CONSEQUENCE

Report of the Independent Investigation Team STEIS 2005/2081 1st April 2008

Consequence UK Ltd
Lydes House
392 Pickersleigh Road
Malvern
Worcestershire
WR14 2QH

This Independent Investigation was commissioned by West Midlands Strategic Health Authority and Yorkshire and the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance titled "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 the 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.

The Investigation Team Members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Dr Michael Clark, Consultant Psychiatrist
- Mr Mike Foster, Head of Nursing Practice and Development Oxfordshire and Buckinghamshire Mental Health NHS Trust

Acknowledgements:
The Investigation Team wish to thank all of the staff at South West Yorkshire Mental Health NHS Trust and at Birmingham and Solihull Mental Health NHS Trust who gave willingly of their time to assist the Investigation Team in understanding the full context of the care and management of the Mental Health Service User (MHSU) involved in the homicide incident on the 18th May 2005.

The Investigation Team also extend their thanks to the mother of the Service User and the sister of the deceased for the time and information they gave.

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EXECUTIVE SUMMARY

Intention

This report sets out the findings and recommendations of the Independent Investigation Team following its analysis of the care and management of a Mental Health Service User (MHSU) by the mental health services in Birmingham and West Yorkshire.

Purpose

The purpose of the work commissioned was to:

- To undertake a detailed and analytical timeline charting the MHSU's contacts with the mental health service.

- To critically analyse the documented care and to identify any areas that appeared weak or unsatisfactory and then to determine the significance of these features in relation to the subsequent course of events and the homicide event on the 18 May 2005.

- To advise the SHA's of any aspect of the MHSU's care and management that required further investigation and to undertake the investigation of these aspects of care.

Outline of Review Process

An initial review of the Mental Health Service User's clinical records suggested that in this case full service wide Root Cause Analysis was not required. Therefore a targeted investigation of his care and treatment was undertaken.

The primary activities were:

- Documentation Review
- Interviews and round-the-table meetings with staff
- Liaison with the MHSU's mother

The MHSU himself refrained from meeting with the Review Team.

Main Conclusions

As a result of this review the main conclusions are:

- Given the circumstances of the incident, it is unlikely that different management and actions by the mental health services could have averted what happened on the 18th May 2005. However, there will always be some degree of uncertainty about this.
- The service afforded the MHSU in Birmingham was of a very good standard.
- Between 2002 and the end of 2004, the service afforded the MHSU in Huddersfield and by the Castle Hill Unit when he was in Sheffield and London, was of a very good standard.

- In May 2005, the Review Team believe that the Castle Hill Unit could have taken a less rigid approach when the MHSU attended the unit in search of medication. Although the Unit acted within their policy guidelines and procedures, these did not incorporate the more flexible approach sometimes required for chaotic Service Users.
- In May 2005, although very reasonable efforts were made to find out the living circumstance of the MHSU by the Castle Hill Unit, no contact was made with his mother. Although the Review Team understand the reasons for this, it is unfortunate that contact did not occur as she was aware of the MHSU's whereabouts.

Recommendations

Note: Although these recommendations are targeted at South West Yorkshire Mental Health NHS Trust it is expected that Birmingham and Solihull Mental Health Trust will assess its relevant services against them and address any omissions identified.

- Because South West Yorkshire NHS Trust does not have a specialist Homeless Mental Health Team, it needs to ensure that all of its Adult Services have clear and consistent guidance on the care and treatment of itinerant and/or homeless Service Users that meets the standards of care and service that would be provided by a dedicated Homeless Mental Health Team.
- The Investigation Team recommends that South West Yorkshire Mental Health Trust undertake an Analysis of i) its CPA Paperwork ii) the way in which Carer's families and external Agencies are invited to CPA meetings, iii) the transparency and robustness of the CPA audit trail
- South West Yorkshire Mental Health Trust ensures that, when serious mental health incidents occur, the investigation of these incidents is commensurate with expected and best practice.

1.0 BACKGROUND

On the 18 May 2005, a Mental Health Service User (MHSU) who was not actively engaged with any mental health service was arrested on suspicion of murder. The victim was the MHSU's house mate at the time. The MHSU and the victim had been sharing the rented house for approximately four weeks at the time of the incident. Prior to this time, the MHSU and the victim were not acquainted.

The MHSU was born in Bradford. At the age of eight, he and his family moved to Huddersfield. His early childhood was unremarkable until the age of 12 years, when he started becoming unmanageable at home and at school. Prior to this he was a capable student who attained good grades. The trigger for the demise in his behaviour seems to have been a change in his relationship with his mother's partner following their marriage and his starting to use what he referred to as "Booda". It was not until he was fifteen years of age that his mother became aware of his involvement with drugs. His deteriorating behaviour until then had been put down to growing up and difficulties in adjusting to the new family dynamics.

The MHSU's first contact with Mental Health Services was in 2000, when he was admitted for a period of nine days. He presented with psychotic symptoms stating, amongst other things, that he had died from Carbon Monoxide poisoning and that a numerical figure written on his arm had special significance. At this time, his differential diagnosis was either a drug induced psychosis, or a psychotic stress reaction relating to impending Court Proceedings. Following discharge, the MHSU did not comply with follow up.

His next admission was in April 2001, following his arrest under Section 136 of the Mental health Act, to St James's University Hospital Leeds. The reason for his arrest was his possession of Ecstasy tablets. Within days of his admission, the MHSU was transferred to the Psychiatric Intensive Care Unit at High Royds Hospital Leeds following an incident on the ward in which he brandished a knife at his then 'Responsible Medical Officer'[1].

The MHSU was transferred to the Castle Hill Low Forensic Psychiatric Unit in Huddersfield in July 2001. It was during this admission that the MHSU was given a diagnosis of Paranoid Schizophrenia. The Castle Hill Unit is generally referred to as CHU and this is how it will be referred to for the remainder of this report.

The MHSU's progress at the CHU was reasonable to the extent that, in May 2002, he was discharged from his detention under the Mental Health Act and discharged to Moorview Hostel, a 24 hour staffed facility that acted as a step down unit for the Forensic Services.

[1] A Responsible Medical Officer is the Consultant Psychiatrist responsible for the care and management of the patient. It is a term that is used within the Mental Health Act.

In addition to his mental health issues, the period of time the MHSU spent in the CHU enabled the mental health team to establish that, although he did have a diagnosable mental health illness, he also had issues relating to immaturity, limited-to-poor anger management skills, and difficulties in accepting boundaries.

In May 2002, it is noted that the MHSU had a history of threatening others, including the brandishing of weapons. His misuse of Cannabis remained a risk factor to his mental health.

In August 2002, the MHSU's tenancy at Moorview Hostel was terminated because of his persistent opposition to the Hostel's rules and guidelines. The MHSU had been in remission of his psychotic symptoms throughout his stay at Moorview Hostel.

The MHSU disengaged from contact with Mental Health Services following his eviction from the Moorview Hostel.

The MHSU next re-presented to Mental Health Services in October 2002, when he was brought to St Luke's Hospital Huddersfield by his mother. He had been acting and talking bizarrely. Although initially admitted on an informal basis, a series of incidents resulted in his being detained under the Mental Health Act. He was subsequently transferred from the in-patient unit at St Luke's Hospital to the CHU on the 19 November 2002.

The MHSU remained a patient of the CHU until 7th November 2003 when he was discharged.

At the time of discharge he was on Olanzapine 10mg and his diagnoses were:

- Paranoid Schizophrenia
- Antisocial personality traits
- Misuse of Cannabis

It is noted in the discharge summary that, although the MHSU's risks diminish when he is in remission from his mental health illness, his risks are never eliminated, as he continually engages himself in low level criminality. He continually poses a risk of physical violence and reckless behaviour which might have serious repercussions for himself or others.

By the 17th November 2003 independent accommodation had been secured for the MHSU despite his previous attempts to sabotage the chances of this. However, on the 2nd January 2004, the police attended his flat with an arrest warrant for the MHSU. He did not answer the door and, as the police believed that he was inside, they exercised their authority to forcibly access the MHSU's flat. Unfortunately, the door was part of a double glazed sealed unit and the whole frame was rendered useless as a result of the forced entry. Consequently, the doorway needed to be boarded up making the flat into a sealed unit with no entrance. As a result of the damage caused, which the MHSU was deemed to be responsible for, his tenancy was terminated.

This incident marked the start of a prolonged period of instability for the MHSU with him moving from area to area and essentially being of no fixed abode.

Between September and December 2004 the MHSU resided in Pentonville Prison. Following his release, he is reported to have made clear his intention not to return to Huddersfield.

In January 2005, the MHSU presented himself to the Homeless Team in Birmingham. He was managed by this team until 7th March 2005, when he was evicted from the Hostel they had found for him because of his unacceptable behaviour. He then left Birmingham even though the Homeless Team had secured accommodation for him with the Salvation Army in the short term[2].

On the 17th March 2005, the MHSU presented at A&E in Bradford reporting that he was depressed. He was subsequently assessed by the Psychiatric Team at Linfield Mount and discharged.

On the 18th March 2005, his mother came across him at the Bradford Interchange (train station) and arranged accommodation for him. To all intents and purposes it appears that he was relatively well and stable for the following six to eight weeks.

On the 3rd May 2005, the MHSU self- presented to the CHU in search of medication. He was advised to see his GP so that he could be assessed and re-referred if necessary in the normal way. At this time, the CHU had had no contact with the MHSU for approximately eight months.

In spite of his mother's best efforts to facilitate the attendance of the MHSU at a GP surgery, he did not do this. The last attempt was on Monday the 16th May, three days prior to the incident.

On the 18th May 2005, the MHSU is thought to have become involved in an argument with the gentleman he shared a rented house with. This resulted in him stabbing his housemate who died from his injuries.

The MHSU was arrested and charged with murder at 00.50hrs on the 19th May 2005.

PLEASE SEE APPENDIX 1 (page 49) FOR A MORE DETAILED CHRONOLOGY OF THE MHSU's CONTACTS WITH THE MENTAL HEALTH SERVCIES

[2] **Note:** It is important to note that the Homeless Team in Birmingham did not find the MHSU to be particularly challenging. Within the context of managing Mental Health Service Users, this MHSU's risk history was not especially remarkable and was in many respects 'par for the course'. The Homeless Team considered the MHSU to have very good social skills and he gave the impression of being able to look after himself. The Homeless Team advised the Independent Investigation Team that this MHSU had a vibrant personality and interacted well with other Service Users and responded to staff well. With regards to boundary pushing, this was expected. But, because of this MHSU's ability to negotiate and charm, it is the Homeless Team's view that he got away with more than other Service Users may have done. This MHSU was considered to be in better health both physically and mentally than most of their client group and it is the Investigation Team's impression that all staff enjoyed their period of contact with him, even though he did need to be admonished from time to time.

2.0 TERMS OF REFERENCE

The Terms of Reference for the Investigation

This investigation was unusual in that there were no prescribed terms of reference in the first instance. The initial task for the Investigation Team was to determine whether or not a full and unabridged independent investigation was required and justifiable.

The terms of reference were therefore:

1. To undertake a detailed and analytical timeline charting the MHSU's contacts with the mental health service.

2. To critically analyse the documented care and to identify any areas that appeared weak or unsatisfactory and then to determine the significance of these features in relation to the subsequent course of events and the homicide event on the 18th May 2005.

3. To advise the SHAs of any aspect of the MHSU's care and management that required further investigation and to undertake the investigation of these aspects of care.

In so examining any areas of concern or uncertainty, the Investigation Team undertook to:

1. Examine the adequacy of the working arrangements, collaboration and engagement with, and communication within and between:
    - The agencies involved in the provision of care and services to the patient - including in respect of risk information sharing.
    - The statutory agencies and the MHSU's family.

2. Examine such other issues relevant to the specific circumstances of the individual case e.g. cultural and social issues.

3. Determine what improvement plans have been implemented since the Trust's Internal Investigations and whether the effectiveness of these interventions has been assessed.

3.0 METHODOLOGY

In this investigation, Root Cause Analysis (RCA) principles were applied. The Investigation Team used the investigative framework from the National Patient Safety Agency's (NPSA) RCA e-learning tool kit.[3]

The specific investigation and analysis tools utilised were:

- The Consequence UK Ltd structured Timeline.

The primary sources of information used to underpin this review were:

- The MHSU's clinical records from Birmingham and Solihull Mental health Trust and South West Yorkshire Mental Health Trust.
- Interviews with staff engaged in the care and management of the MHSU

Note

There was a conscious decision in this investigation to keep a tight focus on the care and management of the involved MHSU only and to not undertake a wider systems analysis.

The reason for this was that the Investigation Team's initial assessment of the MHSU's clinical records revealed a good standard of care up to and including March 2005 and, in our professional opinion, there was insufficient opportunity for reflection, learning and improvement to justify undertaking a full critical appraisal of the MHSU's care and management over this period. (2000- mid January 2005).

The focus of the investigation was therefore what happened between the 8th March 2005 and the 18th May 2005. The clinical records did not provide clarity over this period and it was therefore necessary to investigate this further.

[3] NPSA e-Learning tool kit August 2004
http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/rootcauseanalysis

4.0 ACCESS TO THE CLINICAL AND OTHER APPROPRIATE RECORDS FOR THE MHSU

Following confirmation from the current Forensic Consultant Psychiatrist (Rampton) to the MHSU, a letter requesting access to his clinical records was sent to the MHSU on the 19th April 2007. This correspondence also highlighted the willingness of the Investigation Team to meet with him and invited him to communicate with us any questions he wanted the Investigation Team to answer.

This correspondence was followed up with a telephone call to Anston Ward, Rampton Hospital on the 22nd May 2007. The nursing staff there spoke with the MHSU about our correspondence and secured his authority for Consequence UK to access his records. The signed form of authority was faxed to the offices of Consequence UK on the 22nd May 2007. At this time, the MHSU did not want to meet with the Investigation Team

One month later the MHSU advised his care team that he was no longer happy to authorise our access to his records. Although the Investigation Team had already analysed the clinical records pertaining to his care and management in South West Yorkshire Mental Health Trust and Birmingham and Solihull Mental Health Trust, we were denied access to his pre-sentencing psychiatric reports and the initial assessment undertaken of the MHSU at Rampton. Following protracted correspondence between Consequence UK and Rampton Hospital, and the West Midlands SHA and Rampton Hospital, a decision was taken between the commissioning SHAs and Consequence UK Ltd to proceed with the Investigation on the basis of the information we had. All parties were agreed that access to the most critical information had been obtained and the Investigation Team did not believe that the investigation's outputs would be severely compromised by not having access to the full range of material. This was not a case where any party believed that the expenditure of pursuing access via the courts was justified.

