



An independent review of the care and treatment received by a mental health service user (Mr RS) from Sussex Partnership NHS Foundation Trust.

October 2016

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1 Acknowledgements

From the outset of this independent review the panel were aware of the grief, trauma and anxiety suffered by all the family and two previous partners of Mr RS, the mothers of his children. The independent review panel extend their condolences to his family and former partners.

The independent review panel would like to thank all participants in this inquiry who assisted the independent panel in gaining a better understanding of the pertinent issues in this case.

The independent review panel interviewed staff of the Sussex Partnership NHS Foundation Trust who were involved in the assessment, care and treatment of Mr RS, including one who has moved on from the Trust to work in primary care. This report is informed by their helpful contributions and the independent panel are most appreciative of their willingness to be interviewed and to provide information and their views openly and honestly.

The independent review panel wish to record particular thanks to those who worked hard to ensure that effective liaison took place, who made records and documents available to the independent panel, and who helped to arrange interviews.

The independent review panel are grateful to the internal review team from Sussex Partnership NHS Foundation Trust who compiled the report which provided the springboard for the review.

These contributions resulted in a comprehensive review of the issues raised in this case, which gives the Trust Board an understanding of the context of this homicide, and provides them with contemporary information on which additional recommendations were made.

The independent review panel greatly appreciate the contribution of family members of Mr RS who included relatives of the victim of the homicide, one of who was also victim of a serious assault, and two former partners, the mothers of his children.

Finally, the independent review panel wish to thank Mr RS for agreeing to meet and speak to us, along with members of his current clinical team, and provide them with their views.

All parties provided invaluable information and insights which form the basis of this report.

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2 Executive summary

1 Terms of Reference

1.1 The independent panel was required to address the Terms of Reference agreed with the NHS England.

1.2 The aim of the independent review is to review the mental health care and treatment provided to Mr RS to include:

1. Review the engagement, assessment, treatment and care that Mr RS received from Sussex Partnership NHS Foundation Trust from his first referral in July 2010 up to the time of the incident on 5 October 2012.
2. Review if the Trust and GP fully appreciated the risks and safeguarding issues and management, (which include the safety of the children, the ex-partners and Mr RS's parents) considering the knowledge that Mr RS had anger issues and expressed thoughts of harming his parents which the Trust and GP were aware of.
3. Review the engagement of services with Mr RS after his diagnosis with anxiety in 2010 and Asperger's in 2011 and consider the appropriateness of the pathways and treatment options in line with national standards and best practice.
4. Review the care planning and risk assessment, policy and procedures and compliance with national standards and best practice.
5. Review the communication between agencies and services, especially between the GP and the Trust.
6. Review the communication between Mr RS's family, the GP and the Trust including the sharing of information regarding risks to parents to inform risk assessment and management.
7. To review the circumstances that led to Mr RS being seen by a trainee psychiatrist (sic) on 20 September 2012 considering the known complexities in this case.
8. Review the documentation and record keeping of key information by the Trust's Brighton Urgent Response Service against best practice and national standards and if record keeping is an issue within the Trust.
9. Review the Trust's internal review report and to assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- if the review satisfied its own terms of reference;
 - if all key issues and lessons have been identified and shared;
 - whether recommendations are appropriate, comprehensive and flow from the lessons learnt;
 - review progress made against the action plan;
 - review processes in place to embed any lessons learnt.
10. Having assessed the above, to consider if this incident was predictable or preventable and deliberate on relevant issues that may warrant further review and comment.
 11. To assess and review the Trust's engagement with the victim's family, before and after the incident, including information sharing and involvement in the internal review, measured against best practice and national standards.
- 1.3 Additional details are set out in Section 1 of the main report.

2. Purpose

- 2.1 NHS England commissioned the independent review. An independent review has to be conducted when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the incident, including receiving care under the Care Programme Approach (CPA). The purpose is to examine all the circumstances surrounding the provision and delivery of the care and treatment, to identify any errors or shortfalls in the quality of the service, and to make recommendations for improvement as necessary.

3 Introduction

- 3.1 Caring Solutions (UK) Ltd. was commissioned by NHS England to undertake an independent review of the care and treatment provided to Mr RS by Sussex Partnership NHS Foundation Trust ('the Trust'). This is the report of the results of this review.
- 3.2 The Trust's internal review (Level 2) process and report informed this independent review. The independent review panel (referred to as 'the independent panel') have tried to avoid duplication of the process of the internal review and this was made possible by the clear Terms of Reference from NHS England. Interviews of key stakeholders, a review of Mr RS's health records (for which he had provided his consent), and of Trust policies and procedures further informed this review. The independent panel also reviewed national guidance as appropriate to his care and treatment.

- 3.3 On 5 October 2012 Mr RS travelled from his home in Brighton to his parent's home. There he severely assaulted his father, Mr TS, causing him to spend a week in hospital with potentially life-threatening injuries. His mother, Mrs TS, had a serious heart condition and the stress of the violent attack on her husband and being pushed by her son caused her death. Mr RS pleaded guilty to her culpable homicide and the assault to danger of life on his father.
- 3.4 Mr RS had received services from the Trust's 'Improving Access to Psychological Therapies' (IAPT) service in 2010 - assessment followed by six sessions of Cognitive Behavioural Therapy (CBT); from the Autistic Support Service in Glasgow in 2011 (assessment and diagnosis of Asperger's syndrome, and attendance a number of 'expert patient' groups); and incomplete assessment first by community nurses and second by a trainee GP on placement with the Trust. A third assessment was planned for 8 October 2012, by which time he had committed the homicide and assault.

4 Methodology

- 4.1 The following informed the independent review process:
- interview with Mr RS;
 - interviews with key staff involved in provision of assessment and treatment of Mr RS;
 - interviews with his current clinical team;
 - interviews with his father, sister, brother and sister-in-law; and interviews with both former partners¹, the mothers of his children;
 - review and analysis of clinical records from the Trust and review of court reports;
 - review and analysis of relevant local and national policies, guidance, and research;
 - audit and analysis of the internal review report and action plan, and review of implementation of the action plan.
- 4.2 The independent panel were unable to interview three staff involved in the treatment and assessment of Mr RS. These were: the practitioner who carried out the IAPT assessment (left the Trust); the nurse who participated in the Assessment and Treatment Service (ATS) triage (left the Trust); and the author of the internal review report (retired). However, the independent panel do not consider that any additional information from these individuals would have made a substantive difference to the outcome of the review.

¹ We have used the term former partners when referring to the mothers of his children as this was the term used in our official correspondence. We do however acknowledge that Ms YT may not identify the relationship as a "partnership".

- 4.3 The independent panel have tried to avoid duplicating the internal review. They used the principles of root cause analysis to review the information gathered. This review led them to identify notable practice, care and service delivery problems, patient factors, contributory factors and root causes. The independent panel also identified lessons learned and made five recommendations.

5 Internal review report

- 5.1 The independent panel thought that the internal review report did not do justice to the work done by the two reviewers, and that more information could have been provided about the work done. The report provided a good description of the events from the point of view of the staff interviewed but was hampered by the lack of involvement from the family. The report could have been more analytic. The internal review identified good practice, care and service delivery issues, contributory factors and root causes. The independent panel agreed with these findings and conclusions, and were able to provide much more comprehensive information as a result of meeting the family, former partners and Mr RS himself.
- 5.2 The internal review team made five recommendations, which the independent panel agreed with. These addressed: first medical appointments, particularly in complex presentation, which should be assessed by a consultant or experienced doctor; immediate access to consultant advice at the time for trainee doctors performing new assessments; risk indicators; taking all presenting factors into consideration; following up available information from families; and training for frontline staff on the effects of drugs including 'legal highs'. The independent panel felt that the recommendation for better use of information from families should have been more strongly worded, with a focus on putting the family at the heart of the process.
- 5.3 The recommendations did flow from the findings and conclusions; and work has progressed on implementing the action plan. The independent panel did however find two staff whose practice had been criticised in the review and who reported that they were unaware of this criticism (one remembered having feedback and one did not). Therefore, they could not have been supported specifically in relation to this negative feedback.

6 Summary of main findings and conclusions

- 6.1 At the end of the process the independent panel identified good practice from those in contact with Mr RS; they also identified a number of failings and weaknesses in his treatment and assessment.
- 6.2 In addition to the findings and conclusions of the internal review, the independent panel identified a number of additional issues, notable practices and areas where improvement is required, leading to the identification of eight additional lessons learned and five additional recommendations.
- 6.3 The following are additional points of notable practice – the positive response of the IAPT service in bringing forward Mr RS’s appointment for screening and assessment at the request of his GP; the fact that both the Brighton Urgent Response (BURS) team and the Senior House Officer (SHO) recognised the limits of their competence when assessing his presentation, and referred him for review by a consultant psychiatrist. Sadly, he committed the offences before the date of the new appointment.
- 6.4 Care and service delivery problems, contributory factors, and root causes can be summarised as:
- significant sections of assessment forms (IAPT and BURS) either not completed or erroneously completed;
 - systemic problems in the IAPT service;
 - reliance on self-reporting;
 - failure to involve either his family or former partners;
 - the complex presentation of Mr RS and his denial of intent to do harm to his parents;
 - the triage decision for a ‘routine medical assessment’;
 - the structure and capacity of the BURS service; and
 - weaknesses in the BURS risk assessment and management plan.
- 6.5 The additional lessons learnt emphasised:
- the importance of involving families;
 - the importance of rigorous needs and risk assessment and management;
 - careful allocation of junior doctors;
 - proper completion and use of assessment forms;
 - archiving of interview and witness documentation gathered as part of internal reviews; and
 - the provision of comprehensive feedback and support to staff who are interviewed as part of a serious incident review.
- 6.6 After careful deliberation, the independent panel have concluded that the incident was neither predictable nor preventable. The professional view is that

a direct cause and effect relationship between the failings identified and the outcome cannot be demonstrated. The independent panel do not feel that there is a guarantee that if he had been seen by a consultant in autumn 2012, the subtleties of his presentation would necessarily have been identified.

6.7 However, the independent panel acknowledge that the family do not agree with this conclusion and believe that the incident could have been predicted and prevented. The independent panel feel it is important that the family's views are reflected in this report.

6.8 The internal report was competent, although the independent panel thought the report was more descriptive than analytic. For various reasons neither family nor former partners were contacted: in the independent panel's view this was a missed opportunity to gain a much more comprehensive picture of Mr RS, his presentation, social circumstances and behaviours.

7 Recommendations

7.1 The independent panel agreed with the recommendations produced by the internal review and do not intend to replicate these. The independent panel do not intend to add recommendations to duplicate those the Trust is already addressing. They would, however, make the following new recommendations. The independent panel recommends that:

1. The Trust-wide Risk Panel develop a reliable method for systematically and comprehensively obtaining the views of family members where appropriate when screening for risk.
2. The Trust ensures that all staff fully understand the limits to confidentiality, particularly in relation to risk of harm to self or others, and ensure that practice is in line with legal, professional and Department of Health guidance.
3. The Trust ensures that all medical staff receive sufficient support from colleagues and peers who are available to them. For trainees, this should include supervision by consultants and for consultants, peer group learning. Reflective practice should be embedded into the supervision process, into continuing professional development and into organisational practice.
4. The Trust Board should consider signing up to the 'Triangle of Care' or similar systematic and comprehensive approach to involvement of families, significant others and carers. The objective is to support culture change to promote full engagement of carers, and to include carers as partners, along

with service users and professionals, in all aspects of the appropriate delivery of care and services.

5. As part of its ongoing monitoring and evaluation of the implementation of the recommendations made by the internal review, the Trust should include stakeholder feedback – to answer the question: are these changes making a difference to service users, carers and staff?

3 Main Report

1 Terms of Reference 1

1.1 Commissioner

- 1.1.1 This independent review is commissioned by the NHS England in accordance with guidance published by the Department of Health in circular HSG 94 (27), The discharge of mentally disordered people and their continuing care in the community and the updated paragraphs 33 – 6 issued in June 2005.

1.2 Purpose

- 1.2.1 NHS England commissioned the independent review. An independent review has to be conducted when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the incident, including receiving care under the Care Programme Approach (CPA). The purpose is to examine all the circumstances surrounding the provision and delivery of the care and treatment, to identify any errors or shortfalls in the quality of the service, and to make recommendations for improvement as necessary.

1.3 Terms of Reference

- 1.3.1 NHS England provided the following Terms of Reference, following consultation with the family of the victims.
1. Review the engagement, assessment, treatment and care that Mr RS received from Sussex Partnership NHS Foundation Trust from his first referral in July 2010 up to the time of the incident on 5 October 2012.
 2. Review if the Trust and GP fully appreciated the risks and safeguarding issues and management, (which include the safety of the children, the ex-partners and Mr RS's parents) considering the knowledge that Mr RS had anger issues and expressed thoughts of harming his parents which the Trust and GP were aware of.
 3. Review the engagement of services with Mr RS after his diagnosis with anxiety in 2010 and Asperger's in 2011 and consider the appropriateness of the pathways and treatment options in line with national standards and best practice.
 4. Review the care planning and risk assessment, policy and procedures and compliance with national standards and best practice.
 5. Review the communication between agencies and services, especially

- between the GP and the Trust.
6. Review the communication between Mr RS's family, the GP and the Trust including the sharing of information regarding risks to parents to inform risk assessment and management.
 7. To review the circumstances that led to Mr RS being seen by a trainee psychiatrist on 20 September 2012 considering the known complexities in this case.
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 9. Review the Trust's internal review report and to assess the adequacy of its findings, recommendations and implementation of the action plan and identify:
 - if the review satisfied its own terms of reference;
 - if all key issues and lessons have been identified and shared;
 - whether recommendations are appropriate, comprehensive and flow from the lessons learnt;
 - review progress made against the action plan;
 - review processes in place to embed any lessons learnt.
 10. Having assessed the above, to consider if this incident was predictable or preventable and deliberate on relevant issues that may warrant further review and comment.
 11. To assess and review the Trust's engagement with the victim's family, before and after the incident, including information sharing and involvement in the internal review, measured against best practice and national standards.

1.4 Outputs

1.4.1 Key outputs required by NHS England included the following:

1. A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.
2. A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.
3. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).
4. At the end of the review, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the review.

5. A concise and easy to follow presentation for families.
- 6 A final presentation of the review to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.
- 7 An assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The reviewer should produce a short report for NHS England, families and the commissioners and this may be made public.

1.5 Approach

- 1.5.1 The independent panel will conduct its work in private and will take as its starting point the Trust's internal review supplemented as necessary by access to source documents and interviews with key staff as determined by the team.
- 1.5.2 If the independent panel identify a serious cause for concern then this will immediately be notified to the Regional Investigations Manager (South), NHS England.

1.6 The review panel

- 1.6.1 The review panel consisted of appropriately qualified senior professionals:
 - Chair/Lead Reviewer (Senior Mental Health Nurse, Nurse Educator and Service Manager)
 - Consultant Psychiatrist
 - Lay member/carer
 - Review Manager.

1.7 Principles of the review

- 1.7.1 Approach: The review will not duplicate the earlier internal reviews; this work is being commissioned to build upon the internal reviews.
- 1.7.2 Publication: The outcome of the review will be made public. NHS England will determine the nature and form of publication. The decision on publication will take into account the view of the chair of the review panel, relatives and other interested parties.
- 1.7.3 Data Protection: The completed review reports contain details of the clinical care and treatment the service user received and is therefore subject to the Data Protection Act and if made public could also breach the Human Rights Act.

It is the responsibility of the NHS England to ensure that there is a balance within the report that would protect the rights of those individuals involved in the incident whilst also discharging its duty to publish what is deemed to be in the public interest.

1.7.4 Support to Victims, Perpetrator, Families and Carers. When an incident leading to death or serious harm occurs, the needs of those affected will be of primary concern to the Trust, NHS England and the independent panel. This will be reflected through application of the 7 key principles of serious incidents (NHS England Serious Incidents Framework 2015), which are that they should be managed in a way that is:

- open and transparent;
- preventative;
- objective;
- timely and responsive;
- systems based;
- proportionate; and
- collaborative.

1.7.5 The family of the perpetrator who are also the family of the victims of homicide and assault have contributed to this independent review.

1.7.6 In general families wish to:

- know what happened;
- know why it happened;
- know how it happened;
- know what can be done to stop it from happening to someone else; and
- tell their account of events.

1.7.7 It is important that the debate on the matters of public concern which may arise from this case are grounded on an accurate account of the facts.

1.8 Procedure

1.8.1 All inquiries have to consider what procedure is appropriate for the particular issues to be considered. The objectives must be to conduct an inquiry which, as far as is practicable:

- reviews thoroughly the matters within the terms of reference;
- ensures objectivity;
- ensures all the relevant information is considered;
- is fair to those who are under scrutiny; and
- recognises the position and interests of all those concerned with the events which led to the inquiry.

1.9 Principles of mental health services

- 1.9.1 The independent panel believe that at the core of any mental health service delivered to people with a mental disorder there must be four principles:
- clarity in current diagnosis, objectives, needs, changing the diagnosis, needs and risk assessment and the strategies to clarify and deal with them;
 - coordination of the delivery of service, sharing of information, and action;
 - checking on the outcome of service provision by regular review; and
 - changes in the diagnosis needs and risk assessments, and service provision in light of the review.

2 Introduction

2.0 The independent panel hope this report can offer a brief opportunity for providing all those affected by this serious incident, a degree of understanding with regard to the care delivered to Mr RS up to the time of the offence. The independent panel wish those people well in resolving their individual feelings associated with the tragic circumstances surrounding the subject of this review.

