lost sight of the significance of stress vulnerability because between September 2005 and November 2006, the MHSU demonstrated on more than one occasion his ability to manage stress and thus avoid relapse as a result of this.

It is the opinion of the IIT that a significant challenge with the MHSU was that his triggers for relapse were never really understood. This view was echoed by at least one member of the medical team who had significant contact with him.

Staff perceptions of the MHSU's relapse speed

All staff with a professional registration were asked about the length of time the MHSU could/would relapse over. The consistent message relayed to the IIT was that this MHSU would relapse over a matter of hours or days. There was nothing gentle about his relapses. He could appear fine one day and be in full relapse the next. The only team member who had a different perspective was CC3, who believed his relapse period to be two weeks i.e. that over a two-week period she would be able to identify breakthrough signs before full relapse. The Investigation Team Leader (ITL) had subsequent discussion with CC3 about her perspective, and following this CC3 accepted that somehow she must have misunderstood information shared with her by CC2 when she became care coordinator for the MHSU at the end of 2005. She can see no other reasonable explanation as none of her colleagues

shared her understanding. The IIT's own review of the MHSU's clinical records could find no definitive antecedents to any of his relapses.

CP3 told the IIT that although she knew that relapse was inevitable for him based on his presentation in the previous months, she did not anticipate it occurring when it did. Again, the IIT believes that it would have been very difficult to have predicted when the MHSU was going to relapse.

4.2.2 Was the risk management of the MHSU appropriate?

Two aspects of the AOT's management of the MHSU show that it was mindful of risk. The first is the style of the letters from medical staff who assessed the MHSU from the commencement of CP3's post in autumn 2004. All GP letters outline the current and historical risk status for the MHSU. The letters also were set out in a structured and logical manner so that information was easy to assimilate.

The risk summary was appropriate in all of the correspondence sent to GPs in 2005 and 2006, the critical period analysed most closely in relation to the events of November 2006.

The second aspect of the AOT's management that shows it was aware that the MHSU carried residual risk was the decision to have contact with him on a weekly basis. There was one period where his visits were reduced to fortnightly, this preceded his July 2005 relapse. Thereafter his contacts were weekly.

The review of the MHSU's records revealed only one episode prior to July 2006 where the MHSU was displaying early signs of relapse. This was on 8 May 2006. He was assessed by a locum associate specialist who had previously cared for him as an inpatient in 2003. On this occasion the main feature was the MHSU's elevation in mood. That the MHSU had changed his name was also of concern to this clinician. Consequently the management plan was to increase AOT contacts from once a week to twice a week to observe for further signs of relapse. The associate specialist also planned to see the MHSU in two weeks' time. However this follow up did not occur until 26 June 2006, some seven weeks later.

With regards to the subsequent frequency of AOT contacts with the MHSU, these occurred on:

- Wednesday 10 May 2006 (five days after his outpatient assessment);
- Friday 12 May;
- Wednesday 24 May (this was a gap of 12 days after the last contact);
- Thursday 25 May (for carbamazepine monitoring); and
- Wednesday 31 May.

This frequency of contact was not acceptable and does raise questions about the effectiveness of communications with AOT at the time, and how critical information about care and risk management was communicated. Comparison of the letter to the GP with the electronic notes the AOT team referred to did reveal inconsistency in the information recorded. The electronic record only showed that the management plan was to "raise the olanzapine to 5mg nocte. He was not happ" then the text runs out. It is also notable that the social

worker who saw the MHSU prior to the Associate Specialist on 3 May "had no concerns about his (*the MHSU's)* mood". There was therefore nothing in the progress notes to alert the team to the associate specialist's requirements for increased surveillance. However, there is a copy of the associate specialist's letter in the AOT file so the information was available to the team.

Because of the passage of time, the AOT has not been able to explain how it came to miss such a specifically worded management plan, or how there was no outpatient appointment booked within the timeframe specified[17]. CC3 did advise the ITL that usually all instructions regarding the frequency of visits would be discussed at the next team meeting and reviewed. It is possible that there was a subsequent decision to revert back to weekly visits, but as there is no record of this in the MHSU's clinical records, CC3 cannot say this with any certainty.

By time the associate specialist reviewed the MHSU on 26 June 2006, his bipolar disorder was back in remission and there were no concerning features in his presentation. Follow up was to occur on a weekly basis with AOT, which it did thereafter.

On 4 July 2006 there was a CPA meeting at the MHSU's home with the associate specialist and CC3. At this meeting the MHSU advised that he had stopped taking his sodium valproate and had reduced his olanzapine to 2.5mg. The records show clearly that the associate specialist had a frank discussion with the MHSU about the increased risk of relapse and subsequent hospitalisation if he did not take his medication. A compromise was reached, and the MHSU agreed to take 200mg of carbamazepine nocte. On 20 July it was noted by the community psychiatric nurse (CPN) responsible for monitoring the MHSU's bloods that he consented to blood monitoring and he was given follow up appointments for 3, 17 and 31 August. The first blood monitoring occurred on 27 July. (There is also a record of the MHSU attending for his bloods on 31 August.)

The plan at the end of the CPA meeting was for the MHSU to re-attend for outpatient assessment in two weeks' time. This did not happen and he was next assessed by a member of the medical team on 6 November 2006 when he self-presented at the AOT base. There has been no satisfactory explanation as to why the MHSU was not offered any outpatient appointments for such a long period of time[18].

The MHSU did however have contact with the AOT on 11 occasions during this period. All bar one of these were face-to face contacts with staff who knew him. The only notable occurrence during this period was confirmation

[17] The systems in AOT are now far more robust and it would be very unlikely for such an instruction to be missed today.

[18] Again the systems in AOT are now such that it is unlikely that OPAs would not be booked as per plan.

that he had passed his UK citizenship exam and was therefore applying for citizenship and a passport. This is noted in the progress note of 25 October 2006 by CC3.

Comment by Investigation Team
The above information does confirm that the AOT was risk aware. It also highlights one serious lapse in service provision where twice weekly contacts were requested and did not happen. Reflecting on the MHSU's pattern of relapse, it is fortunate that it was not under these circumstances that the events of 24 November occurred.

4.2.3 Were there timely and reasonable risk assessments undertaken by the AOT in relation to this MHSU?

To fully answer the question: "Were there timely and reasonable risk assessments undertaken by the AOT in relation to this MHSU?" a specific analysis of the documented risk assessments, in addition to those detailed in the medical correspondence to the MHSU's GP, was required.

Usually it would be expected that the risk assessment would be repeated in line with CPA reviews, and when any significant change in the service user's presentation and/or behaviour and/or circumstances occurred.

As this MHSU was on enhanced CPA throughout his contacts with the AOT, one would therefore expect a minimum of two reviews of the documented risk assessment per year.

The following presents an overview of key documentation in relation to the MHSU's risk assessments and relapse prevention plans between September 2003 and November 2006. Because the clinical records did not contain as many formal risk assessment papers as the IIT anticipated, information has been drawn from other documents that also contain specific risk assessment information.

1 September 2003: CPA review and care plan compiled at the MHSU's discharge meeting from inpatient services, following his attendance at Heathrow airport and subsequent admission to Hillingdon Hospital

In this document the MHSU was noted to be of low risk of harm to others, but to have a history of harm to others, including physical harm and threats and intimidation. Other risk issues noted were:

- discontinuing medication;
- failure to attend appointments;
- severe stress; and
- recurrence of circumstances associated with risk behaviour.

However there is no contextual detail noted about any of the above. The document does note the requirement for a risk management plan, but that no further risk assessment is required.

1 September 2003: risk management plan completed by CC1

This risk management plan was devised at the time of the MHSU's discharge from in-patient services. Unsurprisingly, no active risk indicators were noted. Risk history themes were identified but there was no detail recorded about these. The risk management plan documented by CC1 identified the MHSU's target signs as:

- discontinuing of medication;
- thinking he was a prophet;
- holding extreme religious beliefs;
- grandiose ideas;
- failure to keep appointments; and
- poor sleep.

There was no mention of stress or of elation of mood, both of which were noted in the records at this stage.

The actions to be taken if any of the above were present was recorded as:

- urgent assessment of medication and current circumstances;
- may require MHA;
- exercising caution when visiting as there were often young males at the flat and some evidence of substance use.

In addition under "details", CC1 recorded "employ assertive outreach techniques to establish whereabouts and current mental state". There is no explanation of what these assertive outreach techniques should be. However, it is commonly understood within AOTs across the country that such techniques include:

- visiting the service user's residence at different times of the day;
- searching out the service user at known 'haunts';
- talking to neighbours;
- leaving a note so that the service user knows the AOT team member has visited, and asking him/her to contact them;
- contacting family members known to be in close contact with the service user.

The risk management plan set out what action to take in the event of a relapse, but not what actions should be taken if there were features or behaviours in the MHSU's presentation which were known to represent increased vulnerability to relapse.

The date noted for the next risk review was 1 December 2003.

6 October 2003: core assessment undertaken by CC2 at the MHSU's home one month after discharge from inpatient services

In this document CC2 recorded:
"The MHSU recognises that he has mental health needs, he feels that stress is a major factor in this. He feels that medication helps him keep balance, however from experience he feels that medication can influence his motivation and has impacted his ability to work. He identifies that he needs to take medication but needs to find the right dose alongside meaningful activity such as education, part-time work."

There are a number of key areas on the assessment form that were HONOS focused[19]. The form also allowed for notes about medication. It outlined the medication he was on at the time and that he "dislikes injections and feels unwell when blood is taken, reluctant to engage with monitoring service due to this".

Overall the document does provide an insight to the living and social circumstances of the MHSU, and highlights areas of importance in relation to risk management and relapse prevention planning.

A range of interventions was noted for the MHSU under the headings of "social", "patient" and "clinical". The clinical interventions were stated as:

- "to assess mental state"; and
- "to prescribe appropriate medication and monitor side effects".

There is however no depth of information in the plan as to how either of these interventions were to be delivered.

Attached to this document are two updated care plans, one for outpatients dated 17 March 2005 and one for AOT dated 30 November 2005. Both are as sparse in their information as that dated 6 October 2003.

Note: There are no recorded risk assessments for 2004 that the IIT could find.

9 February 2005: risk assessment and risk management plan

This was undertaken by CC2. The target signs were noted as:

- discontinuing medication;
- thinking he is a prophet, extreme religious beliefs;
- grandiose ideas;
- failure to keep appointments; and
- poor sleep.

The risk management plan recommended urgent assessment of mental health and current circumstances in the event of a relapse. It also

[19] HONOS: Health of the Nation Outcome Scales – a way of measuring clinical outcomes in mental health. See Royal College of Psychiatrists website, www.rcpsych.ac.uk/clinicalservicestandards/honos/whatishonos.aspx.

- noted his history of violence to staff and the public; and
- noted the need for caution when visiting his flat as he often had young males present with some evidence of substance misuse.

During her core assessment of the MHSU in October 2003, the MHSU told CC2 that he considered stress to be a risk factor for him, but it is not noted on her risk management plan as a target sign or symptom. Neither is the mood elevation that seemed to accompany the MHSU's relapses.

This plan, as that of 2003, omitted to provide a plan for when signs of early or imminent relapse were present, and/or there are features suggestive of increased vulnerability to relapse even if frank signs were absent.

The risk plan noted that the date for risk review was 9 August 2005. However, the MHSU was an inpatient by this time.

6 September 2005: inpatient staff risk assessment

As with the previous risk assessments, the 'current risk' and historical risk' tick boxes were completed as required.

On this occasion there were a number of 'active' issues. These were:

- 'other' on current warning signs was ticked;
- compulsory admission was also ticked; and
- recent severe stress was ticked.

Unfortunately no further detail was provided about any of these factors.
It was also noted by the inpatient assessor that further risk assessment was required and that this was to be completed by 7 September 2005. There is no evidence that this occurred.

What we do know is that the MHSU had section 17 leave on 12 September, with a return date of 19 September 2005. This was two weeks after the initial assessment.

The care plan during this admission is minimal, and gives the impression of being pre-prepared, or that staff selected inserts from a 'pick list'. There is little in the care plan to convey that it was designed specifically to meet the MHSU's needs. The progress notes however show that he was settled on the ward, compliant with care and returned from any planned section 17 leave within the boundaries set. There was no evidence of any prevailing risks at this stage of the MHSU's care journey.

The progress notes also noted the MHSU sharing that:
"I get poorly because I stopped the olanzapine tablet. I learnt to care for myself more, I feel a normal person, I'm happy for myself. I was stressed at the other hospital." The record also noted that the MHSU denied thoughts of harm to others. He claimed he assaulted staff in Darlington because "they wanted to give me an injection and I believed that they wanted to steal my power".

His overall assessed risk was low risk of harm to others and a low risk of suicide.

30 November 2005: risk assessment and risk plan
This was undertaken by CC2. As with the vast majority of the risk assessments undertaken, the MHSU was displaying no active signs of risk relapse when the risk assessment was compiled. Similarly, common to all risk assessments undertaken to date, there was no elucidation in the risk assessment document about any of the risk issues identified.

The risk plan itself contains no additional information to that contained in the plan of February. This is quite remarkable given that the MSHU had recently been an inpatient on a psychiatric intensive care unit (PICU), where significant amounts of violence and aggression were displayed to fellow patients and staff. CC2 had maintained contact with the PICU concerned and attended the pre-discharge planning meeting, so she would have been aware of these factors.

Also significant was that in the period leading to this most recent relapse, the staff who had contact with him had noted no imminent signs of relapse. The MHSU however was noted to be stressed about his asylum seeker's application on 30 June, but to be coping with it very well, and to have presented as very well. This was one week prior to his most significant period of ill health to date. There was no mention of stress as a possible risk vulnerability factor.

The actions noted in the plan as required if any of the MHSU's risk indicators were present were:

- urgent review;
- increased support from AOT; and
- involving the crisis team if necessary.

As previously the plan was not at all descriptive, and there was nothing that acknowledged that an escalation plan might be required or what specific actions were required. Neither was the time interval for increased contact with the MHSU suggested, nor the specific circumstances under which this should occur.

The suggested date for the plan review was 22 May 2006. This actually occurred on 4 July.

4 July 2006: relapse and risk management plan
This plan was reviewed and updated by CC3.

This is by far the most informative risk relapse and management plan for this MHSU to date.

The information under the headings “Detail” and “Target signs and symptoms” remain largely the same, with a continuing absence of any reference to stress and mood elation as factors that are indicative of increased risk vulnerability. This is disappointing given that in May 2006 the associate specialist had identified this as a significant factor of concern, and requested increased contact with the MHSU to enable close monitoring of the situation. (The fact that this did not occur is irrelevant here.)

The actions noted by CC3 to be taken in event of relapse (or risk of relapse) were:

- urgent review;
- increased support from AOT;
- if concerned that the MHSU might try and leave the country, alerting the police;
- if stopped at customs, a Mental Health Act assessment would be required;
- involving the crisis team if appropriate; and
- avoiding rapid tranquillisation if admitted to hospital, as his constant belief was that he was subject to attention from the Iraqi secret service, who were trying to kill him. He believed an injection was to be the means of his murder; he would therefore fight and was a practised kickboxer.

Greater information, in relation to suggested time intervals for enhanced contact from AOT, would have enhanced this plan. Furthermore, although one can only agree with the suggestion that the police be informed if the AOT suspected that the MHSU was trying to leave the country, at the time this risk plan was documented there had been no warning whatsoever that the MHSU was going to attend an airport until he was apprehended there. It may therefore have been prudent for the consent of the MHSU to have been obtained after his 2005 admission so that information could be provided to the police in a planned way. For example, the MHSU’s habit of attending at an international airport, when relapsing, without identification, money or flight tickets. This information could also have included the actions required such as taking the MHSU to a place of safety and notifying the AOT of his whereabouts.

However, at the time, such proactive working with the police would not have been the usual approach. In trying to gauge more broadly mental health professionals’ knowledge about how they can work with the police in the best interests of their clients, a range of healthcare professionals outside of Yorkshire were asked whether they knew one could work proactively with the police before a service user went AWOL. The following is indicative of the responses received:

Feedback from a senior mental health nurse in a city based mental health trust:

"All staff knew they would report someone AWOL to the police, but were less certain about disclosing information proactively to inform and *with the purpose of having the information* logged. Usually, staff replied it is drummed into them to say as little as possible to the police because of confidentiality worries."