5.0 CONTACT WITH THE FAMILY OF THE MHSU AND THE FAMILY OF THE VICTIM

The Investigation Team extends its thanks to the Care Coordinator for the MHSU at South West Yorkshire Mental health Trust for his assistance in obtaining the correct contact details for the mother of the MHSU.

Contact with the MHSU's mother occurred on the 14th and 22nd October 2007.

The MHSU himself declined to meet with the Investigation team. In addition to the correspondence with this individual in April 2007, a further offer to meet was sent to him in November 2007 and this was again followed up with telephone communication with the staff on his ward at Rampton. Verbal confirmation was provided by the staff at Rampton of the MHSU's wish not to meet with the Investigation Team.

Contact was made with the Dudley Hill Homicide and Murder Investigation Team in order to locate the whereabouts of the victim's family. It was identified that the victim has a half-sister who lives in Southern England. All other relatives live abroad. The victim's half-sister was contacted and advised that the Review was being undertaken and she and her husband were invited to meet with the Review Team. This invitation was declined at this time.

Further contact was made with the mother of the MHSU and the victim's family prior to the publication of the report. Both families were offered the opportunity to read and comment on the draft report. The family of the victim preferred not to meet with the Review Team. However, the victim's half-sister was agreeable to a key section of the report being read to her over the phone. Although not ideal, this was considered preferable to her reading it for the first time after the report had been published. This reading did enable her to make comment and to influence the content of this section of the report. (Findings, 'The events of the 18th May 2005').

6.0 FINDINGS OF THE INVESTIGATION

The following sets out the findings of the Investigation Team following its analysis of the care and management of the MHSU.

6.1 Positive Feedback:

Overall the Investigation Team is of the opinion that all of the clinical teams that came into contact with this MHSU tried their utmost to give him a good standard of care and to help him achieve a stable life in the community. Looking at the totality of contact this MHSU had with the Mental Health Services, it would be difficult to say that they could have done it differently or better. The following represents just some examples of the good practice and considered clinical decisions taken.

- The appropriate use of extended leave from the Castle Hill Unit and the Mental Health Act to maximise the MHSU's independence, compliance with treatment and behaviour improvements between March and May 2003.
- Utilising the option to test for serum levels of Olanzapine to test out assurance given by the MHSU that he was taking his medication. (This was during the period of his extended leave from the CHU in 2003).
- Appropriate use of the Criminal Justice System where the MHSU conducted serious aggressive acts towards others (staff and patients) in the in-patient setting. Of particular note is the memorandum sent to staff on CHU by the responsible Consultant Psychiatrist on the 13 October 2003 setting out clearly what action was to be taken by staff if a significant/serious incident were to occur and if an incident of lesser severity were to occur. This Consultant Psychiatrist made clear in this communication his willingness to be contactable out of hours and stressed the importance of 'discharging the MHSU into the custody of the Police'.
- The Care Coordinator for the MHSU went to considerable lengths to maintain a level of engagement with the MHSU. For example, he was prepared to travel between Sheffield and Huddersfield to maintain contact with his client, made himself very available to him on the phone and ensured that the MHSU had all of his contact details.
- When the MHSU moved out of the Huddersfield Area, there is good documentary evidence to support the Care Coordinator's assertion that he made himself as available as possible to the Homeless or other Mental Health Teams that the MHSU came into contact with. He believed that he had a duty to ensure that these other professionals were as informed as possible about the MHSU's background and the circumstances that were known to increase his risk factors.

The Care Coordinator, in the opinion of the Investigation Team, demonstrated exemplary practice in this respect and a good level of care and concern for his client.

- The Homeless Team in Birmingham discharged their duties appropriately in respect of the MHSU. Accommodation was swiftly found for him and he received assessment of his mental health state from the Consultant Psychiatrist and one of the Mental Health Social Workers attached to the Homeless Team. Furthermore, because of his reported risk history, the MHSU was seen by a team member on at least a weekly basis and sometimes more frequently.
- On the night of the 17th March 2005, the Duty Psychiatric Team contacted the Castle Hill Unit in the early hours of the morning to try and find out some background information about the MHSU. Unfortunately, the nurse on duty at the time was not able to provide any information – at the time she was relatively newly qualified and did not know how to retrieve historical information about past patients from the computer system. However, in spite of her inability to provide up-to-date information to the Duty Psychiatric Team in Linfield Mount in the early hours of the morning on the 17th March, this nurse wrote to the MHSU's previous Consultant Psychiatrist at the Unit to alert him to the request for information.
- The Court Liaison Nurse made good effort, following his brief exchange with the MHSU on the 3rd May, to try and locate the MHSU's current whereabouts so that the relevant GP could be alerted to his need for assessment, medication and referral.

The Investigation Team also believe that the MHSU's mother needs to be positively acknowledged in this section of the report. In spite of the enormous difficulties her son presented and the fact that it was untenable for him to reside in the family home, she did maintain regular contact with her son. She was also disciplined in trying to maintain clear boundaries with him in terms of acceptable and unacceptable behaviour. It is wholly down to her personal efforts that this MHSU found stable accommodation between the middle/end of March 2005 and the date of the incident on the 18th May 2005.

6.2 Issues of Concern

Although the Investigation Team is of the opinion that, overall, the care and management of this MHSU was good, there were three main issues that needed to be explored within the context of this investigation. These were:

- What happened to him between 7th March 2005 and the 3rd May 2005?
- What happened on the 3rd May 2005 when he presented himself at the Castle Hill Unit?
- What happened between the 3rd May and the 18th May 2005?

The Investigation Team's understanding for each of these points is presented below.

What Happened to the MHSU between the 7th March and the 3rd May 2005?

The lack of contact between the MHSU and the Mental Health Services between the beginning of March and early May stands in contrast to the relatively frequent contact the MHSU had with a range of Mental Health Services between 29 December 2003, when he left Huddersfield, and 7th March 2005, the date of his last face-to-face contact with the Mental Health Services in Birmingham..

The review of his clinical records and interviews with:

- His Care Coordinator in Huddersfield.
- The Staff Nurse on Duty on duty at the Castle Hill Unit on the 17th March.
- The Homeless Team in Birmingham.
- The MHSU's mother

revealed the following:

On the 7th March, MHSU was seen by the Ladywood Home Treatment Team (LHTT) following his being barred from 'The Rowans' hostel. The reason he had been barred was because of his incessant drug usage and because of a physical attack upon another resident.

It is reported that MHSU's presentation at the time was agitated and guarded, but that there were no concerns about his mental health state. There was nothing to suggest that he had been missing his medication and his observed behaviours suggested to staff that he did understand that medication helped him[4].

On the night of the 7th March, the MHSU was placed in the LHTT's respite home and the plan was for MHSU to be referred back to the Homeless Team and for further accommodation to be sourced for him.

[4] While resident at The Rowans the MHSU's medication would have been managed, hence missed doses would have been known about. A key activity in the Rowan's was to support residents in being consistent with their medication compliance.

On the 8th March, the Social Worker from the Homeless Team spoke with the Salvation Army Hostel and arranged for the MHSU to stay in emergency accommodation for the night of the 8th March. This same Social Worker also met with the MHSU at the LHTT respite home on the 8th March at 14.30hrs. He was informed of the arrangements with the Salvation Army at this time. He was also given his money that had been retrieved from The Rowans and his Birth Certificate. An arrangement was made with the MHSU that the Social Worker would come and meet with him on the 9th March.

The MHSU did not stay at the Salvation Army Hostel on the night of the 8th and was not there when his Social Worker attended on the 9th to meet with him.

It appears that the MHSU left Birmingham on the 8th or the 9th March, since the Birmingham Homeless Team received a call from Derby to advise that he had been held in custody for a public disorder offence and for an outstanding offence of breach of bail conditions.

Following his release on bail, the MHSU disappeared and no-one was aware of where he had gone.

The MHSU next surfaced in A&E in Bradford on the 17th March. Following assessment by the Psychiatric Liaison Nurse, he was transferred to Linfield Mount and underwent further assessment there. This assessment is reported to have revealed no signs of depression (the MHSU's stated reason for attending A&E coupled with suicidal thoughts), and no psychotic symptoms were identified. He was discharged back to the 'Stop Place' in Bradford and was also given 10mg of Diazepam due to the irritability he displayed. It is reported that the MHSU was upset by this decision as he felt he should have been admitted to hospital.

The Duty Doctor at the time made contact with the Castle Hill Unit because of concerns that the MHSU may re-present and he/she wished to know what if any action plan was in place for him.

The nurse on duty at the Castle Hill Unit at the time (1.30am 17th March) did communicate the concerns of the Linfield Mount Team to the MHSU's previous Consultant Psychiatrist (Cons 1). The position of this Consultant at the time was:

"*The situation regarding the MHSU is that his CPA care was transferred to Birmingham Psychiatric Services in January of this year, after he presented there following his release from prison. Therefore he is not currently under our responsibility. Due to his itinerant and chaotic life style, it is likely that he will continue to present to various psychiatric services and remain difficult to engage. However our own service is not under a specific responsibility at present to provide care for him. Should he re-present in Huddersfield then he would clearly need to undergo*

assessment in the usual way." Extract from correspondence from Cons 1 to the Nurse dated 18th March 2005.

Comment by the Investigation Team

The position taken at this stage was technically correct from the perspective of the operational policies and procedures for the Castle Hill Unit at the time. However, it is the opinion of the Investigation Team that the staff at the CHU could have been more proactive in:

- Ensuring that the Linfield Mount staff had the contact details of the Homeless Team in Birmingham who had last had Care Coordination responsibility for the MHSU.
- Providing the Linfield Mount staff with a comprehensive summary of the CHU's experience with the MHSU following their request for information on the 17th/18th March 2003.

Our rationale for highlighting these points is:

- The MHSU was reported by the Huddersfield Castle Hill Unit Team to be more challenging than any of their other clients when he was under their care.
- The Castle Hill Unit Team had more in depth knowledge of the MHSU than any other service he had come into contact with.
- The Castle Hill Unit Team were aware that the MHSU's risk factors increased considerably if he was not medicated.
- The Castle Hill Unit Team and in particular the MHSU's previous Care Coordinator had a track record of going beyond the basic parameters of expected reasonable practice to try and maintain effective engagement of this Service User and to ensure that other services who were, or were expected to be, in contact with him were well informed.
- It is not appropriate to apply a mainstream approach to the care and management of itinerant Mental Health Service Users. Although we appreciate that the Castle Hill Unit is a Low Secure Forensic Service, it is foreseeable that a percentage of their clients may become homeless and/or itinerant. It is essential, therefore, that their operational and clinical policies make provision for the less rigid and rule bound approach required to maximise opportunities for the continued engagement, or re-engagement, of these clients.

From the 17th March 2005, through no fault of the Mental Health Services, the MHSU essentially fell off everyone's radar until his mother came across him by chance at the Bradford Interchange on Friday the18th March 2005.

The circumstances of this meeting were purely by chance and are reported as follows:

The MHSU's mother recalls looking at a vagrant thinking it was very sad, when the young man sitting on the bench raised his head and said "Mum?".

The MHSU's mother told the Investigation Team that she immediately phoned anyone she could think of who might be able to give her son shelter for just one night, until she was able to facilitate something more permanent for him. In the event, the MHSU stayed with an acquaintance of his mother for approximately five to six weeks.

The MHSU had to leave this accommodation because of a change in his landlord's personal circumstances. We believe that the MHSU went back to the Bradford Interchange, intending to get a Night Stop bed for the first night. This, his mother recalls, was on a Saturday in April 2005. This plan did not materialise, so the MHSU phoned his mother, who picked him up and sorted out accommodation for him in a house with one other tenant.

The Investigation Team were advised that the new landlord told the MHSU's mother that, once the tenancy was up, he would probably be able to provide the MHSU with further accommodation. The MHSU's mother paid the first month's rent for her son. In her view, her son was doing very well at the time and was not unwell. This was approximately three to four weeks prior to the incident i.e. somewhere between the 23rd April and the 30th April.

In the period following his moving into new accommodation, the MHSU's mother had some concerns for his well being and suggested that he present himself at the Castle Hill Unit, where he had previously been a patient, with the purpose of obtaining an assessment and medication. It is her recollection that her son did present at the Castle Hill Unit, but that he was told to find a GP so that he could be referred back to the service in the normal way. He was not, as far as she was aware, given any medication. The MHSU's mother therefore booked him an appointment at her GP surgery. The MHSU did not attend. She therefore arranged a second appointment with the intention of taking him to the appointment. Again the MHSU did not attend. Approximately three-to-four days after his second non-attendance at the GP surgery, the incident occurred.

Note: In the period from the 3rd May to the date of the incident the MHSU's mother was aware that her son was becoming unwell. Her barometer for his levels of wellness was his behaviour towards her. For her the signs of his becoming more unwell were:

- Increasingly demanding.
- Increasingly chaotic.

- Increasingly manipulative.

- Relentless in his demands for money, food, phone cards etc.
- Wanting to come and stay with her, a situation he was very aware was impossible.

In his mother's view, her son was beginning to display all of these behaviours between the 3rd May and the date of the incident. Furthermore, it was the MHSU's mother's understanding that her son had become concerned about the sexual orientation of the other gentleman with whom he was sharing a house. He had become convinced that this gentleman was going to assault him sexually. The MHSU's mother told the Investigation Team that she believed that her son's fears were very real to him and he had voiced concerns to her on more than one occasion. She also told the Investigation Team that she had done her best to allay her son's fears and to encourage him to 'keep himself-to-himself'.

Note: The Investigation Team did not elicit any information that validated the concerns the MHSU shared with his mother about his house mate.

Comment by the Investigation Team
The Investigation Team Leader asked the MHSU's mother whether she was aware that she could have contacted the Castle Hill Unit directly and, in particular, her sons previous Care Coordinator. The response to this question was that "no she did not". Although it was, and remains, the usual practice of her son's Care Coordinator at the Castle Hill Unit to give out a business card with his contact details, she did not recall ever being provided with this.

The MHSU's mother told the Investigation Team that she did what she thought was the common sense thing in suggesting to her son that he attended the Castle Hill Unit.

What happened on the 3rd May when the MHSU presented himself at the Castle Hill Unit?
The exact sequence of events on the 3rd May remains unclear, with only one member of staff, the Court Liaison Nurse, having any recollection of having spoken with or seen the MHSU on this day.

The following is taken directly from the interview notes with this individual:

"I was just coming into the Castle Hill Unit (the CLN had been out of the Unit that morning) and saw the MHSU walking along the path near the Unit. I then became aware of the MHSU behind me at the door to CHU. The receptionist on duty advised me that the MHSU had already been told he needs to go to his GP for medication. I said to the MHSU that I understood that he had been told he needs to see his GP. I

thought the best thing I could do was to try and persuade the MHSU to do that."