2.1 Summary of the Incident

- 2.1.1 During 2012 Mr RS developed a number of bizarre ideas and thoughts about himself, his family and his former partner's family. In July he started to allege that he had been sexually abused by his father and that his mother, along with other members of his family, was complicit in this abuse.
- 2.1.2 On 5 October 2012 Mr RS travelled from his home in Brighton to his parent's home. There he attacked his mother and father. He slapped his mother, pushed her into her chair and pushed her backwards with his foot. He repeatedly punched his father, then went into the garden. His father ran from the house to raise the alarm with neighbours, who called emergency services. He was bleeding to the extent that the neighbours did not recognise him. Mr RS dragged his father from the house, removed his clothes and continued kicking him. Mr RS left moments just before police arrived. These attacks led to the death of his mother from a pre-existing heart condition and to very severe injuries to his father, who spent a week being treated in hospital.
- 2.1.3 Mr RS then went to the nearby beach, went into the sea and returned to change his clothes and dispose of his original clothing in a rubbish bin. He travelled back towards Brighton, staying the night on the way with a friend. His friend reported that Mr RS had said that he had beaten up his father, and the friend noted Mr RS's bruised knuckles.
- 2.1.4 The following day Mr RS called Ms AV and told her he had hit his father and thought his mother had died. He took the train to London and was subsequently arrested at Euston Station, London. He was charged with the murder of his mother and attempted murder of his father. He denied any intent to murder either and pleaded guilty to culpable homicide and assault to danger of life.
- 2.1.5 Mr RS was sentenced on 2 August 2013 to be detained in a high secure psychiatric hospital without limit of time: he cannot be released without approval of the Health Secretary. The Judge authorised the giving of medical treatment. Mr RS remains an in-patient of this hospital at the time of writing this report.

2.2 Background and context

- 2.2.1 Mr RS was one of three siblings, born in July 1974. The family spent 3.5 years between 1980 and 1983 living in Saudi Arabia, in a large ex-pat complex. They returned home for summer holidays and also had the opportunity to travel widely. Mr RS attended an English speaking school in Saudi Arabia. There was a period during this time when he suffered night terrors, requiring his parents to go to his room to calm him down. Although he struggled to re-integrate to primary school on return to the UK, this only lasted a year. He later developed strong friendships at school and is still in contact with several of his friends from his school days. He remained there until he left to go to college in Glasgow, moving after a year to Wales for another year, before returning to Glasgow to attend the Glasgow School of Art. He achieved a HND and BA in Illustration. He developed a drink problem whilst at Art School, he used alcohol to alleviate anxieties around speaking in public and attending lectures.
- 2.2.2 Whilst in Glasgow he met Ms YT, who became pregnant. She moved to Brighton to be near her family. She gave birth to a daughter, Ms WT, in 2000. A couple of years later Mr RS later moved to be near Ms WT. He had help and assistance to find accommodation and work. Mr RS got a job working in an off-licence where he stayed for a number of years, opening up and locking up the shop on occasion. Ms YT and her daughter moved to London shortly before he moved to Glasgow.
- 2.2.3 He met his second former partner (Ms AV) when they both worked in a service supporting people with learning disabilities, Asperger's syndrome and autism.
- 2.2.4 In 2009 Mr RS was on holiday in Florida with his family, including his daughter Ms WT. One day there was an incident in a café. Mr RS held a long conversation with Ms AV in Brighton using his father's mobile 'phone. Mr TS remonstrated with his son, which led to Mr RS picking up the chair with his father sitting in it and threw it and him in the air. This indicates how strong he was. Later in the evening he left his family and did not return until the following morning. His daughter was upset.
- 2.2.5 Ms AV gave birth to a daughter (Ms BV) in early 2010. In July 2010 Mr RS was referred by his GP to the 'Improving Access to Psychological Therapies' (IAPT) service provided at that time by the Trust. Following triage (a system to allocate priority and the most appropriate form of care and treatment, on the basis of a referral letter) and assessment he entered into six individual sessions of Cognitive Behavioural Therapy (CBT) provided by a qualified therapist. These sessions were to address his social anxiety which had become so severe as to prevent him from going to work.

- 2.2.6 Ms AV, Mr RS and their daughter moved back to Glasgow in 2011. He was drinking heavily and started to show signs of 'odd' behaviour. He was referring to conspiracy theories and his behaviour was sometimes intimidating. His GP referred him to the Adult Autism Support Service in Glasgow where he was diagnosed as having Asperger's syndrome. (Details in paras 3.1.6 and 3.1.7). Mr RS and Ms AV separated. First Ms AV and then Mr RS moved back to Brighton.
- 2.2.7 Mr RS was described by his family and both former partners as having a serious drink problem. Members of his family thought maybe he was a 'functioning alcoholic' (definition in Appendix Four). In 2011 he was drinking a bottle of vodka a day. He was also described as being fixed and inflexible in his thinking and wishes, with little regard for other people's feelings. His former partners described him as controlling. He had many friends who remain in contact whilst he resides in the State Hospital. In Brighton, however, he had very little social contact apart from his former partners and their families, and was described as a loner.
- 2.2.8 He had a forensic record of assaults, where typically he intervened if he thought someone needed protection. He was arrested for assault on a number of occasions and charged and convicted twice. He was also known to use cannabis and 'legal highs'. His aggressive behaviour was reported to be triggered by his drinking and drug use.
- 2.2.9 During 2012 he became increasingly obsessed with conspiracy theories, including those proposed by David Icke (a TV presenter in the 1990s), astrology and the paranormal. Mr RS called his parents reptilians and thought that that he and his sister were 'star children'. Above all, he became convinced that his father had sexually abused him as a child and that because his mother and brother denied it that they were complicit. He was also convinced that Ms AV's adoptive parents had abused her and that a teacher had drugged and abused him.
- 2.2.10 In July 2012 his mental state deteriorated further, he became abusive and aggressive on the telephone to his parents. In August 2012 he visited his parents, bringing both daughters, leading to a further incident (details in para. 3.4.24). He was asked to leave and did so a couple of days later. Ms WT was aware of this incident.
- 2.2.11 His mental state deteriorated rapidly in September 2012. His daughters were spending time at his flat during this period. It later became clear that he was neglecting them, leaving them alone with Ms WT (11 years old) looking after Ms BV (2 years old), whilst he focussed on reading up on bizarre theories on the computer. Ms WT is reported to have felt that she was having to look after her father at this time.

- 2.2.12 Ms AV helped him to register with a GP who referred him to the Trust's mental health services on 5 September 2012, where he was placed on a waiting list for assessment two days later. As the telephone calls became more frequent and aggressive his father spoke to his GP on 12 September 2012. The GP saw Mr RS then re-referred him this time to the Brighton Urgent Response Service on 12 September 2012. Mr RS was seen at his flat the following day (13 September 2012) by two Community Mental Health Nurses (CMHNs). They spent about 1.5 hours with him. The management plan was to request the ATS to continue with the routine medical appointment: the records indicate that the CMHNs considered he may require a consultant appointment, owing to the complexity of his mental health needs.
- 2.2.13 He was in fact seen by a SHO, a GP trainee in his second year of clinical placements who had been working in psychiatry for six weeks. He was interviewed and assessed by the SHO who decided that, because of his complexity, Mr RS needed to be seen by the consultant psychiatrist. A further appointment was made for 8 October 2012, by which time the incident had taken place and Mr RS was in custody.
- 2.2.14 When Mr RS attended the IAPT services in 2010, these were part of the Access service, provided directly by the Trust. All mental health referrals went to the Trust – ranging from primary mental health care to a crisis needing an immediate response through to in-patient admission. A service user was referred by the GP; a triage meeting (group, multidisciplinary meeting) was held to identify the particular individual to see the service user for assessment; and then the service user would be referred for treatment to meet those needs, or referred back to the GP with advice on treatment. A member of the IAPT team triaged and assessed Mr RS's case and referred him for CBT by a member of the 'High Intensity Team', a qualified cognitive behavioural therapist
- 2.2.15 The Access service, established in 2007, had become overwhelmed, particularly by crisis referrals (see paras. 3.4.5 and 3.4.6 for further details). This led, in June 2012, to the IAPT services being transferred from the Trust to a partnership of GPs, voluntary organisations and the Trust. Referrals for secondary care were made to an 'Assessment and Treatment' team. The referral would be 'triaged' to the most appropriate service in order for the patient to be seen within the appropriate timescale; assessed by a professional from that service; and then referred on to appropriate treatment within the Trust or back to the GP with advice provided on treatment. A 'routine assessment' was to be carried out within 28 days from referral. When Mr RS was referred to the ATS in September 2012, this system had been 'up and running' for a few months only.

- 2.2.16 In 2012 the Trust also provided an urgent response service to support Brighton and Hove GPs with patients requiring urgent assessment, the Brighton Urgent Response Service (BURS). The Trust created this service from May 2011. The BURS team only accepted telephone referrals and operated from 8.00 am to 8.00 pm (outside these hours, urgent referrals would be sent to the mental health liaison team at A&E). Criteria for accepting a patient for BURS assessment included 'significant mental health concerns' requiring immediate attention. If, usually after discussion with the referring GP, a patient met the criteria for urgent assessment BURS staff would carry out an assessment within 4 hours and provide written feedback within 24 hours. This would include details of the assessment and a care plan. At the time of the contacts with Mr RS, BURS was an assessment and onward referral service only and was structurally separate from the ATS team. Mr RS was referred first for routine assessment to the ATS and a week later was referred to the BURS team.
- 2.2.17 As part of the context, the independent panel notes that Brighton has many characteristics in common with an inner-city area. These include a high transient population; an increasing number of homeless individuals and families; and a high level of alcohol and substance misuse, including the use of 'legal highs'.

Panel consideration

The independent panel were mindful that during the two periods of contact Mr RS with the Trust, the Trust like the majority of Mental Health Trusts was adapting to having undergone significant organisational changes; some of these changes were entered into voluntarily, other changes were forced upon them due to the effect of restructuring occurring in other organisations. The Trust, and more specifically the services provided in Brighton and Hove, had been no exception to this. Such changes when viewed alongside the Brighton demographic have an effect on service delivery and the independent panel acknowledges the consequent demands and how they influence difficulties within service delivery.

2.3 Methodology

- 2.3.1 NHS England sought and received consent from Mr RS for the independent panel to have access to all his clinical and court records.
- 2.3.2 The following informed the independent review:
- interviews with Mr RS's father (Mr TS, victim of assault and widower following the homicide of his wife, Mr RS's mother); his brother and sister-in-law (Mr and Mrs VS); and his sister, (Ms WS);
 - interviews with two former partners (Ms YT and Ms AV), the mothers of his two daughters;

- interview with Mr RS;
- interviews with key staff, specifically:
 - CBT Therapist (Ms CW);
 - Triage social worker (Mr DX);
 - BURS CMHN (Mr EY);
 - Service Director (Mr FZ);
 - General Manager, Community Services (Ms GR);
 - Senior Clinical Director, member of internal review panel (Dr HP);
 - Senior House Officer at the time (Dr JO, now a GP);
 - Mental Health Officer, high secure psychiatric hospital (Ms LM); and
 - Consultant Psychiatrist responsible for his care at the time (Dr KN)
- telephone interviews with:
 - Dr TH, the GP who referred Mr RS to the BURS team;
 - Dr NL, his current consultant psychiatrist/Responsible Medical Officer;
 - Ms TF, Speech & Language Therapist/Clinical Lead, Glasgow Autism Support Service; and
 - BURS CMHN (Ms VG)
- a review and analysis of Mr RS's health records including primary care records, records held by the Trust responsible for his care and treatment as both on in and out-patient, clinical records held by the Trust responsible for his current care, including reports to the Court, the Agreed Narrative and the Judge's Sentencing Remarks;
- a review and analysis of the Trust's key policies and procedures in place at the time of Mr RS's contacts with the IAPT service in 2010; with the ATS and BURS in October 2012, and subsequently; policies relating to the notification and review of serious incidents; and safeguarding policies; (listed in Appendix One);
- An audit and analysis of the Trust's internal report, and review of the implementation of the action plan; and
- the completion of a detailed time line for Mr RS's involvement with specialist mental health services up to the date of the homicide (5 October 2012).

2.3.3 Interviews with health care professionals were audio-recorded and transcripts sent to interviewees for amendment if required and confirmation of accuracy. Notes were taken of telephone interviews and interviews with his family, former partners and Mr RS and also sent to interviewees for comment.

2.3.4 The independent panel undertook:

- a review of the treatment and care of Mr RS provided by the Trust;
- a Root Cause Analysis;
- a review of contributory factors leading up to the homicide;

- the creation of a Genogram to describe visually the significant participants in this review and the complexity of geography and relationships and a 'family tree', again to illustrate the complexities of his family relationships.

2.3.5 Arising from their analysis of the findings of the review, the independent panel made recommendations for consideration by the Trust and the NHS England to support further organisational learning from the homicide.

2.3.6 This Type B (a review by a panel examining a single case) independent review was commissioned by the NHS England from Caring Solutions (UK) Ltd. The review commenced in February 2015. The independent panel are required to present their report to NHS England by the end of July 2015.

2.3.7 The independent panel consisted of the following (see Appendix Three for further details):

Mr Anthony Thompson, Chair of the Independent Review Panel and Lead Reviewer, is an experienced senior mental health and learning disability nurse. He has led a number of independent review panels and brings many years of experience representing mental health and learning disability services within a multi-disciplinary context.

Dr Ashok Roy is a consultant in the Psychiatry of Learning Disability in Solihull Community Services at Coventry and Warwickshire Partnership NHS Trust. He is the Chair of the Faculty of Intellectual Disability at the Royal College of Psychiatrists and represents the Faculty at the Department of Health and at the Learning Disability Professional Senate.

Mr Alan Worthington is a lay member and a carer who has developed support and education services for mental health carers. He has contributed to the Care Quality Commission's inspection standards and participated in the Royal College of Psychiatrists' Accreditation - Peer Assessment Schemes. He is a member of the Department of Health National Mental Health Safety Advisory Committee. Previous relevant experience includes a review of five Serious Untoward Incidents.

Ms Maggie Clifton is review manager and has managed and contributed to a number of independent review panels and to the review and audit of internal and independent Serious Untoward Incident review reports. She is a social scientist, specialising in qualitative research in health and social policy and a general manager with extensive experience in the voluntary sector and NHS.

2.3.8 Within this context the independent review process resulted in a detailed review and elaboration of the issues identified in this process. This was based on the need to improve the components of the mental health service. The independent panel achieved this by a detailed scrutiny of records, case notes, policies and procedures, with reference to evidence based standards. The independent panel enhanced the process further by conducting interviews with key people in

order to present a series of “why” questions. The independent panel were able to determine at which part, if any, of Mr RS’s contacts with the service if it could be established, by asking: Did something happen that should not have? Or conversely, did something not happen that should have?

3 Findings

3.0 The following section of the report covers the detailed chronology of events in respect of Mr RS, notable practice attributed to his care and treatment, an analysis of care and service delivery issues. The independent panel address each item of the Terms of Reference in turn. The independent panel set out contributing factors which they identified during the review. They go on to discuss root causes and whether, in the independent panel’s opinion, this incident could have been predicted or prevented. From the outset of this independent review the independent panel were aware of the grief, trauma and anxiety suffered by all of the family, his two former partners and his elder daughter.

3.1 Chronology of events

3.1.1 The key dates were:

July – September 2010: referral, assessment and six CBT sessions for social anxiety, provided by the Trust’s IAPT service in Brighton and Hove.

2011: Mr RS moved to Glasgow.

June – autumn 2011: referral, assessment/diagnosis and support in respect of Asperger’s syndrome, Glasgow Autism Support Service.

April 2012: Mr RS returned to Brighton.

September – October 2012: referral, assessment and medical appointment, the ATS and BURS in Brighton and Hove.

3.1.2 Mr RS was first referred to the Trust’s mental health service on 5 July 2010 by his GP, Dr NK, who described ‘long-standing social anxiety and difficulties in facing social interactions’. He was triaged to an IAPT High Intensity Team (HIT) for assessment within the next month. The initial date offered for this was brought forward to 21 July 2010 at his GP’s request as Mr RS’s anxieties had deteriorated and he was no longer able to work. The IAPT assessment form, completed by Ms ZE (West Access Team) detailed the impact of his social anxiety, his inability to speak in groups, past use of alcohol to overcome this

anxiety and convictions for assault. However, a number of items were not completed. These included substance misuse, risk information, access to his children. The IAPT assessment form prompts escalation to the more in-depth Level 1 risk assessment if risk of harm or issues related to the care of children are identified.