The issue over confidentiality and disclosing information to the police about the MHSU was certainly a concern for the MHSU's AOT.

The IIT suggest that including actions to be taken (including notification to the police), if:

- the MHSU was not available for planned contacts, or
- he could not be located following the utilisation of 'assertive outreach techniques' within a specified time frame,

would have been more robust.

CC3's documented plan should also have stated more clearly that in the event police notification was required, the police should be made aware of the need for the MHSU to be taken to a place of safety and assessed under the Mental Health Act, and the AOT to be notified. At the time the records were entered onto a system called MHIS which had significant limitations with regard to the amount of free text that could be entered. Although this may not have been a barrier to the clarity of information provided at this specific time, working with the system did mean that staff had adapted to the brevity it required.[20]

Part of the AOT's risk plan was reliant on the MHSU attending at an airport and being picked up by the police, however because of his name change and because there had been no notification of this to the police, a PNC (Police National Computer) check was not going to link the MHSU with the name he went by prior to the summer of 2006. This was not at all understood by the AOT staff.[21]

The suggested date for the review of this risk plan was 8 January 2007. By this time the MHSU was residing in a high secure hospital.

17 October 2006: standard risk assessment by CC3
This was undertaken by CC3. There was no documented change to her previous risk management and relapse prevention plan of 4 July.

[20] The Trust now uses the RiO system for documentation. The AOT staff report that it is much better and that there is much more space for entering free text data. In their view the implementation of RiO has improved the quality and quantity of documentation.

[21] The AOT staff not unreasonably believed that when one changes one's name by deed poll that there is an automatic linkage on relevant national computers with an individual's old name. This is not the case. If one changes one's name by deed poll it is one's own responsibility to notify relevant authorities. This came as a surprise to the AOT and also to the family of the victim who suffers brain damage as a result of the November 2006 incident.

HONOS records
Stress, anxiety and sleep problems were noted in the HONOS records for November 2005, September 2005 and February 2004.

Overall comment by Investigation Team
It is difficult not to be influenced by the incident that occurred on 24 November 2006, when commenting on the overall quality of the risk management and relapse prevention plans documented in the AOT records. However this would be to introduce hindsight bias and this is not reasonable.

With regard to positive feedback, it was good practice that the medical staff specifically identified risk issues in their correspondence to GPs and also stated clearly their management plan in this correspondence. It was also good practice that there were twice-yearly reviews of the risk management and relapse prevention plans for the MHSU in 2003, 2005, and 2006. These did not occur in 2004, and given the passage of time, and the changes that occurred in the AOT during 2004, it is not possible to explain why risk reviews did not occur.

The above being stated, overall the IIT found the documentation of the risk management and risk prevention plans for the MHSU disappointing. Based on their content, it is little surprise that the staff interviewed during the investigation had some inconsistencies in their perceptions of the MHSU's risks, and his risk relapse triggers.

The most important issues for the IIT are:

- That key risk issues were not notated on any plan. One would have expected the following to have been clearly recorded.

    - Kickboxing: the MHSU taking up kickboxing in 2005. It was already known that when violent he hit out with his hands. This type of sport and the skills taught are potentially life threatening in anyone who experiences loss of control. You do not have to practise kickboxing for long to become potentially more dangerous to others. Anyone who is fit, has reasonable hand/eye coordination, and has an aptitude for kickboxing, can be considered more dangerous after a very short period of tuition in the sport.
    - Stress vulnerability: The MHSU's stress vulnerability is mentioned on a number of occasions throughout the medical assessments and progress notes. The MHSU himself was noted to suggest that stress is a precursor to his relapses on two occasions, once with CC2 and once with SpR1, but stress, or the need for enhanced vigilance when the MHSU was stressed, was not notated in any risk management or risk relapse plan.

- Mood elation: A retrospective review of the MHSU's case records shows that mood elation is a relatively common feature in all of his relapses. Yet again this target sign was not detailed in any risk management or relapse prevention plan.

- Commencement of citalopram: in March 2006 the MHSU is commenced on citalopram for his depression. Citalopram does increase the risk of mood destabilisation in individuals with bipolar affective disorders. Although in principle this was mitigated by the sodium valproate 700mg bd he was taking, the increased risk should have been made clear to CC3. It should also have been incorporated into the MHSU's risk management plan at the time.

- It does appear that contributory factors to the MHSU's 2005 relapse were his desire to see his family and also his asylum seeker's status. This should have alerted the AOT to the sensitivity of the MHSU to any aspect of his residency in the UK and any expressed desires to see his family, no matter how ordinary these expressed desires were. There is nothing in the risk management or relapse prevention plans to suggest that heightened vigilance was required by staff during such times.

- That depth of documentation about the specifics of planned actions and interventions was lacking. For example there was an absence of any suggested time interval for increased contact if it was required.

- That there was no stepped risk management plan that acknowledged that a two-tier response plan might have been most appropriate for the MHSU. For example, this could state actions to be taken if signs of increased risk vulnerability were evident, such as stress or reduced sleep, and actions to be taken if clear signs of relapse were present, for example mood elevation or grandiosity with religious overtones.

In addition to these issues there is no evidence that during discharge planning for the MHSU, that AOT or the in-patient team considered keeping the MHSU on extended section 17 leave for a period of time. This section of the Mental Health Act gives leverage to help ensure medication compliance. In saying this the IIT appreciates that responsibility for care management rested with inpatient services, and that core decision making responsibility also rested with inpatient services while the MHSU remained on the ward. It may be that when planning for discharge for known and existing community clients, that there should be shared decision making between inpatient and community teams, especially the medical staff.

However the system worked in 2005, the IIT believes that extended section 17 leave should have been considered for the MHSU after his relapse in July 2005. It would have enabled the AOT to have tested the MHSU's commitment to and compliance with the recommended treatment regime. At the very least the AOT should have discussed the merits of its application and documented its decision. If the MHSU objected to such a decision, the MHA allows for this to be challenged via a Mental Health Act review tribunal.

Overall the perspective of the IIT is that the risk management plans for the MHSU were not sufficiently detailed, and were below the standard one expects from an AOT. There was no contingency planning. It would not have taken anyone an inordinate amount of time to have gone through the MHSU's records retrospectively, to identify all the features that needed to be components of the risk management and relapse prevention plan. This did not require a dedicated case review; it would have been part of good day-to-day client management. This is especially so where the precursors to a service user's relapses are unclear as they were for the MHSU.

4.3 In the weeks leading to the incident on 24 November, was the Assertive Outreach Team's management of the MHSU appropriate?

This question is the question that is of most interest to the families of the deceased and the injured, one of who suffers lifelong brain injury as a result of the attacks made by the MHSU.

On 6 November 2006, the MHSU self-presented at the AOT base wanting to see CP3. She was not available so one of the support workers asked the newly appointed SpR if she would see the MHSU. She agreed to do so. The main precipitator for the MHSU's self presentation was anxiety regarding his application for British citizenship, and the provision of a letter from CP3 to his current solicitor regarding the reasons why he was unable to attend for a scheduled court appearance in 2005 following the Manchester Airport incident. The MHSU was also noted by the SpR to be anxious about his initial choice of solicitor. The contemporaneous record notes that the MHSU "was quite stressed at the moment".
The record also notes that the MHSU reported having been to see a solicitor the previous week regarding his application for citizenship, but that he found the meeting unhelpful. He consulted a second solicitor the following day which he found more positive and supportive.

The records also note that the MHSU "wants to see his family in Liberia and that citizenship will help with this". (Note: in October, the MHSU had successfully passed his citizenship exams).

The SpR also noted that the MHSU said that "he didn't want to become unwell similar to last year when he went to the airport and demanded to get on a flight".

With regards to diet and self care, the records say that the MHSU reported that he was sleeping OK, and that diet and self care were OK.

On mental state examination the SpR recorded:

- "no ftd (frontotemporal dementia);
- affect anxious, not elevated;
- thoughts preoccupied with obtaining citizenship and seeing family but not overly so, able to talk re. other issues;
- no abnormal ideas;
- no thoughts of self-harm;
- perceptions normal;
- concentration fair;
- insightful – increased meds in response to stress;
- attended EH to contact team re. circumstances;
- happy to remain in contact with team this week."

The recorded management plan was:

- "Continue AOT input as arranged – due for review Wednesday (two days after the SpR's assessment);
- continue increased dose of olanzapine 5mg nocte – has adequate supply for now;
- liaise with team and GP about situation;
- ask the MHSU to give contact details for solicitor to try and clarify what information is needed;
- report information with the MHSU's consent only; and
- further medical review as appropriate."

Following her assessment of the MHSU, the SpR spoke with CP3 about him during her clinical supervision meeting that took place on the same day. CP3 agreed with and supported the SpR's management plan.

Comment by Investigation Team

On 6 November the SpR had only been working with the AOT for a matter of weeks. She met with and assessed the MHSU by chance, in response to his self expressed need and because there were no other medical staff present. This SpR did not know the MHSU at all. It is to her credit that she attempted to gain an insight to his diagnosis and risk history by reviewing the available paper records. However these were in such a state of disarray that gaining a comprehensive picture was difficult. (The Trust's internal investigation report also made this point.) She was however able to determine that the MHSU had a history of rapid relapse.

It is the perspective of the IIT that this SpR undertook as thorough an assessment of the MHSU as one could expect in the circumstances. She was aware that he presented a relapse risk, she knew he had a planned contact with the AOT on 8 November at which time she expected him to receive an assessment by one of the AOT staff. The SpR also undertook to discuss her assessment and management plan with the consultant responsible for AOT on the same day as her assessment.

There was however, one aspect of this SpR's contact with the MHSU that required retrospective reflection. This was the subsequent letter she wrote to the MHSU's GP about her assessment and the planned actions. In this letter, and under the heading "impression", she wrote "it would be prudent to continue to monitor him closely at present as in the past his mental state has deteriorated quite rapidly." The IIT is satisfied that the SpR has given her documentation due consideration.

This sentence implied that the AOT were initiating a period of enhanced contact with the MHSU which was not the case. The plan was to continue with the usual planned weekly contact. Both the SpR's contemporaneous clinical record and the management plan detailed in the letter to the GP letter confirm

this. The letter says: “He will be reviewed by the team via his usual arrangements.” This was on a weekly basis.

To conclude:

- in spite of a lack of knowledge of the MHSU, the assessment undertaken by the SpR was of a good standard and appropriately thorough;
- the management plan documented on 6 November was reasonable given that the MHSU was to receive further assessment on 8 November; and
- it was a reasonable expectation that the management plan and the contact with the MHSU on 6 November would be discussed at the AOT meeting on 8 November and any changes required would be agreed then.

8 November 2006: contact with social worker

The internal investigation report (page 31) states that:

“CP3 and *CC3* have verbally confirmed that *the MHSU* was seen on 8 November by..... an Approved Social Worker (ASW) with the AOT. However there was no entry made in the MHIS because the ASW went on sickness absence before he was able to complete his written notes. (See recommendations.)

CP3 has stated that discussion of this appointment took place in clinical reviews on the 8th November and that,
‘the clinical contact and opinion was that *the MHSU’s* mental state was satisfactory ……(and) certainly reassured me that no further urgent medical review needed to be arranged.’”

13 November 2006: telephone contact with CC3

The next time the MHSU had contact with the AOT team was when he telephoned on Monday 13 November. He spoke with his then care coordinator, CC3. Her records note that the MHSU reported that he was not unwell but that he was worried and felt stressed. The cause of stress remained his citizenship application, and the medical report that was required from CP3. The MHSU was advised that his solicitor needed to write to CP3 to obtain this. The records also note that CC3 had to repeat the information on a number of occasions to reassure the MHSU of the process. Pressure of speech was also noted during the conversation. The care coordinator notes that she also confirmed that "we will keep our contact with him on Wednesday". This would have been 15 November. At interview, CC3 advised the IIT that the MHSU's pressure of speech reduced during their conversation. It was her interpretation, at the time, that the pressure of speech was linked to what the MHSU perceived he was being asked to do by his solicitor. She was able to calm the situation down. CC3 advised that if his pressured speech was a symptom of impending mania, she would not have been able to calm him. CC3 also advised that the MHSU's train of thought was consistent and there was no evidence of thought disorder. It was her impression that the MHSU was not displaying signs of early relapse.

15 November 2006

As it transpired CC3 was not able to meet with the MHSU on 15 November so she asked a locum social worker[22] working with the AOT to see him. The MHSU was not at his home at the time the visit was planned for. Later, but on that same day, the IIT is informed that CC3 made telephone contact with the MHSU and arranged with him that the locum social worker would visit on 17 November, which he did.

17 November 2006

The locum social worker's record says "the MHSU showed some anxiety today but was generally well and was coping. He had a busy day planned, helping out at the local mosque. He said he finds the weekends difficult as there is not much to do in Halifax. His solicitor will be contacting CP3 for an updated report to support his claim for citizenship."

At interview, the locum social worker told the IIT that he had intended spending about 45 minutes with the MHSU, however when he arrived the MHSU advised him that he could only stay for 20 minutes as he had plans to help out at the local mosque. The social worker recalled the MHSU as welcoming and friendly. He did have some anxiety but nothing that the social worker was overly concerned about. As an experienced professional working

[22] The locum social worker was very experienced in undertaking out of hours emergency assessments for the out of hours team. With the AOT he was predominantly asked to follow up service users who were perceived to be of low risk. It was his impression that the MHSU was not considered to be an at risk client of AOT at the time he was asked to see him.

in emergency teams, the social worker reported that he was confident and competent to identify any signs of emerging mania. There were none present when he met with the MHSU. The social worker also advised the IIT that there was no religious idealism present and nothing other than normal anxiety displayed in the time he was with the MHSU. The MHSU was appropriate in his behaviour when the social worker left his home, shaking his hand. There were “no tell-tale signs that this chap was becoming unwell”.

The social worker also told the IIT that he was not at all familiar with the detail of the MHSU’s history and received no real briefing on him. However, he said that even had he been aware of the MHSU’s history, including his previous relapse behaviours, he did not believe it would have altered the impressions he formed on 17 November. The social worker asserted that there were none of the usual indicators that would be cause for concern in someone with a bipolar disorder. He also told the IIT that had he been aware of the MHSU’s risk history, he would not have visited him on his own.

It is the understanding of the IIT that on 17 November at the end of day team meeting, there was a discussion amongst the team regarding the benefit of asking the crisis team to make contact with the MHSU over the weekend. As a result of this discussion a decision was made by the AOT that this was not necessary. The MHSU was not displaying any signs of relapse and seemed to be managing his stressors well. Furthermore he had the contact numbers for the crisis team if he felt he needed them.

22 November 2006: the MHSU unavailable

This was the next planned contact with the MHSU. Unbeknown to the AOT, the MHSU had telephoned the previous day to say that he would not be available on 22 November.

Unsurprisingly then, the CPN who attempted contact with him obtained no answer on either his home or mobile numbers. No subsequent action was taken by AOT staff in response to the MHSU’s non-contactability.

CC3 and the current team leader for AOT advised the IIT that in light of the absence of any signs of relapse, there was no clinical need to increase the level of contact with the MHSU. Key to this was the fact that staff did not perceive stress to be a trigger for relapse. Their focus was on non-medication and religious grandiosity.

A selection of staff perspectives regarding the MHSU’s relapse in November 2006

The current team leader for AOT said that as far as he was aware, there were no indicators present to suggest that increased contact was required with the MHSU in the weeks preceding his relapse on 23/24 November. This individual said that the contextual stressors the MHSU was describing were not ones that had previously led to relapse, and furthermore he had previously responded very well to a direct response from AOT which he received on this

occasion, i.e. contacting his solicitor to find out what was required for the MHSU.

CP1, when advised of the MHSU's presentation in the weeks leading to the incident, suggested that for him, the application for British citizenship would have caused greater concern than the pressure of speech. Anxiety as far as he was concerned was a trigger for the MHSU. This consultant also told the IIT that had the MHSU been hypomanic he would not have been able to mask his illness and present as if in control, this just would not have been possible for him.

One of the support workers told the IIT that as the MHSU appeared to be coping with his stressors, then they would not have increased their contact with him. Furthermore the MHSU knew that he could contact them if he was concerned, and generally someone would be available to speak with him or visit him if necessary.