The Court Liaison Nurse (CLN) told the Investigation Team that he was happy to go out and have a chat with the MHSU and did so. He thought this was the best thing to do because he was aware that the MHSU could get agitated and aggressive and believed that speaking with him outside would avoid any such behaviour.

In response to the Investigation Team's queries as to whether anyone had conducted an assessment of the MHSU, the CLN was adamant that he did not undertake any mental health assessment of the MHSU of any kind. He (the CLN) was merely passing by and reiterated the advice which he had been told had already been given to the MHSU. This being said, the CLN told the Investigation Team that he did not note anything untoward about the MHSU's behaviour and did not detect any signs of psychosis in the brief interaction he had with him.

The CLN said that the length of contact he had with the MHSU was approximately two-to-three minutes. His 'on spec impression' was that the MHSU intended to display symptoms that would be instrumental to his achieving a script for the medication he required. For example, he gave the impression of hearing a voice. However, the CLN was not convinced by his portrayal of ill health. His overriding impression was that the MHSU was intent on gaining access to medication.

In addition to the above, the Court Liaison Nurse told the Investigation Team that, at the time of his chance meeting with the MHSU, there was a member of the medical team in the corridor (Staff Grade/Acting Consultant). The Court Liaison Nurse recalls communicating with him 'at a distance' about the MHSU. His recollection is that this Doctor confirmed that the MHSU had been told that he needed to go and see his GP. What is completely unclear is who told the MHSU to attend at his GP surgery.

The Investigation Team asked the Court Liaison Nurse whether he asked the MHSU or the Staff Grade whether anyone had actually assessed him. The Court Liaison Nurse told the Investigation Team that this question had not entered into his thinking. He suggested that he probably assumed that the MHSU had been seen, hence the advice given regarding accessing a GP.

At interview, the Staff Grade on duty on the 3rd May told the Investigation Team that he did not have any recollection of the events of this day. He subsequently advised that he did not see the MHSU on the 3rd May.

Comment by the Investigation Team [1]
The account provided to the Investigation Team above differs somewhat to the content of the Trust's own Internal Investigation Report (undated). The impression given in this document is that the MHSU was

"seen by the Court Liaison Nurse, who knew him and who was under the impression that the MHSU had called previously and been advised to go to his GP as he was no longer a patient of the Service."

The Internal Investigation Report also states

"The Court Liaison Nurse was faced with a dilemma as (the MHSU) was no longer a patient of the service and he would not disclose his address and was known to be itinerant. The MHSU was not deemed to be acutely psychotic and in need of acute admission. The judgement made was to advise that he obtain medication from his GP.
The Court Liaison Nurse checked the position with the Staff Grade Psychiatrist who repeated the advice, which was relayed to the MHSU and he left."

The difference in the two accounts was discussed with the Court Liaison Nurse and the author of the Trust report, the General Manager of the Low Forensic Service. The Court Liaison Nurse was adamant that the information he provided to the Independent Investigation Team was an accurate portrayal of the events that occurred on the 3rd May 2005. He was consistent in his assertion that the Internal Investigation Report was not an accurate portrayal of what happened.

The Investigation Team explored with the General Manager for the Low Forensic Secure Service how the Trust Internal Investigation had been commissioned. It appears that an informal approach was taken to the Trust's own investigation. The information gathered by the General Manager was achieved by way of an 'around-the-table' discussion with the members of the Community Low Secure Forensic Team. This meant that the opportunity to seek the individual accounts of staff was not achieved and the opportunity for cross-checking accounts and exploring differences in these was lost. The Investigation Team places no criticism at the door of the General Manager of the Low Secure Service. He conducted the investigation in the best way he knew how and tried to be rigorous in his approach. However, it is concerning that the Trust was content for the manager of a service involved in the incident to lead such a serious untoward incident investigation. It was known and recognised in 2005 that appointing the manager of the service involved in a serious incident is not good investigation practice and rarely results in the depth of analysis that these investigations require. Furthermore, for an incident of this magnitude, one would have expected a more formal investigation process to have been employed including:

- A series of one-to-one interviews so that the information revealed could be cross-checked and validated.

- For the report to have been presented to and accepted by the Trust Board.

Note: At the time of his interview with the Independent Investigation Team, the General Manager revealed that he had been informed of the

Court Liaison Nurse's (CLN) recollections in the weeks leading to the Independent Investigation Team's interview with him. He was surprised by what the CLN had to say as he (the General Manager) had genuinely believed that the Court Liaison Nurse had been the staff member who had had the substantive contact with the MHSU on the 3rd May 2005.

In order to try and establish exactly what happened on the 3rd May 2005, the Investigation Team explored the reported sequence of events with Consultant 1. He told the Investigation Team that he was not present at the time of the incident. However, he had discussed it with the staff who had been on duty and in his view it was a difficult situation. He was of the impression that the MHSU was not willing to come on the ward to be assessed. He was also of the impression that the MHSU did not appear to be psychotic and that, therefore, there was not really the option to call the police to escort the MHSU to a place of safety. With regards to the MHSU's request for medication, Consultant 1 told the Investigation Team that he could appreciate that staff would have been reluctant to prescribe if they were not satisfied about how the medication was to be used, and if it was to be safely used. The safety of the situation was in his view paramount.

The Investigation Team also asked the Staff Grade Doctor about his recollections. This doctor was reported to be in the vicinity of the corridor on the 3rd May and was reported as having confirming to the CLN the advice given to the MHSU that he should present himself to his GP. As previously stated, this individual reported to the Investigation Team that he had no recollection of the events of the 3rd May.

The MHSU's mother was also asked if she had any recollections of anything her son had told her in the immediate period after he had left the CHU premises. The MHSU's mother told the Investigation Team that the only information she could recall was that her son told her that the CHU staff had advised him that they would call the police if he did not leave the premises. Her understanding is that her son was 'kicking off' at the time because of the CHU's refusal to give him medication. The MHSU's mother also advised the Investigation Team that it was her recollection that the main reason for her son's presentation at the CHU was to be away from his housemate.

Comment by the Investigation Team [2]
Although no member of the Low Secure Service at South West Yorkshire Mental Health Trust recalls undertaking the initial communication with the MHSU prior to the arrival of the CLN, it seems

clear that someone saw him and told him to go to his GP. It would also seem clear that, whether or not a full assessment was offered to the MHSU, no assessment of the MHSU's mental state occurred. The Investigation Team draws this conclusion because:

- The Trust's own Investigation Report makes no reference to any assessment having been offered. It communicates an assumption that one was offered when in fact it appears that the CLN had passing contact only with the MHSU.
- There is no documentation of any kind in the MHSU's records that any assessment was offered and declined. The only documentation for the 3rd May is made by the CLN, who details his concerted efforts to try and establish whether the MHSU had a GP and the whereabouts of the GP and the MHSU's current address.
- It is inconceivable to the Investigation Team that, had a professional spoken with the MHSU and offered and tried to persuade him to accept an assessment, this would not have been documented, or remembered and reported to the General Manager of the Service at the time of the Internal Investigation.

Comment by Investigation Team [3]
The Investigation Team spent some time exploring with the interviewees from the Low Secure Castle Hill Unit the rationale for not administering medication to a Service User who was:

- Known to them
- Had a diagnosis of Paranoid Schizophrenia
- Was known to be at risk of relapse if unmedicated. (Importantly his Consultant Psychiatrist between 2001 and 2004 told the Investigation team that, with antipsychotic treatment, the MHSU was capable of going into full remission of psychotic symptoms.)

All of the interviewees from the CHU were unified in the range of their concerns. These were centred on:

- A Service User they had had no contact with in eight or nine months.
- A Service User believed to be adept at manipulating the system.
- A Service User who may want the medication to sell on the street[5] (Olanzapine apparently does have a street value, especially in the prison population).

[5] This point was discussed with the MHSU's mother. It is her opinion that had her son been aware that Olanzapine had a street value then he would have stockpiled this and sold it previously. His chief motivation was money. It is her opinion therefore that he was never aware of the drug's potential for earning money.

The following are two extracts from interviews conducted:

"The MHSU pitched up in various places asking for medication and one could not be certain that his motivation was honest. At one point previously he pitched up and they gave him meds – but this was when he was in their (CHU's) care – but in this case they hadn't assessed him for eight months. Organisationally I'm not sure that it was justifiable – he wasn't their responsibility – there was no urgent need clinically for him to be given meds" "*There was* no clear evidence of thought disorder, no evidence that he was unwell – therefore no meds." (The MHSU's Care Coordinator 2003 – 2004)

The Consultant Psychiatrist to the Castle Hill Unit said:
"They (the CHU) do not act as a Crisis Team and it would not have been in their framework to give a one off small dose – quite outside normal practice in fact."

However, upon reflection he also shared that:

"The benefit of a 2 day (or short term) supply (of medication) in terms of treating his mental state would be fairly minimal – it is purely in terms of the possible 'hook' back into services that it would have some potential benefit. So I think the possible value of having prescribed to him on the final occasion (3rd May 2005) is far from clear. Staff are also very concerned about risk of prescribing in an unsafe context – he (the MHSU) refused to divulge his circumstances, and he could not be trusted to give reliable information about any other medication (including illicit drugs) etc – in the event of an untoward incident, say he had been found dead – they (the staff) would have had to account for their decision to prescribe. That being said I think we as a service need to review how best we can meet the needs of SU's (Service Users) who present chaotically in this manner, and I would accept there is something about adopting a flagging system for itinerants, and having agreed contingency plans in place."

The Investigation Team are in accord with this Consultant Psychiatrist regarding the above. However, it is also the opinion of the Investigation Team that the CHU has left itself open to a criticism of a 'lack of caring' in giving 'rule based' advice to a client whom they knew (and knew well) without conducting, or at least offering, an assessment at the time of his presentation at the CHU. Had the decision not to medicate been based on a considered assessment of the risks (i.e. the risks of medicating and the risk of not medicating), then this would have been a different matter entirely. All of the information gathered during this investigation suggests that there was no such considered assessment of the risks.

Recommendation:
Because the CHU does have clients who may become homeless and/or itinerant following their discharge from the inpatient service into accommodation arranged for them in the community, the Investigation Team believes that it is essential that the clinical and operational

policies utilised by the CHU are developed to incorporate best practice in the management of the itinerant and chaotic client. This should facilitate the ongoing optimisation of continuous service contact where possible for these individuals.

It is also important that the CHU consider how they might manage a similar occurrence as occurred with this MHSU on the 3rd May 2003 in future. A number of assumptions appear to have been made by the staff present at the CHU on this day that were not evidenced:

- Although it is accepted that the MHSU said that he was living in Bradford, his living circumstances were far from clear.
- The team did have access to the mental health teams who had last had clinical contact with the MHSU (Birmingham and Bradford.). Contact with these may have revealed useful information.
- There was a mis-perception about the MHSU's relationship with his mother.

Note: In making this recommendation, the Investigation Team is mindful that the MHSU did withhold information from the CLN at the CHU, which directly hampered any and all efforts by the CLN to facilitate contact between the MHSU and primary care or other Mental Health Services.

After the MHSU Left the Castle Hill Unit:
Once the MHSU had left the premises, the CLN's first thought was to try and find out whether the MHSU had a GP. However, his searches revealed nothing. He told the Investigation Team that he spent approximately three hours trying to locate the GP with whom the MHSU was registered. The CLN was not aware that at this time the MHSU was not registered with any GP, or that he was living in Huddersfield and not Bradford as the MHSU reported. The CLN told the Investigation Team that the main thing that hampered his efforts to determine whether or not the MHSU had a GP was the MHSU's refusal to tell him his address. The MHSU would only say that he was living in Bradford.

The only additional action the Independent Investigation Team believes the CLN could have taken was to contact the MHSU's mother to determine whether she knew her son's whereabouts. The CLN does not feel that this is an action he would have taken, as his belief was that the MSHU and his mother were not in contact. Furthermore, he believes that to have contacted her may have caused undue anxiety to her. This position is supported by the MHSU's Care Coordinator (2003 – January 2005). Although the Independent Team can appreciate the thinking behind these views, it must be remembered that the MHSU's mother did know where her son was and could have provided valuable information to the CHU staff. On balance, therefore, the Investigation

Team believes it would have been better to have contacted the MHSU's mother rather than not to contact her.

Although the Investigation Team and the CLN differ in their views, the Investigation Team does consider the actions and efforts of the CLN to present good and commendable practice.

The Events of the 18th May

Because of the MHSU's withdrawal of consent for the Investigation Team to access his records, including records held by his defence solicitors, the Investigation Team were not able to have direct access to the police investigation papers to explore the events of the 18th May as thoroughly as they would have wished. However, the MHSU's mother was able to provide a comprehensive overview of her understanding of what had occurred. Her recollections are based upon:

- speaking with her son
- speaking with her son's then landlord
- speaking with her son's defence solicitors
- attending to view the scene of the crime after the forensic team had completed their examination of it.

The Events of the Night of the 18th May 2005

On the night of the incident, the MHSU's mother understands that her son overheard his housemate talking on the phone. The content of the telephone conversation reportedly led the MHSU to believe that his housemate was going to target him sexually. This made him anxious and he went out. When he returned home, there was some lubricant gel on the table. The MHSU took one of his housemate's architectural pens and stabbed it through the tube of lubricant to give a clear message to his housemate. "No means no". He then went to his room.

The mother of the MHSU understands that when the housemate eventually returned to the house, her son was calmer, but the housemate was angry that her son had used one of his expensive pens in this way. A heated argument followed.

The MHSU's mother told the Investigation team that her son's landlord told her that, on the same night, her son's housemate called him at around 11pm. He could hear an argument in the back ground. He was apparently not unduly concerned until he heard the mention of a knife, or words to that effect. The MHSU's mother believes that the landlord asked her son's housemate where her son was. She believes the response indicated that he had gone back to his bedroom. She also believes that the landlord told her son's housemate to stay away from the MHSU and that he was coming straight over, which he did. On arrival at the house, the landlord called the police when he saw blood on the door handle to the house. On entry to the property, the MHSU's housemate was found dead in the MHSU's bedroom from multiple stab wounds, the fatal one being a stab wound to his neck.

Note: Once the Investigation Team had elicited the above, they were able to re-approach West Yorkshire Police to seek validation of what they knew. The West Yorkshire Police were able to confirm that:

- On the 18th May, late in the evening, an argument had ensued between the MHSU and his housemate, the precipitating factor being damage to the housemate's architectural pens.

- A tube of lubricant had been 'stabbed' with a pen.
- The housemate did call his landlord at 22.48hrs.
- The landlord did attend the home of the MHSU and his housemate, and that he did call the police when he saw blood on the external door handle.
- The landlord did hear the MHSU's housemate say "He's got something in his hand" and that a loud and heated argument occurred before the phone went dead.