- 3.1.3 Mr RS attended the first of six sessions of CBT on 17 August 2010. With the therapist he addressed his shyness, anxieties in social situations. He carried out tasks and practised techniques to overcome his anxieties between sessions, although he did not always complete this 'homework'. He did talk about using alcohol to help him socialise but said that he had given up drinking because it had led him to be aggressive. He and the therapist jointly signed the discharge letter, in which they recorded that he had improved significantly, had a plan to continue going into social situations he feared in order to minimise his fears. The discharge letter to Dr NK stressed that he could be referred back to the service if Mr RS felt things had changed or become worse.
- 3.1.4 In 2011 Mr RS moved to Glasgow with Ms AV and their daughter. During this time he struggled to get work. His behaviour is described as odd during this period and he fixated on conspiracy theories.
- 3.1.5 Whilst in Glasgow he attended his GP on 17 June 2010 and was referred to the CMHT, for a routine appointment, with a possible diagnosis of Asperger's syndrome. Mr RS had been reading about Asperger's and felt this might explain his social anxiety. At this time, Mr RS was described as currently a 'light drinker' and previously a 'binge drinker'.
- 3.1.6 On 11 August 2011 Mr RS was seen by a therapist at the Glasgow Autism Support Service. At an initial assessment, Mr RS scored above the minimum score, leading to a more detailed diagnostic assessment over two appointments on 1-2 September 2010. Ms AV accompanied him and he took a questionnaire his mother had completed about his early development. He was assessed using the 'Diagnostic Interview for Social and Communication Disorders' (DISCO). There was no clear indication of childhood autism but a positive diagnosis of Asperger's syndrome.
- 3.1.7 Mr RS participated in a course for people following this diagnosis, he was given information about a specialist employment scheme, and was invited to telephone the service to see a clinician in the future if he needed to. He attended a group course for 2-3 weeks. Ms AV left Glasgow to return to Brighton with her daughter as the relationship with Mr RS was breaking down.
- 3.1.8 Mr RS left Glasgow in April 2012 to return to Brighton, to be near his younger daughter but remained separated from Ms AV.
- 3.1.9 In summer 2012 Ms AV was also becoming increasingly worried about Mr RS's mental health, he had become increasingly controlling, wanting to interfere in her

life and they argued a lot. She arranged for him to register with a GP and he attended an appointment on 5 September 2012. Prior to this she had contacted the Glasgow autism service for help and was advised to go to his local GP. Mr RS was seen by a locum GP, Dr OG, who referred him to the West Brighton ATS that day, on the grounds of his complex past history. He was advised that it might be 6 weeks before an appointment.

- 3.1.10 On 7 September 2012 the referral was triaged by a multi-disciplinary group, including Dr KN (consultant psychiatrist) Ms YC (mental health nurse) and Mr DX (social worker). The outcome was referral for a routine medical appointment.
- 3.1.11 On 12 September 2012, Mr TS contacted Dr TH, Mr RS's GP. He expressed concern about the increasingly bizarre telephone calls, by now on a daily basis, they were concerned about his allegations of abuse, he was calling his parents Satanists, threatening to come and kill them, that he was hearing voices. His parents did not think they could cope with these calls until his appointment and asked Dr TH if he could speed up the process. They did not want Mr RS to know about their conversation with Dr TH. Dr TH asked Mr RS to come into the surgery just to follow up the referral and he attended on 13 September 2012.
- 3.1.12 At this appointment, Dr TH noted complex paranoid ideas, hallucinations, allegations of sexual abuse by his father, frequent difficult telephone calls to his parents, but that RS denied any thoughts of harming his parents. Dr TH thought that the situation might escalate so he faxed a referral for the BURS team the same day. Later that day the BURS CMHN, Ms VG, rang Mr RS twice with no reply and she left messages for him to contact BURS. With a colleague she made a 'cold call' to his home but he was not in. At 20.00 hours he telephoned and spoke to Ms VG. He agreed to a home visit the following day.
- 3.1.13 On 14 September 2012 the two CMHNs from BURS visited his home to carry out an assessment. The assessment record includes reference to his two daughters being cared for by his former partners and his continuing contact with them; to the reasons for referral given by Dr TH; and to Mr RS's account of events leading up to his referral. These included his thoughts of having been physically, sexually and psychologically abused by his parents but that he was not sure if these events were real or linked to his diagnosis of Asperger's syndrome. Mr RS felt his parents were controlling him. He reported his history of violence, his past binge drinking, occasional use of 'legal highs'. He wanted help to understand these thoughts and to deal with them. As a result of this assessment they noted the diagnosis of Asperger's syndrome and possible psychosexual delusions: his fixed thoughts of abuse by his parents; his willingness to accept help. They concluded that there was no immediate risk but that his mental state might deteriorate and there was a possible risk to his

parents. The management plan was for a routine medical appointment, but preferably with a consultant due to the complexity of his presentation.

- 3.1.14 A Level 1 risk assessment form was completed, dated 14 September 2012. This assessment concluded there were no risk factors for suicide, 'difficulty communicating' as a neglect risk factor; current risk factors for violence and aggression. The management plan was the same.
- 3.1.15 This referral was passed on to Dr KN who allocated it to his Senior House Officer, Dr JO. Mr RS attended an appointment on 20 September 2012. Dr JO noted his Asperger's diagnosis, previous convictions for assault, anger at his parents, allegations they had abused him as a child and his preoccupation with conspiracy theories. Mr RS was very distrustful of his parents, he felt his mother's behaviour was strange and unusual. Dr JO recorded Mr RS's mild alcohol intake, that he smoked 'herbal essence' (refers to a form of psychoactive drug commonly known as a legal high) but did not use recreational drugs. Mr RS is described as 'bright and articulate'. Dr JO stated that Mr RS reported he had shouted at his mother but had no intention of visiting his parents or harming them. Dr JO telephoned Dr TH to confirm that Mr RS did not know that his father had telephoned. He discussed the interview with Dr KN when he was next available, the following day. They thought there was no immediate risk to Mr RS himself or of harm others and they agreed on a further assessment appointment with both doctors present. Dr KN suggested that a referral to the Mankind service providing support to men who had experienced child sexual abuse, and Dr JO included this in his letter to Dr TH.
- 3.1.16 On 5 October 2012, Mr RS travelled to his parent's home and committed the homicide and assault.
- 3.1.17 An appointment was sent to Mr RS for 8 October 2012, to see Dr KN and Dr JO. When he did not attend he was telephoned. Later that same day a forensic community psychiatric nurse telephoned Dr JO for information, following the incident.
- 3.1.18 In March 2013 Mr RS pleaded guilty to culpable homicide of his mother and the assault with danger to life on his father.
- 3.1.19 On 2 August 2013 Mr RS was sentenced to be detained indefinitely in the State Hospital, to be released only with minister's approval. His diagnosis was 'paranoid schizophrenia' at this time. It was later explained that his psychosis was in all probability induced by use of psychoactive substances.

Timeline of events

(The root causes, contributory factors and care and service delivery problems are those identified in this independent review.)

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
5/07/2010	Referred to Brighton and Hove Mental Health Services by Dr NK, GP. Mr RS reported 'longstanding social anxiety' and 'unable to face social interaction' No mention of discord with parents at this stage.					GP referral letter.
13/07/2010	Triage decision – to HIT triage assessment (by 09/08/2010)					Clinical records
14/07/2010	Letter sent to Mr RS for 13/09/2010 screening appointment.					Clinical records
21/07/2010	Letter to Mr RS, offering appointment (but date/time not specified) with the High Intensity CBT Team. Copied to Dr NK					Clinical records
22/07/2010	GP rang to request earlier appointment, as Mr RS was no longer able to work. New appointment arranged over telephone;	Appointment brought forward in response to GP request				Clinical records
27/7/2010	IAPT assessment completed, Ms ZE (West Access Team). This confirms the social anxiety, inability to speak in front of groups				Significant sections of the form are not completed.	Clinical records.
29/07/2010	Mr RS prioritised as not able to work.					Clinical records
04/08	Letter to Dr NK from Ms ZE, reports					Clinical

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
/2010	difficulties with depression and social anxiety, and that Mr RS had been prioritised as he was not able to work.					records
06/08/2010	Letter from Ms CW (Cognitive Behavioural Therapist) to Mr RS, offering appointment on 17/08/2010. Copy to Dr NK.				Systemic problems in the IAPT service – set up to deal with minor to moderate problems; part of the Access service which became overloaded and struggled to cope.	Clinical records
12/08/2010	Telephone call from Mr RS, to confirm appointment on 17/08/2010.					Clinical records
17/08/2010	First CBT appointment, included confirmation of the issues identified in the assessment; and his homework was to identify opportunities for challenge his social avoidance.					Clinical records
24/08/2010	Second CBT session. Mr RS feeling much worse because of two stressful events, but he had engaged in some social situations and been pleased with the results Homework – to contact a friend to go out socially.					Clinical records
31/08/2010	Third CBT session. Mr RS had engaged in social activities which went well; he is trying to think more positively, positive experiences giving him					Clinical records

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
	confidence. Homework: to contact some galleries to sell his artwork; go to girlfriend's family barbeque and engage in small talk.					
07/09/2010	Fourth CBT session. Mr RS had achieved both homework activities. Homework: to get back to a woman who wanted to commission a painting and what he would charge; and get back to the gallery.					Clinical records
21/09/2010	Fifth CBT session. Mr RS had not contacted the gallery or the woman; he had engaged successfully in other social activity; When he gets emotional in situations he reprimands himself and feels he is thick because he is not calm and confident – this a core belief. Homework – a core belief worksheet to challenge his feeling that he is 'thick'.					Clinical records
28/09/2010	Sixth and final CBT session. Mr RS had gathered more evidence to support his core belief than to contradict it, he discounted positive things about himself, and held different rules for himself and others. Discharged.					Clinical records

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
28/09/2010	<p>Access/IAPT Discharge template completed & signed by Mr RS and Ms CW. Presenting problems were significant social anxiety and discomfort in social situations, avoiding social situations, misinterpreted others' behaviour to confirm his view of himself as 'thick'.</p> <p>Objectives agreed – to help Mr RS work towards going out socially, and make contact with galleries to market his art work.</p> <p>Interventions given – exposure to social situations and behavioural experiments to compare his predictions with actual outcomes in relation to how others react, behavioural activation in contacting art galleries.</p> <p>Outcomes – Mr RS has improved significantly.</p> <p>Relapse plan – to maintain exposure to feared social situations, to continue to challenge negative predictions, to try to keep thinking more positively, to remember that many of his social issues are self-created, that tackling his fears helps to minimise them.</p>					Clinical records
28/09/2010	<p>Discharge letter to Dr NK, enclosing the discharge template. Letter added that Dr NK could ask if wanted any further information and that Mr RS had been assured that Dr NK could re-refer Mr RS if he felt things had changed or become worse.</p>		Reliance on self-reporting			Clinical records
April	Moved to Glasgow with Ms AV and Ms BV.					Interviews

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
2011						
17/06/2011	Routine referral by Dr WD (Glasgow GP) to CMHT (Greater Glasgow & Clyde). Presenting complaint was possible Asperger's syndrome. Similar symptoms to those previously described; and that Mr RS was a light smoker, light drinker, previous binge drinker.					GP Records
18/08/2011	Letter from Ms TF to Dr WD, reporting on meetings with Mr RS in August 2011. Mrs TS completed a questionnaire and Ms AV provided information in past and previous behaviours. Ms AV attended all appointments with him. Initial assessment led to Mr RS being further assessed, to be carried out using the DISCO assessment schedule.					Clinic letter
01/09/2011 and 19/09/2011	Mr RS was assessed using the DISCO schedule over two sessions. There was no clear evidence of childhood autism, but a positive diagnosis of Asperger's syndrome. Mr RS's presentation satisfied all criteria for a positive diagnosis under the headings of 'social interaction'; and some criteria under the heading of 'repetitive activities'. Recommendations were made for Mr RS to follow up. (Mr RS informed Dr OG of this diagnosis and took the diagnostic report to the BURS assessment in Sept. 2012)					Clinical records
Sept.	Following the diagnosis:					Tel.

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
2011	<p>Mr RS attended an 'expert patient' programme for 2-3 weeks, Mr RS was given information about the National Autistic Society (NAS) employment support service and given the Autism Alert Card.</p> <p>Mr RS was told he could book an appointment with a clinician if he wanted to see some-one.</p> <p>Mr RS informed the service he was moving back to Brighton to be 'part of Ms BV's life', but not to get back with AV;</p> <p>Ms TF reported that on the surface he looks like anyone else, he engages well, looks very socially skilled, but he has a severe impairment in his ability to read other people, a high degree of incapacity under the surface, a high level of stress and anxiety.</p>					Interview. (At the time this group did not keep records of their meetings, they do now.)
April 2012	Mr RS returned to Brighton					Interviews
Summer/autumn 2012	Ms AV had telephoned (from Brighton) her secretary and said she was struggling and needed help. Ms AV was advised to go to his Brighton GP and seek help from local mental health services or social services. They could not assist further as he was in Brighton.					Tel. interview. There is no record of this call, and witness could not recall the timing.
5/09/2012	Dr OG (locum GP) saw Mr RS who reported similar issues to those noted previously regarding his parents, his		Complex presentation;			Referral letter

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
10.52 hrs	<p>previous diagnosis of Asperger's, denied any current depression, denied any symptoms of paranoia which family and close friends seemed to this he had. Mr RS seemed appropriate with insight into his symptoms and did not appear psychotic; Mr RS completed the PHQ9 and scored 3/27</p> <p>Dr OG discussed options of medication or referral to a psychiatrist with Mr RS, who was keen to be referred. Dr OG thought referral was merited in light of his complex past history; and advised Mr RS to access the NAS website to seek support services from them.</p> <p>Dr OG referred Mr RS to the mental health service the same day.</p>		Reliance on self-reporting			
5/09/2012	Mr RS informed family and Ms AV that there was a waiting list of about six weeks					Interviews
7/09/2012	<p>Triage by Dr KN, Mr DX, Ms YC of the referral, outcome was routine medical assessment (ATS)</p> <p>Consultant Psychiatrist was a member of the triage team.</p>				Triage decision to 'routine medical appointment'	Clinical records
12/09/2012	Mr RS's parents telephoned Dr TH (Brighton GP). His father expressed serious concerns their son's behaviour and described his history and current accusations of child sex abuse, hallucinations of speaking to God, concerns of grandeur, threats to kill them.					Interviews

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
	Parents were aware of referral to mental health services, but worried that he needed to be assessed more urgently. Parents did not want Mr RS to know about this call to his GP.					
12/09/2012	Dr TH contacted Mr RS, inviting him to an appointment on pretext of follow-up from his referral to the ATS. Mr RS accepted the appointment, he sounded calm and denied any acute problems					GP records
13/09/2012	Mr RS attended appointment with Dr TH who then made a referral to the Brighton Urgent Response Service (BURS). In the referral he notes the telephone call from his father and their concerns about his behaviour. Dr TH felt that Mr RS was asking for help, had a psychotic episode and his parents reported frequent, difficult phone calls and texts. He reiterates that the telephone call from his parents is unknown to Mr RS. Dr TH reports his concern that the situation may escalate so is making a request for an urgent referral; and that Mr RS was aware of referral and at the time was keen to be seen and for help. A handwritten note on the fax adds that Dr TH does not think Mr RS needs to be seen same day if the team is busy, but he does not want the referral to be missed		Complex presentation			GP referral fax
13/09/2012	Mr RS told Dr TH that his parents were putting a spell on his knee.					Tel. interview
13/09/2012	Referral received Ms VG tried to telephone Mr RS but no					Clinical records

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
16.00 hrs	answer, message left for him to contact BURS					
13/09 /2012 17.20 hrs	Further telephone call to Mr RS by Ms VG, still no reply, message left. Ms VG agreed with a colleague to do a 'cold call' to his home					Clinical records
13/09 /2012 18.30	Ms VG and colleague visited his home (18.30) but no one was in. Plan – to try to contact Mr RS the following day, to contact Dr TH if unable to make contact.					Clinical records
13/09 /2012 20.00 hrs	Mr RS called the CMHN and agreed to a home visit the following day.					Interviews
14/09 /2012 11.30 hrs	Dr KN's PA telephoned Mr RS regarding an out-patient appointment with SHO at the ATS following triage on 07/09/2012. Mr RS told her that someone was going to do a home visit and assessment that day. Appointment was put on hold until the BURS assessment complete					Clinical notes
14/09 /2012 13.00 hrs	Mr EY and Ms VG (CMHNs) carried out assessment at the home visit as planned. The assessment record includes notes the existence of 2 children, being cared for by his former partners in London (eldest) and Brighton (youngest), their dates of birth are provided, addresses are unknown and no		Complex presentation Reliance on self-reporting Structure and capacity of	Structure and capacity of BURS service Weakness in assessment and		Clinical notes

Date/ Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
	<p>safeguarding issues identified. At the end of the assessment, they recorded that no immediate risks were identified but they noted that his mental state may deteriorate with a possible risk to his parents. They noted:</p> <ul style="list-style-type: none"> • a difficult childhood; possible abuse which maybe delusional; • diagnosis of Asperger's; • no precipitating factors; • his preoccupation and fixation with thoughts of childhood abuse; believes parents involved in 'magic' and 'satanism'; some distress caused by these thoughts; limited insight; does not feel mentally unwell; • he had no thoughts to harm to self, no immediate risk to self or others; willing to accept help/assessment. <p>The outcome of the assessment and diagnosis were that Mr RS had possible delusional/over-valued psycho-sexual ideas – it was unknown if these were based on true childhood events; and a formal diagnosis of Asperger's syndrome. The management plan was to refer Mr RS to the ATS for a "routine medical appointment".</p>		<p>BURS service</p> <p>Weakness in assessment and management plan</p> <p>Family not involved</p>	<p>management plan</p>		
14/09 /2012	<p>Level 1 Risk Assessment (Comprehensive Screening) form was completed, using the information gathered during the interview. The form consists of several lists of risk factors items. Some suicide risk factors are identified; one neglect factor is identified;</p>		<p>Weak assessment</p>		<p>Significant omissions and errors in completion of the form.</p>	<p>Clinical notes</p>