All staff interviewed, who were working within AOT in 2006, highlighted to the IIT that none of the stress situations the MHSU had experienced in the previous twelve months had resulted in a hypomanic episode (i.e. relapse).

Overall comment by the Investigation Team

It is the overall opinion of the IIT that during the period 6 November to 22 November 2006, contacts with the MHSU should have been increased to at least twice a week, thereby achieving a situation of contact every three to four days. It is also the opinion of the IIT that on 22 November efforts should have been made to assertively track the MHSU. AOT staff were not aware that he had advised of his non-availability at this time. This came to light after the incident. Our rationale for our opinion is that although no overt signs of emerging hypomania had been detected by the AOT, the MHSU was displaying a number of stressors that increased his relapse vulnerability. These stressors were:

- anxiety regarding his application for British citizenship. Achievement of this was central to his being able to apply for a passport; and
- a desire to see his family. This desire had been expressed at times over the preceding six months.

Our review of the MHSU's clinical records revealed that stress was something that the MHSU himself reported as a precursor to his previous relapses.

It was of interest to the IIT that all of the staff who had experience of the MHSU's relapses prior to July 2005 also said that displays of anxiety over his quest for British citizenship, coupled with an expressed wish to see his family, should have resulted in an increased level of contact with the MHSU. This was not because they believed he would relapse, or that relapse was predictable, but because of the increased vulnerability to relapse for the MHSU, and that one never knew when relapse might occur.

In stating the above the IIT appreciates that the 'at the time' information gathered by AOT staff between 6 and 17 November revealed nothing suggestive of imminent relapse. However, the MHSU did not have any further full and detailed clinical assessments over this time. Staff formed their impressions on the basis of telephone contacts and one limited face-to-face contact with the MHSU on 17 November. Although the IIT respects the breadth and depth of experience held by the locum social worker who met with the MHSU on 17 November, the impressions formed were just that. For there to have been certainty that the MHSU was not displaying any early indicators of hypomania, a detailed psychiatric/clinical assessment would have been required. Mania is all about "I am busy". Nowhere in the records is it stated what the MHSU's plans were for that day, or subsequent days. Staff impressions about the MHSU between 6 and 22 November (i.e. the last time there was any planned contact) were just impressions. It is important that staff impressions are not confused with the outputs of a detailed psychiatric clinical assessment.

The IIT believes that in 2006, because of recent experience of the MHSU, staff had been lulled into a false sense of security regarding his ability to manage his stressors. This coupled with the lack of recorded detail in the risk management and relapse prevention plans, and the fact that there had been no detailed team-based clinical review for this gentleman, meant that the team never really had a clear perspective of the things they needed to be mindful of, or of the agreed philosophy of management for the MHSU.

In the case of the MHSU it seems that it was not so much a matter of knowing what the risk triggers were for the MHSU, or spotting early signs of mania, it was more a matter of understanding:

- That relapse for the MHSU was almost impossible to predict. However, 2004 excepting, the MHSU did seem to relapse once a year (for example in 2001, 2002, 2003, 2005, and 2006).
- The range of issues that increased his risk vulnerability and the need for enhanced vigilance when these were present, especially if some time had elapsed since the last relapse.
- That for this service user, the most reliable tools AOT had to spot early relapse signs such as mood elevation were frequent contact with him, structured mental state examination, and spending a reasonable amount of time with him.

In addition to enhanced contact with the MHSU between 8 and 24 November 2006, it is the perspective of the IIT that there should have been a reconfirmation of the management plan and a revisiting of his last risk management and relapse prevention plan. This would have enabled the AOT to agree the actions that were to be taken if the MHSU was not available for any of the planned contacts, and how the risk plan was to be escalated should contact not be achieved with a defined time frame (possibly 24 hours).

The above being said one cannot draw the conclusion that:

- had the contact with the MHSU been more frequent,
- had there been assertive follow up on the 22 November, when he was not available, and
- had the police been notified of the MHSU's non-availability, or had there been an agreed plan for what would initiate a missing person alert to the police,

the incident on 24 November was preventable. One cannot say this at all.

The MHSU's propensity for rapid relapse, without any warning signs, means that even if the team had made daily contact it may still not have observed any features or behaviours of early relapse (see appendix 2 page 100 for a focused chronology of his relapses between 2001 – 2005).

However, for the families affected by the incident, the lack of enhanced contact represents a loss of opportunity to have identified that the MHSU was becoming unwell. The IIT does believe that there was lost opportunity.

To clarify, for there to have been the opportunity to:

- identify that the MHSU was relapsing, and
- prevent the incident that occurred,

the following activities would have been required.

- A clear risk management plan that set out the frequency of client contact and what specific actions were to be considered if contact was not successfully achieved.
- Proactive notification to the police of the MHSU's change of name.
- The creation of an alert on the Police National Computer for this MHSU, with the MHSU's consent, so that if he re-presented at an airport without identification, money or flight tickets, and was subsequently apprehended by the police then they would know a) that he had a mental health disorder and b) that there was a strong likelihood that he was relapsing and needed to be taken to a place of safety

It must be stressed that even had these actions taken place, one cannot say absolutely that the events of 24 November could have been avoided. However the chances of avoidance would have been enhanced.

The issues that could have undermined the effectiveness of the above plan are:

- The withholding of consent by the MHSU. In this case his risk profile was such that the AOT would have had to consider very carefully the balance between the best interests of the service user and its duty of confidentiality to the service user. His identified risks, prior to the 24 November 2006, were not to the general public so its public duty would not have outweighed their duty of confidentiality. The weighing up of the risks of disclosure without consent versus the potential benefit to the service user would have been challenging in this case.
- The AOT's lack of clarity regarding the lawfulness of their notifying the police of the MHSU's change of name. This lack of clarity around what is acceptable in relation to information sharing across agency boundaries is challenging for all mental health trusts.
- That the MHSU displayed no overt signs of relapse in the days leading up to 24 November. This is a very likely scenario looking at the pattern of his previous relapse episodes that all came without warning.
- An individual giving a false identity when stopped and questioned at Heathrow airport. The IIT is informed that this is not an uncommon occurrence. This would render any information on PNC ineffective.

To conclude, in answer to the question: "In the weeks preceding the incident did the AOT take appropriate treatment and surveillance measures and were the staff cognisant of the increased risks to the MHSU during this time?" it is the opinion of the IIT that it did not. However, even if it had, there is only a slim chance that the outcome would have been any different.

A different outcome required the police to have been aware of the MHSU's name change and for very specific information to have been detailed on the Police National Computer regarding what to do if he was stopped and questioned at an airport. The IIT is not at all confident that these two actions would have been taken by another AOT caring for a similar type service user under similar conditions and with no hindsight bias.

Because of the continual challenges information sharing poses to mental health trusts on 9 September 2009 the Department of Health issued new guidance on this subject. The guidance document is entitled Information Sharing and Mental health – Guidance to Support Information Sharing by Mental Health Services. The document can be found at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104948.pdf

4.4 Was the medication management of the MHSU appropriate?

As the previous sections have highlighted, medicines non-compliance was a recognised risk factor with the MHSU. Consequently the AOT found itself in the position of compromising with the MHSU in relation to the medications prescribed and their dosage, in order to maintain contact with him and to achieve a situation where he was at least taking some medication. This scenario is not at all uncommon with service users. However, given that the MHSU became very ill when in relapse, and relapse was inevitable for him with the dosages of medication he was on in 2006, the IIT did review his medicines management to assure themselves that nothing could have been done differently in relation to this specific area of clinical management.

As a result of this review the IIT is satisfied that:

- The MHSU enjoyed long periods of stability on the medication doses he negotiated with AOT, even though his olanzapine dose was sometimes low.
- The AOT did initiate appropriate serum monitoring of the MHSU's carbamazepine and sodium valproate levels.
- That the MHSU did attend for serum monitoring of his sodium valproate and carbamazepine levels. Consequently the medical staff were aware of any gap between his serum levels and the therapeutic levels recommended.
- All AOT members were consistent in their reiterations to the MHSU that taking his medication was important, and that without it he would become ill and in all likelihood require further hospitalisation.
- That AOT staff took a reasonable course with the MHSU in relation to medicines management. Compromises were made to ensure that he took medication, and this partnership working did enable continued engagement of the MHSU with AOT which was important.

As mentioned in section 4.2 page 33 of this report there is only one aspect of the MHSU's medication management that the IIT believes could have been approached differently. This was at the point of his discharge from inpatient services in September 2005. The MHSU had suffered his third hypomanic episode and it had, as on the previous occasion in 2003, been preceded by medication non-compliance. Furthermore the MHSU's displays of violence and aggression were increased during this relapse and stabilising him took longer. This was eventually achieved with sodium valproate 700mgs bd. Continuance of a mood stabiliser at therapeutic levels was therefore central to his continuing mental health. The MHSU's previous history of compliance with medication on his terms meant that the chances of his continuing to take the recommended medication as prescribed were slim.

In December 2004 there was a ruling by J Pritchard following the case of CS against the East London and City Mental Health NHS Trust (see appendix 6 page 124)

In this case:
"CS was a patient liable to be detained on leave of absence from hospital (leave). She challenged the decision of the Tribunal which had confirmed the lawfulness of her detention following renewal on the grounds that she was no longer receiving hospital treatment which justified continued detention. The court, whilst restating that hospital treatment must be "a significant component" of the treatment plan to be lawful under the Mental Health Act 1983 (the Act), found that, although the Responsible Medical Officer's (RMO) grasp on the patient was "gossamer thin", it was a "significant component" sufficient to justify continuing detention. As a patient liable to be detained, CS could be recalled to hospital for treatment if she refused or failed to take her medication in the community which introduced an element of compulsion that she accept treatment in the community."

This ruling marked a significant change in how the Mental Health Act was viewed and also how section 17 leave could be used in the community after discharge from hospital in cases where medication compliance was a concern, as it was in the case of the MHSU. The IIT suggests that the above ruling could and should have been considered by AOT, and the MHSU kept on section 17 leave for a longer period of time in the community, before being discharged from detention under section 3 of the MHA. This would have provided the AOT with the necessary leverage to achieve compulsory readmission if the MHSU did not comply with his treatment regime.

The MHSU was never consistently compliant with the medications prescribed for him. Although for the most part he did take his medication, this was often at progressively lower doses as determined by him. This significantly increased his chances of relapse, a point not fully appreciated by CC3. Although the MHSU was not perceived to present any risk to the general population his behaviour when in relapse made him very vulnerable, and put him at significant risk, and he did pose a known risk of harm to health professionals working in inpatient psychiatric hospitals. Consequently any leverage to support the reinforcement of treatment is valuable for service users such as the MHSU. Today service users like the MHSU would be considered for a community treatment order (CTO)[23].

In relation to the above, it is notable that CC3 was looking for some formal leverage with the MHSU should he become medication non-compliant or not meet with the AOT for planned contacts, when she sought for a restriction order to be placed on the MHSU when he attended the magistrates court in

[23] Community Treatment Order: under amendments made to the Mental Health Act in 2007, this enables mental health service users to be treated in the community with the proviso that they can be recalled to hospital for treatment if need be.

relation to his attendance at Manchester Airport in July 2005. This court hearing occurred in the summer of 2006.

Note: There was no realistic chance of CC3 achieving a restriction order in relation to the MHSU's attendance at airports. His offence was one of trespass. The Airport Act of 1986 dictates that such offences are not criminal in nature. It is a summary offence and the maximum penalty is a fine. Furthermore because the offence is not considered to be criminal in nature it should not generate a PNC record.

A full charting of the MHSU's medication chronology is contained in Appendix 3 of this report page 106.

5.0 CHANGES TO SYSTEMS AND PROCESSES IN THE MHSU's AOT SINCE 2006

The MHSU incident was taken very seriously by SWYMHT as an organisation and also by the involved AOT. Consequently a range of initiatives were implemented to address the recommendations in the internal investigation report and also to address issues identified by the AOT itself.

Appendix five, page 113, details the recommendations made in the internal investigation report and the actions taken since 2006. It is notable that almost all actions agreed following SWYMHT's own internal investigation report have been completed.

The IIT has been impressed by the energy and enthusiasm for implementing quality improvement, following its own reflection on the MHSU case and also following this subsequent independent investigation.

The following lists some of the changes that the involved AOT has achieved since 2006.

Changes to how the AOT team meetings are conducted

- The 'end of the day' handover meeting has been brought back to 16.15 to allow time for staff response to issues identified as a result of the handover/discussion. By the AOT team leader ensuring this meeting is succinct, yet thorough, this ensures staff also have the time to input the day's events directly onto the RiO system[24].
- Morning meetings remain at 09.15 for a fifteen minute check-through of planned visits, and also to allocate any additional work that has come through since the day before. This can take the form of telephone calls from service users, carers, or other professionals, or information gleaned from the RiO system overnight.
- The outcome of the weekly multidisciplinary clinical review meeting is now entered directly on to the RiO system. All care co-ordinators also prepare their reports for this meeting in advance. If the care co-ordinator is absent due to training or annual leave they will ensure provision of the reports in advance, for the team leader or nominated other to present. AOT also has systems in place to ensure the team allocates cover for unplanned absence (such as sickness) of care co-ordinators or the entry of information on to RiO of their reports.

[24] RiO is an electronic record keeping system (see www.cse-healthcare.com/RiO/index.html). The RiO System has detailed risk assessments, psychiatric assessments, comprehensive health and social care assessments and more detailed contingency/ crisis plans than were available on the previous (MHIS) system used in 2006.

The reports include a brief précis of the care plan, zoning system[25], next outpatient appointment and CPA review. The reports also contain free text describing the service user's progress since the previous clinical review. After this report is read and reviewed (including the zoning system) any amendments agreed within the team are recorded electronically. All of these reports are amalgamated into one weekly clinical review document that is subsequently stored on an external hard drive that all AOT staff have access to. This has enhanced information exchange. The individual entries on RiO for service users are available for all authorised Trust/health and social care employees to access. This ensures appropriate seamless information exchange across teams.

- The outcome of the weekly case review is also stored electronically on each patient's RiO system records.
- When having case reviews and discussions, especially for new referrals, the team often invites professionals who have been involved with the patient in the past to provide previous knowledge; this then forms part of electronic record on the RiO system.

The documentation and communication of risk relapse and prevention plans

All AOT staff now have access to the RiO system and are trained in its effective use. The RiO system has detailed risk assessments, psychiatric assessments, comprehensive health and social care assessments and more detailed contingency/crisis plans than were available on the previous (MHIS) system used in 2006.

The crisis and contingency plans now include not only a list of risk relapse signs and suggested (prevention) interventions from services, but also a service user personal safety plan. This is called the wellness and recovery action plan (WRAP). It is a paper document completed with, and signed off by, the service user. This document clarifies with the service user (among other things) their experience of early warning signs, who they do and don't want to be informed and an agreed plan of action should they or any involved service provider identify early warning signs of relapse. Trigger factors such as danger situations, people, places, or times of year are identified and clearly recorded along with a plan of how to manage these. Although the service user keeps the paper copy of WRAP, it is immediately added electronically into the free text field in the crisis and contingency plan on the RiO system. The use of the WRAP tool was suggested by the AOT who had cared for the MHSU and

[25] The zoning system is the traffic light system used to highlight higher and lower risk service users on the AOT caseload at any point in time. It is essentially a "ready reckoner" to indicate recent stability or changes in wellbeing or risk profile. This is recorded in the clinical review documentation, CPA reports and on a wall mounted list of service users.

has been agreed for organisation-wide use by the trust-wide AOT forum. Completion of a WRAP is also noted in the clinical review reports.

Handover between care coordinators when there is a change in care coordinator

A handover of care is now planned in advance and with the service user's consent. Any planned change of care coordinator is tabled for discussion as part of the agenda for the CPA review. The service user's views about the plan and the proposed new care coordinator are sought.

It has been the standard in the AOT for at least the last twelve months that the incoming and outgoing care co-ordinator will have a formal handover of care at the CPA review, where the new care co-ordinator will be briefed on the history and care plan/crisis contingency plan. The handover of care when service users first join the team has also been aided greatly by the Trust-wide agreed referral and assessment process. This process was devised and agreed as a consequence of the internal enquiry into the serious untoward incident (SUI) involving this MHSU. The new referral and assessment process has led to much more detailed information gathering on service users' history. Fortunately within the MHSU's AOT there has been little change of care coordinators for service users which is good.