In relation to the issue of the MHSU's allegation about his housemate's sexuality, this is completely unconfirmed. At the time of his arrest on 19th May 2005, the MHSU would not speak to the police about his motivation for his attack on his housemate, other than to say it was self defence He would not talk about his or his housemate's sexuality at all.

A subsequent discussion with the half-sister of the deceased (i.e. the housemate) revealed that he had a child from a previous girlfriend and that she (the sister) had spoken to her brother's past girlfriend on a number of occasions. Her brother had not married the mother of his child, as he believed that marriage was for life and he wanted to be sure that, when this occurred, the relationship was right for both individuals. The deceased's half-sister told the Review Team Leader that her brother had strongly held Christian beliefs and that to the best of her knowledge he was heterosexual.

Comment

On the basis of this information, it is difficult to see how any intervention from the Mental Health Services could have averted this incident. The MHSU was an individual who would have been managed in the community and not on an in-patient basis. Furthermore, there is nothing to suggest from the information provided by the MHSU's mother, and on the basis of the post incident psychiatric assessment, that the MHSU was psychotic at the time, or displayed any symptoms that would have warranted an admission under the Mental Health Act.

It is important to remember that this MHSU had a long history of carrying knives and of aggressive and violent behaviour. It was foreseeable that at some point a situation was going to arise where serious injury or a fatality could occur. Although the Mental Health Services have a responsibility in the identification and management of the risks associated with mental health disorder and its associated manifestations, the management of violence risk that is not attributable to mental health disorder is not the responsibility of the Mental Health Services. There is a social responsibility via the criminal justice system to ensure that effective deterrents are utilised when persons are arrested for the carrying of dangerous weapons, regardless of whether the individual has a mental health disorder or not. In this case, there was compelling evidence to show that the MHSU had the capacity for a level of violence and aggression that could pose a threat to others, even when he was effectively in remission from his mental health disorder.

6.3 Findings in Relation to the Terms of Reference

Collaboration, Engagement with and Communication with the Agencies Involved in the MHSU's care

It is the opinion of the Investigation Team that, between January and September 2004, the period of time where the MHSU was most mobile in terms of his whereabouts (Sheffield, Leeds, and London), his Care Coordinator from the Castle Hill Unit in Huddersfield demonstrated exemplary practice in his efforts to be informed about the MHSU's whereabouts. It is also the opinion of the Independent Investigation Team that, on a number of occasions, this Care Coordinator went further than one might ordinarily find in his efforts to provide the Mental Health Teams who came into contact with the MHSU, with as much information as he could about the history and risk factors associated with the MHSU. When the Homeless Team in Birmingham were asked about the quality of information provided, they told the Investigation Team that they had been sufficiently informed and were very satisfied with the information provided.

With regards to communications between the Castle Hill Unit staff and agencies local to Huddersfield, the information provided to the Investigation Team coupled with our analysis of the MHSU's clinical records, shows these to have been of a good standard.

The CPA documentation evidences the attendance of housing, social care and police representation at some if not all meetings. It is difficult to ascertain which agencies were invited to specific meetings and did not attend, as the CPA documentation does not make this transparent.

The progress notes also show evidence of appropriate communications with the housing services during the periods where finding accommodation for the MHSU was particularly challenging. The main period of discord between the mental health and housing services was at the end of 2003, when the MHSU was considered to have made himself intentionally homeless. It appears that he was not afforded emergency accommodation at this time, a situation his Care Coordinator was most dissatisfied about. It is, however, unclear as to why the MHSU was not considered to be vulnerable enough to require this. This issue was discussed with one of the Housing Needs Officers for Kirklees Housing. Unfortunately, the records for 2003 were not available. However, the process described by the Housing Officer leads the Investigation Team to believe that, had the MHSU's situation warranted it at the time, he would have been offered emergency accommodation for the statutory period of 28 days. Thereafter, one cannot say whether he would have been offered further permanent accommodation[6].

[6] The MHSU's Care Coordinator (2003 – 2004) continues to be dissatisfied at the treatment this particular Service User received from the housing service in Huddersfield. Unfortunately, it has not been possible to explore the situation with staff involved in housing at the time. However, many of the processes in Huddersfield have improved since 2003 and there

With specific reference to risk information sharing, this was generally of a good standard throughout the MHSU's contact with Mental Health Services.

Engagement with and Communication with the MHSU's Mother

The MHSU's mother told the Investigation Team that the initial contact she had with the Mental Health Services, when her son was admitted to hospital for the first time, was good.

The clinical records revealed that the MHSU's mother attended two CPA meetings in July and November 2001. The Moorview Hostel records also show that she was in attendance at all of the CPA meetings held in 2002. In the CPA paperwork, the input of the MHSU's mother is noted along with her concerns. In the CPA records, the MHSU's mother and his grandmother are noted to be the most significant Carer's and the two people with whom the MHSU is most responsive.

Following the MHSU's eviction from Moorview Hostel, the clinical records show that his mother did not attend any further CPA meetings. When asked about this, the MHSU's mother could not recall having been invited to any CPA meetings in 2003. The 25th September excepting, the Investigation Team have not been able to reveal any information that shows that she had been invited. The MHSU's Care Coordinator during 2003 could not recall whether or not the MHSU's mother had been invited. The impression given by this individual was that it is possible that she had not been invited, as the perception of the CHU Team was that she was uninvolved with her son at the time. Note: It was the MHSU's mother who precipitated his admission to St Luke's Hospital on the 29th October 2002. It was this admission that led to his subsequent admission to the CHU on the 19th November 2002.

The MHSU's mother told the Investigation Team:

"Had I been invited to my son's CPA meetings after 2002 I most certainly would have attended. I have attended all the review meetings I have been invited to at Rampton[7]."

In response to a question relating to how much notice she would have needed to reorganise her employment commitments, she said: "I would have needed 2-4 wks notice to attend meetings. Rampton so far has given me 12 months prior notice of each meeting"

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appears to be a real commitment to collaboration between the various public services involved in the care and management of those with mental health and housing needs.

[7] It is important for the reader of this report to appreciate that the nature of high secure hospitals such as Rampton enables them to plan CPA meetings a considerable period of time in advance. This degree of long-term planning is not possible in less secure and open care settings, owing to the lack of predictability of future events. However, one would expect families and Carer's to have at least two to three weeks notice of CPA meetings, as the time periods for the meetings are fixed well in advance, usually three to six months.

In response to a question regarding modes of communication had she not been able to make a CPA meeting, the MHSU's mother said: "Had I been given the option of telephone meetings should I not have been able to attend a meeting I was invited to, I would have gladly accommodated this. Follow up calls would have been useful to discuss any minutes taken."

It is the Investigation Team's impression that, because the MHSU was not residing with his mother and because she was unable to offer him this type of support (i.e. living accommodation), there was an assumption made by the MHSU's Care Coordinator that there was no real contact between mother and son. This we believe may have influenced her apparent non-invitation to CPA meetings.

With regards to a Carer's Assessment, there is no evidence that the MHSU's mother was offered a Carer's Assessment at any time. Given her close relationship with her son and the noted significance of her and the MHSU's Grandmother to the MHSU, the Investigation Team considers this to have been an oversight by the clinicians involved with the MHSU between 2000 and 2003, this being the period where the MHSU was located within the Huddersfield Area.

The only other contact the MHSU's mother recalls having with the Mental Health Services was when her son was evicted from his accommodation after Christmas 2003. His Care Coordinator brought the MHSU to her house on the 29th December 2003. To the best of her recollection, her son stayed with his grandmother for a few weeks after that. It was not possible for him to stay with her owing to the previous threats of violence to her husband and her son's general behaviour. (She had two small children at home.) Note: The MHSU's Care Coordinator at this time has advised the Investigation Team that the MHSU went straight to Sheffield that night and remade contact with him (the Care Coordinator) on the 31st December.

The MHSU's mother does not remember ever having been provided with any contact details for her son's mental health team, or being advised under what circumstances she could make direct contact with them.

Comment

In all of the CPA documentation between February 2002 and September 2003,[8] the MHSU's mother is listed as his next of kin and Carer. She is also identified as a person who would routinely be invited to attend CPA meetings. There is no evidence that the Independent Investigation Team has been able to elicit that suggests that the MHSU's mother was ever invited to these meetings, except on the 22nd

[8] The CPA of September 2003 was the last CPA for the MHSU before he left Huddersfield early in 2004. From this time, his whereabouts changed frequently, until his period in Pentonville Prison in September 2004. From there, he went to Birmingham and the care responsibility was transferred from Huddersfield to Birmingham.

September 2003 when the MHSU's mother was invited to an urgent CPA meeting to be held on the 25th September at midday.

While it is accepted that this CPA was 'unplanned' and therefore reasonable timescales for notification were not possible, the MHSU's mother would, at the most, have had two working days notice of the meeting. The MHSU's mothers' professional work commitments at the time would have precluded her from attending this meeting. Two days notice would not have been sufficient notice to rearrange her existing commitments.

With regards to CPA meetings generally, the Investigation Team did ask the MHSU's Care Coordinator (end 2002 – January 2005) about the MHSU's mother's attendance at CPA meetings. Understandably, given the period of time that has elapsed, he could not recall whether or not the MHSU's mother had been invited to meetings. He was only aware of her non-attendance.

In the absence of any clear information, it is difficult to be overly critical of the contacts the Mental Health Services in Huddersfield had with the MHSU's mother between the end of 2001 and the end of 2003. Furthermore, it is the recollection of the MHSU's Care Coordinator (2003 – end 2004) that the MHSU gave the mental health professionals the impression that his contact with his mother was limited. This would have influenced the rigour with which she was invited to meetings.

However, although the above is noted, the lack of an auditable communication process within the CPA paperwork is not satisfactory.

Recommendation

The Investigation Team suggests that it is made clear within the CPA paperwork:

- Those individuals who have been invited to attend CPA meetings.
- The reasons for not inviting persons who are identified on the 'to be invited to all CPA meetings' list.
- The reasons for non-attendance if known or apologies if known.

It does not seem sufficient for the CPA documentation to only identify those persons who were present or not present, without any indication of whether they were invited or not. In view of the regular contact the MHSU had with his mother and grandmother over this period, it is unlikely that he would have objected to their attendance.

Risk Assessment

It is very clear from the records that the risks associated with this MHSU were well recognised with appropriate management plans in place. Perhaps the most notable of these plans was the positive risk taking that was decided upon during the course of the MHSU's care and treatment in 2003. The nub of the clinical team's decision was that this MHSU should be managed in the community and that admissions to in-patient services should be avoided where possible.

The MHSU's then mental health team deduced from their clinical contact with him that his risk factors were escalated to an unacceptable level when he was in a contained environment and where there were prescribed boundaries of acceptable behaviour. The Investigation Team believes that the position taken by the MHSU's then clinical team was correct.

7.0 OTHER ISSUES ARISING FROM THE INVESTIGATION

The main issue that permeated most of the interviews and conversations the Investigation Team had with the mental health professionals in Huddersfield and Birmingham was that of housing for Service Users such as this one. However, the topic of the provision of Supported Living Accommodation for Mental Health Service Users who:

- have a drug habit.
- have a criminal and/or forensic history.
- push the boundaries when rules of behaviour are imposed.

was, and is, a larger and more complex issue than could be accommodated within the boundaries of this investigation.

However, the Investigation Team believes it is important that the substance of what the mental health teams shared at interview is communicated within this report, because the achievement of sustainable housing was a particular issue for the MHSU who is the subject of this report.

Huddersfield

Securing accommodation for the MHSU was challenging throughout his period of contact with Mental Health Services in Huddersfield. It is the recollection of his Care Coordinator (end 2002 – Jan 2005) that, after his eviction from Moorview Hostel, he was provided with Private Landlord and Housing Association accommodation rather than funded accommodation, because he was considered to be too high risk for the housing stock provided by Kirklees Council.

In all instances, the MHSU's tenancies usually came to an end because of problems with rent arrears or because the MHSU refused to comply with the rules associated with acceptable tenant behaviour. The final incident of eviction occurred in December 2003. The precursor to this was the MHSU's failure to open the door of his flat to the police, who had arrived to affect his arrest for an outstanding warrant. As a consequence, the police forced entry to the flat and in so doing rendered it unusable. Unfortunately, the frontage of the flat was a sealed unit which was damaged beyond repair during the entry. Although the General Manager for the CHU made funds available towards the repair of the entrance to the flat, no additional private or public funding was forthcoming to enable the necessary repairs to the MHSU's flat to be carried out. It is the recollection of the Care Coordinator that the MHSU was considered by the housing services to have made himself intentionally homeless[9]. The Investigation Team did try to follow up with Kirklees Council why this decision was made.

[9] Where individuals have been provided with accommodation and subsequently behave in a manner that jeopardises the fabric of this, or their tenancy, then an individual will be considered to have made themselves intentionally homeless. In the case of this MHSU, he did not open the door to the police, resulting in forcible entry, which rendered the flat insecure and therefore not habitable. This may be why he was deemed to have been 'intentionally homeless'.

However, the records for 2003 are no longer available[10]. It is important to note that the MHSU's Care Coordinator strongly disagreed with the decision of the then housing services not to provide emergency accommodation for the MHSU, or to repair the damage to his flat.

From a contemporary perspective, the Care Coordinator for the CHU advised the Investigation Team that he has no clients on his caseload for whom accommodation has not been secured.

The Contemporary Situation

A Housing Needs Officer for the council in Kirklees advised that, over the past few years (post 2003), he and the Housing Support Team have been trying to work more closely with the Community Mental Health Teams and other teams working with Mental Health Service Users in the area so that the system is more effective. Members of the Homeless Housing Team are invited to CPA meetings and they do attend where possible. The Housing Officer advised that, in his experience, if the nominated officer cannot attend, then it would be usual for this individual to either speak with the Care Coordinator in advance of the CPA meeting, or to nominate a colleague to attend on their behalf. The Housing Needs Officer told the Investigation Team that he receives at least half-a-dozen calls from Community Psychiatric Nurses each week.

With regards to supported housing accommodation, the Housing Needs Officer advised that in Kirklees this is predominantly provided by the voluntary sector and by housing associations. He agreed that, for Mental Health Service Users who would not, or could not, live within the rules imposed by the Landlord, then sustaining supported living accommodation was very challenging and sometimes not possible.

The Housing Needs Officer also advised that the Council has a statutory responsibility to provide accommodation for an individual for a period of 28 days from the moment the person is deemed to have made themselves intentionally homeless if the individual meets the homeless criteria. Valid criteria would be issues such as:

- The person has a diagnosed mental health illness.
- The person is considered to be vulnerable if 'on the streets'.
- It is unreasonable for the family to provide assistance owing to prevailing risk issues.
- The person needs supervision.