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
	aggression/violence risk factors are identified; previous self-injury is also identified as risk factors (previous, not current).					
14/09/2012 16.00 hrs	Ms VG – telephone call to the ATS and agreed with triage nurse: Mr RS for routine medical appointment; to email confirmation.					Clinical notes
14/09/2012 16.15	Tel call to Ms VG, explain that further triage not required					Clinical notes
17/09/2012 11.15	Email sent to administration support team saying they have received a referral from BURS for a routine medical appointment 'preferably with a consultant', and the referral does not need to go through triage again.	The BURS CMHNs recognised the limits of their competence				Clinical notes
17/09/2012 11.30	Dr KN's PA had spoken to Ms VG; referral in tray for Dr KN to see & allocate.					Clinical records
20/09/2012 11.15 hrs	Appointment with Dr KN's SHO, Dr JO. Mr RS was seen by Dr JO, notes Asperger's diagnosis, allegations of abuse by his parents, conspiracy theories. He has shouted at his mother but no intention of visiting or harming them or himself. Does not present as psychotic, but had overvalued ideas about things that	Dr JO recognised the limits of his competence	Complex presentation Reliance on self-reporting Weak assessment			

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
	<p>happened in his childhood.</p> <p>Plan – discussed with Dr KN - no immediate risk to self or others, to see again with Dr KN.</p>		<p>Family not involved</p> <p>No immediate access to consultant advice</p>			
20/09/2012	<p>Letter to Dr TH, dated 20/09/2012, typed 8/10/2012 (received 12 October 2012), with information from the clinical record and adding that the BURS team felt he needed ‘a more comprehensive psychiatric assessment’.</p> <p>Dr JO wonders if Mr RS’s paranoid ideas about childhood abuse are more to do with the Asperger’s then developing psychosis. Thinks the ‘Mankind’ service in Newhaven might be of use to him.</p> <p>Records that Mr RS did not attend the 8/10/2012 appointment.</p>					Clinic letter to GP
21 Sept 2012	<p>SHO discussed Mr RS with consultant psychiatrist. Agreed further assessment was necessary, which was to be joint with both doctors. This was arranged for 8 October.</p>					Interviews
5 Oct 2012	<p>Incident – Mr RS attacked both parents, he was charged with alleged murder and attempted murder. His mother died in hospital, father seriously injured.</p>					Interviews
8 Oct 2012	<p>Mr RS did not attend the planned appointment and was telephoned.</p>					Clinical records
8 Oct	<p>Community Forensic Mental Health Nurse</p>					Clinical

Date/Time	Event description, action and outcome	Notable practice	Root causes	Contributory factors	Care and service delivery problems	Source
2012	contacted Dr JO for information, following the incident.					records
March 2013	Mr RS pleaded guilty to the 'culpable homicide' of his mother who died of a known serious heart condition following the attack; and to 'assault to danger of life' against his father.					Court records
July/August 2013	Mr RS was detained indefinitely in The State Hospital, to be released only with ministers' approval. In psychiatric reports to the Court he was diagnosed with 'paranoid schizophrenia'.					Court records

3.2 Notable practice

3.2.1 The independent panel agreed with the actions identified by the internal reviewers as notable practice. These were:

- The consultant was involved in the triage decision on 7 September 2012, following the initial GP referral to the mental health service.
- The GP, Dr TH, contacted Mr RS on the pretext of following up the outpatient referral, thereby maintaining the confidentiality of the parents.
- The BURS team made two attempts to telephone Mr RS and did a home visit.
- The BURS team engaged Mr RS in the assessment.
- The BURS team recognised the complexity of his needs and requested a consultant assessment.
- Dr JO, the SHO, arranged a follow up appointment for Mr RS with himself and Dr KN.

3.2.2 In addition, the independent panel would add the following as notable practice:

- i. The IAPT appointment was brought forward in response to Mr RS's inability to work.
- ii. The BURS CMHNs did recognise the complexity of Mr RS's presentation and that this complexity was beyond their competence to fully assess thereby re-referring him to a medical assessment, preferably with a consultant.
- iii. Similarly, Dr JO, then SHO, recognised that the complexity of Mr RS's presentation was outside the limits of his competence and requested a further, joint appointment, with the consultant Dr KN to complete the assessment.

3.2.3 Finally, although not part of notable practice in terms of the assessment and treatment of Mr RS, the independent panel were impressed by the honesty and candour of staff whose practice was questioned. The independent panel wish to commend staff for their openness and professionalism.

3.3 Patient factors

3.3.1 The independent panel identified two particular aspects of Mr RS's presentation as 'patient factors' in the events leading up to the homicide. These are:

- i. The complexity of his presentation, with Asperger's syndrome, expression then denial of intent to harm his parents, sometimes presenting with paranoid and psychotic symptoms and at other times not. He was described as a loner without friends. This seemed to be true of his circumstances in Brighton, but there were reports of him holding parties

(when illegal drugs were available); he had been able to hold down a job working in an off-licence relating to customers; and in fact he had friends from his school days. His needs were not fully understood.

- ii. Deliberately or otherwise, Mr RS was not fully open about his use of psychoactive substances, including legal and illegal drugs, and alcohol.

3.4 Care and service delivery issues

3.4.1 The independent panel agree with the nature and extent of the main problems in the provision of care and service which were identified in the report of the internal review. These issues were:

- i. Neither the BURS nurses nor Dr JO probed 'ideas of reference' (a psychotic symptom, (detail in Appendix Four) and feelings towards parents.
- ii. Neither BURS nurses nor Dr JO appeared to take into account the diagnostic report and how Mr RS presented.
- iii. Seen by an SHO for the first medical appointment despite preference expressed for consultant assessment. The consultant was present at the triage and made a judgement that Mr RS could be seen by an SHO. After the first appointment Dr JO did discuss with Dr KN and it was agreed that further assessment with the consultant was required because of complexity.
- iv. Mr RS was assessed by the GP, Dr TH, BURS and DR JO and was due to have a further assessment as no conclusion had been reached.
- v. Violence was not fully assessed.

3.4.2 In this analysis of care and service delivery problems the independent panel include the consideration of the human and other contributory factors. The independent panel also refer to these in the identification of risk points and their potential contribution to the homicide and assault. The independent panel explored this area by considering the questions - what happened at critical times that should not have? Together with - what did not happen that should have? In turn, this approach to examining the chronology of significant events prior to the Serious Incident (SI) assisted the independent panel when identifying later any root cause in organisational processes using evidence or a series of "why" questions posed during consideration of key phases of contact with Mr RS.

3.4.3 The Trust internal report clearly identified anomalies in service delivery during the autumn of 2012. In order to meet the Terms of Reference, the independent panel examined these further and included the elements of service provision from 2010 when Mr RS sought help to alleviate his increasing anxiety. The independent panel felt it was important to take this approach as the human

factors based on contact with the Trust's practitioners were very limited. In fact Mr RS was only in contact on three occasions and with only four professional staff. These comprised the cognitive behavioural therapist in 2010 and the two BURS community nurses who undertook assessment of his mental state after referral by the GP and Dr JO the SHO in 2012.

- 3.4.4 The longest period Mr RS had to engage with the Brighton service was the six sessions he attended with the cognitive behavioural therapist in 2010.
- 3.4.5 The mental health care organisation in Brighton evolved in the time that Mr RS was in contact with them during and after 2010. These changes were due to the previous service model, which was formed in 2007, being beset with systemic problems. The IAPT service which provided the CBT had been set up to deal with minor to moderate mental health needs. These services had been placed within the managerial remit of the Access team. The Access teams were over loaded and struggled with the referral and transition of complex and high risk clients. Such clients would then need to be steered to the Recovery service for care delivery under the auspice of the Care Programme Approach. One major difficulty arising from these systemic problems resulted in the Access team managing more complex and difficult cases for long periods (further details in Verita, 2014).
- 3.4.6 Following an independent review of the acute psychiatric provision by Professor K. Wilson in 2009 (quoted in Verita, 2014, p. 9), the Trust implemented changes in 2011-12 after an agreement with the commissioning Primary Care Trust in 2010.
- 3.4.7 Brighton and Hove Mental Health Community Services were also restructured in 2012 as part of the response to the problems of provision of care and service delivery at that time.
- 3.4.8 There are now three referral points to the Brighton and Hove Mental Health Community Services depending on the severity of the condition and the urgency of the treatment required. These referral points are:
- 1) Mild to moderate mental health problems referred to the Brighton and Hove Wellbeing service.
 - 2) Complex mental health needs referred to Secondary Care through the Hub's Assessment and Treatment Services (5 day priority and 28 day standard response times).
 - 3) Emergency assessments (within 4 hours) referred through the community pathway to the Mental Health Rapid Response Service (MHRRS), or the A&E liaison service out of hours.
- 3.4.9 Under these arrangements Mr RS would have been initially referred to the second service point (West ATS) by the locum GP (Dr OG) on the 5 September

2012. This referral was because Mr RS was complaining of issues of anxiety, anger control and discord with his parents. It would be part of the role and function of the ATS to receive referrals for consideration (i.e. triaged) in the assessment team. The triage occurred some two days after the referral on the 7 September 2012. A consultant psychiatrist was instrumental in the triage decision to refer Mr RS to the ATS for a routine medical appointment. Another option available within the ATS that could have been taken subsequent to triage was that of seeking to allocate straight to the Recovery Service for care under the CPA. This option was available as the structure of the service was designed so that the need for a referral from one team to another had been removed.

3.1 3.4.10 Given that further exploration of the nature of the delusions and the escalating psychosis may have become apparent to a psychiatrist, the option would have opened the door to CPA. If this had occurred, the CPA would have included a carer's needs assessment and it may have increased the chances of the family being able to input pertinent views as to the chaotic situation that was developing as a result of the bizarre beliefs of Mr RS and his attempts to confirm these beliefs.

3.2

3.3 3.4.11 It was eight days later after the initial referral that a second more urgent referral was made by Dr TH. This was made subsequent to an earlier telephone conversation that this GP had held with the parents of Mr RS. They did not wish the GP to disclose this conversation to Mr RS at that time. It is clear to the independent panel that the GP was correct when he emphasised on the referral that he "did not want it to be missed". This was a most accurate referral to the correct part of the mental health service, as Dr TH was concerned that the situation would escalate. This situation which was confirmed and aptly described to the independent panel by Mr RS on interview. The referral did not specify that Mr RS had threatened to kill his parents: if included, this information might have reinforced to the BURS team the potential seriousness of the situation.

3.4

3.5 3.4.12 Under the current arrangements, the referral by Dr TH would have been to the third service point - MHRRS - for an emergency assessment. This referral point is for situations when a client needs an urgent assessment due to immediate risk or acute need. In 2012 the BURS service was a relatively new one having being implemented in 2011 after the re-design of the acute service. It aimed then to provide a referral route for primary care with emergency assessment available to a client within 4 hours. In September 2012 the team

consisted only of two community mental health nurses and structurally sat outside of the ATS, which meant that the ATS consultant, Dr KN, did not have access to the full BURS records, only the assessment and risk assessment form left in hard copy in an in-tray.

3.6

3.7 3.4.13 The independent panel note that, prior to the incident, the BURS assessors did attempt to contact Mr RS at 18.30 hours on 13 September 2012 and they attempted to carry out a home visit. This was recognised in the internal review as good practice. They did not get any response from either telephone calls or when they first visited the home. The independent panel now know that Mr RS was probably at home when the BURS assessors called as he reports hearing a banging on the door and feeling scared. This was because he thought it was his father and others “who had come to sort me out”.

3.8

3.9 3.4.14 Mr RS did however phone the BURS team later at 20.00 hours and a visit was agreed for the following day (14 September 2012).

3.10

3.11 3.4.15 The independent panel has critically appraised the assessment process undertaken by BURS elsewhere in this report when they examined aspects of the risk assessment and management process. The information offered to the independent panel by Mr RS regarding his recollection of his mental state at the time was of particular value to them when they scrutinised key service and delivery issues.

3.12

3.13 3.4.16 In fact his mental health had been a problem since 2010. The domestic pressures he and his former partner were experiencing during 2010 led to him seeking help having been diagnosed earlier by Dr NK with social anxiety disorder. It was as a result of this that he was assessed and received six sessions of CBT via the Brighton and Hove IAPT service. He subsequently felt better for a short while and returned to work. The anxiety state returned however, and after the birth of his second child this became increasingly apparent. This coincided with the mother of his eldest child - moving away from Brighton to London. Mr RS was precluded from regular contact with the child whereas until then, she had stayed with him occasionally during the week. An arrangement was made for her to stay with Mr RS for a limited period during school holidays.

3.14

- 3.15 3.4.17 It was at this juncture that Mr RS and the mother of his second child decided to relocate to Glasgow where Mr RS had lived as a student when studying art.
- 3.16
- 3.17 3.4.18 This move was not successful and the domestic situation deteriorated as did the resilience of Mr RS to cope with any stressful situation. The result was that Mr RS resorted firstly to excessive drinking alcohol and then to smoking cannabis and legal highs. He had been prone to binge drinking since 2005.
- 3.18
- 3.19 3.4.19 It was during the above episode that he began to contemplate a previous idea that he may have Asperger's syndrome. He saw a GP on 17 June 2011 who referred him to the Stewart Resource Centre, CMHT, Greater Glasgow and Clyde. This led to him attending the Glasgow Adult Autism Service. Here he underwent a battery of diagnostic tests and as a result he was considered to have Asperger's syndrome. A diagnostic report and support plan was issued to him.
- 3.20
- 3.21 3.4.20 The domestic arrangement with his partner collapsed and she decided to return to Brighton. He remained in Glasgow until April 2012 when the lease on their accommodation expired, when he also moved to Brighton to be near his younger daughter but remained separated from Ms AV.
- 3.22
- 3.23 3.4.21 Mr RS reports that it was during this time of transition in 2011 whilst waiting the lease to expire on what up till that time was still shared accommodation with his partner and child, that he smoked a joint of "synthetic cannabis". He maintains his belief that it was this action which triggered schizophrenia. It is a fact confirmed by his former partners and family that during this time Mr RS became increasingly psychotic. This manifested itself as hearing voices and believing that extra-terrestrials were communicating with him.
- 3.24
- 3.25 3.4.22 His paranoid views continued when he moved back to Brighton. He explored the loft space in his new flat as he thought cameras had been installed to monitor him.

3.26

3.27 3.4.23 During this phase he had regular contact with his younger child who stayed with him approximately twice a week and less frequent contact with his elder daughter who lived in a different city. He was preoccupied with conspiracy theories and the presence of aliens. He was convinced that, as the year 2012 was the end of the Mayan calendar, a cataclysmic event was going to occur. His thought processes included theorising about reptilian aliens being disguised as child abusers.

3.28

3.29 3.4.24 During the summer of 2012 he took both children to visit his parents. At some time during the holiday with them he made a comment about Nazis, a topic he had also researched, and a Jewish person. He felt that his father had wrongly rebuked him and he felt extreme anger. This resulted in Mr RS swearing at his father, calling him a child abuser and going on to punch both fists through a garden bench.

3.30

3.31 3.4.25 Mr RS and the children returned to Brighton and London. He continued to smoke 'legal highs' and he vividly recalls becoming increasingly paranoid. He was also experiencing visual hallucinations and feeling that he was an important part of future revelations.

3.32

3.33 3.4.26 Mr RS deduced whilst in a highly paranoid and emotionally aroused state that he had been drugged by his father when a child and been sexually abused. Mr RS voiced his views to his former partner, the mother of his youngest daughter who by this time was very concerned about the state of his mind. The situation was by then becoming very serious with Mr RS defaulting on rent, getting into debt and levelling accusations over the telephone to his father. Despite his parents offering to travel to Brighton to see him, he was fearful and stated that he did not want his father near him. The predominant thoughts held by Mr RS at this time were that society was "rife with child abusers", and that his social network had been infiltrated by them.

3.34

3.35 3.4.27 Mr RS also thought he was indestructible. Whilst he was looking after the youngest child in his flat, he recalls becoming increasingly angry due to thoughts that his father and perhaps his mother had been abusing his children. He considered that his parents were part of a secret satanic cult.

3.36

- 3.37 3.4.28 Mr RS took his child to the local park in an attempt to calm down and on the way called at the GP surgery, hoping to be prescribed Valium in order to “calm him down”.
- 3.38
- 3.39 3.4.29 He could not get an immediate appointment and so later that afternoon returned and spoke with Dr OG. This consultation resulted in the first referral to the ATS. Mr RS recalls that his actual motive for seeing the GP was so that he could prove to his former partner that he was sane and therefore justified in his accusations.
- 3.40
- 3.41 3.4.30 Unbeknown to Mr RS his parents then spoke with the GP (Dr TH) to express their concerns about his mental state. The independent panel were able to confirm that Mr RS responded to a request from Dr TH for him to attend the GP surgery on 13 September 2012.
- 3.42
- 3.43 3.4.31 It was as a result of this consultation that a referral to BURS was made. The independent panel have commented on the BURS process that followed earlier in this report. Mr RS recalls subsequently talking for approximately one hour to the SHO (Dr JO). He left with the impression that Dr JO was not unduly concerned and Mr RS then informed his former partner that he felt Dr JO thought he was all right. Whilst she expressed her doubts regarding this conclusion, Mr RS perceived this was reinforcing his convictions. Mr RS was seeking help from healthcare professionals to confirm to himself his view that there was nothing wrong with him and to enlist help in resolving the conspiracies against him.
- 3.44
- 3.45 3.4.32 This culminated in extreme anger and fear being experienced by Mr RS. He was experiencing conflicting emotions regarding his perceived need to confront his father in person and “get things out in the open”.
- 3.46
- 3.47 3.4.33 The paranoia was escalating and he decided to telephone his parents but they were not in at that time. Whilst in this heightened state of arousal he spoke with the house cleaner and during the conversation there was mention of an article in the paper about a child abuser. Mr RS recalls her sentiment something to the effect that ‘stringing them up was too good for them’. He

interpreted this as a sign that she was undercover and was confirmation that good people were watching over him and that the time had come to confront his father.