This information is shared with the whole team as part of a case review before deciding whether the service user is taken on by the AOT. Subsequently this information is stored on the RiO system in the same way as all case reviews.

How 'memory' is retained

The current Consultant Psychiatrist and Team Leader for the MHSU's AOT are clear that the principle of information being retained in "memory" is not acceptable to the AOT. They do not believe it ever has been acceptable. The issue following this MHSU was how to ensure that the complexity of a service user's risk history, presentation and clinical course are not lost with changes in individual AOT staff members. Consequently it is custom and practice, and standard, for AOT that all information relevant to its service users is recorded in the appropriate part of the RiO system. This system provides numerous easily accessible areas for relevant information to be stored and the Consultant Psychiatrist and Team Leader for AOT are confident that all the AOT staff are accurately inputting this information. This includes a much expanded crisis and contingency plan augmented with the WRAP.

Use of Compulsory Treatment Orders (CTOs)

CTOs have only been available to NHS staff since the MHA 1983 amendments in 2007. The MHSU's AOT does appreciate the scope CTOs provide and has placed service users on a CTO where necessary. For all patients on the AOT caseload who are admitted for inpatient care under Section 3 of the Mental Health Act, consideration is given to the appropriateness or otherwise of using a CTO. This takes the form of direct liaison and attendance at CPA meetings as clinically indicated with what are termed "responsible clinicians" who care for AOT patients during inpatient

admissions (including private providers). Discussions are held within AOT as to the appropriateness of use of CTOs and the decisions documented on RiO.

Full clinical reviews and medical assessment
The pre-assessment process in AOT is much more robust than it was between 2004 and 2006. All new referrals to AOT have a full clinical assessment by AOT before being accepted on to its caseload. This enables the AOT to have a good appreciation of past psychiatric history, past forensic history, any history of substance misuse and the service user's medical history.

In addition to the more structured assessment process, it is routine for there to be a 'medic to medic' handover for all new referrals.

The system of weekly case reviews and the enhanced rigour in the documentation of these has been described above.

Since 2006 the rigour of CPA reviews has also been enhanced. These reviews now include documentation of early warning signs, exacerbating factors and crisis plans. CPA reviews also routinely include a review of the existing care plan on RiO with the service user.

How changes in the clinical management plan made in outpatients are communicated to team members
In the MHSU's case a clear clinical instruction made at an outpatient appointment (OPA) in 2006 was not followed through by the AOT, the reasons for which remain unclear. Now however the systems for communication transfer between OPA and AOT team meetings are more robust. The following occur:

- Electronic recording of OPAs as RiO entries.
- Copies of GP correspondence form part of RiO entries.
- Contemporaneous recording of OPA medical contacts on RiO usually on the same day.
- Direct liaison with team members at handover meetings.
- If a consultant recommends early review, he/she will usually book it into the diary himself/herself.
- Update of RiO in the weekly clinical review meeting which is attended by medical staff working in AOT. Activity in the previous week is reviewed so all team members at the meeting would now be aware if specific activity of concern occurred in the previous week.
- Care coordinators who know they cannot attend the weekly clinical review meeting are required to update RiO so that information can be shared in their absence.
- A clearer diary system with all OPAs in one paper diary rather than on separate sheets.

OPA and CPA appointments are also recorded on a patient database, taken into clinical review meetings and referred to when discussing individual patients.

How the team has enhanced its knowledge and understanding of data protection and reasonableness of information sharing with third parties such as the police

AOT has now identified individuals within the local police force, with whom it regularly liaises and shares risk data about service users.

This includes the Vulnerable Victims Team (V-VT), and the police ASBO (anti-social behaviour order) liaison officer. The MHSU's AOT has a number of service users on its caseload who are also on the case loads of the V-VT and the ASBO liaison officer. Furthermore the role of the V-VT has been made clearer to AOT. The AOT Team Leader and the AOT are now clear that, should they believe that a crime may take place or occur as a result of a relapse of illness (or that there has been a change of name in a person who may commit crime) they will inform the V-VT. They advise that they have already done this.

Subsequent to this a safeguarding planning meeting takes place to look at the risks to the service user and others as a result of the identified risks.
As a result of contact with the V-VT and the ASBO liaison officer, the MHSU's AOT has noted occasions where police information systems have been updated in response to the changing risks of specific AOT service users.

In addition to the above, the AOT now has a section in the CPA document and the GP correspondence template on confidentiality, and space to note with whom information can be shared with the agreement of the client.

CP3 also advised that now this team has a much lower threshold for communicating with the Trust's legal team for advice, should they experience difficulties in determining the appropriateness of sharing information about a service user with a third party.

6.0 CONCLUSIONS OF THE INVESTIGATION TEAM

The task of the IIT was to analyse the MHSU's care and treatment by the mental health services in South West Yorkshire and determine:

- whether it was reasonable;
- whether it met the standards expected of an assertive outreach team; and
- whether different management could have averted the tragedy that occurred.

As a result of its investigation the IIT concludes that:

- For the most part the care and management of the MHSU was reasonable. The AOT had regular weekly contact with the MHSU, with some short periods of fortnightly contact. It also provided appropriate support to the MHSU when he was stressed or needed assertive follow-up.
- Medications management for the MHSU was reasonable. In 2005 and 2006 it is difficult to see how the AOT could have managed the MHSU's medications differently. If he was a patient of any AOT today one would strongly consider placing him on a Community Treatment Order.
- There is one instance in May 2006 where a member of the medical staff requested twice-weekly visits for the MHSU because he appeared to be showing signs of early relapse. These enhanced contact visits did not occur and there is no adequate explanation for this. For the four weeks between this instruction and the subsequent outpatient appointment, where the MHSU was again considered to be in remission, his care management fell below the standards expected of an AOT and the purpose of him being with the AOT was thwarted.
- On 6 November 2006, the MHSU self presented and was assessed, and as a result the plan was to continue with weekly contacts. Because of the nature of the MHSU's stressors at the time, he should have received enhanced contact at least twice a week after 6 November. That no such decision was taken is the collective responsibility of AOT and not any individual practitioner.
- Following assessment on 6 November and then subsequently on 8 November, there should have been a clearly agreed plan for what action was to be taken if the MHSU could not be contacted.
- Although the AOT did have contact with the MHSU on 6, 8, 13, 15, and 17 November, only two of these contacts constituted a face-to-face assessment. On 22 November, the MHSU was not contactable by telephone as had been planned. There should have been assertive follow up of this, but there was none.

- The IIT discovered during its attendance at New Scotland Yard that there was the facility for the MHSU's AOT to have core information about the MHSU entered on to the Police National Computer (PNC) as part of its risk management plan. Although it was part of the AOT's plan to notify the police if the MHSU went absent without leave (AWOL), proactive logging of his details on to the PNC and what actions were recommended if the MHSU were to attend at an airport without money, identification, or a means of boarding an aeroplane were not. The main reasons for this were as follows:
    - The AOT believed that the police records would already show that the MHSU had a history of attending at airports when unwell as this had occurred in 2002, 2003, and 2005. On all occasions the MHSU had come to the attention of the police. The AOT did not know that the trespass offences are not criminal offences and therefore should not generate a record on the PNC[26].
    - Although this AOT was clearly willing to share information with the police the team, as with many other health teams, would not usually share information in advance of there being a developing or actual concern because of perceived risk of breaching the Data Protection Act.

      This concern around the Data Protection Act, as an impediment to proactive and prudent information sharing with agencies such as the police, is not unique to the MHSU's AOT.

With regards to the predictability of the MHSU's attack on members of the public the IIT do not believe that it was predictable that he would present a high and immediate risk to the public. It was however predictable that if he relapsed he may make his way to an airport, attract attention and possibly put himself at risk.

With regards to preventability had information about the MHSU and his known behaviour of attending at airports, when in relapse, been entered onto the PNC and had the police been aware of the MHSU's change of name in 2006 then the police officer, who asked for a check of the MHSU's name on the PNC on 24 November 2006, could have been given information about him that would have better informed his decision making that day. Under these circumstances it is reasonable to suggest that there was the opportunity for incident prevention.

This being said the MHSU's consent would have been required for the AOT to have been able to share information with the police in advance of there being serious concern about him. The reason for this is there was nothing in the

[26] It would not be reasonable to expect mental health professionals to be aware of this.

MHSU's history to suggest that he posed a serious risk of harm to the general public. Had the MHSU withheld his consent for this the AOT would have had to consider very carefully whether his 'best interests' outweighed its duty of confidentiality, and the lawfulness of any information exchange made without the MHSU's consent. The IIT cannot guess at what may have happened if the AOT had asked the MHSU for consent. What the IIT can say is that the information it gathered suggests that it would not be common place for information sharing to occur so proactively where there is no emerging or immediate cause for concern, and where there is no known risk to the public. One of the reasons for this seems to be a lack of understanding of the Data Protection Act and mental health staff's anxiety about being in breach of this.

As previously noted on page 58, on 9 September 2009 the Department of Health issued up-to-date guidance to mental health trusts entitled "Information Sharing and Mental Health – Guidance to Support Information Sharing by Mental Health Trusts"[27] This guidance states:

"A reluctance to share information because of fear, or uncertainty, about the law or the lack of suitable arrangements to do so has been a feature of some public services in recent years and a factor in numerous accounts of untoward incidents, including homicides. A natural reaction to uncertainty is to take what appears to be the least risky option and, for information sharing, that can often mean doing nothing – and that may be the worst outcome for the individual and others."

The DH guidance is, in the opinion of the IIT essential reading for all community based mental health practitioners.

Could anything else have prevented the incident?
The IIT does not believe so. Although aspects of the MHSU's care could have been managed differently one cannot say that the following would have prevented the incident:

- Enhanced contact with the MHSU by the AOT between 8 and 22 November.
- Implementation of assertive tracking of the MHSU on 22 / 23 November.
- Notification to the police of the MHSU's change of name in the summer of 2006.

The reason the IIT does not believe that the points cited above would have prevented this incident are as follows:

- The MHSU's sudden and unpredictable past relapses. This was a service user who could present as well and then rapidly relapse

[27] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104948.pdf

without any warning at all. In November 2006 the AOT identified no clear signs of early relapse in the MHSU.

- Even had the AOT instituted efforts to follow up the MHSU on 22 November it is unlikely that this would have occurred until the following day, or even the day after, given the team's relative lack of concern about his relapse risk at the time.
- Even had the AOT advised the police of the MHSU's name change there was nothing on the PNC that would have alerted the police officer at Heathrow Airport of the need for the MHSU to be taken to a place of safety. [28]

The families of V1 and V2 were particularly interested in preventability based on the police knowing the MHSU's real name at the time of the incident, and whether a change is required as to how we in the UK are enabled to change our name by deed poll. The IIT is aware, from information exchanged between the wife of V2 and the Home Office that in the near future there are plans for biometric testing to be available across all police forces and this will more frequently be used to assist in the identification of individuals. Technology is now available to enable this to occur without requiring an individual to attend at a police station. This technology will mitigate against any perceived weakness in the system of deed poll as fingerprint recognition is a far more reliable approach. It is important to note that even had biometric tools been available to the police at Heathrow Airport on 24 November 2006 it is highly unlikely that their actions would have differed because there was, at the time, no information on the PNC to alert them to the fact that the MHSU had a serious mental health illness and had a history of attending at airports when acutely unwell.

The key therefore to preventability of future incidents in similar circumstances, in the opinion of the IIT, is a greater degree of information sharing between the police and the mental health services that is supported by national policy and clear operational systems for how to, and with whom, information needs to be communicated so that it finds its way on to the PNC in a timely manner.

In addition to the above the wife of V2 continues to feel strongly that the system of deed poll in this country is too lax, compared to systems in other countries and especially in relation to data management. Consequently, with the support of her family, she is now campaigning to have the laws relating to deed poll changed so that when a name change occurs there is an obligation on the agencies facilitating this change to ensure notification to all relevant parties such as the police occurs. At present this responsibility lies solely with the individual wanting a name change.

[28] Note: The offences that the MHSU had been involved in preceding November 2006 were not of a criminal nature and he should not have had a PNC record at all as a result of these.

7.0 RECOMMENDATIONS

Recommendations

Unusually for this type of investigation, the IIT has no recommendations for SWYMHT or the MHSU's AOT. We were impressed by the developments in systems and processes within this AOT that have continued since 2006. The AOT has good leadership in both its consultant psychiatrist and its team leader.

However, the IIT has five recommendations, which apply nationally.

Recommendation 1: information sharing

It has been requested that the National Patient Safety Agency work with the Department of Health to ensure that it's recent information sharing guidance[29] is translated into clear workable operational policies in individual mental health trusts. The message that needs to be underlined is that in all circumstances where there is benefit to the service user in sharing information with other agencies, such as the police, third sector agencies and probation, then all reasonable efforts should be made to obtain the consent of the service user to do so. In circumstances where the service user withholds consent, or obtaining consent is not possible, the healthcare team must then consider the risk to the service user and the wider public of not sharing the information. The issues considered and the output of this consideration must be documented in the service user's clinical record and risk management plan. Furthermore the professionals should seek advice from:

- the Trust's Caldicott Guardian,
- the vulnerable persons officer,
- the police liaison officer,

where appropriate, particularly if there is any uncertainty whatsoever as to the most reasonable course of action to take, i.e. 'to share' or 'not to share'.

In this case the AOT did not tell other agencies that the MHSU had changed his name by deed poll because of concerns around client confidentiality. Furthermore it did not proactively engage with the police in the risk and contingency plan for the service user because of similar concerns. These concerns are commonplace amongst mental health professionals. However, to have shared information with the police in this case would have undeniably been in the MHSU's best interests. In this case, lack of clarity about when it is acceptable and not acceptable to share information without consent removed the opportunity for incident prevention.

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29 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104948.pdf

Recommendation 2: information sharing and the police national computer

It was the working assumption of the Assertive Outreach Team caring for the MHSU that if he was 'picked up' at an airport without any money, identification, or tickets to board a plane, then he would be taken to a place of safety and mental health services would therefore become immediately involved with him. This is what had occurred on two of the previous three occasions he had attended at an international airport. The AOT believed that because the MHSU had been arrested by the police before that there would automatically be a record on the Police National Computer (PNC) about him and the circumstances of his arrests. Unfortunately this was not the case.

Trespass is not a criminal offence and therefore does not generate a PNC record.

The PNC does however have the facility to record core information about service users about whom the mental health services have significant concerns if they go 'absent without leave' (AWOL), or fall out of contact with the services. Furthermore the PNC can accommodate instructions on what actions to take, and who to contact, should the service user be stopped by the police in 'identified circumstances' and a check made against their identity. A service user does not have to have to have any previous criminal record for this facility to be utilised.

An ad hoc survey of a small number of mental health professionals revealed that about 50% were unaware that the PNC could be used positively as part of the risk management planning for a service user. It also revealed that 100% of those professionals approached believed that if arrested for any reason a PNC record would be generated and that the circumstances of the arrest would also be recorded. The responses received also suggested that the bar is set quite high when it comes to sharing information with other agencies because professionals are anxious of being in breach of the Data Protection Act.

In this case had important information about the MHSU been entered onto the PNC in advance of the incident, as part of a proactive risk management and contingency plan, then this incident would have been prevented.

Because of the numbers of victims as a result of this incident, and its potential preventability, it is essential that all mental health professionals are aware:

- Of the importance of proactive information sharing with other agencies where to do so enhances the safety of the service user and/or the safety of the public, even if the service user withholds consent.

- Of the optimal times to address the issue of information sharing and the obtaining of consent with a service user. For example after a relapse and in the early period of wellness.
- Of the practical measures professionals can take to determine whether the information sharing is lawful if a service user refuses consent, or is unable to give consent (i.e. liaison with the Caldicott Guardian, the Trust's vulnerable person's officer and the police liaison officer – essentially reasoning it out with others).
- Of the scope of the PNC for logging the details of service users who are known to go AWOL when unwell and place themselves in high risk situations (e.g. vulnerable or dangerous situations), and/or pose a potential serious risk of harm to others. And the absolute acceptability of this where the mental health professional(s) believe that to add a service user to the PNC will enhance the risk management plan and therefore the safety and well being of the service user.

To achieve the above it is essential that training workshops on data protection, clinical risk assessment (as it pertains to service users) and local and national guidance documents on information sharing ensure that the above messages are incorporated and that staff do not have an ungrounded fear of information sharing that is detrimental to the delivery of safe and effective care.