If there are individuals who are known to be problematic from a housing perspective (e.g. rent arrears, damage to property etc), their case

[10] It is tempting to draw a causal link between the MHSU's eviction in December 2003, his subsequent period of itinerant behaviour and the incident that occurred on the 18th May 2005. Although it is entirely possible that the situation in December 2003 could have been managed better by the Police and Kirklees Housing Department in 2003 it is difficult to say 'but for' this event the subsequent chain of events would not have occurred. Similarly it is difficult to say whether more open communications between the mental health and police services could have changed the way in which this instance of arrest was conducted.

would go to a panel that comprises of Service Managers for consideration. This panel would consider a range of issues, such as any prevailing mental ill health and the vulnerability of the individual.

If the outcome of a panel assessment is that funded accommodation cannot be offered, then the Housing Team provides assistance to the individual to secure private landlord accommodation. The assistance provided may include measures such as providing the first four weeks rent, or by securing the accommodation with a Bond Guarantee (the equivalent of four weeks rent that is redeemable at the end of the tenancy providing the accommodation is in good order).

Excepting the provision of supported accommodation for challenging Mental Health Service Users, the Investigation Team's impression is that Housing and Mental Heath Staff appear to have reasonable systems of communication to facilitate effective working relationships. The only constructive comment we have to make is that the accessibility of the Housing Needs Officers is made explicit in any South West Yorkshire Mental Health Trust clinical or operational policy targeting the care and management homeless Mental Health Service Users. For example relevant policies could state clearly the main contact number for each Housing Needs Officer.

Birmingham

The Team who raised most concern about the provision of appropriate accommodation for Service Users with complex needs were the Homeless Team in Birmingham. This is perhaps unsurprising, as it is they who are having the most contact with Mental Health Service Users such as the MHSU referred to in this report.

It is of particular concern to the Investigation Team that the good and successful efforts the Homeless Team made in 2005 to provide accommodation for this MHSU would be unlikely to occur now. The Rowan's Hostel, where the MHSU was placed, and where he was stable for a reasonable period of time, is no longer available. The Investigation Team were told by the Homeless Team in Birmingham that the needs of the residents placed at The Rowan's were considered to be too high. It is the Investigation Team's understanding, based on conversations with the Birmingham Team, that the withdrawal of funding from accommodation catering for more vulnerable persons and those that present particular challenges in the community has become an increasing problem in Birmingham.

A report compiled by the Homeless Team in November 2007 reveals that the following facilities that allowed for the 'safe and speedy assessment of those excluded from mainstream housing provision' no longer exists:

- The Trinity Night Shelter.
- The Lighthouse Mission.

- Southfields Hostel – a 24hour staffed, 12 bedded hostel designed to care for homeless people with mental health difficulties and complex needs.
- The Rowans Hostel – a 16 bed rehabilitation unit that provided a complimentary service to Southfields Hostel. Individuals from Southfields were moved to the Rowans for assessment and rehabilitation to independent living.

It appears that the creation of Supporting People (SP) Funding in 2003 has created a crisis in homeless services, as all hostels now receive their funding from SP. Initially, the criteria for funding enabled existing hostels to continue to provide the same level of service they had previously. These criteria, we are informed, have changed over the last four years and it seems that Service Providers are no longer able to provide the care and support that many individuals coming into contact with Homeless Mental Health Services need. With specific reference to 'The Rowans', when Southfields Hostel closed, 'The Rowans' was expected to take over the roles of both. However, SP funding required that it subscribe to its criteria for admission. This did create problems, as many of the clients who were referred did not meet these criteria. Consequently they were excluded from the service.

The above information is concerning as, in 2005, this was not the situation. In real terms, the Homeless Team members interviewed during this investigation told the Investigation Team that, had the MHSU who is the subject of this report, presented in Birmingham today, the Homeless Mental Health Team in Birmingham are doubtful that they would have been able to secure accommodation for him based on his prior history in Huddersfield. The likelihood is that he would have been placed in B&B accommodation, if they could place him at all. This situation seems to be wholly unsatisfactory to the Independent Investigation Team.

The Investigation Team does not believe it within their authority to make a national recommendation calling for a review of:

- how hostels such as Southfields and The Rowans are funded;
- the imposed eligibility criteria imposed by SP.

However, we do feel that the extent to which vulnerable persons with mental health and complex needs have been disadvantaged with regards to the provision of supported housing staffed by appropriately skilled staff, needs to be established. If the experience in Birmingham is shown to be replicated by other Mental Health Services working with the homeless, then socially and morally this cannot be acceptable. From a risk perspective the risks of:

- self harm;
- neglect;
- harm to others, including serious injury and/or death

can only increase if there is a lack of appropriate housing provision for the most vulnerable and needy with mental health difficulties.

8.0 ACTIONS TAKEN TO DATE

As a result of the internal analysis undertaken by Birmingham and Solihull Mental Health Trust following the incident on the 18th May 2005, and subsequent discussions with the Mental Health Services in Sheffield and Huddersfield, the Medical Director for Birmingham and Solihull (and Chair of the Royal College of Psychiatrists, West Midlands Division Medical Directors Group) initiated the development of a guideline on the sharing of information in the management of high risk and itinerant Mental Health Service Users in the UK. This guideline was presented for discussion at the West Midlands Medical Directors meeting on the 20 March 2007.

At the time of undertaking this investigation, the guideline document remained in draft format and it is probable that further extensive consultation and amendment will occur before it is completed and accepted as a national guidance document. Nevertheless, the fact that the issue of the management of complex Mental Health Service Users has been raised at the West Midlands Division Medical Directors Group can only positively raise the profile of the complexities involved in the management of this client group.

As part of the Investigation Team's work, we agreed to provide feedback on the draft guideline document. This is a follows:

The guideline currently represents a comprehensive summary of all of the key issues that may influence (positively and negatively) effective communications between Mental Health Services across the country regarding the care and management of itinerant Mental Health Service Users. It provides theoretical, policy and statutory information in relation to issues such as:

- Information Governance;
- NHS Strategic Tracing Service;
- The personal Demographics Service;
- Personal Health Records;
- The Information Spine;

Interspersed with the technical information regarding issues that can affect how health professionals may communicate, are practical issues that constitute guidance on practice.

For example:

- All Services that have managed the Service User within the previous twelve months should consider joint responsibility for the person.
- Mental Health Teams hold responsibility for patients under CPA until they have discharged them or handed over care to another mental health team.

- Earnest attempts should be made to locate Mental Health Service Users who move without providing a current contact address, if they are considered to require ongoing support.
- Where information is available, the onus is on the previous team to alert the relevant clinical or homeless team in the new area that the Service User should be sought in the new area.

There is no doubt that, within the current draft guideline, there is a wealth of useful information. However, to convert the current document into a user friendly document that will be of use at the point of care delivery, the document requires some considerable work. The authors need to be clear about the elements of content that constitute 'educational' or 'encyclopedic' data that will most usefully be placed in clearly identified appendices to the final guidance document, and those elements that truly constitute practice guidance. From the perspective of the Independent Investigation Team, it is suggested that the following be considered for inclusion in the practice guidance.

- In the current draft guidance document it is suggested that, where a Service User moves area and two mental health teams are engaged in the continuing care and management, then the team that has had most contact with the Service User should take the lead responsibility. The Investigation Team believes it would be more pragmatic for the guideline to state that, when such occasions arise, it is clearly documented in the Service User's records and by written correspondence between the two teams who is to take lead responsibility. This would a) remind teams of the need to formalise and document their agreement and b) enable them to have the flexibility to come to a workable agreement.
- That the expected standard of communications between mental health teams is clearly defined when it is known that the Service User has moved from area A to B. On the basis that a national register of Homeless Teams is available, it should be possible to define a range of global standards e.g. within 48hours of notice that a Service User has moved out of Area Y and into Area X, Area Y will provide information to Area X about the Service User.

  At a minimum this information will include
  - Name and Date of Birth if known
  - Physical Description
  - Mental Health Diagnosis
  - Medication and the amount of medication the Service User is thought to be in possession of
  - Any specific risk factors and the context of risk taking behavior and its manifestation.

Where the exact location of the Service User is not known, but it is believed that the Service User has moved into the general area of say Bradford, London, the South West or West Yorkshire, then the

guideline could specify a standard that all local Homeless Teams in the relevant geographical area are notified that a Service User about whom there is some concern has moved into their geographical area.

Any national guideline also needs to contain guidance for non-specialist Homeless Teams, who may have some itinerant Service Users on their case load, and the need for their operational policies to specifically identify discrete actions to be taken in the foreseeable circumstances that an itinerant Service User may present. For example, if there is a period of non-contact where the Service User has moved out of area and then re-presents at his/her original mental health team, what standards should apply? Should there be a national expectation that the Service User will receive the same standard of service as would be received if he/she presented to a Homeless Team?

The piece of work the Medical Director at Birmingham and Solihull Mental Health Trust has spearheaded is important, given the number of itinerant individuals with mental health illnesses. To achieve a document that is useful to practitioners and sets a common standard nationally will, we believe, require considerable dedication, but will be welcomed by mental health professionals.

9.0 CONCLUSION OF THE INVESTIGATION TEAM

This investigation has revealed that, on the whole, the care and treatment of the MHSU by all involved mental health services was of a good standard.

His Consultant Psychiatrist took care not to label him with a diagnosis of Personality Disorder, believing that that to do so could mean he would be disadvantaged in the services that may subsequently be offered.

His Care Coordinator, between the beginning of 2003 and when he was detained in HMP Pentonville, showed diligence in his efforts to maintain contact with the MHSU and also diligence in his communications with neighboring Mental Health Services when the MHSU moved into their area. Although the Investigation Team has not been able to speak with the MHSU, it does appear that his Care Coordinator was able to build an effective therapeutic relationship with him. This in itself was commendable.

When the MHSU moved to Birmingham, he received an efficient and effective service from the Homeless Team working in the city. He was placed in appropriate rehabilitative accommodation at The Rowans and was seen by the mental health team at least once a week and generally more frequently. When he eventually had his tenancy terminated, he was found immediate emergency accommodation.

When he left Birmingham on or around the 8th March 2005, the mental health professionals did not have any significant concern about his mental health state. The MHSU was considered to be stable with an engaging character.

Between 9th March 2005 and the 18th May 2005, through no failing of the Mental Health Services, the MHSU was effectively lost to the Mental Health Services bar two fleeting contacts, one on the 17th March 2005 and the other on the 3rd May 2005. The Investigation Team is of the opinion that the actions of the Psychiatric Emergency Services in March 2005 were appropriate and that their contact with the Castle Hill Unit in the early hours on the 17th represented good practice.

With respect to the MHSU's final contact with the Mental Health Service on the 3rd May 2005, the Investigation Team is of the opinion that the Castle Hill Unit (CHU) staff could have acted differently on this day. The Investigation Team believes that the MHSU should have been offered an assessment at the time of his presentation at the Unit. Although the CHU had no continuing care management responsibility for the MHSU, they were well versed in his history and the risks associated with him being unmedicated. However, the subsequent efforts to try and locate his current whereabouts (based on the information provided by the MHSU) were reasonable, though the Investigation Team remains of the

view that the potential benefit to be derived from making contact with the MHSU's mother outweighed any concern the CHU staff may have had regarding this.

In stating the above, the Investigation Team acknowledges that the MHSU in this case thwarted the efforts of the Mental Health Services in Bradford, Huddersfield and Birmingham to ensure that he was provided with effective care management, by withholding information about his accommodation whereabouts between March and May 2005. We do not know his reasoning for this but, compared to behaviours prior to March 2005, this behaviour does seem to have been out of character for him. (Previously, this MHSU openly provided information about his Care Coordinator in Huddersfield and ensured that he accessed Mental Health Services when he was in need of them.)

The Investigation Team support the view of the Consultant Psychiatrist to the Low Secure Forensic Team at the CHU that their operational policies need to be reviewed and developed to ensure that their approach and management of Service Users who become homeless and/or itinerant subsequent to their discharge from inpatient services embraces best practice in the management of this type of Service User.

With regards to the MHSU's mother, the Investigation Team does believe that the Mental Health Service did not serve her as well as it could have done. She was noted within all of the CPA paperwork as a significant person in the life of the MHSU but, during 2003, she was effectively marginalised. It is the Investigation Team's opinion that assumptions were made about her status and about the relationship between the MHSU and his mother that were incorrect. What is very clear is it was solely down to his mother that the MHSU found accommodation upon his return to Bradford and Huddersfield in March 2005. It is unfortunate that this lady did not realise that she could have contacted the mental health service directly about her son over the March to May 2005 period.

Although the MHSU's mother would have been able to advise the Castle Hill Unit of her son's whereabouts and circumstances, it is by no means certain that his previous clinical team and, in particular, his Care Coordinator, would have been able to successfully re-engage the MHSU. His reported behaviour in the weeks preceding the incident are not suggestive of an individual willing to engage. However, there will always be a question in the mind of the MHSU's mother and the family of the victim, regarding the possibility that re-engagement may have occurred and that this may have resulted in the MHSU's re-medication and potential reduction in his concerns with regard to his housemate.

Whether or not such re-engagement would have avoided the circumstances of the 18th May 2005 it is impossible to say.

What is clear is that this MHSU was a persistent risk to himself and others by virtue of his predilection for carrying weapons and his

tendency to aggressive and violent outbursts. What is also clear is that, on the 19th May, the day after the incident, the clinical records show that he was assessed in police custody by the acting Consultant Psychiatrist to the CHU, an approved social worker (ASW) and his previous Care Coordinator (end 2002 – Jan 2005). This assessment revealed no evidence of thought disorder. Furthermore, the MHSU denied any abnormality of perception and did not appear hallucinated. His cognitive function also appeared grossly intact. The consensus opinion of all three professionals involved in the assessment was that there was no evidence that this MHSU was suffering from a mental illness that would warrant detention in hospital under the Mental Health Act 1983. Although noted not to be himself, the MHSU's presentation was, in the opinion of those present, in keeping with a reaction to the circumstances he was in.

10.0 RECOMMENDATIONS

There are three recommendations arising from the Independent Investigation Team's analysis of the care and management of this MHSU.

Note: Although these recommendations are specifically targeted at the development of systems and processes in South West Yorkshire Mental Health Trust, it is expected that Birmingham and Solihull Mental Health Trust will benchmark their own internal systems and processes against these recommendations and make appropriate adjustments to these where gaps are identified.

Furthermore, it is expected that the Medical Director for Birmingham and Solihull Mental Health Trust will continue to progress the development of a National Guideline for the Care and Management of Homeless/Itinerant Mental Health Service Users and that he will take note of the comments made in Section 8 (page 32) of this report.