3.48

3.49 3.4.34 This psychotic phase culminated in Mr RS withdrawing cash from his daughter's account, travelling by train to his parent's on the same day and, on entering the house, in attacking his father. The attack was vicious in the extreme and his mother who suffered from a chronic heart condition suffered heart failure and later died.

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3.51 3.4.35 Mr RS was arrested the following day at Euston station having spent the night with a friend.

3.52

3.53 3.4.36 Mr RS was most helpful to the independent panel in providing them with his recollection of events in order for them to present the chronology. This enabled the independent panel to consider at what juncture and risk points in mental health care the service might have been more effective. Further, Mr RS provided the independent panel with a detailed account of his current motivation to progress whilst detained indefinitely within the High Secure Service.

3.54

3.55 3.4.37 Whilst the Terms of Reference end at this point the independent panel acknowledge the ambivalence the family and former partners of Mr RS feel. They appreciate his mental health appears to be improving yet they are still having to adjust to the impact and aftermath of the consequences of his actions.

3.56

3.57 3.4.38 Later in this report the independent panel comment on the engagement of services with Mr RS after his initial diagnosis with anxiety in 2010 and then with Asperger's syndrome in 2011 (Section 3.7). His diagnosis on admission to the State Hospital was paranoid schizophrenia. The independent panel's consideration of the appropriateness of the care pathways and treatment options end at the time of the incident. Those treatment options prior to the incident have been identified and examined, in line with national standards and best practice.

3.58

3.59 3.4.39 It has been necessary to explore the processes of care and service delivery and use the concept of risk and recovery as a yardstick with which to

measure the effectiveness of service input at specific times of Mr RS's engagement with the Trust.

3.60

3.61 3.4.40 His first contact with the Trust resulted in a six session treatment with a cognitive behavioural therapist (CBT) under the IAPT service. This was a newly developing service at the time and part of a national pilot scheme. The independent panel have been able to confirm that this symptom reduction service was effective for a while. The independent panel have, however, criticised some aspects of the process of the assessment and recording of risk at that time. This criticism is balanced alongside the national standards and practice associated with IAPT services during 2010. Whilst there was a lot of work and research evidence available about risk assessment in secondary mental health care, relatively little was known about the process at the commencement of a patient's care pathway within IAPT services or within GP practices.

3.62

3.63 3.4.41 The drive for developing IAPT services was promoted by the NHS (2010) in a report titled, 'Realising the Benefits. IAPT at Full Rollout'. It was not until two years later that valuable research from Warwick University contributed to exploration of some of the issues that the independent panel have identified when they scrutinised areas of weakness in the initial IAPT risk assessment (Vial and others, 2012).

3.64

3.65 3.4.42 The researchers found variable approaches to mental health risk assessment in eight GP practices and eight IAPT clinicians from two primary care trusts. The clinicians were anxious that important risk information as part of service delivery and care was being missed, and risk communication was undermined. Patients felt uninvolved in the process and both the clinicians and patients expressed concern about risk assessment skills.

3.66

3.67 3.4.43 The research concluded that a more structured and systematic approach to risk assessment in general practice and IAPT services was needed, to ensure important risk information was captured and communicated across the care pathway. The point was clearly made that IAPT services provide clinicians with direct access to mentally ill patients who may be a risk. Understanding the risk assessment process within such services and trying to strengthen practice

were essential if adverse risk outcomes were to be avoided for large numbers of patients.

3.68

3.69 3.4.44 The independent panel comment later with regard to the IAPT minimum data set scoring being incomplete in 2010 (para 3.12.1). The contemporary research evaluating national practice at that time, found similar inconsistencies to be not uncommon. Despite the range of tools used, the research findings showed IAPT practitioners did not have set procedures or specific questions for assessing mental health risk, and were being flexible in the approaches they adopted. They often relied on their own clinical judgement and experience about how to approach the topic of mental health risk.

3.70

3.71 3.4.45 Although that approach may have offered the practitioners some flexibility, weak screening or a failure to identify risk information in any systematic way means there will always be a potential for important pieces of information to be missed. "Gut instinct" can be an important clinical resource, when based on observing patterns of risk cues in a patient's presentation over years of experience. If, however, any unease based on gut instinct is also located within the precise details of a risk profile, relevant information is more likely to be communicated and shared within and between services.

3.72

3.73 3.4.46 The independent panel was supplied with the policies and procedures now being used in the Trust mental health services. These are reinforced by the provision of training and professional development. The work undertaken by the Trust reflects the benefit of implementing a more systematic approach to the assessment of risk. These processes, which are expected to be followed throughout the service, are aimed at ensuring coverage of all risk areas which need to be considered. They also provide suitable questions and prompts for tapping into necessary information.

3.74

3.75 3.4.47 The independent panel formed the opinion, based on scrutiny of the work that has been undertaken throughout the service since the incident, that it is likely to contribute to improved outcomes for service users, families and clinicians; helping to keep people safe; and likely to bring greater peace of mind and confidence respectively.

3.76 3.4.48 The challenge for Trust clinicians and for the primary care services, including GPs, is to develop a mechanism by which all relevant risks can be screened rapidly, whilst at the same time ensuring the safety of the patient and others around them. The objective being that information can then be

communicated to other clinicians further along the service user pathway, who have more time and the opportunity to undertake more in-depth assessment.

3.77

Panel consideration

Much of the above is concerned with a pre-requisite of HOW risk information is collected. The service care and delivery problems identified by the internal level 2 internal review clustered around the USE of information when it was collected.

The independent panel felt that these problems contributed to a lack of consistency in assessing risk and the tools used across the service areas. This lack of consistency meant there was inevitable variation in the risk information collected and the way it was actually recorded and then communicated, within and between services.

3.78

3.79

3.80 3.4.49 As a result of intensive work on risk assessment and management the Trust has now introduced a system that is much more capable of providing a transparent audit trail regarding what information the risk decisions are based upon. The audit criteria monitors on an annual cycle, compliance against standards detailed in the Trust policy and procedures, the NHS Litigation Authority and the Care Quality Commission outcomes.

3.81

3.82 3.4.50 A level of 70% compliance is considered acceptable and in the year following the incident concerning Mr RS (2013-14) there had been a small decline in compliance. Community teams scored lower in comparison to in-patient services on most standards and scored consistently lower across all aspects of risk review. The independent panel were made aware of action plans that had been designed to address areas of particular concern for each care group.

3.83

3.84 3.4.51 The Clinical Risk Assessment and Safety Planning /Risk Policy and Procedure was ratified in December 2014. This document identifies key elements which pertain to the service care and service delivery problems associated with the engagement of Mr RS with mental health services between 2010 and 2012.

3.4.52 Of particular relevance are the instructions that:

- staff will work collaboratively with service users and carers in an assessment of risks and the development of safety/risk management plans;
- at first contact or assessment all service users must have at least a screening risk assessment; and
- if there is new information or a change in the service user's presentation or circumstances which could potentially impact on risk, the assessment should be reviewed.

3.85

3.86 3.4.53 The independent panel was impressed with the work being undertaken in the context of risk and how this impacts on the quality of care and service provision.

3.87

3.88 Recommendation 1

3.89 The independent panel recommend that the Trust-wide Risk Panel develop a reliable method for systematically and comprehensively obtaining the views of family members where appropriate when screening for risk.

3.4.54 In the light of this recommendation, the rationale for such action and the implications for patient confidentiality, it is helpful to refer to relevant Department of Health guidance on confidentiality and disclosure.

3.90 3.4.55 Agencies should have in place clear agreed policies on information sharing, which advise on the "need to know". If someone other than the service users is at risk, advice must be sought from the public protection team or multi-agency public protection arrangements, so that an appropriate public protection plan can be activated. The rationale for any disclosure without consent, for example to prevent harm, should be clearly documented.

3.91

3.92 3.4.56 When the service user has a first crisis episode and has not had contact with mental health services before, the family and in particular the main carers' contribution to information gathering is critical. In this situation, the carer has the most knowledge about the service user and is a vital source of information and support. But this could be a stressful time for the carer as well as the

service user and practitioners must acknowledge this when working with carers during a first crisis episode (see also recommendation 5 in the internal report, quoted in para. 7.1.22).

3.93

3.94 3.4.57 In the Department of Health (2010) guidance the point is made that confidentiality within accepted parameters should not be a barrier to effective communication. The Code of Practice on Protecting the Confidentiality of service user information reinforces such vital components in the management of risk. Health care professionals should be aware that it is not regarded as a breach of confidentiality for them to receive information from carers, family or significant others; it is a breach of confidentiality to disclose or discuss personal information provided by service users to carers, family or significant others without lawful authority.

3.95

3.96 Recommendation 2

The Trust should ensure that all staff fully understand the limits to confidentiality, particularly in relation to risk of harm to self or others, and ensure that practice is in line with legal, professional and Department of Health guidance.

3.4.58 The Trust's 'Safeguarding and Child Protection Strategy' in place at the time is also very clear as to the need to 'think family' and for the Trust Board to ensure that 'all clinical risk assessment proformas, and other, documents prompt staff to Think Family' (para 4.4).

3.97 3.4.59 Addressing the above points should lead to better practice at the Trust, enabling experienced consultant input when needed in order to establish accurate diagnosis and due consideration of complex presentation such as that seen in Mr RS in September 2012.

3.98

3.99 3.4.60 Recognition of the need to access consultant level expertise is reflected in the Trust's contemporary Risk and Safety policy when it quotes a definition of a main approach to assessing risks. The statement acknowledges the relative values of:

- i) an unstructured clinical approach which tends to be anecdotal and inconsistent information which is gathered systematically;
- ii) an actuarial approach which tends to focus on risk factors statistically in large samples of specific sections of the population;

- iii) a structured clinical (or professional judgement) which is the approach that offers most potential where violence risk management is the objective. This approach involves the practitioners making a judgement about risk on the basis of combining:
 - o an assessment of clearly defined factors from research;
 - o clinical experience and knowledge of the service user; and
 - o the service user's own view of their experience.

3.100

3.101 3.4.61 In addition, a detailed clinical risk training programme which includes the opportunity for staff to attend a five day course run by the University of Surrey and a half day which focuses on violence, is being rolled out during 2015. The Trust wide Clinical Risk Panel continues to provide consistent clinical, managerial and organisational guidance for the most complex and high risk patients.

3.102

3.103 3.4.62 The independent panel was able to evidence the positive progress being attained in the area of risk assessment and its contribution to helping staff when they have to face care and service delivery problems associated with service users who may be an "unknown quantity" when first engaging with mental health services.

3.104

Panel consideration

The above points which relate to the nature of care and service delivery are reflected in national professional concerns about the mismatch of what service users need and clinicians want, and what too frequently actually occurs in practice even if though this may be in a minority of cases. These concerns tend to be linked to a lack of resources and pressures of busy workplaces.

Themes from national surveys include resource issues and of inadequacy in being able to follow through on detailed assessments. These are sometimes linked to a tendency to focus on risk assessment based on a misguided notion that it is possible to predict the future. Although a lot of the evidence relates to crisis care, similar pressures apply in community mental health teams (Royal College of Psychiatrists, 2008).

3.105

3.4.63 The independent panel examined the reasoning behind the level 2 internal review report's recommendations and felt that all of the recommendations reflected a clear link between contributory factors, care and service delivery problems and the lessons learned. Of particular note was the importance of the

first recommendation regarding “first medical appointments”, particularly those with a complex presentation, to be assessed by a consultant or an experienced doctor when pursuing best practice standards in this area of care and service delivery. The national position between 2010 and 2012 had much in common with the Royal College of Psychiatrists’ description in their report (2008). This highlighted the need for an improvement in the culture of practice in organisations so that reflective practice should be embedded into supervision and organisational practice. Although aligned with the poor support in many areas for junior doctors dealing with self-harm cases the critique was most apt when assessing risk to others.

3.106 3.4.64 Respondents to this survey identified that many staff felt that they were either not trained, or not adequately trained, or supported and supervised on psychosocial assessment.

3.107

3.108 3.4.65 Dr JO recognised weaknesses in some areas of his own preparation for undertaking such assessment. He was most helpful in discussing with the independent panel how, on reflection, he felt that the supervision processes in place at the time of his assessment of Mr RS could have been improved.

3.109

3.110 3.4.66 Findings from such national surveys that have particular relevance to the situation in the autumn of 2012 in the Brighton service. Relevant findings from the Royal College of Psychiatrists’ report (2008) included:

- Young psychiatrists reported that they felt ill equipped for the work- particularly in areas where risk is associated with drugs and alcohol.
- Others reflected on the inadequate assessments that they and others made because of the lack of experience and time.

3.111

3.112 3.4.67 The report concluded that such a situation was unacceptable by any reasonable standards, stating “experienced clinicians need to supervise and ideally to assess these patients. Lives may be at stake and wellbeing certainly is”.

3.113

3.114 3.4.68 Supervision is not just relevant to junior medical staff, however. As doctors become more experienced so the need for supervision will decrease. Once appointed as consultants doctors must also participate in peer group

learning. All doctors should engage in reflective learning whether as trainees, senior doctors or consultants. Once fully qualified, all doctors must demonstrate participation in continuing professional development, including reflective practice, as part of the revalidation process and in order to remain licensed to practice as a doctor (General Medical Council, 2012).

3.115

3.116 Recommendation 3

3.117 The Trust should ensure that all medical staff receive sufficient support from colleagues and peers who are available to them. For trainees, this should include supervision by consultants and for consultants, peer group learning. Reflective practice should be embedded in the supervision process, in continuing professional development and in organisational practice.

3.4.69 The independent panel thinks that, if implemented, this recommendation will assist in clinicians designing formulation based approaches to assessing and managing potential risks, rather than stock piling information or reverting to the weakly defined categories e.g. low, medium and high. The ultimate aim is to encourage the multi-disciplinary team to avoid defensive documentation, to provide structure to care planning, risk assessment and risk management, and to add value to professional development.

3.5 Review of engagement, assessment, treatment and care from July 2010 to October 2012

3.5.1 These issues are covered in detail in the following sections. His assessment, care, treatment and engagement with the IAPT service in July – September 2010 are reviewed in section 3.7, as is his involvement with the Autism Support Service in Glasgow in 2011. Aspects of his assessment and engagement with the BURS team and the medical appointment with the SHO are discussed in detail in sections 3.4 and 3.5. Care and service delivery issues, risk management, communication with other agencies and with Mr RS's family and former partners are reviewed in detail in sections 3.4, 3.6, 3.9, 3.10 and the independent panel do not propose to repeat those discussions here.

3.5.2 With specific reference to 'engagement', it was evident from the clinical records and interviews that Mr RS was keen to engage with services and seek help. On occasions he took the initiative, with the support of his family and Ms AV. Initially the independent panel, along with others, interpreted this as simply seeking help to address and resolve his mental health issues. There were times when he expressly said he wanted help to understand his thoughts. However, it became apparent from the interview with Mr RS that when he attended appointments in September 2012 with his GP and the SHO, he was actually looking for help to be declared 'sane' and to legitimate his bizarre

thoughts. He could then inform his former partner of this. He was also seeking help to tackle the conspirators about whom he developed his paranoid ideas. This discrepancy in interpretation of a simple word 'help' serves to highlight the complexity of his presentation and the ease with which over reliance on self-reporting can mislead health professionals.

3.6 Review of risk, safeguarding issues and management

- 3.6.1 This section describes best practice and national standards for risk assessment, and indicates compliance by the Trust and where practice deviated from these standards. The nature of the identified problems around the limited contact that RS had with the Trust were rooted in the poor identification of risk points and the potential contribution of these to the serious incident. Further in-depth examination by this level 3 independent review could not establish a single and clear link between any likely cause and effect. However, the independent panel were able to evidence aspects of weak assessments which were sometimes based on inaccurate inadequate record keeping, systemic and service demand problems. There was also lack of recognition by professionals of the value of seeking information from the family and relevant parties being affected by the nature and degree of the mental health issues presented by Mr RS.

Panel consideration: Self-reporting and Risk Assessment

In several ways this case has highlighted the problems that may be encountered when professionals rely too heavily on self-reporting of information when they form judgements about risk.

Recent research (Royal College of Psychiatrists, 2008) tends to reflect concerns that the views of service users are not paid sufficient attention in policy or practice. Concerns are based on the service users who are aware that they could pose a risk to other people when experiencing psychosis. Those service users are motivated by wanting to help reduce the chances of this occurring.

There is also a converse situation that must be considered by those undertaking the assessment of risk. That is, the possible consequences associated with someone who is either unaware of the risk they pose, or intends to deliberately obstruct accurate assessment.

This dilemma is one of the reasons that careful, well informed risk assessment and management is a key requirement for mental health professionals.