To ensure that this very important issue, in particular the scope of the PNC to support effective risk management planning, receives the attention it needs. The Director of Patient Care and Partnerships/Chief Nurse for NHS Yorkshire and the Humber is asked to bring this recommendation to the attention of the Chief Nursing Officer for the NHS and the NHS Medical Director so that an effective risk reduction solution can be generated, working with relevant partners such as the police and the Information Commissioners Office.

Recommendation 3: occupational therapists and medicines management

One of the relapse triggers for the MHSU was medication non-compliance and on numerous occasions staff underlined for the MHSU the absolute importance of taking his medication. However, at some times the MHSU took only very low doses of his medication and his care coordinator, an occupational therapist (OT), and other non-medical staff were not sufficiently aware that this posed an inherent risk of relapse.

Discussions between the IIT and the OT identified a potential professional conflict between the guidance provided by the College of Occupational Therapists (COT) to its members about medicines management and the role and responsibility of a care coordinator. It was the OTs understanding, in 2005, that the college advised that OTs did not need to have any knowledge

about medicines. However, with the evolution of New Ways of Working[30] in mental health, in the opinion of the IIT, a care coordinator, regardless of his/her professional background, does need to have at least a basic understanding of the medicines their clients are on and the usual dose range of these.

Clearly it would be unreasonable for an OT to take responsibility for complex medicines management. However it should be within their capability to be informed about the medications prescribed for clients for whom they are care coordinator. Guidance issued by the COT to its members in September 2008 makes clear the responsibility for an OT to ensure that he/she has the competencies to fulfil their job role. For a care coordinator this must include a basic knowledge of common mental health medications, the normal dosage and common side effects.

It is recommended that the allied health professionals (AHP) lead in the Directorate of Patient Care and Partnerships at NHS Yorkshire and the Humber and the SWYMHT OT liaise with COT on the matter of what skills and competencies are required by OT's who are care coordinators for service users. The COT should take an active role in working with relevant partners in defining these core competencies, especially as they relate to medicines management, for the sake of consistency nationally.

Recommendation 4: Client Focused Risk Management Training and Risk Assessment

This investigation highlighted two issues need to be addressed in client-focused risk assessment training delivered in all mental health trusts and in documented risk assessment.

The first is the concept of 'risk vulnerability', a concept that was not well understood by all members of the MHSU's care team. Furthermore it does not appear to be routinely included in risk assessment training. In the case of the MHSU, situational stress increased his risk vulnerability but was not a 'relapse indicator' per se. The lack of appreciation of this concept did adversely affect the risk management plan agreed within his care team.

The second is staff's awareness of the risks posed by service users engaged in sports such as karate, kick boxing, boxing, kung fu etc. When individuals become competent in any of these sports their hands and feet are considered to be dangerous weapons. For some of these sports such as kick boxing, it does not take long for some degree of competency to be achieved as this case highlights. It is essential that mental health professionals' awareness of this is enhanced as it has real implications within the process of risk

[30] Mental Health: New Ways of Working for Everyone Department of Health May 2007

assessment especially where service users are prone to relapse and to hit out with their hands and feet.

It is therefore recommended that the Adult Services Lead for NHS Yorkshire and the Humber liaise with the chairs of the national Mental Health and Learning Disability Nurse Directors' and Leads' Forum and national Mental Health Medical Directors' Forum respectively, so that this case can be used for learning lessons nationally. The appropriateness of incorporating (i) the issue of risk vulnerability and (ii) awareness of risks associated with martial arts and other contact sports, such as boxing, into risk training programmes shall be considered by these fora. Consideration should also be given to liaising with the Royal College of Psychiatrists.

APPENDIX 1: DETAILED CHRONOLOGY OF CONTACTS BETWEEN the MHSU AND SWYMHT

Date	Contact
7 October 2001	The MHSU was assessed at Weetwood Police Station at 7.30pm at the request of the police surgeon. A MHA assessment occurred. It is noted at this assessment that the MHSU went by a number of names: Saad, Saad Al-Jesere and Laidi. The initial assessment revealed religious delusions and a need for further assessment, therefore the MHSU was sectioned under section 2 of the MHA and admitted to Leeds. A number of documents were studied by staff, including: ❑ photocopies of his diary containing dates of important religious events; ❑ a drawing of a hand doing a scout's salute; ❑ two verses of the Koran; and ❑ a letter about his girlfriend. Overall the documents the MHSU had were difficult to follow. The interpreter on the ward revealed that he was talking of going to see the Pope to give him a present. The interpreter also revealed that the MHSU was aware that he may be stopped by the police. Overall there was a strong religious flavour to the MHSU's issues for example, visions of God, that he had been given a new name by God, and the Pope was mentioned a lot. The MHSU had shaved a patch on the left side of his head to show that he had been talked to by Allah. The MHSU at this time had no insight to the fact that he was unwell. He reported feeling well. He had no persecutory ideas, and denied his previously expressed ideas. His family live in Tunisia. His brother reportedly committed suicide. The MHSU said there was no family history of mental health problems. No thoughts of harm to self or harm to others. (Became distressed when issue of harm to self was raised). The clinical impression was of an acute psychotic episode, possibly bipolar disorder. Outcome: compulsory detention under Section 2 of the MHA recommended.

Date	Contact
7 October 2001	The inpatient records clearly show that a standard physical examination was conducted. The inpatient plan was for: ▫ level 1 observations; ▫ chlorpromazine 25-50mg (up to 100mg); and ▫ second line of medication lorazepam 1-2mg (oral or intramuscular).
8 October 2001	Reassessed on the ward. Had experienced a command hallucination. God told him to shave his head. Because the MHSU had a social worker with the Asylum Seekers Team it was likely that he would be transferred back to Halifax. The MHSU was inappropriate in his affect (emotions) for example, to many of the questions he was asked he laughed and smiled, but not appropriately. Plan: continue to assess and transfer to Halifax when there was a bed available.
9 October 2001 8.30am	The MHSU became violent to other patients. A member of the medical staff was called to assess. The MHSU kicked another Asian patient in the head. He was refusing all other medication except lorazepam. The assessing doctor offered an 'injection' but the MHSU refused this. It is noted that although the MHSU appeared to have little insight he was difficult to assess because of the language barrier. It is also noted in the record that the MHSU "does not seem bothered that he hurt another patient". He made good eye contact, and was sitting quietly when assessed. Plan: for Clopixol Acuphase 100mg IM with immediate effect, and 1mg lorazepam oral. For review on consultant round regarding longer term medications.

Date	Contact
10 October 2001	The MHSU was assessed by a specialist registrar. Plan: ▫ for transfer to Halifax on 11 October; ▫ for more Clopixol if required. i.e. if MHSU remained unsettled over 24-48hr period; and ▫ level 2 observations prescribed with 5 minute checks.
10 October 2001 7.30pm	The MHSU was again involved in a physical altercation with a fellow male patient. However on this occasion the MHSU was not violent himself. The incident was instigated by the other patient. The MHSU did however become verbally aggressive after the incident. The MHSU indicated to staff that he wanted to leave. The MHSU was assessed by the duty doctor. The language barrier continues to pose communication difficulties. Repeated desire to leave ward.

Date	Contact
11 October 2001	**Now an inpatient on an acute mental health ward.** There was a detailed historical summary and physical assessment. In addition there was a very detailed management plan, including a drugs urine screen. This assessment revealed that the MHSU had been a dealer for cannabis in Italy as well as a cannabis user. Plan: ❑ haematological investigations (FBC, LFT's, U&E's, blood glucose, TFT's); ❑ urine drugs screen; ❑ medications: zuclopenthixol 10mg bd, procyclidine 5mg bd, Clopixol 10mg prn (max tds) lorazepam 1-2mgs prn, haloperidol 5-10mg prn (max 20mg); ❑ level 3 observations; ❑ not to leave the ward unescorted; ❑ staff to observe behaviour, mood and eating behaviour. **Comment:** The management plan at this time seems very comprehensive and directive for all staff. It would be surprising if anyone said they were unclear as to what the plan was. It represented very good practice.

Date	Contact
12 October 2001	The MHSU remained psychotic with no insight into his situation. During a medical assessment he suddenly became elated and started praying in Arabic. The words “need interpreter” are written in notes. Level Three observations continued, and MHSU was not to leave ward unescorted.
15 October 2001	The clinical records (File 1) show that: ▪ a ward round occurred; ▪ his bloods were normal except for bilirubin which was 29 (the normal range is 3-17). It is also noted that although the MHSU attended the ward round the wrong interpreter attended. An Arabic speaking interpreter was therefore booked for two days’ time (17 October). The records note that the MHSU was settled and accepting most doses of medication. He remained deluded with little insight.
17 October 2001	Much the same, no ideas of reference but some odd behaviour during assessment. The clinical record notes “he turned a milk bottle upside down and papers and dabbed water on his head from the tea pot during interview” His rationale was “something magical is going on and he is being tampered with by British people”. Impression: remained psychotic, no self harming thoughts but again refusing medication. Plan: To have a test dose of Clopixol 100mg IM. After 5-7 days to have 200mg IM weekly.
17 – 29 October 2001	Remained on Section 2, no real change in the MHSU’s presentation. Remained insightless with variable ideas of reference. His delusions of grandiosity around his religious status i.e. being the ‘chosen one’ remained. No real change in management plan over this period other than an increase in Clopixol to 200mg weekly on 22 October.

Date	Contact
29 October 2001	The clinical records note that Section 3 of the MHA was recommended. Level 3 observations continued. It was also noted that Clopixol should be increased to 20mg bd.
1 November 2001	The MHSU was interviewed with a social worker who was later to become his care coordinator (CC2).
2 November 2001	The MHSU was interviewed by a senior house officer. The content of her records reveal the first occasion where the MHSU showed some insight. The records note that his fixed and firm ideas about the Koran having been tampered with were no longer true from his perspective. The records also note that he was asking questions about immigration, money and Halal meals. The MHSU no longer believed he had to visit the Pope but he did now believe that he had the power to heal. (This belief had already been previously cited). Overall the MHSU was noted to remain delusional. No morbid thoughts.
2 November 2001 cont	Plan: ▪ to continue with medication as prescribed; ▪ for Section 17 leave the following week to be discussed as the MHSU would like to buy more clothes; and ▪ to continue level 3 observations. Not for leave unless escorted.

Date	Contact
5 November 2001	There was a consultant led ward round. Much of the information recorded repeats already known data. That the MHSU considers his Koran not to have been tampered with was reiterated. The MHSU denied receiving messages from the TV. Admitted to using cannabis (hashish) whilst in Italy. He said that he would accept psychotropic medication. The records also note that the MHSU was unsure if the medication has made him better or God. The plan was to: ❑ continue with medication; ❑ Section 17 leave during the day; ❑ level 3 observations; ❑ re-risk √; and ❑ review next week.
9 November 2001	The MHSU was reviewed. The records note that he had had Section 17 leave, he was compliant with medication and had had an appointment on 12 October with someone in social services regarding his finances and various forms. **Important:** This record notes that the MHSU spoke good English. This is the first time it was reported in the medical records that he did speak English. Blood results – noted that the MHSU's bilirubin was now 18 instead of 29 (normal range = 3-17).

Date	Contact
12 November 2001	The MHSU was seen at a ward round. The outcome was: ❑ the Section 3 was revoked; ❑ the depot zuclopenthixol was discontinued; ❑ re-risk (done); and ❑ to sort out housing/benefits. The record also notes that the MHSU said that the authorities had taken possession of his house.
19 November 2001	Ward round outcome: ❑ oral zuclopenthixol reduced to 10 mg bd; ❑ for one week's leave – to attend ward round on 26 November; ❑ the MHSU would arrange to stay at a friend's; and ❑ the MHSU to contact social services about accommodation.
26 November 2001	The MHSU attended his ward round as requested. An address for him was obtained. It is noted that he had a GP. The outcome of the ward round: ❑ diagnosis of acute psychotic episode; ❑ standard CPA – key worker was noted to be his consultant psychiatrist; ❑ outpatient appointment in two weeks; ❑ continue medication at current levels; ❑ Section 117 pre-discharge meeting held; ❑ re-risk (done); and ❑ discharged.

Date	Contact
7 December 2001	The MHSU was seen by his consultant psychiatrist (CP1). He was noted to be asymptomatic and his medication was reduced. He was advised to take Clopixol 10mg nocte and procyclidine 5mg nocte. This is in response to his complaints of continual tiredness. The letter from the consultant psychiatrist to the MHSU's GP also recommended further reductions in his Clopixol by 2mg per week to discontinuation.
December 2001 – May 2002	Nothing of significance occurred.
23 May 2002	The MHSU was noted to be paranoid. He believed he was being spied on. He was exhibiting grandiose delusions, believing he had the ability to stop wars and help all of the poor people. He also had delusions of reference – everything said innocently was interpreted as being of special significance. The MHSU agreed to hospital admission, his insight however was poor. The notes say that "he does not believe he is mentally ill – `I'm very well' ..." However he was willing to accept admission and was initially willing to accept medication. Subsequently he only agreed to the "same tablets as before". The plan therefore was to reinstate antipsychotic medication, with zuclopenthixol 10mg tds and procyclidine 5mg bd recommenced.
23 October 2002	The MHSU was taken to A&E by a friend because he had "strange ideas". He had stopped his medication three days earlier. He had also started drinking alcohol four days prior to admission and taking hashish a few months prior to attendance at A&E. the MHSU reported feeling "very happy at present", his sleep was reduced to about five hours per night and he had lots of energy. His friend advised that the MHSU was also overspending. Ideas of grandiosity with religious overtones were also evident. The MHSU's friend suggested that he had exhibited grandiose ideas for approximately three weeks. The MHSU's command of the English language was noted to be excellent.

Date	Contact
29 October 2002	The MHSU was detained under section 3 of the MHA for treatment non-compliance. He did not believe he needed treatment. By 1 November he was considered to be hypomanic with no insight and tried to leave the hospital. He was noted to be irritable at times.
8 November 2002	The MHSU's behaviour was noted to be becoming more aggressive. He hit another patient (they were arguing over what TV channel to watch) and he also threw a cup of tea at a member of staff.
11 November 2002	There was a letter from the ward based staff grade doctor to the consultant forensic psychiatrist at the Castle Hill Unit. The letter was an urgent referral following further escalation in violence and aggression towards clients and staff. the MHSU had: ▪ punched a fellow patient in the eye; ▪ bitten a female member of staff; and ▪ punched another member of the female staff in the face (she was badly hurt and was off work). Clopixol Acuphase was given with little impact on his mental state. Staff no longer felt that he could be safely managed in an open ward.
12 November 2002	The forensic consultant at Castle Hill Unit wrote to the referring doctor. He advised the staff grade doctor that he had spoken with the ward manager of Elmdale ward, who advised that the situation had improved with the MHSU expressing regret and expressing willingness to comply with treatment. Assessment was set for 15 November 2002.

Date	Contact
15 November 2002	The MHSU was assessed by the forensic psychiatrist as planned. The outcome of this was a detailed letter to the staff grade advising that: ❑ The MHSU did not present a continuing high risk to others. The MHSU was noted to have been remorseful, was able to explain why he attacked the nursing staff but not the patient, was willing to take his medication, provided a accurate history of his past circumstance and family background, and his attitude and demeanour were appropriate. He had no animosity towards anyone of other religions to himself, or urges to harm others. ❑ The trigger for his attack on the staff was that when they approached him to give the Acuphase he thought it was to kill his Muslim beliefs. ❑ The MHSU could be managed on an open ward but there should be rationalisation of his treatment regime and commencement of Section 17 leave programme. ❑ Work to improve the MHSU's insight should be undertaken with the assistance of an interpreter – even though his English was noted to be reasonable. It is noted that at times he struggled with questions. ❑ It was recommended that the MHSU needed prolonged aftercare on enhanced CPA. ❑ If the MHSU were to behave violently again, in the context of further future relapse, he would benefit from rapid access to PICU for short term containment to effect treatment.