Finally, although the Investigation Team has made no recommendation about the provision of supported accommodation for Mental Health Service Users with complex needs, we are concerned about the reported demise of the supported housing stock in Birmingham since the inception of Supporting People[11]. Clearly, a piece of survey work is required to assess whether or not this reduction in provision is indicative of a pattern that has been experienced nationally across Mental Health Services. If it can be shown quantifiably that there has been a reduction in supported housing for Mental Health Service Users with complex needs and that their mental health recovery has been jeopardised as a result of this, then it will be important that actions are taken at a national level to address this. The Investigation Team suggests that the Strategic Health Authority and the Chief Executives, Medical and Nursing Directors for South West Yorkshire Mental Health NHS Trust and Birmingham and Solihull Mental Health Trust are best placed to decide how such a survey could be initiated.

[11] Please note that the Housing Officer also confirmed that supported accommodation for persons with mental health disorder and complex needs was also insufficient in Huddersfield.

Recommendation 1:
Because South West Yorkshire NHS Trust does not have a specialist Homeless Mental Health Team, it needs to ensure that all of its Adult Services have clear and consistent guidance on the care and treatment of itinerant and/or homeless Service Users that meets the standards of care and service that would be provided by a dedicated Homeless Mental Health Team.

On the 3rd May 2005, when the MHSU self-presented at the Castle Hill Unit Low Secure Team premises, he was told to seek the input of his GP with regards to medication. This advice was commensurate with the operational procedures in place within the Low Secure Forensic Unit at the time. However, these procedures did not and do not accommodate the less rigid approach mental health providers often need to take in the engagement of mental health service users who are, or become, difficult to engage, itinerant, or homeless.

Although the Independent Investigation Team is not convinced that, had the MHSU been assessed and medicated on the 5th May 2005, he would have subsequently positively engaged with the service, or that the subsequent incident on the 18th May would have been prevented, assessment would have provided more opportunity for engagement than sending him to a GP would have done. Furthermore, the CHU staff were much better placed to undertake an assessment of the MHSU and to determine his medication needs than a GP would have been.

In determining what guidance needs to be included in each Community Mental Health Team's Operational Policy and in the Operational Policy for community based Forensic Teams, the Investigation Team suggest that the following activities occur:

- The formation of a practice guidance development group.
- A review of any existing guidance on the care and management of homeless and itinerant mental health service users within the Trust.
- The collection of the policies and procedures in place in neighboring Mental Health Trusts and Birmingham and Solihull City Homeless team to enable a structured exploration of what approaches might be suitable i.e. achievable, within a Community Mental Health Team and within the context of the delivery of community based forensic services.
- A review of the Draft Guidance on "Sharing of Information in the Management of High Risk, Itinerant Mental Health Service Users in the UK" to ensure that any practical guidance is incorporated where practicable within a community team's operational policies

The Investigation Team also suggests that any practice guidance includes prompts on useful contacts when trying to locate a known itinerant Service User who is known to be back 'in area'. The reason we suggest this is that, had any contact been made with the MHSU's mother between the 18th March and the 18th May, then the Low Secure Community Team at the Castle Hill Unit would have found out the MHSU's location and would have been given a detailed overview of his behaviours at the time by his mother.

Target Audience:

The Assistant Director for AWA

The Governance Committee and Service Delivery Groups for Adult, OPS, PLD and Forensic at South West Yorkshire Mental Health Trust

Recommendation 2:
The Investigation Team recommends that South West Yorkshire Mental Health Trust undertake an analysis of its CPA paperwork, and the way in which carer's, families and external agencies are invited to CPA meetings and the transparency of the audit trail surrounding this.

This investigation has revealed that CPA reviews were held regularly to enable a full review of the care and treatment of the MHSU. The list of persons who were to be regularly invited was comprehensive and represented an inclusive process, which is good practice. There were also a number of meetings where the attendance of external agencies to the Mental Health Trust was in evidence, including representation from housing and the local police force. This is commendable.

In the initial years of the MHSU's contacts with the Mental Health Services, notably 2001 and 2002, there is also evidence of the attendance of the MHSU's mother at CPA meetings.

However, the most challenging period of the MHSU's care (end 2002 - 2004) evidences no attendance of the MHSU's mother save for one occasion. Furthermore, the emergency CPA in September 2002 excepting, there is no evidence to suggest that she was invited to CPA meetings. The MHSU's mother has clearly communicated to the Investigation Team that, had she been invited, then she would have made every effort to attend.

The Investigation Team therefore suggests that it is made clear within the CPA paperwork:

- Those individuals who have been invited to attend CPA meetings.
- The reasons for not inviting persons who are identified on the 'to be invited to all CPA meetings' list.
- The reasons for non attendance if known or apologies if known.

It does not seem sufficient for the CPA document to only identify those persons who were present or not present, without any indication of whether they were invited or not.

Furthermore, as an integral component of the CPA, the Independent Investigation Team suggests that consideration is given to including the following as defined options for engaging with families and carers as integral and auditable components of the local approach to CPA:

- Where the Service User is agreeable to the presence of family members and/or carer at CPA meetings, but the named family members and/or carer is not able to attend the

planned CPA meeting, then they are given the option of a separate face-to-face or telephone meeting with the Service User's Care Coordinator. This will enable them to share any concerns or views they have, so that they can be shared at the CPA meeting.

- That the family member and/or carer who is not able to attend a CPA meeting is offered the option of a post CPA meeting debrief, so that they are fully appraised of changes in the care management plan, issues they need to be aware of, and issues they, with the agreement of the Service User, can usefully alert the mental health team to.
- That express consent is sought from the Service User to provide named family members and/or carers with a copy of the minutes of the CPA meeting. Where consent is withheld, this must be clearly recorded on the CPA paperwork. **Note:** The status of the consent or non-consent should be checked with the Service User and notated in the records prior to each CPA meeting.
- The validity of any 'to be invited to CPA meetings' listing/register should be checked prior to each CPA meeting and checked with the Service User where possible. There should also be some way of notating the accuracy of the contact details listed for each person who is to be invited. Changes to contact details, including deletions to the list, should be fully auditable.

Note:
The Investigation Team is aware that it is suggesting activities that may not be common practice within the CPA framework. However, the purpose of Independent Homicide Investigations is to identify areas of practice and aspects of standardised systems that can be improved for the benefit of providers of services, those in receipt of services and their families. We believe that the above constitutes such improvements.

Target Audience:
The Assistant Director for AWA

The Governance Committee and Service Delivery Groups for Adult, OPS, PLD and Forensic at South West Yorkshire Mental Health Trust

It is also recommended that the Investigation Teams suggestions be shared with:
The Care Programme Approach Association
Whitecotes Lane, Walton Hospital, Chesterfield, Derbyshire. S40 3HW.
Telephone: 01246 515 975 Fax: 01246 515 976

E-mail: cpa.association@derbysmhservices.nhs.uk

RECOMMENDATION 3
South West Yorkshire Mental Health Trust ensures that, when serious mental health incidents occur, the investigation of these incidents is commensurate with expected and best practice.

The internal investigation undertaken by South West Yorkshire Mental Health Trust did not follow the accepted good practice of identifying the investigative lead as someone unconnected with the service involved in the incident scenario. Furthermore, the investigator was not provided with a clear or comprehensive terms of reference that set out clearly the boundaries and expectations of the investigation.

For future reference, South Yorkshire Mental Health Trust is encouraged to ensure that the following standards underpin the way the investigation of serious untoward incidents are commissioned:

- The lead investigator and core members of the investigation team are unconnected with the service involved in the incident. (The current Trust policy documents do not specify this.)
- For incidents such as Homicide investigations and other incidents of similar gravitas, it is suggested that the Executive Team for the Trust will formally appoint the investigative lead for all such investigations. This should not be the responsibility of the Assistant Director and General Manager for the Service.
- That the terms of reference guidance is expanded to include:
    - The identification of good practice
    - The identification of any significant care concerns that had a direct impact on the outcome of the incident
    - The identification of significant care delivery concerns that did not have an impact on the outcome of the incident
    - A causal (root cause analysis) of the significant care concerns that had a direct impact on the incident outcome.
- For patient safety incidents, the lead investigator must present the commissioners of the investigation with a project plan for the investigation, following the initial analysis of the patient record. (It is at this point that a grounded discussion about the full extent of the investigation work required can be held.)

- That expectations regarding any systems (root cause) analysis are clearly defined within the terms of reference for the investigation[12].

Note: It is important for the Trust Executive and the SHA to appreciate that a full and detailed Root Cause Analysis may take more than the eight week time scale currently set by the SHA. It is important for serious untoward incidents that there is flexibility regarding timescales and that each investigation is conducted to good project management principles.

[12] It is possible once the initial review of the clinical records and the manager's 72hr report has been received to more precisely define where a systems analysis is required. For example if the risk assessment of a client is a concern, and this has been identified by other investigations one of the terms of reference may be to 'conduct a full systems analysis of the approach to, and training of staff in the clinical risk assessment of the Trust's Service Users'. Where this degree of precision is not possible the terms of reference may simply require 'a causal analysis of each significant/critical care delivery concern identified regardless of its impact on the outcome of the incident' or 'a causal analysis of those care delivery concerns that had a direct impact on the outcome of the incident'.

APPENDIX 1 – CHRONOLOGY OF THE MHSU's CONTACTS WITH MENTAL HEALTH SERVICES

This chronology gives a comprehensive picture of the MHSU's contacts with Mental Health Services between October 2000 and the 18th May 2005. It does not, however, list every single episode of care.

Date	Chronology
11 Oct 2000	Admitted to St Luke's Hospital. Informal admission.2-day history of not sleeping, believed he had died from CO2 poisoning. Described a vision of god believed it was OK, sensed demons in other people. Believed he could slap the demons out of others but did not act on this. Precipitants believed to be smoking Cannabis and a pending court case. The arrest prior to admission was as a result of the MHSU threatening his step-father with a knife.
20 Oct 2000	The MHSU was discharged from hospital but refused follow up and failed to attend for two out patient's appointments and was subsequently discharged. **Comment:** These days the MHSU would have been referred to Early Intervention however in 2000 although there was information around Early Intervention there was no financing for the service. It is only in recent times that Early Intervention Services have become established and funded .
7 February 2001	The MHSU was referred by his GP to Psychiatric Services for CPN assessment. At this time the MHSU was in breach of his probation. The Police and his Grandmother were also contacted. The CPN however could not locate the MHSU. **Comment:** Difficulties in locating and maintaining a track of the MHSU's whereabouts was to be a persistent feature of his contact with the Mental Health Services.

Date	Chronology
12 April 2001	The MHSU was admitted to High Royds Hospital in Leeds under Section 2 of the Mental Health Act. The MHSU had been picked up by the police under a section 136. He had been living in a hostel (Seacole House) and had exposed himself to female residents and had been spitting on female residents, behaving bizarrely and acting aggressively. The MHSU was transferred on the same day to Langbarr PICU. The reason for this was he removed a knife from the ward kitchen and tried to stab his Cons Psychiatrist after section 37 leave was denied. The MHSU also attacked the ward sister of Ward 37 with a pair of scissors he had taken from the ward office.
13 July 2001 – October 2001.	The MHSU was transferred from PICU to the Castle Hill Low Secure Unit in Huddersfield. This period of the MHSU's admission was punctuated by periods of absconsion when he was on unescorted ground leave. He also displayed aggressive behaviour on a regular basis. He didn't engage well with rehabilitation activities and when he absconded he tended to go to his mother's and a friend's. Generally the MHSU was verbally abusive and rude when his behaviours are challenged for example on the 9th Oct 2001 he was challenged for stubbing his cigarettes out on the carpet. By the end of October his behaviour begins to settle. **Comment:** It is not usual for someone who is not on a forensic detention (i.e. non-part III detentions) to be placed in secure facilities. Admission to secure facilities is an indication of the level of risk that the MHSU was considered to pose to staff working in a non-secure setting. The MHSU's absconding behaviour would have made it difficult to progress his development and to give him more responsibility. Moving him to independent living would have been challenging.

Date	Chronology
October 2001 – May 2002	The MHSU's behaviours are noted to have gradually improved over this period although he remained reluctant to engage with therapeutic activity and in particular drug counselling. In February 2002 he was assessed for his suitability for Moorview Hostel, a step down facility for the CHU. He was accepted for this Hostel and discharged to this facility on the 2nd May following a two month period of graduated leave and over night stays.
4 July 2002	The MHSU was reviewed by his Consultant Psychiatrist. It was noted that: "He is failing to comply with all aspects of his care plan and refusing depot." He had no engagement with the Moorview Hostel staff, he was refusing drugs screening, and pushing the boundaries of his curfew. There was however no violence at this stage.
6 August 2002	The MHSU was thought to be drug dealing and is intimidating to staff and residents but is not thought to be showing signs of mental illness.
9 August 2002	CPA Meeting at Moorview Hostel This was attended by the MHSU, the MHSU's Consultant Psychiatrist, his Probation Officer, his Social Worker, his Community Care Officer, a representative of the Mary Seacole Project in Leeds, his CPA Care Coordinator (Moorview), the Residential Care Officer for Moorview and his mother. It was highlighted that the MHSU was "pushing boundaries in terms of his curfew order, Hostel rules and constant MISPERS (missing persons alerts) being implemented since 'the MHSU' removed his tagging device." The CPA record noted that the MHSU "has not received any structured supervision (from the Probation Service) over the last few weeks and has been verbally hostile to staff on his returns to the hostel. The Hostel has also received threatening phone calls, the content of which have consisted of verbal hostility towards staff and the MHSU." The CPA record also states that the MHSU "has been non-compliant with his medication regime for 3 months" It is also noted that "due to his breach of curfew order, the MHSU, is to attend Magistrates Court on the 23 August 2002."

Date	Chronology
9 August 2002 continued	The representative from Mary Seacole Project told those present at the CPA meeting that the MHSU had behaved in a similar way there. He was given four warnings and eventually an incident occurred that meant that staff had no choice but to give him 28 days notice. They then lost contact with him for several months until he spontaneously represented. Since then the MHSU has attended the Project periodically and has presented no management problems. All present at the meeting agreed that the MHSU presented serious management problems and that he demonstrated superficial compliance only with his treatment plan. He is noted to be predominantly angry, sullen and anti-authority. He was noted to be at risk of committing an offence but was not thought to be mentally unwell at the time. The CPA record notes that the MHSU "was quiet throughout" the meeting but stated "he would like a referral to Leeds and had resigned himself to imprisonment in his forthcoming court appearance". The MHSU and his mother were informed of the main concerns of the care team, namely: ❑ The MHSU's behaviours in the community ❑ The recent incidents ❑ The breakdown of communications with staff at the Hostel ❑ Non compliance with medication ❑ MISPERS ❑ That relapse was inevitable if the situation continued. **Comment:** The MHSU's anti-authority attitude and persistent anger and boundary pushing were constant features of his presentation even when he was in remission of his mental illness. His refusal to engage in activities that may have helped him manage his life better was a significant limiting factor on the impact the Mental Health Services could have in assisting him to have a stable life in the community.