- 3.6.2 Most professionals are aware that despite consistent research evidence showing that service users' contribution to violence in society is minimal, service users are increasingly defined in terms of risk and dangerousness. (L Langen and V Lindow, 2004)
- 3.6.3 The risk assessor has to consider what negative impact the focus on risk of violence can have on a service user, healthcare professionals and organisations. This negative impact may involve excluding the service user from decision making regarding their life. In addition, inappropriate over-reliance on risk assessment forms ('tick-box culture') can be a sign of defensive organisational or medical culture, used to protect against litigation rather than as a basis for care and management (Royal College of Psychiatrists, 2008).
- 3.6.4 One of the problems that presented to those assessing risks associated with Mr RS was that of placing previous assaultive behaviour, serious verbal threats and intimidation within a context of his beliefs and ideas. It appeared most difficult for professionals to be sure whether his prior aggressive behaviour was due to any situational factors, e.g. his zeal when feeling compelled to avenge what he interpreted as a wrongful act being committed or due to a psychotic episode.

- 3.6.5 The CMHNs who completed the BURS risk assessment and Dr JO were aware of his previous history of assaults. The challenges for assessors of his risk behaviours meant that it should have been considered essential to explore the nature of his previous assaults, together with ensuring that accurate examination of as much supporting information as possible was made. All of the acquired data should have then have been recorded accurately on the Trust standard risk reporting documents.
- 3.6.6 The weaknesses identified above are not uncommon when time-pressured risk assessments are made. This can result in examples where service users are not actually involved in the risk assessment. However, it can also result in service users, family or significant others being unaware that professionals were formally assessing risks.
- 3.6.7 Whilst it is uncommon for service users to be given copies of any risk assessments, some services have workers in the field who consider this to be good practice and are working towards doing so. A problem remains for professionals when they explore and discuss risks with service users as they may find the content difficult. Professionals tend to find discussion easier when they know the service user well, including their positive qualities. This of course means that a good relationship exists with them which has been built up over time. The BURS process could not rely on such a relationship due to the functioning of the referral service. Therefore, for effective collaborative risk management to follow the initial assessment, the content and quality of data entries can be critical.
- 3.6.8 In summary, a balance had to be made during the initial assessment of risks between holding a full and frank discussion and protecting the personal safety of the assessors and others who may have informed the process. This sort of discussion could have caused distress to Mr RS with a subsequent disengagement from assessment. Disengagement was a possibility because Mr RS later expressed his anger and was contemptuous of questions asked regarding his relationship with his children, when he described the assessment to a former partner.
- 3.6.9 On the other hand, Mr RS had a right to know what was written about him and this may have increased the trust between him and the BURS assessors with a potential for collaborative risk management.
- 3.6.10 This point is reinforced when considering that Mr RS had responded to the advice from a former partner (and prompted by his parents) to seek help by attending the GP surgery on 5 September 2012.

- 3.6.11 The independent panel explored these points with the family and the former partners. With the exception of one former partner, there was a consensus that, if the possibility of an informal admission to the service had been an option based on possible risks associated with his distorted logic whilst psychotic Mr RS would likely have accepted this option. Mr RS himself confirmed at interview that he would have been willing to accept treatment, including informal admission as an in-patient.
- 3.6.12 The independent panel was able to evidence that the recorded accounts which would have informed risk assessment were consistently poor or inaccurate (Section 3.12 of this report). This aspect became increasingly obvious when the independent panel sought the views of former partners, who are the mothers of his children, his family and Mr RS himself. Service users have the right to have accurate information about them on record. Overestimation of risk can lead to them developing an unwarranted lifelong reputation for being dangerous. They are then responded to on that basis by agencies. Underestimation of risk can lead to the service user being under supported and professionals and importantly others, particularly those close to them being placed at risk.
- 3.6.13 Following on from a diligent initial risk assessment there should be a basis for the production of a risk management plan. Ideally this should be informed by the input of a qualified psychiatrist and it may include the requirement for compliance with prescribed medication. Risk management is more likely to be successful when the service user receives a quick and effective response to any difficulties.
- 3.6.14 Uncertainty about whether such a response will occur can be a major concern to the service user and their relatives. It certainly seemed to be a concern for the family of Mr RS whilst they waited to hear the outcome of their attempt to get Mr RS an accelerated appointment with specialist psychiatric help via the GP (Dr TH). A speedy and accurate response following assessment is required because the period between the service user realising that they are becoming unwell and seeking help, and becoming so unwell that they reject help or become a risk to other people can be a matter of days if not hours in some cases.
- 3.6.15 Contemporaneous evidence highlights some of the benefits of types of support that can be identified at assessment and then integrated into an initial care plan. Of these, the following provisions may have benefited Mr RS, his family, former partners and daughters:
- specialist support for any children being adversely affected by a parent with mental health difficulties;
 - specialist assistance for alcohol and substance misuse;
 - therapeutic input; and
 - anger management and self-help or self-management group work.

Panel consideration

The independent panel are aware that the service demands at the time may have constrained the ability of BURS assessors to undertake a detailed systematic level 1 risk assessment and a subsequent outline risk management plan. They did indicate that due to complexity, Mr RS should be seen by a consultant (hand written note by Ms VG). The independent panel do not assume that the risks would have been more accurately assessed and any consequences predicted if this action had occurred. However, the independent panel do suggest that the revised system for risk assessment and risk management includes a format to be developed which ensures the service user's views and those of significant others are taken into account.

- 3.6.16 The internal review report highlighted the weak elements of risk assessments as part of the care and service delivery problems. A root cause noted in the report was that of mental health assessments not fully considering Mr RS's violent history.
- 3.6.17 One response to this criticism has been the production of good updates on the Trust's Clinical Risk Assessment and Safety Planning/Risk Management Policy. These updates include the results of the reviews of the clinical risk tools, the clinical risk training package and strategy, the Trust Clinical Risk Panel and the Trust Audit of Clinical Risk.
- 3.6.18 The policy revision has been made in line with national guidance and was ratified in December 2014; it will be presented for revision again in 2017. A key element included instruction that staff will engage and work collaboratively with service users and carers in an assessment of risks and the development of safety and management plans.
- 3.6.19 As part of the Terms of Reference the independent panel are asked to review risk assessment, policy, and procedures and their compliance with national standards and best practice. In order to do this the independent panel examined the deficits in the way in which risk had been considered in the components of the three assessments that Mr RS had during September 2012, including the GP, BURS and the SHO. The independent panel were then able to comment on how risk assessment information best practice to national standards might have been administered to better effect.
- 3.6.20 A systematic approach would have gathered information in order for the service to consider at least three important dimensions. These are:

- history and pre-existing risk factors;
 - mental state, with current thoughts and emotions; and
 - current social circumstances and care options.
- 3.6.21 The level 1 risk assessment used by BURS on 14 September 2012 included prompts on risk factors found to be associated with an increased risk particularly of suicide and violence.
- 3.6.22 Those prompts were intended to act as a stimulus to alert the assessors to a possibility of increased risk, factors to pay attention to, and, when further information may need to be sought.
- 3.6.23 Many of the factors associated with the increased risk of violence are not related to mental illness. Clinical practice suggests that the presence of active symptoms of psychosis are associated with an increased risk of aggression but are only one factor in the complex interplay of biological, psychological and social factors, history and experiences which inhibit or support adaptive functioning.
- 3.6.24 Examples of other factors include more general correlates of potential offending such as previous aggression, substance abuse, history of conduct disorders, plus demographic factors such as frequent moves from residence, unemployment etc. However, if the service user has any history which may include offending, the risk assessment should include any links between this and a mental disorder, e.g. active symptoms, belief systems and level of insight.
- 3.6.25 The aim of screening the risks is to gain as much history from interview with the service user and others, where information should be sought specifically on past incidents of harm or potential harm to self or others (including periods of risky behaviour). Detailed examination of past incidents should be considered and include, the nature of any incident, exactly what harm was caused, the circumstances of the incident, who suffered as a consequence, risk factors present at the time, and the outcome. This should include:
- recency: the more recent the more alert the assessor should be;
 - severity: the more severe the more alert the assessor should be;
 - frequency: the more frequent the more alert the assessor should be; and
 - the pattern of any previous incidents.
- 3.6.26 Such examination regarding what was going on in the life of the person being assessed at the time helps in the identification of protective/triggering factors and circumstances that can alter risk. It is important for the assessor to ask the service user what they feel is protective, i.e. what has reduced risk in the past and why. Typical examples usually include: being in supportive relationships; fewer financial worries; appreciating early warning signs; seeking help in a crisis; different coping strategies; and abstaining from alcohol and/or psychoactive substances. Clearly, knowing these areas can indicate to

assessors where the referral should be targeted for the most effective intervention.

- 3.6.27 One of the reasons that Mr RS was assessed by BURS and later by Dr JO was to examine his mental state as the GP had indicated concern including reference to possible risk based on information from the parents of Mr RS. Risk is dynamic and can change rapidly hence the importance of following best practice when considering history particularly the highlighting of particular symptoms or thoughts or behaviour present prior to any past incidents or crisis. The areas of weakness in both assessments included the need to explore more the frequency, prominence, and intensity of any thoughts of harm, his level of impulsivity, and his attitudes towards family and peers and those in authority. These areas are important to note when implementing best practice. In addition, it is important for the assessors to consider current coping strategies, alongside discrepancies in what is reported and what is observed together with incongruence in verbal and non-verbal cues e.g. the BURS assessors found it difficult to challenge his beliefs with rational argument.
- 3.6.28 Furthermore, Mr RS admitted thoughts of harming his parents to the BURS assessors on 14 September 2012 but “smiled and said I probably shouldn’t tell you that”. This was a thought he also echoed to a former partner when telling her about the assessment that was undertaken by BURS. Other individuals, including children and family members, may be at particular risk where they are incorporated into the service user’s delusional or belief system. There was no indication from Mr RS that his children were at risk except that they were being exposed to bizarre thoughts and beliefs around conspiracy theory and reference to him telling his elder daughter that he had been abused as a child by her grandparents, which was not correct.
- 3.6.29 Consideration needs to be given to current social and environmental stressors when seeking best practice in risk assessment. If these are similar to those present prior to any previous recorded or reported incidents then concerns should be raised. High risk circumstances are those in which there is current access to means and identified potential victims, especially where those people are vulnerable (e.g. children, the elderly, vulnerable women /partners). It is most important when considering any risk to be aware that strangers are many times less likely to be victims of someone who is mentally ill than their partners and family.
- 3.6.30 The summary of a risk screen should aim at creating a case formulation of risk. This may include the identified risks (their nature, to whom and in what circumstances), the reasons for coming to the conclusions and where there may be gaps in information. The formulation should address how serious, imminent, volatile and specific the risk is. From this information it is then possible to

determine how effective the plan following the referral to a particular service is likely to be in addressing the risks.

- 3.6.31 Failures in risk management are frequently attributed to key information about risk not being passed to others likely to be involved in care delivery. This includes failure to share information both within services and between agencies.
- 3.6.32 It has to be acknowledged that the build-up pressure of working within a busy mental health service, such as Brighton and Hove, can compromise best practice in risk assessment. There are a number of implications for resources, most notably staff time. A risk assessment which is fit for purpose demands close scrutiny of notes, seeking information from other services, interviews with significant others, and the time available to document and share information with those who need to know. The independent panel have described elsewhere the action the Trust has taken since this serious untoward incident to achieve the above objective of best practice.

3.7 Review of engagement of services in 2010 and in 2011 and pathways

- 3.7.1 The terms of reference required the independent panel to consider and review the engagement of services with Mr RS, together with the appropriateness of the pathways and treatment options in line with contemporaneous standards and best practice. Aspects of Mr RS's contacts with the IAPT service in 2010, including the six sessions of CBT, have been discussed above, as has the research evidence regarding IAPT services published in 2012. (Paras. 3.4.40 – 3.4.42)
- 3.7.2 A specific example of the way in which service demand pressures could influence practitioner mistakes made in aspects of routine or standard assessment was found in the IAPT access screening process. Such mistakes could then, in turn, influence future assessments.
- 3.7.3 The process began with a referral from a GP Dr NK on the 5 July 2010. The IAPT Triage document which included the Access Risk Screening Tool was undertaken by CBT therapist (Ms ZE) on the 27 July 2010. At that time there was a 12-16 week waiting list for CBT sessions. The process relied almost totally on self-reporting of symptoms and needs. Examination of the information contained in this document clearly shows errors in completion and therefore the administering of the process of referral (Section 3.12).
- 3.7.4 The independent panel would add here that the treatment Mr RS received was in line with best practice at the time. He could have attended more than six sessions if he and the therapist had agreed that this would have been helpful, but both felt that more sessions were not required. He did engage with the sessions and completed some, but not all, of the 'homework' which he had agreed to work on between sessions.

- 3.7.5 CBT focusses only on managing symptoms in the present – nothing more. It is not appropriate for people with complex and confusing presentations who need a deeper understanding of how they arrived at their present circumstances, their risk and their management. With hindsight, it transpired that Mr RS's presentation was complex and confusing. There was still the central pathology of his inability to have empathy, to understand that people may have feelings different from his own and to see things from other's points of view. His anxiety came from a larger problem, not something that CBT could resolve.
- 3.7.6 The diagnosis of Mr RS with Asperger's syndrome in 2011 was a significant aspect of his care and treatment. This diagnosis of Asperger's syndrome was made when Mr RS attended the Greater Glasgow & Clyde NHS Adult Autism Additional Support Team. It was subsequently recorded by the team that as part of the likely assessed signs Mr RS appeared to smile as a "default" rather than as an expression of any true emotion. The recommendations following this diagnosis were that Mr RS:
- be invited to participate in next post diagnosis course, at the Autism Resource Centre (ARC);
 - be given information about the NAS employment support scheme;
 - be given information about the 'Autism Alert Card'; and
 - is welcome to phone the ARC to see a clinician to discuss 'issues that may arise in the future'.
- 3.7.7 These recommendations were for Mr RS to follow up. He attended group sessions for people recently diagnosed with Asperger's syndrome, was given information about the NAS employment support service but did not take up the offer to contact a clinician.
- 3.7.8 The diagnostic report was known to Mr RS's GP and the GP included this fact as part of the referral to the West Brighton Assessment and Treatment Service on the 5 September 2012.
- 3.7.9 Examination of the evidence (detailed in Appendix Seven) with regards to whether there is an actual link between Asperger's and violence and if so, to what extent it could have been a contributory factor in this case, was undertaken as part of the task. In order to do this it was firstly necessary to follow a process of defining Asperger's syndrome in order to note any special relevance to the diagnosis following the Glasgow assessment of Mr RS.
- 3.7.10 Secondly, the independent panel considered the published evidence with respect to linking Asperger's syndrome to violence, both planned and reactive. Thirdly, the independent panel considered the evidence from a perspective of

violent acts in terms of Asperger's syndrome hypersensitivity, social malfunction and associated comorbidities.

- 3.7.11 In essence, the weight of published academic evidence did not appear to the independent panel as being able to produce a reliable and thorough or detailed definitive answer. That is, the independent panel could not discern a substantial link between Asperger's syndrome and planned violence.
- 3.7.12 In summary, the overwhelming evidence (see Appendix Seven), albeit chronologically flawed, details very esoteric and rare cases of murder and violence; such cases are in the vast majority reactive, instantaneous, and situational behaviours. These cases are not the premeditated, instrumental violence that is often depicted in the popular media. The more conventional presentation and features of the condition (e.g. lack of emotion, lack of empathy) would have confronted the Glasgow Adult Autism Team in October 2011. Their task may have been further influenced by the degree of insight that Mr RS had about the condition. This was due to the fact that both he and a former partner had previously worked in a unit which provided services for people with Asperger's syndrome and Autistic Spectrum Disorders.
- 3.7.13 Finally, the independent panel note that the DISCO scale as used by the Glasgow Autism Support Service is recognised as the gold standard used by clinicians to assist them in diagnosing autism and Asperger's syndrome. On the basis of the diagnostic report, the independent panel conclude that the diagnosis of Asperger's syndrome in the case of Mr RS was sound. The recommendations which concluded the report were appropriate. However, Mr RS left Glasgow so did not continue with the recommendations and did not attempt to initiate contact with any service when he moved back to Brighton.

3.8 Review of care planning and risk management

- 3.8.1 The mental health needs and risk assessments were not fully completed by Trust staff. Mr RS was offered an appointment for a third assessment by the Trust but had committed the offence before this appointment was due to take place.
- 3.8.2 The management plan was for further assessment to identify specific care needs on which a plan could be based. The weakness in the assessment completed by the BURS nurses is linked to weakness in the management plan – in that, if further information had been sought from the family they might have concluded that urgent medical input was required; that referral to the Recovery team or to the Crisis team might have been more appropriate given the earlier threats of harm to his parents.

3.9 Review of communication between agencies and services

- 3.9.1 Communication between the referring GP (Dr TH) and the BURS team was appropriate. Dr TH faxed the referral to the service with a clear statement of the urgency of the referral and the risk of escalation of Mr RS's presentation. The nurses took the initiative to clarify the situation regarding Mr TS's telephone call with Dr TH.
- 3.9.2 Neither BURS nor Dr JO contacted the Glasgow Autism Support Service regarding the Asperger's syndrome diagnostic report to ascertain if or how he had engaged with services thereafter or for any further information the service might have.
- 3.9.3 There was no attempt to follow up criminal history, although there was a facility to do so and an established route to access forensic information. Similarly, there was no attempt to discuss alleged child abuse with a specialist, again there was a facility to do so. At the time of the BURS and Dr JO assessments they were not clear as to whether the allegations were delusional or true, but confirmed in interview that they had no concerns about Mr RS physically harming his children, he 'doted on them'. However, the independent panel would indicate that leaving a 10 year old to look after a toddler and exposing children to bizarre ideas could have put them at risk of emotional harm: again, the weaknesses in the BURS assessment and failure to involve the family for the purposes of information gathering led to weaknesses in the actions taken following that assessment.
- 3.9.4 The independent panel recognise, however, that despite the situation his daughters were placed in on occasion, there is no evidence of persistent emotional maltreatment of the children such as to cause severe and persistent adverse effects on their emotional development.