Date	Contact
21 November 2002	There was a letter from the Department of Work and Pensions essentially advising the MHSU that he had been turned down for a crisis loan to purchase items necessary for the basis furnishing of his accommodation, including a bed, a fridge, and a settee.
17 December 2002	The MHSU was discharged from Elmdale Ward.
17 January 2003	There was a letter from the consultant psychiatrist (CP1) to the MHSU's GP advising that he had not presented for his outpatient appointment. The community psychiatric nurse (CPN) was also experiencing difficulties in meeting with the MHSU because he had commenced full time employment working nights. The plan was to 'assertively outreach him', and he had been offered an outpatient appointment for six weeks' time.
22 January 2003	There was a letter from the team leader of the South Halifax CMHT (also the care coordinator for the MHSU) advising the MHSU's GP that he had been able to assertively work with the MHSU and would be meeting with him in the afternoons. The letter told the GP that the team leader had advised the MHSU to take his medication in the morning rather than at night, given he was working night duty and sleeping during the day. The letter notes that the MHSU was mentally well.
12 February 2003	CC1 advised the GP that the MHSU remained well but was again becoming reluctant to take his medication. On discussion with his consultant psychiatrist his Clopixol was reduced to 4mg nocte and he was advised to continue with zopiclone 7.5mg to aid his sleep.
28 February 2003	The MHSU was seen by his consultant psychiatrist in outpatients. Medication to remain the same. No ideas of self-harm. Further review in three weeks time. Also noted that lithium carbonate might be considered in the future if his mood did not settle.

Date	Contact
28 April 2003	The MHSU was seen by his consultant psychiatrist on the 24 March – nil of note. He was also seen on 24 April by the staff grade doctor and was noted to be low in mood, lacking enjoyment in life, with diurnal variation in mood and feeling low on awakening, he was tearful but unable to cry. There were no reported morbid thoughts and no psychotic features. The staff grade doctor notes the MHSU was very insightful into his mental state. There was a very clear management plan and the changes in medication were clearly noted: ▪ the MHSU remained on Clopixol 2mg nocte and zopiclone 7.5mg nocte; ▪ commenced on carbamazepine 200mg BD; and ▪ was to be followed up in four weeks.
23 May 2003	The MHSU was seen by his consultant psychiatrist. It is noted that he was only taking his carbamazepine once a day – thus only receiving a half dose. A community treatment nurse was noted to be in the process of lithium initiation. The MHSU had had all other relevant bloods done. The consultant psychiatrist advised that the MHSU should discontinue Clopixol, and supplied him with a month's supply of fluoxetine 20mg mane. Plan for follow up in four weeks.
12 June 2003	The MHSU was commenced on lithium. His lithium level was 0.34 which is within the therapeutic range. He was on 400mg daily.

Date	Contact
19 July 2003 – 20 July 2003	The MHSU was admitted to Hillingdon Hospital following his arrest at Heathrow Airport trying to get a flight to Tunisia without a passport. He was admitted on a compulsory basis under the MHA. The discharge summary from Hillingdon addressed to the duty doctor on Elmdale Ward shows that the history they have elicited from the MHSU, while bearing some resemblance to what has happened since 2001, is inconsistent and muddled. The discharge summary notes aggression and the need for tranquilisation but no specific details.
20 July – 20 August 2003	The MHSU's presentation was not dissimilar to 2001. It is changeable in affect, he has poor insight, and medication acceptance is problematic. He absconded on 14 August. On 11 August his consultant psychiatrist had prescribed Clopixol Acuphase but the MHSU did not want to accept this. On return to the ward on or around 16 August he did accept Acuphase – he was returned to the ward by the police. There is no record of any violent incident during this period. No morbid thoughts. The medical records suggest that there was a dramatic improvement in the MHSU's mental state after the administration of Acuphase. He very soon started to display some degree of insight. Section 17 leave was rescinded on a number of occasions over this time – and appropriately so.
20 August 2003 – 1 September 2003	Following return to the ward he was given section 17 leave which appears to have been used appropriately. There was a Section 117 pre-discharge meeting. Plan: ❑ refer to AOT; ❑ continue with prescribed medications; ❑ enhanced CPA; ❑ reduce olanzapine to 7.5mg nocte; ❑ re-risk (done); ❑ carbamazepine levels to be monitored (the MHSU would not take lithium); and ❑ OPA in three weeks.

Date	Contact
25 September 2003	The records suggest there was a CPA meeting with the MHSU and members of AOT and his care coordinator. The outcome of this was the transfer of care to AOT. The MHSU was provided with an AOT outpatient appointment for two weeks' time.
9 October 2003	The MHSU was seen by AOT medical staff, accompanied by his newly appointed care coordinator (CC2).
10 October 2003 – end June 2005 OVERVIEW	There was regular follow up by AOT and in OPA. The MHSU appeared largely well. There were no overt signs of mental illness and he appeared to be taking his medication. There was a CPA meeting on 9 February 2005. The main note was that the MHSU's current risks were all assessed to be low. He was noted to be medication compliant, and there was no perceived need to make alterations. The only date of note is 25 April 2005 where the records state that he was not happy taking medication and had not taken it for the last two days.
14 Feb 2005	**CPA review** This confirmed that the MHSU was doing well in the community. It notes he had taken up kickboxing which he found relaxing and enjoyable. The MHSU was noted to be very worried about getting unwell again. He was being seen weekly by AOT. He continued to attend college and attend social skills. There was no change to his medications.
25 April 2005	**Outpatient appointment** It is noted that the MHSU remained well but would like to come off his medication. A reduction in medication was agreed. His olanzapine was stopped and his carbamazepine was reduced to 200mg nocte and the morning dose was stopped.

Date	Contact
25 April 2005 cont	The management plan was: ▪ for the MHSU to continue receiving AOT support; ▪ to discuss his continued follow up within the team with a view to reducing the visits to fortnightly; and ▪ an OPA was given for four weeks time.
5 May 2005	AOT home visit by social worker (CC2). Mentally well, no problems reported. Visits now every two weeks.
19 May	AOT home visit. Nothing new to note.
25 May 2005	Outpatient appointment. No new problems noted. The MHSU noted to be stable in his mood with no symptoms of psychosis or elevated mood. Medication remained unchanged. Management plan continued with two weekly AOT visits.
20 June 2006	Outpatient appointment. Nil additional of note.
6 July 2005	**Seen at The Dales and then admitted to hospital** The MHSU was seen by CC2 and his previous care coordinator CC1. He had become unwell, had punched CC1, he wanted to go to Saudi Arabia; he was mute and uncommunicative and preoccupied with delusional thoughts. He was due in court on 7 July regarding his asylum application for extended leave to stay in the UK. His temporary residency was due to expire on 20 July. The outcome was that the MHSU was sectioned under Section 3 of the MHA. In keeping with the forensic advice in 2002, he was admitted directly to a Psychiatric Intensive Care Unit. **Note:** In the hours prior to his attendance at The Dales, the MHSU had been arrested at Manchester Airport because he was in a restricted zone as an unauthorized individual.

Date	Contact
7 September 2005	The MHSU was returned to inpatient services from PICU. He was much improved. No ideas of harming self or others. The plan was for six hours of unescorted leave until 12 September 2005. At the point of transfer from PICU to the acute in-patient psychiatric ward, medications were as follows: ❑ olanzapine was now being given as “Velotab” (this dissolves very quickly in the mouth); ❑ sodium valproate was being given in syrup form; ❑ lorazepam, which had been reduced and discontinued.
14 September 2005	Following a small number of successfully managed periods of section 17 leave, there was an AOT ward-based review. The outcome of this was that the Section 3 was revoked. At this time the MHSU was on leave for a week.
15 September 2005	**CPA pre-discharge meeting in outpatients** The MHSU was ready for discharge. The CPA record was clear and concise. All short-term risks were low or unknown (“unknown” risks were in relation to sexual and drug offences). The long-term risks were noted to be high to others - notably inpatient staff. There was also a long-term high risk of vulnerability for the MHSU. In all other respects the MHSU’s long term risks were noted to be medium. The AOT record notes that a relapse signature and prevention plan was required, along with an advance directive. In addition OPA follow up was required in one month.

Date	Contact
19 September 2005	The MHSU was seen at home by CC2 and in outpatients. All remained stable and risks (current) were noted to be low. A CPA meeting was booked for 21 September. The management plan was as follows: ▪ follow up was again to be weekly in AOT; ▪ the MHSU's care coordinator (CC2) would progress working on advance directives and recognition of early warning signs; ▪ it was mooted that there might be a benefit in reducing the MHSU's medications but in a gradual way to avoid manic relapse; and ▪ serum levels of carbamazepine were to be measured.
20 September 2005	**Discharge letter from staff grade at Middleton St Georges** This correspondence was of good quality and provided comprehensive information to the MHSU's AOT.
21 September 2005	The MHSU returned to Elmdale Ward for the planned ward round. It was noted that he appeared well. He was discharged back to the care of the AOT.
29 September 2005	The MHSU was seen at home. He was now on sodium valproate 700mg bd. Noted to be stable in thoughts, planned to go to college in October. Nil else of particular note.

Date	Contact
6 October 2005	AOT visit at 'Lyndhurst' by CC2. This was a tracking visit as the MHSU had failed to attend the day before. The notes show that CC2 went to considerable lengths to find the MHSU – driving around town, calling, leaving a note, going to a friend of the MHSU's etc.
13 October 2005	AOT visit at home by CC2. The MHSU reported reduced benefits. AOT staff contacted the benefits office and had the previous in-patient level of benefits reinstated for the MHSU. He was noted to be low in mood but there were no suicidal thoughts present.
8 November 2005	AOT home visit by an AOT support worker. The purpose was to accompany the MHSU to court. The case was adjourned to enable the obtaining of a psychiatric report.
21 November 2005	The MHSU was assessed by CP1 on behalf of the AOT. Nil of note. (CP3 was on sick leave and there was no replacement dedicated consultant cover to AOT).
30 November 2005	AOT visit: routine support at the client's home by CC2. AOT staff were seeing the MHSU weekly at this time. The MHSU disclosed that sometimes he was only taking half the dose of his olanzapine. The notes evidence that he was counselled appropriately about this, and the risks of relapse and hospital readmission stressed.

Date	Contact
15 December 2005	The MHSU was seen urgently at request of CC2. He was lethargic but otherwise seemed well. He was encouraged to reduce his olanzapine to 10mg daily but to continue sodium valproate at the same dose. To review in eight weeks.
30 March 2006	The MHSU was assessed by the locum associate specialist working substantially with AOT. The only point of note was an increase in his risk of harm to self or others from low to medium. This risk categorisation was based on the associate specialist's longevity of knowledge about the MHSU. He had previously cared for him when he was an inpatient following previous relapses. At this time: ❑ the MHSU was prescribed citalopram 20mg once a day; ❑ olanzapine was reduced by 5mg; ❑ the plan was for AOT to phone the MHSU in the morning so that he would be up for college; and ❑ for review in OPA in two months. Note: on 27 April there was a note from the associate specialist to AOT confirming that olanzapine was reduced to 2.5mg.
8 May 2006	The MHSU was reviewed by the locum specialist. There were early signs of relapse emerging and the letter from the associate specialist planned: ❑ an increase in olanzapine to 5mg nocte; ❑ AOT visits twice a week; and ❑ a medical review in two weeks.

Date	Contact
09 June 2006	There was a letter from the GP returning a carbamazepine (CBZ) blood level result. The GP also asked the significance of the CBZ level as the MHSU was not on the drug at this time. Note: There was an error made by staff. Serum levels of sodium valproate should have been requested.
26 June 2006	The MHSU was seen by the associate specialist from the AOT. The record of the assessment was unremarkable except that the MHSU was stating that he no longer wanted to take his medication. The plan was: ▪ for the MHSU to remain on the same medication; ▪ weekly AOT visits; and ▪ to attend outpatients in two weeks.
4 July 2006	Outpatients appointment with care coordinator 3 (CC3). The records reveal that the MHSU stopped the sodium valproate (SVP) two weeks previously and had reduced his olanzapine to 2.5mg. CC3 discussed with the MHSU the need to maintain a steady mental state, and speed of relapse if not medicated. As a result the MHSU agreed to switch SVP for carbamazepine (CBZ) and to continue with 2.5mg olanzapine. No psychotic symptoms identified.

Date	Contact
4 July 2006 cont	CPA review (same meeting). The MHSU was assessed by the associate specialist to AOT. It was noted that the MHSU was medication non-compliant. He thought he was fine. The associate specialist counselled him about relapse risk and the MHSU agreed to go back on to 200mg carbamazepine (CBZ) nocte. Re: risk status. This says that the current risks were: ❑ harm to self – low; ❑ harm to others - low /medium; ❑ relapse - low/medium; ❑ compliance - medium/high; ❑ lack of engagement - low. The care plan was: ❑ to add in carbamazepine 200 mg nocte, two weeks supplied; ❑ for review in two weeks; ❑ blood counts for CBZ every two weeks for two months; ❑ AOT to visit weekly and assist with potential move to Leeds; ❑ CPA enhanced; ❑ care coordinator to remain the same.
25 October 2006	The progress notes say that the MHSU asked a house guest to leave as his presence was too stressful and he (the MHSU) was concerned that this would trigger a relapse. It is also noted that the MHSU passed his citizenship exam.
1 November 2006	The MHSU made telephone contact with the AOT requesting an appointment regarding his benefits.

Date	Contact
6 November 2006	The MHSU self presented at the AOT base in an anxious state wanting to see a doctor. He had been to see a solicitor the week before regarding his citizenship and the meeting had been unhelpful but subsequently he had a more helpful meeting with another solicitor. The MHSU was on this occasion seeking the active help of AOT. His medications were increased – olanzapine to 5mg at night and CBZ to continue unchanged. The assessing SpR (SpR2) and the support worker accompanying the MHSU were impressed by the MHSU's spontaneous recognition that he needed to increase his olanzapine dose. The records also note that the MHSU reported taking his CBZ 200mg bd (this is hand written, the remainder of the notes are typed). The letter to the GP of 8 November says that "it would be prudent to monitor him closely at present as in the past his mental state has deteriorated quite rapidly" . However the typed notes of this SpR's assessment did not make this point at all. Her management plan was to continue with scheduled AOT visits and for "further medical review as appropriate". The SpR's notes also say: "happy to remain in contact with Team this week" and "continue AOT input as arranged – due for review Wednesday".
8 November 2006	The IIT is informed that a member of the AOT staff did see the MHSU on this day. However there is no record of this assessment and no information to say how long the MHSU was seen for, the nature of the assessment that took place nor the opinion of the assessing individual.
11 November 2006	**Telephone contact:** the MHSU contacted the AOT. He spoke with CC3. He stated that he felt stressed. This was related to his citizenship application, without which he could not apply for a passport. The MHSU revealed that he had attended an appointment with a solicitor and he was concerned about gaining a medical report for him. CC3 had to repeat information to the MHSU several times to reassure him of the process. Pressure of speech evident, but this diminished during the conversation.

Date	Contact
15 November 2006	The MHSU was not available for a planned AOT contact. Subsequent telephone contact was achieved and the home visit rearranged for 17 November.
17 November 2006	The MHSU was visited by a locum social worker. The records noted that the MHSU had a busy day but was finding weekends difficult because of lack of activity. The impression of this professional at the time was that the MHSU's stress/anxiety levels were not out of proportion to his situation and that there were no overt signs of relapse.
22 November 2006	An AOT team member attempted telephone contact with the MHSU via his home number and mobile number. Successful contact was not achieved. No further action was taken.
24 November 2006	**INCIDENT DATE**

APPENDIX 2: CHRONOLOGY OF the MHSU'S EPISODES OF HYPOMANIA AND RELAPSES

Date	Chronology (Key aspects of the MHSU's relapse presentation, his identified risk behaviours and attacks on others)
7 October 2001	Presentation: The MHSU was arrested for a public order offence at Leeds Bradford Airport. The police became concerned about his behaviours and a medical assessment was requested. This resulted in assessment under the Mental Health Act (1983) and subsequent admission to hospital. Risk behaviours: Religious delusions. At the time of his arrest he wanted to board a flight to Italy. He wanted to give the Pope a present of a Koran. Written information on the MHSU's person at the time also revealed a strong religious theme to his delusional beliefs. However there was nothing in his presentation that was suggestive of violent behaviour. Violence to others: None.