Date	Chronology
15 August 2002	The MHSU's tenancy at Moorview Hostel was terminated as a result of his refusal to comply with the rules of residing at this facility. On discharge his CPA status was reduced from enhanced CPA to standard CPA. The main reason for the reduction in CPA status was the reduction in out-patient follow up and that the MHSU was to have the input of one professional only, his Care Coordinator. **Comment:** Although the records note that the MHSU's CPA status was to be reduced this actually did not occur. He remained on Enhanced CPA and this was appropriate.
16 October 2002	There was a CPA on this day. The MHSU did not attend this meeting, neither did his mother. However one of the action points arising was for the MHSU's then Care Coordinator to make contact with her and to inform her of the outcome of the meeting. The action plan was: ❑ Again to try and assess the mental state of the MHSU if detained by the police ❑ To liaise with relevant services if the MHSU is subject to the Criminal Justice system ❑ If arrested or detained for the CHU or Moorview to be notified. (West Yorkshire Police) The notes show that the MHSU did not attend his Out Patient Appointments in August and September. The notes also suggest that the MHSU does not attend his CPA meetings (it is unclear from his CPA paperwork whether or not he was invited). The notes do show however that there is some contact between the MHSU and probation. There is a note in the records on the 18th September 2002 to the probation officer that there is uncertainty regarding the MHSU's living circumstances. The record of the 18th October also notes that the MHSU missed one probation appointment. The plan at the end of the CPA meeting was: 1. To undertake an assessment of the MHSU if he is detained by the police for any reason 2. To continue with outpatient management and contact with probation services At this CPA Review the current whereabouts of the MHSU were not known.

Date	Chronology
29 October 2002 (Midnight)	The MHSU is admitted informally to St Luke's Hospital, Ward 1. He was referred by PenDoc (out of hours GP service) and was accompanied by his mother. He was talking bizarrely, and had been doing so for approximately four days. He also showed signs of neglect. A Mental Health Act assessment was conducted that evening however the MHSU's admission was not converted to a detention under section as he agreed to remain as an inpatient. The MHSU was recommenced on oral Clopixol but due to the side effects experienced, including raised Prolactin and a low white count, Clopixol was tailed off and stopped on the 5th Nov and Olanzapine 20mg is commenced. (an atypical medication). There was a worsening of the MHSU's behaviour after commencing on Olanzapine – prior to this his behaviour had been improving. As a result of this and non-compliance with treatment he was sectioned under Section Three of the Mental Health Act and transferred to the Castle Hill Low Secure Unit (CHU) following an urgent assessment by them.
19 November 2002	The MHSU was transferred from the general in-patient psychiatric ward to the Castle Hill Low Secure Unit (CHU). The precipitating factors were the MHSU's aggressive behaviours on the open ward and his unmanageability. His behaviour included threatening his GP, threatening to throw a brick out of the window, spitting out his medication and appearing to make a weapon out of a pool ball and a sock, setting off the fire alarm, bullying and sexually inappropriate behaviour towards others. A member of staff had also sustained a broken finger during a violent incident involving the MHSU.

Date	Chronology
19 November 2002 continued	At the time of his admission to CHU the MHSU continued to display intimidating behaviour, it was difficult to establish a rapport with him because of his posturing. However the content of his speech was appropriate. He did appear guarded but there was no evidence that he was responding to auditory hallucinations. The MHSU denied thought of self harm but did threaten to harm a couple of patients on the CHU. The MHSU showed no insight to his problems and attributed all of his issues to Cannabis use. The MHSU's medication at this time was Olanzapine 20mg and Lorazepam prn. He had had a positive drug screen on Ward 1 for Cannabis. All other blood tests were within normal limits at the time of admission to the CHU.
19 November – 10 December	The MHSU's antisocial behaviour continued with spitting, tripping staff and patients up and punching. He never showed any remorse for any of these behaviours. He also showed evidence of grandiosity and talked of being a rap star and that he had to protect his friends who he believed to be in danger. **Comment:** As mentioned previously the MHSU's antisocial behaviour was a constant issue. His Care Coordinator between the end of 2002 to his transfer to the care of the Homeless Team in Birmingham in January 2005 had this to say about him "A difficult chap with complex needs and problems. Particularly in any environment where he has a shared living environment and where he is 'rubbing up against others'. A ward environment was problematic but more so was the Hostel Environment. Q: why more so the hostel I would have thought this would have increased his sense of living space and freedom? R: "I suspect that as there was more "freedom" it was more tempting to do whatever he wanted and had more scope to break what rules there were, he had access more readily to local "dealers" etc who became problematic at the hostel, less staff made it easier for him to intimidate others. I suppose with more freedom comes more responsibility which he struggled with." This MHSU gave new meaning to the words "belligerent" and "awkward".

Date	Chronology
10 December 2002 – 14 January 2003	Between the 10th December and the end of December the MHSU continued to present as a significant management problem in the CHU with continuing evidence of delusional ideation. Since the end of December there was a gradual improvement in his presentation and behaviour. One of the triggers for his improved behaviour appeared to be the return to the MHSU of potentially hazardous items in response to sustained periods of improved behaviour. There was a reduction in the MHSU's preoccupation with ideas of evil concerning others which was suggestive that his mental state was improving. The MHSU had also begun attending the Units Gym and attending education sessions where his behaviour was reported to be appropriate. However although improvements were noted incidents of violence and aggression continued. As a result the MHSU remained on timed observations of 15minutes. On the 2nd January 2003 the MHSU was granted escorted ground leave for 15 minutes per day on the condition that there was an incident free 48hr period preceding this. Between this date and the 14th January the MHSU utilised this leave on a regular basis. His leave period was increased to 30 minutes on the 9th January 2003. It was the view of the clinical team at this time that the next step would be to secure a supported living environment for the MHSU in preparation for his eventual discharge. Chantry Housing Association were therefore contacted to ensure that this MHSU was on the waiting list. With regards to his medication this remains as Olanzapine 20mg daily. Although the MHSU is taking his medication the clinical view at this time was uncertainty regarding the MHSU's level of insight and motivation to continue with the medication in the long term.

Date	Chronology
15 January 2003 continued	At this stage it was the opinion of his Consultant Psychiatrist that: ❑ The MHSU continued to suffer from Paranoid Schizophrenia. ❑ The MHSU continued to pose a serious risk of interpersonal violence when psychotic, including the brandishing of weapons and unprovoked assaults. ❑ The MHSU remained at risk of defaulting from service contact leading to a deterioration of his mental state. ❑ That although the MHSU was no longer acutely psychotic his mental illness remained of the nature which warranted his continued treatment in hospital under detention in the interests of his own health and safety and for the protection of others.
17 January 2003 – 4th March 2003.	There was a Mental Health Review Tribunal. The outcome of this was that the MHSU's detention under Section Three of the Mental Health Act should continue. The MHSU appealed this decision and the appeal was initially timetabled for the 14th February and then rearranged for the 4th March 2003. The outcome of the appeal was that the order for detention should remain in place. Clinically the MHSU's presentation and behaviours remained largely unchanged over this period. The CPA Review Meeting of the 6th February which was attended by the MHSU identified the following: ❑ That the MHSU had issues with the visiting restrictions and his escorted ground leave. ❑ That the MHSU agreed to continue with his medication. ❑ That participating in Anger Management sessions had been suggested to the MHSU who said he would "try it and see how it goes" but that he didn't think it would do any good. ❑ Housing reported that there was no chance of the MHSU being given council accommodation because of his track record and that supported housing may not be appropriate because of the MHSU's lack of willingness to cooperate with a support worker. Private Landlord Housing was considered by housing to be the best option.

Date	Chronology
March 2003 – May 2003	The MHSU's mental state remained relatively stable over this period. He is compliant with medication which remains at Olanzapine 10mg daily. The MHSU has continued to demonstrate a diverse range of interactions with staff members. With OTR and Out Reach staff he demonstrated consistently good interactions and tended to participate well in activities with no management problems being experienced. Within the contained in-patient setting however he continued to present with irritability and hostility towards the nursing staff with some episodes of assaultative behaviour. This continued until he was granted extended leave on the 17th April. Between 6th March 2003 and the 10th April 2003 there were nine significant incidents. All of these occurred during a phase of pre-discharge planning when the MHSU was aware of the steps being taken to discharge him to his own accommodation. It was also noted that as the day of discharge approached his behaviour towards the nursing staff escalated. These behaviours indicated that a discharge from detention form the Mental health Act would be premature as there was a real risk that the MHSU would not comply with voluntary arrangements for his aftercare if discharged. However, the firmly held view of the clinical team was that the MHSU needed to be moved from the acute ward setting to his own accommodation but remain on detention. The initial plan to achieving this was to continue with extended leave until the MHSU demonstrates a willingness to comply voluntarily with aftercare arrangements. The care plan was therefore for the MHSU: ❑ To attend the weekly Multidisciplinary Team ward round ❑ To comply with meeting arrangements as arranged by the community team staff ❑ To remain compliant with medication ❑ To abstain from illicit substances and to provide a urine specimen following attendance at the weekly ward round In addition to the above the MHSU was to be actively encouraged to continue attending OT activities even though he had declined to since commencing extended leave.

Date	Chronology
March 2003 – May 2003 continued	**Note 1:** Following the granting of extended leave on the 17th April the MHSU complied well with meeting arrangements. He had accrued some rental arrears but this was being addressed. He attended for his CPA on the 1st May. He also attended the ward round on the 8th May 2003. **Note2:** Although the MHSU was utilising fully his extended leave and residing at his own address (14th April 2003) the risk of his not complying with treatment remained such that a discharge from his detention could not be recommended at this time. **Comment:** The strategy regarding extended section 117 leave was a risky strategy but our review of the notes suggests that it was not a reckless decision and that the clinical team were very aware of the risks this MHSU presented. The Investigation team discussed the MHSU's behaviours at interview with his Consultant Psychiatrist (2001 – 2004) and the clinical teams rationale for managing him in the community setting: "He (the MHSU) coped very poorly with communal environments and the ground rules/restrictions associated with them. As you know he had a history of eviction from numerous hostels. While illness may have had a role in some of this he also displayed a consistently antisocial/antiauthoritarian attitude such that even when in apparent full remission (e.g. while at Moorview hostel) he posed major management problems. This was also evident on the ward e.g. frequent confrontations with staff, importing of cannabis, and would not engage in therapeutic activities. Once in remission of active illness there was no benefit in attempting hospital based rehabilitation, if anything it became counter-productive."

Date	Chronology
15 May 2003 - 18 September 2003	The MHSU remained on extended leave at his home address. A review of the weekly review summaries reveal that largely this period is uneventful. There are some incidents, that was to be expected, but the documentation shows that the greatest concern was the MHSU's continuing rent arrears that was posing a real threat to him being able to stay at his accommodation. There is however a change in the week commencing the 7th September with the MHSU found in possession of a knife on the 11th. The reason was stated as self defence. On the 13th September he sprayed the contents of a 'pop' bottle over the car of an ex. member of staff. **Note:** In the past the carrying of weapons had been established as an indicator that the MHSU's mental state has relapsed. This is clearly noted in the weekly nursing summary of the 18th September.
20 September – 7 November 2003	On the 21st September the MHSU attended CHU to see his Consultant Psychiatrist about the imminent eviction from his address. Because the reason for eviction was non-payment of his rent the stance of the Housing Department was that Housing is not obliged to find him somewhere to live. Because of this on the 26th September the MHSU was readmitted to the CHU to prevent any possible deterioration in his mental state. The MHSU is also removed from his section of the Mental Health Act around this time as there are no longer grounds to hold him on this – he is treatment compliant and there is no evidence of mental illness. He is/was therefore a guest on the Forensic Unit on an informal basis until accommodation can/could be sorted out for him. The Independent Team's analysis of the nursing records shows that staff did try and accommodate his needs as far as they were able to and in a way that would minimise the risk of altercations with him. Unsurprisingly however as on previous in-patient episodes his behaviour towards staff did deteriorate and his habit of boundary pushing re-emerged.

Date	Chronology
9 November 2003	The MHSU presents at Bradford A&E complaining of hallucinations. He is discharged from A&E and advised to contact his community team. The Investigation Team believes that this action was appropriate.
27 November 2003	There is a CPA meeting where it ~~is~~ was/had been noted that accommodation has been found for the MHSU and that he moved in on the 17th November. The MHSU is discharged from the CHU on this date.
19 December 2003	The MHSU did not attend his out patient appointment. He had been arrested on a warrant for failing to appear at court. He was released on bail.
29 December 2003	The MHSU failed to attend a court summons on the 29th.
2 January 2004	The police attended at the home of the MHSU with a warrant for his arrest. He did not answer the door and the police exercised their right of forced entry. This unfortunately rendered the flat uninhabitable as the double glazed door frame was completely destroyed resulting in the flat needing to be boarded up. The MHSU was released on bail the same day. Accommodation was arranged for the night with the salvation army but owing to his aggressive behaviour this did not materialise. The MHSU was effectively homeless again. **Note:** The incident on the 2nd January marked the start of a significant period of itinerant behaviour in the MHSU. Up until this point he had physically based himself within the Huddersfield, Bradford and Leeds areas where it was relatively easy for his Care Coordinator to maintain tabs on him.
9 January 2004	The MHSU went to stay with his Aunt in London for a few weeks. The MHSU's mother told the Investigation Team that he had not initially gone there with the intention of staying. She also told the Investigation team that his Aunt would have put him up for longer but that this was not possible owing to the size of her home, her commitments to her children and the fact that the MHSU was a financial drain on her.

Date	Chronology
22 January 2004	The MHSU was now in Sheffield. He did not attend the CHU on this day for the preparation of his Psychiatric Report for the Court and he also failed to attend Court on this day. A warrant was therefore issued for his arrest.
4 February 2002	The MHSU remained in Sheffield for approximately four weeks. The MHSU was initiating twice weekly telephone contact with his Care Coordinator at the CHU during this period.
17 February 2004	The MHSU is now known to be in London. He had again failed to attend the CHU for the preparation of his psychiatric report. He was now in breach of his bail conditions. He remained in contact with his Care Coordinator at CHU.
1 March 2004	The MHSU reports having a permanent address although he will not divulge this. He remained in close telephone contact with his Care Coordinator and had a month's supply of medication. He remained reluctant to appear in court even though he was due to do so.
31 March 2004	The MHSU has not been in contact with his Care Coordinator or anyone else at CHU for three weeks. This lack of contact marks a change in the MHSU's contact with the service. Although he had not been in physical contact he had always maintained regular telephone contact. During this time the Huddersfield Team were refused information regarding the MHSU's potential whereabouts by Police and Probation on data protection grounds. A GP makes contact with one of the MHSU's Support Workers but does not leave contact details. It appears that the GP is providing medication for MHSU.
19 April 2004	The MHSU remained out of contact with the CHU team. It seems that he was permanently residing in Sheffield. CHU therefore made a referral to the **HAST Team** in Sheffield.