3.10 Review of communication and engagement with the family

- 3.10.1 The failures to communicate with the family by the BURS assessment team and by Dr JO were identified by the internal review report in their care and service delivery problems. The independent panel fully concur with this conclusion. This failure to seek information from his family and former partners represents a missed opportunity to develop a more detailed and comprehensive understanding of the risks posed by Mr RS. The independent panel have spoken to his father, sister, brother and sister-in-law, and both former partners. In the course of this information gathering the independent panel have discovered, in addition to the information gathered by the Trust's healthcare professionals, that:

- he was drinking very heavily in 2011 and his family thought he might possibly be a 'functioning alcoholic';

- he was using psychoactive drugs (legal and illegal);
- there were two incidents (in 2009 and August 2012) involving serious aggression towards his father;
- both daughters were visiting him at his flat in the period leading up to the incident, where he was ignoring them whilst researching his 'conspiracy theories' on the computer. His 10 year old daughter was looking after the two year old daughter at these times;
- his elder daughter had stopped staying overnight at his flat because she felt anxious there at night;
- his elder daughter reported that she felt that he needed her to look after him;
- children's toys and belongings were evident in his flat;
- he was in contact with both former partners, if only to arrange contact with his daughters. His more recent former partner was taking the initiative in try to get him help – by contacting the Glasgow Service for advice and by helping him to get registered with a GP;
- his parents had been supporting him emotionally and financially for some time; both his daughters had been to visit and stay with them; his elder daughter had been on holiday with them;
- his parents were feeling increasingly threatened by him, to the extent that his mother was seeking help for her anxieties about his behaviour; and
- he had been in social contact with the parents of both his former partners.

3.10.2 The independent panel think that the term 'former partners' more accurately reflects the situation than 'ex-partners'. The independent panel noted during interviews that health professionals in 2012 were not aware of the extent of his continuing contact and interactions with both them and his daughters and consequently inferred that the relationships with the mothers of his children were in the past, except for arranging his contacts with his children.

3.10.3 The independent panel also note that the health professionals in 2012 were not aware of the previous incidents in which he had been physically aggressive to either his father or to his father's property. They were not aware of his ongoing visits, nor the recent visit to his parents. In light of these gaps in their knowledge, healthcare professionals concluded that the fact of geographical distance reduced the risk Mr RS potentially posed to his parents. It is clear however that there was significant information about Mr RS's mental state and behaviour that could have been available to the health professionals in 2012 if they had made contact with the family. The BURS nurses acknowledged that not involving the family had been a weakness. The independent panel have discussed in para. 3.4.54 the issues of confidentiality and consent as they relate to this case. The independent panel have also noted that the Trust's own policies and procedures emphasised the importance of involving family and carers.

- 3.10.4 The independent panel are aware that there is a question of how reasonable it is to expect pressured professionals with limited time (40 minutes to one hour was the routine time spent on BURS assessments at the time; the CMHNS spent about 1.5 hours with Mr RS), and that the structure, capacity and relative newness of the BURS service at this time mitigated against more detailed examination and assessment. The independent panel appreciate that simply saying 'more resources' is unlikely to be a solution. However, the independent panel do suggest that there is a question of 'how' the time and resource available is spent: working 'smarter' may be a more productive approach.
- 3.10.5 The second issue around communication with Mr RS's family and former partners is to do with the internal serious incident review. The decision by the internal review team not to contact the family is understandable, in that they did not want to add to the family's stress and distress. This however was not good practice - then or now. The independent panel note that the internal reviewers reported that they had attempted to trace and contact Mr RS's former partners but had been unable to do so, although the former partners indicate that it should have been possible for the Trust to trace and contact them. This illustrates the point that inadequate recording at the initial contact (the BURS assessment) follows through into limiting practice at a later stage. The family were not contacted by the Trust until Mr RS's brother took the initiative in 2014, some two years after the incident. This was prompted by Mr VS being contacted by Mr RS's first former partner to ask if she could give their contact details to NHS England who wished to speak to them regarding participation in this independent review.
- 3.10.6 This decision not to involve the family in the internal review appears to have not been compliant with the Trust's own 'Being Open' policy, which clearly states that:
- "Being Open involves apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident. It ensures that communication occurs as soon as possible following an incident and is open, honest and adapted to suit the recipient's needs." (para. 2.0)
- 3.10.7 Although the particular circumstance of this type of SI is not specifically stated in the policy, there is reference to implementing 'Being Open' in incidents where a service user has died, including the need for communication that is 'sensitive, empathic and open'. The policy recognises the importance of considering 'the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened'. The policy notes that family and carers 'will need emotional support' and that 'establishing open channels of communication may also allow the family and/or carers to indicate if

they need bereavement counselling or assistance (para 5.3.1). Whilst the independent panel recognise that the circumstances of a service user's death as a result of an incident is quite different from this homicide and assault, they consider that the principles expressed in this paragraph of the policy equally apply in the case of Mr RS, his family and former partners.

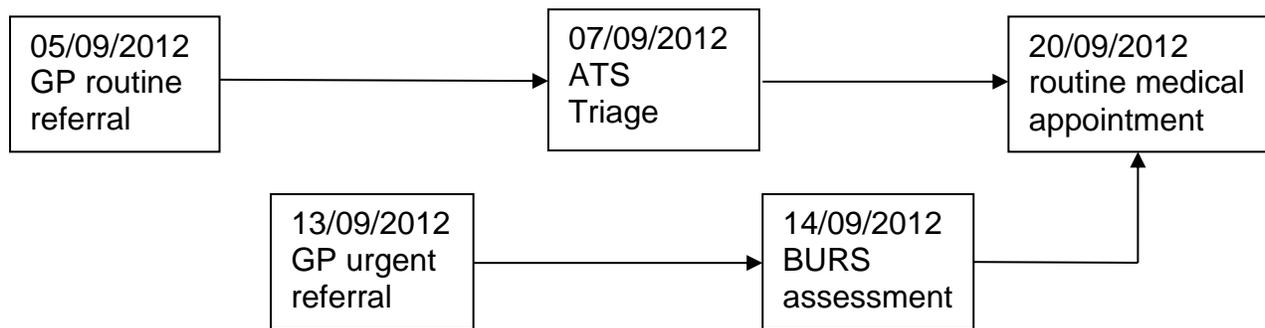
- 3.10.8 The independent panel are informed that the Trust did apologise unreservedly in the autumn of 2014 for the failure to contact Mr RS's father and siblings about the internal review. The Trust did not contact his former partners at this time and they did not receive an apology. The Trust was committed to take steps to minimise the risk of this happening again, including changes to the way actions are recorded after a tragedy. The independent panel are in full agreement with the Trust's response in October 2014 which is to be commended. In addition, the 'duty of candour' legislation enacted in April 2015 requires NHS providers to contact and involve families, both at the time of the incident and at the time of the internal review. The Trust will be working to ensure that this legal obligation is met.
- 3.10.9 The independent panel have included a 'Genogram' and 'family tree' in Appendices Eight and Nine. The purpose of the former is to provide a graphic overview of the complexities of Mr RS's family relationships and his use of specialist mental health services; and the second illustrates his relationships with his parents, siblings, former partners and daughters in more detail. These complexities include his movements between his parent's home, Brighton and Glasgow, using services in both places; his family of origin; himself with each former partner moving between Glasgow and Brighton. These diagrams also reflect current family formation where families can break down on more than one occasion and still remain in contact with each other. Both Mr RS's former partners had contact with each other, and both daughters were in contact with his parents, their grandparents. Mr RS had been in contact with his first former partner's parents.
- 3.10.10 The independent panel have looked at the 'Triangle of Care' approach to full engagement with carers (R Hannan and others, 2013). The independent panel are aware that a representative from the Trust attends 'Triangle of Care' implementation meetings. However, the Trust has not joined the membership scheme nor taken steps to embed the principles. This would have important effects on the way staff relate to carers; recognise the role they play; and share information about this with colleagues. It would also create consistent ways of working with carers across the whole Trust.

Recommendation 4

The Trust Board should consider signing up to the 'Triangle of Care' or similar systematic and comprehensive approach to involvement of families, significant others and carers. The objective is to support culture change to include carers as partners, along with service users and professionals, in all aspects of the appropriate delivery of care and services.

3.11 Review of circumstances leading to assessment by trainee GP

3.11.1 As described previously (paras. 3.1.9 – 3.1.12), Mr RS was referred to the Trust twice in September 2012, was triaged and assessed twice. The following diagram is provided to try to illustrate this course of events.



3.11.2 The first routine referral on 5 September 2012 was triaged for a routine medical appointment with the ATS. Dr KN, who had been a member of the triage team, allocated Mr RS to an appointment with his SHO, Dr JO. This allocation was based on the information contained in the referral letter and the fact that Dr JO had already seen service users with a diagnosis of Asperger's syndrome. This appointment was arranged for 20 September 2012. Following the telephone call from Mr RS's parents and further consultation with him, on 13 September Dr TH referred Mr RS to the BURS service. On the following day the BURS CMHNs visited Mr RS in his flat for assessment. The assessment concluded with the management plan for a routine appointment, preferably with a consultant. On receipt of this assessment, Dr KN decided to stay with the plan for his SHO to see Mr RS on 20 September 2012. The next routine appointment with Dr KN would have been after 20 September 2012 so that Mr RS's assessment would have been delayed. On the basis of the information Dr KN had at that time and the recommendation for a routine appointment this meant that Mr RS's appointment with the SHO took place sooner than a consultant appointment.

3.11.3 The decision to see Mr RS seems reasonable in that it resulted in quicker engagement with Mr RS and in the light of the BURS assessment and management plan. As already noted (paras 3.6.1, 3.6.16), the independent panel consider that the BURS assessment was weak and led to a weak management plan. Furthermore it was extremely unfortunate that, on 20 September 2012, when Dr JO had seen Mr RS and decided that he needed further assessment with the consultant, Dr KN was out of the building and that no other consultant was available to provide advice. This was reported as an unusual occurrence – otherwise it is likely that Mr RS would have been seen by

Dr KN that same day. Dr JO knew that Dr KN would be in the building the following morning and that he would be able to discuss Mr RS's presentation with him then.

3.12 Review of documentation and record keeping

3.12.1 There were clear failings in completing documentation. The IAPT assessment document (2010) has a number of incomplete items. These include:

- No details of telephone contact with the patient are filled in – yet the section which asks if a message can be left is answered by the assessor as 'Yes'.
- There are no next of kin details, the dependents/children section is not filled in.
- No NHS number is identified.
- The PHQ-9 (Patient Health Questionnaire), the GAD -7 (Generalised Anxiety Disorder Questionnaire), Phobias and WSAS (Work and Social Adjustment Scores) are not given. These data are included in the Minimum Data Set which should be correctly completed.
- The section to identify the agreed Problem Statement is left blank and is important as it is the basis for treatment in a step 2 CBT based formulation.
- Sections which ask for an account of previous substance misuse and current misuse are left blank. These were significant features of the behaviour of Mr RS manifested in later problems he experienced.

3.12.2 The Access Risk Screening Tool (2010) was not completed fully. Information which should have prompted the assessor to complete a Trust Level 1 risk assessment together with a child and families referral form, or if appropriate to enact safeguarding procedures, was not completed. This resulted in an instruction on the form which reflected risk policy not being followed. Where relevant information was recorded (previous history of self-harm), the prompt was not acted on.

Panel Consideration

The propensity for error that arises from any practitioner assessing aspects of mental health is increased if the subject is unwilling for any reason to disclose relevant information. Fallibility and uncertainty in the process of assessing are lessened by the design of forms, policies and procedures which aim to stimulate further inquiry and to ensure accurate recording.

The independent panel were able to establish by scrutiny of the IAPT forms used in 2010 (to a lesser extent) and the BURS assessment undertaken in 2012 (to a greater extent) that errors of administration and recording had occurred.

The consequences of any tendency to wittingly or unwittingly not pay sufficient attention to the context and means of recording information varies. The internal review could not determine evidence that the SI regarding Mr RS suggested that it could have been predicted and therefore prevented. It did however identify a lesson learned. This was focussed on the possible advantage of professionals talking to significant others, particularly family in order to form a more objective and comprehensive assessment. The independent panel later concluded that family involvement would have been instrumental in achieving accurate information about the likelihood of risks and the mental state of Mr RS.

- 3.12.3 The same section addresses any belief or evidence that the patient could cause harm to others and if there is any evidence to suggest that they pose a risk to their own or other children - both these sections are left blank.
- 3.12.4 The processes and procedures involved in the BURS assessment of Mr RS in 2012 seemed to recognise that there is an inherent uncertainty when practitioners have to form opinions regarding how someone presents during an assessment of mental state. The forms available to assist this process had been designed to guide the assessor, and to direct them to further support and safeguards associated with potential risks.
- 3.12.5 In this case, missing, incomplete or erroneous information on the BURS mental health and level one risk assessment forms included:
- 'no other contact with services' – when Mr RS had in fact received six sessions of CBT from the IAPT service which were known to BURS;
 - family, friends and carers contact details are not completed;
 - forensic history is not assessed;
 - use of substance misuse services not completed;
 - section on 'any persons known to be at risk' left blank;

- current family/carer/social support not completed;
 - suicide risk indicators – psychiatric diagnosis and unemployment noted, separated status incorrectly completed; no misuse of drugs or alcohol stated but elsewhere current drug use is noted; and
 - risk assessment – states ‘No’ for both initial assessment and re-assessment.
- 3.12.6 The independent panel would however note that some components of the form itself were not very ‘user friendly’ and appeared quite confusing with the use of double negatives in certain sections. The independent panel understand that the form has been completely redesigned and is more appropriate for eliciting and recording risk information in a useful manner.
- 3.12.7 The BURS form was not completed properly and either more robust information was not obtained or the information retrieved was incomplete. The independent panel thought that these facts weakened the initial assessment considerably. Therefore, the prompts contained in the form could not fulfil their purpose.
- 3.12.8 The barriers for preventing the above documentation errors were further weakened as there was heavy reliance on self-reporting by the patient. Mr RS was at the time likely to be influenced by his delusional or belief system. This point is reinforced when one considers that he himself “knew no fear”. He was also able to revert to a “default” position of smiling when it suited his perception. He was described as ‘quite jovial’ during the assessment but also that the environment was quite tense.

4 Contributory factors

- 4.1 The internal level 2 review report identified that the diagnosis of Asperger's syndrome was the contributory factor to the incident. An important feature which was recorded in the detailed diagnostic report was that Mr RS "smiles as a default position", not as a demonstration of true emotion presentation. The review determined that these features did not appear to have been taken into account by either BURS, or the SHO, Dr JO, when assessing the mental state of Mr RS. Whether the signs were aligned with a correct diagnosis of Asperger's syndrome or were also consistent with some features of psychosis is debatable but the independent panel felt the point was made that the outward presentation of Mr RS possibly disguised an underlying emotional state.
- 4.2 The independent panel support this view and, further, do not think that the function of the service model around BURS at the time was capable of undertaking further detailed examination and differential diagnosis. There was no consultant input into the assessment, the service had not been in existence for a significant length of time and consisted of two Band 6 CMHNS and one support worker only. BURS was also structurally separate from the ATS (it was located with the crisis team) and their records were not accessible to ATS consultants or other medical staff. Officially there was medical cover from the crisis team consultant but in day-to-day working they did not have a dedicated consultant psychiatrist.
- 4.3 If the service model had had greater capacity there may have been a better and more rapid opportunity for a detailed assessment by an experienced psychiatrist, leading to a more appropriate formulation and identification of assertive support. The independent panel note that the current arrangements are very different to the situation in 2012. BURS has been replaced by the Mental Health Rapid Response Service (MHRRS), which is located within the ATS service and shares office space with the ATS duty worker. The service consists of more Band 6 nurses and two Band 7 nurses, including a nurse prescriber, and has better access to medical cover.
- 4.4 Whilst the independent panel have commented in detail elsewhere in this examination of the risk assessment process regarding mental state, the intensity and prominence of thoughts of harm should also be viewed in the context of life events affecting Mr RS at the time. The independent panel thought that these events contributed to his propensity to experience extreme anxiety and later to fuel the elements of paranoia displayed in the psychotic episode. The subsequent weakness in formulation and support which followed the initial assessment, contributed in part at least to a lack of a comprehensive overview of Mr RS's needs. This, in turn, contributed to a failure to respond

effectively to what then became deterioration in his mental health in the few days prior to the serious incident.

Panel consideration

A number of the features associated with Mr RS are reflected in a contemporary report of a national review of mental health services which was published in June 2015 by the CQC. (*Right Here and Now*. CQC). The independent panel thought that the ways in which personal mental health may manifest itself to crisis and urgent response teams was of particular relevance. These indicators included extreme anxiety, psychotic episodes and behaviour considered to be “out of control” or irrational to the extent that a person becomes a risk to themselves or to others.