Date	Chronology (Key aspects of the MHSU's relapse presentation, his identified risk behaviours and attacks on others)
9 October 2001 08.30 hrs	Presentation: While an inpatient, the MHSU became violent towards another patient. The clinical records convey that The MHSU kicked another Asian patient in the head. He was refusing all other medication except lorazepam. The assessing doctor offered an 'injection' but the MHSU refused this. It is noted that although the MHSU appeared to have little insight it was difficult to assess because of the language barrier. It is noted in the record that the MHSU "does not seem bothered that he hurt another patient". He made good eye contact, and was sitting quietly when assessed. Risk behaviours: This is the first recorded unprovoked attack on another. Furthermore the incident was the first where the MHSU used his hands/feet as weapons. Violence to others: Yes, unprovoked.

Date	Chronology (Key aspects of the MHSU's relapse presentation, his identified risk behaviours and attacks on others)
10 October 2001	Presentation: The MHSU was involved in a second altercation with a male patient. On this occasion the MHSU was not the perpetrator and he did not engage in physical violence. It is notable that at this time his English was not good and effective communication with him was challenging. Risk behaviours: None notable. Violence to others: None.
23 October 2002	Presentation: The MHSU was readmitted to hospital on an informal basis following attendance at A&E. He was accompanied by a friend. The MHSU presented again with grandiose delusions and became more unwell following admission subsequently requiring detention under Section 3 of the MHA on 1 November 2002. Risk behaviours: Grandiose delusions, believed he could stop wars and assist all poor people in the world. It is noted that he had growing anger when challenged or asked to take medication. He punched a fellow patient in the eye following what appeared to be a dispute over TV channels. When staff attempted to restrain him he resisted violently. He bit a female nurse. He hit/punched another nurse. In the aftermath, Acuphase is reported to have had little effect and the MHSU remained without insight (as on previous admission). A forensic opinion was sought which concluded that: ▪ the MHSU attributed his violent behaviour to being unwell. He fought to defend himself against "Christian people who were trying to give him an injection to kill him".

Date	Chronology (Key aspects of the MHSU's relapse presentation, his identified risk behaviours and attacks on others)
Oct 2002 cont	▪ Relapse of psychosis was the main risk factor for violence. ▪ Risk reduction would depend principally on maintaining him in remission. ▪ He would benefit from rationalisation of a maintenance treatment regime and commencement of a Section 17 leave programme. ▪ If he behaved violently again in the context of relapse, then there should be rapid admission to PICU for short term containment and to effect treatment. Prognosis was good if the MHSU remained in contact with the service. Violence to others: Yes. This was: ▪ unprovoked; ▪ following the initiation of restraint; and ▪ in resistance to compulsory treatment.
19 July 2003	Antecedents to admission: The MHSU was admitted to Hillingdon Hospital under section 136 from Heathrow Airport. He was trying to board a flight to Tunisia without a passport. He was behaving bizarrely and had auditory hallucinations. Presentation: ▪ He was hearing voices from Allah that he had the power to make peace. He was a slave for God. ▪ Without insight into his condition. ▪ Non-compliant with medication. ▪ Aggressive outbursts on the ward but no violence. ▪ Absconded once. Picked up by police at home and returned to ward. Violence to others: No. Verbal aggression only.

Date	Chronology (Key aspects of the MHSU's relapse presentation, his identified risk behaviours and attacks on others)
6 July 2005	Antecedents to admission: Admitted to hospital following Section 136 from The Dales. He had arrived elated there from Manchester Airport where he had been arrested for being in a restricted area. On arrival at The Dales he punched a member of staff. In view of previous aggressive outbursts when unwell, he was taken to a local police station while somewhere more suitable was arranged. He was subsequently admitted to a PICU under Section 3 of the MHA.
7 July 2005 – 6 September 2005	Presentation (on admission to PICU): ▪ Grandiose ideas. ▪ Speaking about seeing things from God. ▪ Only he could stop war. ▪ Irritable and angry on admission saying "you will all die". ▪ Refusing to take his olanzapine. ▪ Abusive and threatening to staff when asked to stay in his room. There was abusive and aggressive behaviour, with attempts to assault staff when he was being restrained in order to deliver required medication. This resulted in the MHSU being managed in seclusion for his safety and the safety of staff. The period of seclusion lasted for three days. The MHSU's mental state improved following a course of Clopixol Acuphase. He was then treated with olanzapine 20mg nocte and lorazepam 2mg four times a day (qds). When asked about the attacks on staff, the MHSU is reported as saying that he did not do it because he was poorly but "because he had to do it". By 26 July he had improved to the extent that he was commenced on short periods of ground leave. However, by 4 August he was again refusing medication and exhibiting signs of relapse. By 6 August he was again quite aggressive towards others. By 9 August the MHSU's behaviour had again settled following further Clopixol Acuphase and an increase in his dose of sodium valproate to 700mgs twice a day (bd).

Date	Chronology (Key aspects of the MHSU's relapse presentation, his identified risk behaviours and attacks on others)
24 Nov 2006	The MHSU attacked eight people on the perimeter road outside Heathrow Airport having been ejected from the airport a short while previously. As a result of his attacks: ❒ one person died; ❒ one person was brain damaged; and ❒ 6 people, including one of the paramedics who attended the scene, suffered shock and minor injuries. What seems clear from the police statement from Heathrow Airport is that at the time the MHSU was ejected from the airport he was polite and calm. A PNC check did not reveal that the MHSU was known to the police authorities under a different name. In retrospect, the police officer who apprehended him for petty theft found him unusually calm and with a fixed smile on his face. There were no grounds for arresting him on the morning of 24 November. Eye witness accounts suggest that the MHSU made a protective circle around himself after the start of the incident, and it appeared that only persons entering that circle were attacked. As with his previous history of violence in an inpatient setting, he lashed out using his fists. One of those attacked said the MHSU came up to him very calmly, a smart man with a smile on his face, then punched him in the face, and repeatedly punched him. The victim did try to defend himself and then left the scene. It took three to four police officers to restrain the MHSU.

APPENDIX 3: the MHSU's MEDICATION HISTORY 2001 – 2006

Note on abbreviations used:

- mg = milligrams
- bd = twice a day
- nocte = at night
- od = once a day
- prn = as required
- mane = in the morning

Note on types of medication:

- Zuclopenthixol (Clopixol) is an antipsychotic neuroleptic drug.
- Procyclidine is an anticholinergic given to reduce the side-effects of antipsychotic treatment.
- Zopliclone is a hypnotic used for short-term treatment of insomnia.
- Lithium carbonate is used to treat manic states and bipolar disorder.
- Carbamazepine is a mood stabiliser and antiepileptic.
- Fluoxetine is an antidepressant.
- Clopixol Acuphase is an injectable antipsychotic for short-term use.
- Mirtazapine is an antidepressant.
- Sodium valproate is an anti-epileptic also used as a mood stabiliser.
- Citalopram is an antidepressant.

Medication history

Following his first hospital admission in October 2001 the MHSU was discharged on the 26 November with a prescription for zuclopenthixol 10mg bd and procyclidine 5mg bd.

7 December 2001: The zuclopenthixol was reduced to 10mg at night because of the MHSU's complaints of excessive tiredness. The plan was to reduce this by 2mg weekly until discontinuation. (Note: at this stage a bipolar disorder had not been diagnosed. The diagnosis at this stage was an acute psychotic episode.)

23 October 2002: the MHSU was admitted to the local hospital via A&E on an informal basis. On 11 November 2002 he was referred for a forensic opinion owing to his violent and aggressive behaviour on the ward. At this time his medications were zuclopenthixol 10mg bd and procyclidine 5mg bd, but he was noted to be non-compliant with this following his initial admission period where he did appear to be complying. The advice following forensic opinion was rationalisation of his medication and prolonged aftercare under enhanced CPA.

17 December 2002: the MHSU was discharged from the local Hospital on:

- zuclopenthixol 10mg nocte
- procyclidine 5mg once a day (od) and as required (prn)
- zopiclone 7.5mg nocte prn.

17 January 2003: There were difficulties in achieving contact with the MHSU owing to his having started full time employment working nights. CC1 was to try and assertively outreach him. This was successfully achieved on 21 January. It was noted that the MHSU was "reluctant to continue with his psychotropic medication" but that he had agreed to do so. At the suggestion of CC1, he was going to take his medication in the mornings before he went to bed so that it did not interfere with his performance at work.

12 February 2003: CC1 continued to have contact with the MHSU but the MHSU continued to be reluctant to take his medication. The MHSU's rationale for not wanting his medication was that "he was becoming depressed." Also that he had "loss of appetite, general loss of interest in life and continually feels `drugged up'". Following discussion with CP1 the zuclopenthixol was reduced to 4mg at night instead of 10mg. Zopiclone was to continue at 7.5mg. CC1 committed to follow up the MHSU at "regular intervals".

28 February 2003: the MHSU was reviewed by CP1 at outpatients with CC1. It is noted that the MHSU was "somewhat low in mood but there has been some improvement since we decreased his Clopixol". CP1's letter to the GP also says: "One should consider the introduction of lithium carbonate should his mood not improve."

24 March 2003: the MHSU was seen at outpatients by CP1 and CC1. His mood was noted to be settled and he was noted to be compliant with his reduced dose of zuclopenthixol which was now 2mg a day.

28 April 2003: The MHSU was seen at an outpatient's appointment (OPA) by a staff grade doctor in psychiatry (subsequently the associate specialist in AOT in 2005/2006). He was noted to be taking Clopixol 2mg and zopiclone 7.5mg. At this time the staff grade noted that the MHSU was "anhedonic[31], low in mood and finding he was not hungry and is tired. He is unable to sleep without a hypnotic." He was noted to have insight and knew that he needed medication. Consequently the MHSU was commenced on carbamazepine 200mg bd. A 28-day supply was provided and it was requested that the GP prescribe it thereafter. The MHSU was also receiving weekly contact from CC1.

23 May 2003: OPA follow up with CP1. The MHSU advised that he was only taking his carbamazepine at night, not twice a day as prescribed. CP1's letter to the GP notes that the MHSU was in the process of lithium initiation with the community treatment team. He was also advised to discontinue his zuclopenthixol (Clopixol) and he was prescribed 28 days of fluoxetine 20mg mane.

12 June 2003: the MHSU was followed up in outpatients. He was noted to have stopped his fluoxetine after a few days but was compliant with lithium

[31] Anhedonia – the absence of pleasure or the ability to experience it.

carbonate 400mg daily. His lithium level was noted to be sub-therapeutic at 0.34 but the MHSU was reluctant to accept an increased dosage of this. His lithium levels were being monitored weekly.

15 July 2003: the MHSU's lithium levels were 0.34. This was an acceptable level in view of the length of time he had been taking this medication. (He had first been seen by the community treatment team on 1 June 2003).

19 July 2003: Relapse – attendance at Heathrow Airport trying to board a plane to Tunisia without a passport. The letter from Hillingdon mental health services to SWYMHT notes that: "He saw no reason why he should take medications." Following his transfer back to the mental health service in south west yorkshire, the MHSU's compliance with oral medication remained poor. Consequently on 11 August 2003 CP1 decided that Clopixol Acuphase[32] was required.

1 September 2003: the MHSU was discharged from in-patient services on the following medications: carbamazepine 200mg bd and olanzapine 7.5mg nocte. It is also noted that he was to be transferred to the Assertive Outreach Team (AOT). CC1 would continue to follow up the MHSU until the transfer of care was complete.

4 September 2003: CC1 visited the MHSU at home following his discharge from inpatient services on 1 September. He was accompanied by an AOT social worker who was subsequently to become CC2 to the MHSU. At this visit, the MHSU admitted to not taking his medication as prescribed since his discharge. Again he complained that the medication was draining him of his energy and preventing him from getting on with his life. He was counselled about this and agreed to take his carbamazepine. Note: at this time the MHSU was being transferred to the AOT.

29 September 2003: CPA review. Present were CP1, CC1 and an AOT staff member. Following discussion with CC1, the MHSU was advised to take olanzapine 5mg four days prior to being seen, and to continue with his carbamazepine as prescribed. Follow up was planned for two weeks' time.

6 October 2003: CC1 transferred care to CC2 in the AOT. Contact would remain weekly and a key task was to encourage medication concordance.

14 October 2003: the MHSU was seen in outpatients by the staff grade to CP1. It is noted that the MHSU believed that "his medication stops him from leading a normal life. I tried to convince him that this was not the case and told him of other cases whereby the patient worked while suffering from a bipolar disorder". It is noted that the MHSU would continue with the same medication, olanzapine 5mg nocte and carbamazepine 200mg bd.

[32] Clopixol Acuphase is given by injection.

6 November 2003: at OPA, the MHSU was noted to be more settled. His medication was now olanzapine 2.5mg nocte and carbamazepine 200mg bd.

11 February 2004: it is noted at this appointment with the associate staff grade, who was now a locum consultant psychiatrist (CP2), that the MHSU had watched an Arabic film, he felt he knew how it would end and "said he would be happy killing himself". It is also noted that "he raised the Olanzapine to 7.5mg on his own as he says he was not feeling very well".
As a consequence of this appointment CP2 added mirtazapine 15mg nocte to the MHSU's medications.

21 May 2004: OPA with CP2. The mirtazepine was stopped but other medications continued.

24 June 2004: OPA with CP2. No change to medication. No suggestion that the MHSU was not compliant. He appeared well.

11 October 2004: OPA with a new specialist registrar to CP3. (CP3 was the substantive consultant psychiatrist to AOT). CC2 was also present. The OPA was at the MHSU's request as he was concerned about his medication and Ramadan. It was noted by the MHSU that an early sign of relapse was preoccupation with religion. He demonstrated insight regarding the need for medication. No changes were made to his medication at this time. OPA review in two weeks.

8 November 2004: OPA with the specialist registrar (SpR1). The MHSU was noted to be stressed because of his decision not to fast during Ramadan, because he was anxious about relapse. No changes to his medication were made. It was noted that the MHSU "is keen on taking the tablets as he realises how important it is to prevent a relapse". OPA follow up was planned for two weeks.

22 November 2004: OPA with SpR1. the MHSU was noted to have a number of stressors in his life at this time but seemed to be managing them. SpR1 did discuss with the MHSU the possibility of increasing his olanzapine a little to see if it helped with his sleep. The MHSU did not want to do this preferring to stay with the 5mg dose. However he was agreeable to reviewing it again.

15 December 2004: OPA with SpR1. Key points noted were that the MHSU had ended his relationship and had moved in with a friend and was feeling more settled about life. The MHSU saw the relationship as causing the undue stress in his life. Medication was discussed, and the MHSU was encouraged to continue with his medication which he agreed to do.

20 December 2004: OPA with SpR 1. Medications remained olanzapine 2.5mg nocte and carbamazepine 200mg bd. The clinical impression was that the MHSU was doing well as far as his mood was concerned. At the end of the appointment the plan was for his medication to remain unchanged.

Weekly AOT input continued. The MHSU was also encouraged to keep a diary of his thoughts between this and his next appointment.

12 January 2005: OPA with SpR1. The clinical records note that “currently the MHSU is well maintained”. He was agreeable to continuing with medication and continued with AOT support.

9 February 2005: CPA review with SpR1 and CC2. All of his risk indicators were noted to be low in the short term. He had an up and coming asylum application in May which it is noted he might find stressful. It was also noted that “with a combination of medication and support from the team he is doing well”. The plan was for medication of olanzapine 2.5mg nocte and carbamazepine 200mg bd to continue along with weekly input from AOT.

23 February 2005: SpR1 visited the MHSU at home with CC2. It was noted that he was generally well. He told SpR1 that he had run out of his medication a couple of days ago but had now got a repeat prescription and had started his medication again. There was no change to his management plan at this time.

24 March 2005: OPA with SpR1. On this occasion the MHSU was unaccompanied. Nil of note was recorded except that the MHSU lost his prescription so he was issued with another. Monthly OPAs were to continue, medication to remain the same and weekly AOT input to continue.

25 April 2005: OPA with SpR1. the MHSU was again noted to be well. However, at this appointment it is noted that the MHSU wished to stop all his medications as he has been well for the past two months. In fact he had stopped taking his medication in the last two days. SpR1 advised the MHSU that a planned reduction in medication was safer and asked him to stay on his carbamazepine but at 200mg at night. Input from AOT continued, but SpR1 was to discuss with the team about reducing contacts to fortnightly now.

25 May 2005: OPA with SpR1. No changes of note. The MHSU remained compliant with 200mg carbamazepine nocte. The potential stress of his asylum application was again noted. The MHSU’s insight was noted to be good. At this time the MHSU’s mental state had been stable for approximately two years.