Date	Chronology
21 April 2004	The MHSU was arrested in Sheffield and taken to Huddersfield owing to outstanding arrest warrant. His CHU Care Coordinator saw him in the cells. The Care Coordinators assessment and impression was that the MHSU was well mentally. He denied taking much Cannabis and says he is taking his Olanzapine as prescribed. The MHSU is given bail to his permanent address. He is to reappear in court on the 11 May.
30 April 2004	A date is agreed with the Sheffield Care Team to formally accept the MHSU on to their caseload from the CHU Team in Huddersfield. This date is the 25th May. In the interim period it is agreed that they will jointly manage the MHSU.
10-11 May 2005	The MHSU is arrested following the theft of a mobile phone. He is admitted to hospital on Section 3 of the Mental Health Act. It appears that he was detained in Sheffield and then transferred to a private PICU managed by the Signet Group.
2 June 2004	The MHSU was discharged from the Cygnet Unit back to Stanage Ward in Sheffield. The plan is for him to remain on Stanage Ward until he is seen by the Assertive Outreach Team on the 17th. On the 18th June the MHSU leaves the ward and Sheffield. He goes to Leeds.
29 June 2004 – 3 July 2004	The MHSU is not registered with GP in Leeds and therefore local services will not take him on. On 2nd July the MHSU registered with a Leeds GP. On the 3rd July - a telephone call received by his Care Coordinator with the Assertive Outreach Team in Sheffield. It advised that the MHSU had been caught with 3 young women in his room. (We do not know who made the communication). The inference in the clinical records is that these girls were below the age of consent. This member of staff liaises with the Leeds Services and the Sector 7& 8 CMHT agree to take the MHSU's case.
9 August 2004 – 16 August 2004	Somehow the MHSU ended up in Wembley and was admitted under Section 2 of the Mental Health Act. He was transferred back to Sheffield on the 12 August. He was subsequently discharged from Stanage Ward on the 16th August in absentia.

Date	Chronology
16 August 2004	The AORT Care Coordinator (Sheffield) receives a call advising that the MHSU is in Westminster City Council Homeless Team. On the 19th August this Care Coordinator received a call from the MHSU's previous Care Coordinator at the CHU (Huddersfield) to say that the MHSU was now back there. Huddersfield confirmed that they would again provide care for the MHSU.
7 September 2004	The MHSU is now in Bradford. Huddersfield (CHU) inform Sheffield AORT that he is again on the move and his last known location.
15 September 2004	The MHSU assaults a lady trying to steal her mobile phone in London. He is arrested and subsequently assessed by the North London Forensic Service on the 21st September. The record of the assessment shows that it was well informed historically. The outcome of this assessment was an opinion and recommendation of: ❑ That the MHSU has a diagnosis of Paranoid Schizophrenia and that in the past drug misuse has played a large part in the deterioration of his mental health. ❑ That on the basis of the assessment undertaken on the 21 September the MHSU is not psychotic at this time but does show characteristics consistent with a diagnosis of dissocial personality disorder. He is easily irritated and has a low threshold for physical violence. He shows marked disregard for social norms and a failure to learn from previous experiences. ❑ The Assessing Team did not feel that a hospital admission was indicated. However if a custodial sentence were issued it was recommended that his community psychiatric team should be informed of his whereabouts. ❑ The MHSU is fit to plead and to stand trial.
19 September 2004	It is recognised/noted that the MHSU had left Bradford following the destruction of his accommodation on the 13th.

Date	Chronology
29 September 2004	The AORT Team in Sheffield are informed that the MHSU has received a custodial sentence and is in Pentonville Prison. He estimated release date is the 30 December 2004.
30 December 2004	The MHSU is released from Pentonville and it is reported that he has no intentions of returning to Yorkshire.
CRITICAL PERIOD IN TIMELINE JANUARY 2005 TO MAY 2005	
4 January 2005	The Huddersfield community records note that the Housing in Staff in Birmingham ask for assistance with the MHSU. He has been in a Salvation Army Hostel but is not welcome back because of his intimidating behaviour. Information re. history and risk history faxed to Birmingham and advised that although Huddersfield Mental Health Services remain available to support the MHSU there is no accommodation for him in Huddersfield – he has exhausted his options there.
10 January 2005	The MHSU is assessed by a social worker and ASW with the city's Homeless Team. The clinical record reveals good knowledge of and insight in to the MHSU's risk factors. The MHSU was placed in an emergency bed at the BCM (? full name of Hostel). The plan was for the CMHT for the Homeless to continue with his assessment. That same morning the social worker spoke with staff at BCM who agreed to offer the MHSU permanent accommodation until alternative accommodation could be arranged.
20 January 2005	The MHSU was asked to leave the BCM hostel for smoking Cannabis on the premises. He presented at the Homeless Services and an emergency Salvation Army bed was secured for him for one night. At 15.50hrs the CPN for the Homeless Team made contact with the Rowans (a supported living hostel) and negotiated a bed for him there. It was reiterated to the MHSU that substance misuse will not be tolerated at all on the premises. The plan is for the MHSU to have an assessment with the Consultant Psychiatrist attached to the Rowans the following week.
25 January 2005	The MHSU is assessed. (The assessment by the Consultant Psychiatrist was appropriate and the amount written suggests that a good period of time was spent with the MHSU. However the record is difficult to read.) On this same day care is formally transferred from the CHU in Huddersfield to the Homeless Team in Birmingham.

Date	Chronology
26 January 2005 – 24 February 2005	This period is relatively uneventful. The MHSU is stable at the Rowan's. There are concerns that he is using Cannabis and he receives a number of warnings that his continued use could jeopardise his tenancy at the Rowans. On the 11th February the MHSU indicates that he would like to stay in Birmingham. The Resettlement Officer organises the application for supported housing. By the 23rd February the MHSU is keen to leave the Rowans and for his own accommodation. On the 24th February a visit is arranged for the MHSU to visit 'Future Housing'. The visit date is the 1st March.
1 March 2005	The police are called to the Rowans as a fight has erupted between the MHSU and another resident. It appears that the MHSU is now unhappy at the Rowans and is 'desperate to move out.' On this same day the MHSU was taken to view accommodation, he likes it and the accommodation is accepted.
4 March 2005	The MHSU is pushing the boundaries at the day centre, bursting balloons with his lighter. The Day Centre staff have also been informed by the Rowans that a package of Cannabis was found in the MHSU's room. They will be contacting the police and asking the MHSU to leave. **Comment:** The Investigation Team was informed by the Homeless Team in Birmingham that the MHSU was popular with the staff at the Rowans. His length of stay without serious incident was remarkable for their client group, and the staff at the Rowans had been relatively lenient with the MHSU because a) they liked him and b) because of his buoyant nature. They told the Investigation Team that although they were aware of the difficulties the MHSU had presented to the CHU in Huddersfield their experience of him was good, compared to a) their expectations of him and b) the behaviours they experience with other homeless clients. This MHSU was in many respects the least of their worry and concern on their caseload. He certainly was not remarkable in terms of his challenging behaviours.

Date	Chronology
7 March 2005	It appears that the MHSU returned to the Rowans and beat another resident up; consequently the MHSU was barred from the Rowans. The Resettlement Officer collected all of the MHSU's belongings from the Rowan's. The MHSU spent the night of the 7th in the Ladywood Home Treatment Teams respite home. They were to refer him back to the Homeless Team the following day.
8 March 2005	The social worker for the Homeless Team arranged for the MHSU to stay at the Salvation Army Hostel for the night. She also went to meet with the MHSU at the Home Treatment Teams Respite Home. She informed him of the arrangements she had made. She also gave the MHSU all of his money and his birth certificate. She made arrangements to see him again at the Salvation Army Hostel on the 9th.
10 March 2005	The MHSU did not stay at the Salvation Army Hostel on the 8th. The Social Worker at the Birmingham Homeless Team received notification on the 10th that the MHSU 'had been in custody in Derby for a public order offence and an outstanding offence of breach of his bail conditions'. He has since left Derby and has not been seen since.
17 March 2005	The MHSU presented at A&E in Bradford, he was subsequently assessed by the Psychiatric Team at Linfield Mount and discharged.
18 March 2005	The MHSU's mother came across him at the Bradford Interchange (train station) and arranged accommodation for him. On this same day the MHSU's previous Consultant Psychiatrist in the CHU in Huddersfield wrote to one of the in-patient nurses advising her that they did not have a specific duty towards the MHSU as his care had been transferred to the Birmingham Team on the 25th January. To his knowledge the MHSU was not residing in the area and the care management remained Birmingham's responsibility. The letter also says that if the MHSU were to represent then he would be assessed in the normal way. (Note the intention of this correspondence was to advise the Nurse that Care Coordinator responsibility had been transferred and that Care Coordination was no longer their responsibility. The letter was not intended to suggest in any way that the Forensic Service had no duty towards the MHSU.)

Date	Chronology
21 March 2005	There is some communication between Birmingham and the CHU in Huddersfield. It is our impression from the Team in Birmingham that there were a number of missed communications with the CHU team with messages being left on answer phones. There was no formal transfer of care from Birmingham to the CHU from Huddersfield. The primary reason for this appears to have been because the MHSU's whereabouts were not known.
12 April 2005	The Birmingham Homeless Team records reveal that the MHSU had been in contact with them and advised that he had left Birmingham and would not be coming back. He told them he was in the Yorkshire area but would not say where.
(18 March to the 5th May)	Based on the testimony of his mother, to all intents and purposes it appears that the MHSU was relatively well and stable for the six to eight weeks following her chance meeting with him in Bradford Interchange. Over this period the MHSU experienced one change in accommodation but with the assistance of his mother he secured private rented accommodation.
5 May 2005	The MHSU self presented to the CHU (Huddersfield) in search of medication. He was advised to see his GP so that he could be assessed and re-referred if necessary in the normal way. At this time the CHU had had no contact with the MHSU for approximately eight months.
5 May – 16 May 2005	In spite of his mother's best efforts to facilitate the attendance of the MHSU at a GP surgery he did not do this. The last attempt was on the Monday on the 16th May when the MHSU's mother had offered to accompany him to the GP surgery. The MHSU did not meet his mother at the pre-arranged time and so missed his appointment.
18 May 2005	The events of this day are not entirely clear. However what is clear that an altercation did occur between the MHSU and his housemate. The end result of this was that the housemate died from multiple stab wounds, the most critical being a stab wound to his neck. The MHSU is arrested on suspicion of murder.

APPENDIX 2- A SUMMARY OF THE MHSU'S VIOLENT INCIDENTS AS RECORDED IN HIS CLINICAL RECORDS

Date	Offence	Outcome
Recorded Incidents 2000		
February	Abusive and threatening behaviour	Conditional discharge
February	Threatened his Step-father with a knife	
April	Abusive and threatening behaviour	Conditional discharge
11 October	Threatened staff while an inpatient	
December	Threatened his Step-Father with a knife	
Recorded Incidents 2001		
12 April	Tried to stab a member of the medical team with a Knife	
April	Tried to stab the Ward Manager with scissors	
April	Took out a craft knife and threatened to gouge out the eyes of anyone who came near	
5 June	Secreted a knife about his person - ? with what purpose	
June	A report states that the MHSU is "regularly armed with Stanley Knife"	
26 July	A report mentions the MHSU hitting a Bus Driver with the blunt end of a Stanley Knife	
15 October	Attempted to hit staff	
Recorded Incidents 2002		
30 January	Attacked another patient	
31 January	A risk note mentions that the MHSU brandishes weapons	
15 August 2002	Escalating risk to staff and other residents at Mary Seacole House	Banned from supported accommodation placement
18 November 2002	Picked up a brick and threatened people	
28 November 2002	The nursing report notes "lots of assaults and threats"	

Date	Offence	Outcome
Recorded Incidents 2003		
9 January	MHSU puts a 'pool ball' in a sock (?motive)	
31 January	Threatens to seriously harm female staff	
3 February	Records note that the MHSU says "Just wait 'til you get outside" to a staff member	
7 February	Tried to punch staff``	
8 February	Kicked Staff	
12 February	Incited patients to attack staff	
17 February	Attempted an assault on a female member of staff	
3 March	MHSU said he would kill a nurse	
30 March	Secluded due to violent and threatening behaviour	
3 April	Secluded due to violent and threatening behaviour and threatened to shoot staff	
4 April	MHSU said he would 'get nurse'	
10 April	Threatened to kill staff when he was discharged	
22 April	Threat to throw a brick at his Consultant Psychiatrist's car	
26 June	Threatening and abusive to a Taxi Driver	
11 September	In possession of a knife when seen by his Consultant Psychiatrist	
20 September	Attempted to assault staff. Also reported to be verbally and physically abusive on several occasions.	
1 October	Attempted to head-butt a nurse	
October 2003	Threatened a gentleman's wife with scissors.	An injunction followed this threat.
8 October	Guidelines issued to staff on how to manage the MHSU's aggression.	
16 October	A 6 inch pair of scissors were found in the MHSU's room.	
18 October	The MHSU refused to be searched. A nurse was superficially injured in the subsequent struggle.	

Date	Offence	Outcome
2003 continues		
23 October	Scissors were found in the MHSU's bedroom.	
25 October	Attempted assault on the night staff – kicking, punching, and biting.	
5 November	Grabbed a nurse by the throat.	
7 November	The Castle Hill Unit is "no longer prepared to put its staff at risk"	
27 November	Attacked staff – punching and kicking	
30 November	Kicked door, a nurse's finger was trapped and fractured.	
1 December	MHSU was stopped by the police in possession of a kitchen knife.	
2004 Recorded Incidents in the records		
10 February	Intimidating behaviour at Salvation Army Hostel.	Evicted from Hostel
7 May	Intimidating people	Admitted under Section 2 of the Mental Health Act.
12 May	Threatening towards staff.	
15 September	Stole a mobile phone and chased a woman but the public and police intervened.	
None recorded for 2005. This was to be expected given the lack of substantive contact with the Services March – May 2005, and his period of time in Birmingham January – March 2005.		

In addition to the above it is known from the pre-sentencing report prepared on the 21 September 2003 that the MHSU had 13 previous convictions for 17 offences. These included:

Year	Nature of Offence	Number of offences
2000	Offences against the person	1
2000	Fraud and kindred offences	1
2000	Public Order offences	2
2000 - 2002	Drug Offences	2
2000 - 21 September 2004	Theft and kindred offences	5
2000- 21 September 2004	Offences relating to the police, courts , prisons	5
2004	Firearms, shotguns, offensive weapons	1