20 June 2005: OPA with SpR1. At this appointment it is noted that the MHSU was in remission, but that his mood had been elated for a few days the week previously although he coped with it. He was noted to be very worried about his asylum status. His exceptional leave to remain in the UK was due to expire in July 2005. He had applied for an extension of this. It was noted by the SpR1 that “in view of the odd periods of elated mood it might be advisable for him to continue on the medication for the time being and not to come off it”. Olanzapine 2.5mg nocte was therefore reinstated in addition to his carbamazepine. Fortnightly contact with AOT continued.

6 July 2005: the MHSU relapsed. He was subsequently admitted to a private medium secure psychiatric intensive care facility in Darlington.

15 September 2005: pre-discharge CPA meeting. The MHSU was assessed at home by CP3 and CC2 prior to his planned discharge from inpatient services. The antecedents to his most recent relapse were clearly documented. It was noted that the MHSU would be keen to "look at early warning signs and relapse work". It was also noted that he was willing to continue on his medication but would like a reduction in the olanzapine because of excessive sedation.

Consequently the high dose of olanzapine he had been on since relapse was reduced to 15mg nocte. Further reductions could occur in the future in a "very gradual way to avoid manic relapse". Serum assessment of his carbamazepine (CBZ) levels was also requested. Communication between the community treatment team and the care coordinator occurred on 19 September regarding arranging an appointment for the MHSU and CBZ monitoring. Weekly contact with AOT was reinstated. **Note:** at this time the MHSU was on sodium valproate 700mg, not carbamazepine. The request for CBZ monitoring was made in error. This was altered in handwriting on the CPA record.

The discharge summary, provided to CP3 on 3 October 2005, notes that at discharge the MHSU's sodium valproate levels were slightly sub-therapeutic at 41mg/l (the therapeutic range is 50–1100mg/l). Consequently it was increased to 700mg. On this dose the MHSU's mental state continued to improve.

29 September 2005: At this OPA with SpR1, the MHSU put his relapse down to "the fact that he discontinued his medication and the stress he was under with the extension of his asylum application". At this time he was saying that he would continue on his medication as it would help him get well.

15 December 2005: the MHSU was seen urgently on the request of CC2. The MHSU was noted to be lethargic but otherwise symptom-free. CP1 advised that the olanzapine should be reduced from 15mg to 10mg nocte but that the sodium valproate should continue at 700mg. In November his carbamazepine levels were within normal range.

9 March 2006: OPA with the AOT associate specialist (previously the staff grade to CP1). Citalopram was added to the MHSU's prescription and olanzapine was reduced from 7.5mg nocte to 5mg.

4 May 2006: OPA with associate specialist. At this time medications were noted to be olanzapine 2.5mg nocte, sodium valproate 700mg bd and citalopram 20mg nocte. Following assessment the olanzapine was increased

to 5mg nocte. The MHSU was exhibiting early signs of relapse. These subsequently settled.

26 June 2006: OPA with associate specialist. The MHSU was noted to be back in remission. He was however noted to be non-compliant with medication and wanted to stop this. His sodium valproate levels were noted to be slightly below therapeutic range but not so much as to cause concern. The MHSU was advised to continue with his medication. AOT follow up would continue weekly.

4 July 2006: the MHSU attended for outpatients with the AOT associate specialist. It was noted that he had stopped his sodium valproate two weeks prior to his appointment. The MHSU believed he was fine. The associate specialist counselled him regarding medication and the risks of becoming unwell and requiring hospitalisation. The MHSU therefore agreed to take carbamazepine 200mg nocte. OPA follow up was set for two weeks and blood monitoring was requested every two weeks for the next two months. The MHSU attended for serum monitoring on 17 August, 31 August and 14 September.

There is a gap in medical monitoring from July – November 2006.

6 November 2006: the MHSU requested assessment. The impression from the clinical record was that he was taking his carbamazepine and also olanzapine 5mg nocte. It was also noted that because he felt unwell he increased his olanzapine dose by 2.5mg on 4 November. No changes were made to his medications as a result of this attendance. No firm plan was made in relation to further OPA follow up.

APPENDIX 4: INVESTIGATION METHODOLOGY

The methodology for this investigation constituted:

- Critical appraisal of the MHSU's clinical records and the identification of areas to explore that would have been 'essential' and 'desirable' were the investigation to be undertaken from scratch.
- Benchmarking the South West Yorkshire investigation report and its content against the issues identified during the appraisal of the MHSU's clinical records. During this process the IIT came to a decision regarding the merits of undertaking any re-investigation of the MHSU's care and management in between 2002 and 2006.

The investigation tools utilised were:

- Structured timelining.
- Triangulation and validation map.
- Investigative interviewing.
- Affinity mapping.
- Qualitative content analysis.

The primary sources of information used to underpin the findings of this investigation were:

- The MHSU's mental health records.
- The Trust's own internal investigation report.
- Interviews with the MHSU's consultant psychiatrists between 2002 and 2006.
- Interviews with all medical staff who had any substantial contact with the MHSU between 2002 and 2006.
- The MHSU's care coordinators between 2004 and 2006.
- A selection of staff working in assertive outreach between 2004 and 2006.
- A meeting with the Metropolitan Police involved in the investigation of the November 2006 incident.
- A review of witness statements collected at the time of the incident.
- A meeting with V2 and his wife.
- A review of key policies and procedures.
- Meeting with a member of staff at the Policy and Planning PNC Bureau (Metropolitan Police)

APPENDIX 5

South West Yorkshire NHS
Mental Health NHS Trust

Action plan following the internal review of report of SUI 2006/8119

Ref.	Recommendation	Actions	Completed/ comments
AOT - Documentation - (Ref: 10.8)			
1.	The AOT should undertake a further piece of work to ensure that:		
	i. Any changes regarding level of risk, including subsequent changes to the care plan and relapse prevention plan, are recorded in one place that is accessible to all team members.	1. A protocol is to be drawn up in regard to how the 'important contact' flag can be used on the MHIS system. 2. Communication of this will be by email and at the AOT team meeting and monitoring via managerial supervision.	Important contact flag being used by the team. This is to be reaffirmed in a future meeting. This has been in place since July 2007, and there is a flagging system on RIO. **Completed July 2007.**
	ii. The medical case notes and AOT paper notes are amalga-mated in to one paper file and are accessible to all team members.	1. Process will be agreed in line with the Trust's existing records management policy. 2. Process to be monitored by General Manager Adult Services (Calderdale)	This is ongoing – process is now in place led by the team secretary. The time and complexity was not appreciated. However it is viewed that this process will be completed by Dec 2007. The team secretary with some additional support

Ref.	Recommendation	Actions	Completed/ comments
			has now completed this work. There is only one record for all patients. Completed December 2007.
	iii. Actions from clinical review meetings are recorded straight on to the MHIS.	Action clarified and agreed in AOT team 'time out' in March 2007. To be monitored by AOT lead and CPA Manager Processes of migration to RIO system to be understood by the team and supported by CPA lead.	This is complete. 2. This is ongoing. RIO implementation by Nov 2007. System of transfer is in place including training. Actions are recorded directly to RIO from clinical reviews. **Completed Autumn 2007**
	2. A chronological log of all contacts and attempted contacts is maintained. These may need to be completed by another member of the team if a team member is unexpectedly absent after contacting a service user.	1. Contacts to be recorded directly on to the MHIS (RIO from November 2007 onwards) and into the patients paper record. This will include 'failed' contacts. Failed contacts will include note of action to be taken. 2. A process to ensure medical contacts are recorded in a timely way will be determined to ensure that working arrangements do not interrupt the process of recording contacts.	This is complete as per ongoing timescale. Failed contacts are recorded. This is still work in progress, however there is an immediate communication system back to the team for all contacts with the consultants, including those seen as posing increased risks. This will be flagged on MHIS. This has now progressed. The consultant and medical staff are inputting directly on to the progress notes in RIO. **Completed December 2007.**

Ref.	Recommendation	Actions	Completed/ comments
2.	A review of the current system of storing and maintaining the AOT medical case notes in [redacted] is undertaken to ensure that, while being readily available to the clinical team, there is a system in place to ensure that these records are regularly reviewed and when necessary reorganised. This process will be monitored.	This is covered by proposed action 1 (ii).	
3.	Any training undertaken as part of the induction process should be recorded according to the Trusts Induction Policy	Process of recording training for both SWYMHT and [redacted] MBC currently being agreed at the Integration Board. Will be communicated and circulated via the management system and team briefing.	This is still outstanding. Dates for confirmation of protocols to be communicated to staff now in Nov 2007. Protocols have been circulated following events in November. **Completed. November 2007.**
4.	The team to receive training on the process of risk assessment, formulation and management, including how this should be recorded, the development of relapse strategies and management plans.	Programme of training will be confirmed and training (SWYMHT) recorded as per Mandatory Training Policy. This will by necessity include Risk Assessment & Management. Management of violence and aggression.	Initial training day (risk) back in March. Risk assessment management (Sainsbury's) and management of violence and aggression being determined for team members by Service Manager and Team Leader. Completion date to be confirmed. Staff training log

Ref.	Recommendation	Actions	Completed/ comments
	This training will be recorded.		being collated. All staff accessing Sainsbury's training. Revised completion date: April1st 2008.
5.	All staff within the team should receive supervision which is recorded in accordance with SWYMHT's and [redacted] Social Services supervision framework.	SWYMHT and [redacted] Social Services Supervision Framework to be re-communicated through the team processes. Supervision to be monitored through an audit and action plan to be developed as appropriate.	Completed as per original timescale. Supervision takes place and is recorded for all team members.
6.	The Trust undertakes further work to review and benchmark the Trust's Assertive Outreach Teams with one another and against national guidelines to identify standards for best practice in the areas of:	Ref 6 & 7 This will be a 12 month Trust wide project involving the 5 AOT teams in SWYMHT. This will be a systematic review with clear, deliverable outcomes.	Summary: see also separate update information from Gill Green AD Two groups have been established for all Trust AOTs, a bi-monthly scrutiny group and a policy review group which is chaired by the Assistant Director for Adults of Working Age Services. The policy review group has completed a benchmarking exercise around the AOT policies and procedures for the above. Following this the group is now
	1. Standardised AOT operational policies	The outcomes will be monitored via audit programme agreed with the Trust Clinical Governance Support Team.	
	2. Induction and training		

Ref.	Recommendation	Actions	Completed/ comments
	3. Care plans to include minimum standards for individual service user review by members of the Assertive Outreach Team, including medical staff and the care coordinator.	Assertive Outreach Team	developing a Trust-wide AOT policy which will include clear policies for all the areas identified in the SUI investigation report action plan. In addition on the 4th February 2008 the AOTs held a 'learning lessons meeting' to present and discuss this incident to all AOTs in the Trust. All actions completed by AOT project team – October 2008. Outstanding leaflets to be completed by AOT network by March 2009. Leaflets to be produced by March 2009.
	4. Documentation including maintaining a chronological record of all contacts and attempted contacts with service users.	AOT Project team	
	5. The process of risk assessment, formulation and management, including how this should be recorded, the development of relapse strategies and management plans.	AOT Project Team	

Ref.	Recommendation	Actions	Completed/ comments
	6. Medication management • Benchmarking approaches to medication management with other AOTs • Medication concordance training for AOT staff	AOT Practice Network	These actions were completed in March 2007. Now all the Trust AOT teams have a clear system, managed by the admin person(s) of each team to invite GP's to CPA meetings and clearly communicate by letter and discussion in regard to relapse prevention.
	7. AOT organisation and management of care contacts		
	8. Working with primary care-AOTs to: • Actively engage GPs in the CPA and relapse prevention process by including inviting GPs to CPA meetings. • Provide GPs with information about the nature and role of AOT both generally and where someone from the practice is being supported by the AOT.		

Ref.	Recommendation	Actions	Completed/ comments
	9. How the teams manage communications and messages		All the Trust AOT teams now have a central message system which is particularly checked at the beginning and end of each day at team review.

Ref.	Recommendation	Actions	Completed/ comments
Risk assessment, formulation and care planning (Ref:10.3 and 14.0 points 6 and 8)			
7.	When assessing risk staff need to understand and take into account the widest potential for risk and contributing stress factors that might impact on this. The Trust is currently rolling out training in the use of the Sainsbury risk assessment tool. These aspects of risk assessment, formulation and management (in relation to identifying the full risk profile and potential risks) will be brought to the attention of the trainers.	See reference to project outlined in 6 page 5.	This information has been shared with the risk training coordinator and the training has been reviewed and amended. Learning from SUIs is also included as one aspect of the course. **Concluded October 2008**

Ref.	Recommendation	Actions	Completed/ comments
8.	The Trust needs to ensure:		
	i. Services have a clearly defined process for accessing relevant information about service users from all available sources, particularly information from another area when a person is transferred or has received out-of-area care.	The Trust's existing Records Management Policy will be amended to include the requirement to request all appropriate recent healthcare records, even if the service user is known to the clinician from a previous contact with services in another organisation.	In relation to another action plan an amendment to the CPA Protocol has been made, to include the requirement for previous recent records from another provider to be sought, even if the service user is known to the clinician from a previous contact with services in another organisation. This was approved at the Information and Governance Trust Action Group on 9 July 2007.
	ii. Ensuring that this information is fully considered and if relevant included in the assessment and care planning processes and the source clearly identified.	Policy update to be communicated to all clinical and administrative staff via team brief and training and the updated policy to be amended on the Trust's Intranet.	**3rd August 2007** Meeting arranged with medical records representative to look at whether this information is recorded and how this can be captured and audited. **Nov 2007 update** The updated protocol has been communicated and is now available to all staff on the Trust intranet The electronic patient record system (RiO), currently being implemented Trust-wide, has data fields available to capture this information

Ref.	Recommendation	Actions	Completed/ comments
8. cont ...	iii. This is taken into account in planning the new PICU and in developing the role of the new co-ordinator for out-of-area placements.		
	iv. That this is monitored	To be monitored through a clinical audit and an improvement action plan developed as appropriate.	
Trust electronic records system (RiO) - (Ref: 10.8)			
9.	The investigation team found a tendency for staff to record only brief records ('sound bites') of case contacts on the current [redacted] MHIS. This could be due to the limited space to write free text on this system and/or could be due to a tendency for staff to do this when using an electronic recording system. It is therefore recommended that when the new Trust-wide electronic RiO system is implemented to record case contacts that the Trust should monitor how these records are maintained, to ensure that appropriate records are completed.	The RIO Project Board will monitor this following the full roll out of RIO Trust-wide due to be completed in November 2007.	RIO roll out commenced Dec 2007 – Phase 1 in [redacted].

APPENDIX 6: The Pitchford Ruling

The Pitchford Ruling December 2004

Susan Thompson and Stuart Marchant[1]

R (on the application of CS) v Mental Health Review Tribunal; Managers of Homerton Hospital (East London and the City Mental Health NHS Trust) (Interested Party)

Queen's Bench Division, (Administrative Court), Pitchford J., 6 December 2004 EWHC (Admin) 2958

The decision of a Mental Health Review Tribunal under section 72(1) Mental Health Act 1983 not to discharge patient on section 17 leave from hospital was not unlawful. The link between hospital and treatment may be "gossamer thin" but still a "significant component" to justify renewal of detention

Introduction

CS was a patient liable to be detained on leave of absence from hospital (leave)[2]. She challenged the decision of the Tribunal which had confirmed the lawfulness of her detention following renewal[3] on the grounds that she was no longer receiving hospital treatment which justified continued detention. The court, whilst restating that hospital treatment must be "a significant component" of the treatment plan to be lawful under the Mental Health Act 1983 (the Act), found that, although the Responsible Medical Officer's (RMO) grasp on the patient was "gossamer thin", it was a "significant component" sufficient to justify continuing detention. As a patient liable to be detained, CS could be recalled to hospital for treatment if she refused or failed to take her medication in the community which introduced an element of compulsion that she accept treatment in the community.

Footnotes:

(1) Solicitors who acted for the interested party. Susan Thompson is a partner at Beachcroft Wansbroughs. Stuart Marchant was fomerly a solicitor at Bevan Brittan, now at Ridouts.

(2) Section 17 Mental Health Act (MHA) 1983.

(3) under Section 20 MHA 1983.