An indication of the service pressures facing such teams is well described in the CQC report and it highlights the fact that some 68,000 people were admitted to mental health wards for urgent care in England as in-patients in 2013-14.

- 4.5 The service pressures experienced by the BURS teams reinforced in a number of ways how safety in the mental health services competed with other objectives and was easily marginalised in the process of care delivery.
- 4.6 While safety contributes to the quality of care it is not synonymous with it. Safety is dependent on the interaction of components that may contribute to the capability of any response a service can make to the persons mental state at the time of assessment.
- 4.7 The aspects of Mr RS’s mental state, together with his personal and social circumstances in the autumn of 2012, contributed significantly to the contextual factors and any service constraints in the West Brighton and Hove service at that time.
- 4.8 Mr RS and his current clinical team at the high secure psychiatric hospital have been most helpful in the independent panel with a detailed personal history as part of the remit providing to scrutinise the relevance of this in order to meet the Terms of Reference. This augmented the contributory factors identified by the family of Mr RS and his former partners. The information provided then assisted the independent panel when they explored the contextual factors alongside the following care and service delivery problems during the period under scrutiny (2010 to 2012).

5. Root causes

5.1 The internal review team identified a number of root causes which were:

- possible use of 'legal highs' and cannabis;
- failure to consider in depth Mr RS's ideas of parental abuse, ideas of reference, paranoia, and the information from Dr TH; and
- the failure to fully consider Mr RS's violent history.

5.2 The independent panel agree with these findings, but would formulate the root causes as:

A combination of Mr RS's very complex presentation; the reliance of the service on his self-reporting of his mental state, mood, feelings and intentions about harming his parents; weaknesses in information gathering and recording, and in the risk assessment and management plan; the structure and capacity of the BURS service at that time; the unusual and unfortunate situation where the Dr JO, SHO, did not have immediate access to consultant advice at the time of his assessment; and, significantly, the failure of the service to involve his family and former partners. Input from the family and former partners would have enhanced the health care professional's understanding of Mr RS, his circumstances, mental health needs and potential risks.

5.3 The independent panel consider that the likelihood of the incident occurring would have been reduced if these failings had not been present. The independent panel do not consider this constitutes a direct cause and effect to the extent that the incident could have been prevented (see also para. 8.1).

5.4 In addition, the independent panel wish to acknowledge that significant changes have taken place since September 2012. These are described in detail elsewhere, but the key points are:

- introduction of extra specialist nursing support for people with Autism Spectrum Disorders, including Asperger's syndrome;
- improved training, ongoing discussion and annual audit of risk assessments;
- consultant input to trainees and supervision of assessments;
- improved approach to involving families and carers; and
- restructured urgent response service, with more experienced staffing which is integrated with the ATS and located with the duty officer.

6 Lessons learned

- 6.1 The internal review identified as a 'lesson learned' the need for professionals to talk to significant others, particularly families and carers, as part of the assessment. The independent panel are in full agreement with this. The additional information provided to them by Mr RS's family and his former partners has provided a much broader and holistic picture of Mr RS and his mental health needs.
- 6.2 The independent panel would summarise the key lessons learnt from this review as:
- the vital importance of collecting information from family, carers and significant others;
 - the vital importance of comprehensive needs and risk assessment and, following on from that, rigorous risk management planning;
 - the need for appropriate allocation of cases to junior doctors and timely access to consultant opinion in situations where a junior doctor considers the service user's presentation to be more complex than his/her level of competence can adequately address;
 - that collecting and recording information for needs and risk assessment is not sufficient alone: the question is how it is then used, shared and disseminated to support clinical decision-making;
 - the prompts used on assessment forms should stimulate further enquiry, for example, regarding family relationships and relationships with children;
 - documentation collected for an internal SI review (e.g. witness statements, notes or transcripts of interviews) should be retained in case of further review, for which in this case, they may have shed further light on the circumstances leading up to the incident; and
 - staff whose practice is criticised in internal reviews should receive clear feedback explaining the criticism and the reasons for it; they should also be offered appropriate support to help them work through any responses to this criticism.

7 The adequacy and appropriateness of the internal review

7.1 Review of the internal report

7.1.1 The independent panel reviewed the following internal reports:

- Serious Incident (SI) Notification Form;
- Level 2 (SI) Review Report (Root Cause Analysis): SI Final Report.

7.1.2 The Notification Form was completed within the required timescale. The date of the incident is recorded incorrectly (8 October 2012 instead of 5 October 2012); the details of the incident are correct; some items on the form are incomplete (e.g. ethnicity, disability); date of treatment is misleading (8 October 2012, whereas contact commenced on 14 September 2012 and continued until 20 September 2012, Mr RS failed to attend an appointment 8 October 2012). In response to the question 'Has the senior person in charge notified those directly involved by the incident? (E.g. next of kin) is answered 'NO', with the reason being given that 'Police investigating suspected homicide'.

7.1.3 The Level 2 Review Final Report is dated 4 December 2012 which, at 42 working days, is quite not within the timescale set for completing internal reviews by the Trust's policy at the time (35 working days).

7.1.4 The membership of the review team and the authorship of the report are both clear. The members were a clinical director and a service director, but there is no further information about their clinical or other backgrounds or expertise.

7.1.5 The date of the incident is recorded, and the place given. There is no detail about the incident although there is a summary of Mr RS's allegations and mental state, his expressed denial of any intent to harm his parents or himself and his parent's concerns as told to his GP. The only information about Mr RS following the incident is that he was a patient in a secure psychiatric hospital in Ayrshire. This is not quite accurate: following on from assessment from a community forensic mental health nurse he was remanded in a prison immediately after the incident awaiting psychiatric reports to the court.

7.1.6 The Terms of Reference for the internal review were appropriate but quite general, e.g. 'to establish the facts', and quite limited. There is no reference to his contacts with the IAPT service, nor any requirement to contact the Glasgow Autism Service for any more information, nor any requirement to contact family, former partners or friends. The Terms of Reference did not ask the reviewers to consider compliance with local or national policies. The Terms of Reference

erroneously refer to Dr JO as a 'trainee psychiatrist' when he was in fact a trainee GP.

- 7.1.7 Key staff from Mr RS's 2012 contacts with the Trust were interviewed or provided witness statements; a GP was interviewed; there is no reference in the report to attempts to contact family or his former partners. Notes were taken of interviews with the GP and the consultant. The independent panel were informed at interview that the Service Director had made unsuccessful attempts to trace the former partners but the team felt they were treading on difficult ground. The team did not approach family members because they did not want to cause further distress.
- 7.1.8 Relevant clinical records were reviewed, including the Glasgow Autism Support Service diagnostic report. There was no review of local (or national) policies and procedures.
- 7.1.9 No other agencies were involved with Mr RS at the time of the incident. There was no contact with the Glasgow Autism Support Service, where he had received support in 2011.
- 7.1.10 Appropriate arrangements for sharing learning and the report within the Trust were described. The findings of the review were fed back to the clinical team.
- 7.1.11 There is a brief description of Mr RS's early life, family, his former partners and daughters and his history of violence. There are factual inaccuracies, in that the report states he was brought up in Glasgow which is incorrect and that he lived in Jeddah for 10 years (actually, for three and a half years). His psychiatric history is described, including diagnoses.
- 7.1.12 The report concludes that risk assessments were weak. The service did not fully assess the risk of violence. The fact that assessment scores were different was identified as a problem.
- 7.1.13 The report does not identify any safeguarding issues there may have been regarding his children or parents. There is no information within the report as to any contact he might have had with his daughters. The report contains the information that he was in contact with one of his former partners, but there is no detail.
- 7.1.14 The report comments on the fact that the medical appointment was with a trainee and not with a consultant, despite the recommendation from the BURS team. The report identifies gaps in the BURS assessment and in Dr JO's assessment. The reports describes clinical decisions and identifies some weaknesses, but does not ask why a number of items identified as Care and Service Delivery Problems occurred.

- 7.1.15 The lack of contact with Mr RS's family is noted, even though the service did know that his father had been in contact with his GP.
- 7.1.16 There is reference in the report to the healthcare professionals not taking into account of how the Asperger's syndrome may have affected his presentation – the Autism Support Service diagnostic report refers to Mr RS smiling inappropriately, as a 'default' response.
- 7.1.17 The report is descriptive rather than analytic, the question 'why' is not asked. For example, the decision for a trainee to see Mr RS when the nurses who assessed him expressed a preference for a consultant; or why there was no involvement of the family. However, at interview Dr HP, now a Senior Clinical Director, accepted that point and he provided further explanation which revealed a more detailed consideration of the Terms of Reference. The independent panel considered that the report itself does not fully do justice to the work completed by the internal review team.
- 7.1.18 The conclusions do follow from the evidence presented, for the most part, and relate back to the Terms of Reference.
- 7.1.19 The internal review report identified several points of 'Good Practice', which are detailed in para. 3.2.1 of this report. The report also identified a number of care and service delivery problems, which are detailed in para 3.6.1 of this report.
- 7.1.20 The review identified as a contributory factor to the incident the fact that neither the BURS team nor Dr JO appear to have taken into account the point made in the diagnostic report from the Glasgow service that Mr RS smiles as a default position rather than as an expression of how he is really feeling. They identified as root causes the possible uses of 'legal highs' and cannabis which were reported in the BURS assessment but not by Dr JO; the failure to consider in depth Mr RS's ideas of parental abuse, ideas of reference, paranoia and the information from the GP during his contacts with the mental health service; and the failure to consider fully Mr RS's violent history.
- 7.1.21 A 'lesson learned' was the need for professionals to talk to significant others, particularly families and carers, as part of the assessment. This will facilitate a 'more objective and comprehensive' assessment. The independent panel are in full agreement with this. The additional information provided to them by Mr RS's family and his former partners has provided a much broader and holistic picture of Mr RS and his mental health needs.

7.1.22 On the basis of their review, the internal review report identified that mental health professionals should talk to significant others to get a 'more objective and comprehensive assessment' and made the following recommendations:

1. First medical appointments, particularly those with complex presentation, to be assessed by consultant or experienced doctor.
2. A system so that all new assessments performed by psychiatric trainees be discussed with a consultant psychiatrist at the time of assessment and the consultant psychiatrist to review the patient if needed accordingly.
3. Consider all risk indicators, including historical, at all appointments and seek more expert advice immediately if concerned.
4. Take all presenting factors into consideration. In this case this would have included how Asperger's syndrome affects how a patient presents.
5. Available information from families should be followed up and taken into account.
6. Training for frontline staff regarding the effects of drugs including 'legal highs' and regular updates.

7.1.23 The independent panel are in full agreement with these recommendations, with the exception of the wording of Recommendation 5. The independent panel felt that this was a weak recommendation in that 'available' information might not be comprehensive; and 'taken into account' could have been more strongly worded. In the spirit of the 'Triangle of Care', families should be at the heart of information gathering, formulation and care delivery. The recommendation would have benefited from being more prescriptive, and from recognising who carers are, what role, if any, they have and what influence they might have.

7.1.24 There is an action plan which specifies a deadline and the person responsible for action dated February 2013 with an expectation that progress towards implementation will be reported by the end of March. A progress report that records all action points as being closed is dated 9 January 2015. The action points follow directly from the recommendations made.

7.1.25 The report is generally clear and easy to follow. It is a 'broad brush' report, primarily descriptive with limited analysis. Some of the information in the timeline puts events into a broader context which could have been drawn out more clearly in the report. The report is reasonably well-written.

7.2 Observations

- 7.2.1 The Terms of Reference for this independent review required the independent panel to address whether the review satisfied its own terms of reference; if all key issues and lessons had been identified and shared; and if the recommendations were appropriate, comprehensive and flow from the lessons learnt? These are addressed below.

Panel consideration

In the internal review report, the reviewers record the witness statements received and notes made of meetings with key staff involved in the referral of Mr RS and his assessments carried out by the Trust.

However, when the independent panel requested copies of these documents they were not available. The independent panel consider that it is important and would reflect best practice that records of this nature should be kept – so that evidence can be provided to support findings and conclusions if required; and so that external reviewers can have access to all documentation to facilitate a comprehensive review of the report.

- 7.2.2 The independent panel agreed that the internal review had addressed its own Terms of Reference, but noted an omission in the Terms of Reference (see 'Panel Consideration', below). The independent panel did consider that key issues and lessons had been identified and shared, and the independent panel agreed with items identified as 'good practice' and 'care or service delivery problems'.
- 7.2.3 The internal reviewers identified as root causes the possible uses of 'legal highs' and cannabis which were recorded in the BURS assessment but not by Dr JO; the failure to consider in depth Mr RS's ideas of parental abuse, ideas of reference, paranoia and the information from the GP during his contacts with the mental health service; and the failure to consider fully Mr RS's violent history. The independent panel agree with these conclusions.
- 7.2.4 The independent panel conclude that the recommendations for improvement were for the most part appropriate, comprehensive and flowed from the contributory factors, root causes and lessons learnt. The independent panel support the recommendations made.

7.2.5 The report was shared with appropriate senior managers and directors at the Trust and was disseminated to the Governance IGT, service and team meetings and SI meetings. Findings and recommendations were fed back to the BURS team although neither were aware that the team had been criticised in the report.

Panel Consideration

The service delivery problems identified by the internal review team were accurate but they were based on limited and sometimes inaccurate available information. This was particularly so of facts held by the family and former partners of Mr RS. However, the independent panel recognise that the Terms of Reference for the internal review did not include seeking information from the family or former partners. That was a missed opportunity to gain in depth information of high quality from those who held it. The independent panel were able to expand the fact based chronology of events, together with valuable input from the parties involved and Mr RS himself.

The independent panel's capability to drill down into the elements of the care and service delivery provided to Mr RS enabled them to reinforce the recommendations made in the internal report. The independent panel were able to investigate and seek further evidence from the Trust, pertaining to any changes in service delivery alongside steps taken by them to effectively monitor the progress in implementing the recommendations.

7.2.6 The internal level 2 review report found that a number of individual practitioner errors could be identified, together with some weaknesses in organisational processes. The review did not reveal the weight of evidence either necessary or sufficient, to be able to conclude that the incident could have been predicted and therefore prevented. However, it was able to clearly identify care and service delivery problems. These problems were reinforced by contributory factors associated with a diagnosis of Asperger's syndrome and the presentation of Mr RS to mental health professionals. As a result the internal reviewers subsequently identified a lesson learned and made five recommendations to the Trust.

7.2.7 There are a number of factual errors in the report which are transferred from errors in the clinical records and which would have been corrected if the review team had contacted the family and taken information from them. However, these corrections would not have made a material difference to the conclusions and recommendations put forward in their report.

7.2.8 The independent panel were informed by two staff whose practice had been criticised in the review report that they had not received this feedback. One recalled a feedback meeting and the other did not, but neither recalled the criticism. The independent panel consider this to be unhelpful in that it deprives them of an opportunity to learn from mistakes and unfair if they later find out through a third party. Following on from being given negative feedback, staff should be offered appropriate support by the Trust.

7.3 Review of implementation of the action plan and services changes.

7.3.1 In respect of the Monitoring and Quality Assurance of the Action Plan following the internal review, Mr FZ (Service Director) provided evidence in the form of a progress update on the action plan. This followed the receipt of the report and recommendations of the internal review. The independent panel were assured that a monitoring system is in place in the Trust which tracks the operational delivery of Serious Incident reviews and their findings. The Trust implemented remedial action based on the recommendations. This identified the progress status, the person responsible for completion of actions and the target dates. Specific details are included in Appendix Six.

7.3.2 The independent panel were able to verify the positive actions taken during interviews with senior operational managers and clinicians. The level 1 serious incident reports and action plans are reviewed within the Trust against reliable and valid quality assurance criteria. Senior management receive a report of assurance audits of the completion of action plans, with the closure of target dates identified in this report, or the current state of ongoing implementation of the actions.

7.3.3 During the period of examination of the service provided to Mr RS between 2010 and 2012, the Brighton and Hove mental health services were undergoing a number of service redesigns. This included change in personnel.

7.3.4 The nature of the changes were considered as part of an external independent review into the new services once they had come into operation (Verita 2014).

7.3.5 The objective of that review was to explore the themes and aims identified in the organisational structures. During this independent review the Trust was able to produce evidence of the implementation of the 2014 Verita report recommendations. This assisted the independent panel when they examined

the previously identified systemic contributory factors associated with problems of access to treatment and care co-ordination.

Panel Consideration

The independent panel wished to avoid duplication of externally generated recommendations and possible operational confusion when the management were making a lot of effort to comply with a previous SI report findings. Therefore the independent panel requested and received comprehensive feedback of the current level of progress of the service, regarding contemporary action based on themes identified in the 2014 report as this had relevance for this examination of care delivery for Mr RS.

7.3.6 This process enabled the independent panel to address:

- how the contemporary service configurations help the service to meet the challenges such as those presented by Mr RS and his mental health needs;
- how the various practitioners, teams and services interface with each other from the GP referral process to the various contact points; and
- how quality is assured in the clinicians' risk assessment and subsequent management.

Panel consideration

The need for maintaining the impetus when the service faces such challenges was reinforced in November 2014. This related to a critical report which was made by Her Majesty's Senior Coroner for the city of Brighton and Hove. The criticisms focussed on a GP referral of a patient who was later to become the subject of a SI. The Coroner commented on the fact that there seemed to be no facility for a psychiatrist to be involved in the assessment procedure and to indicate a course of treatment for such a referral.

The issue was exacerbated because no contact with the GP was made by the ATS and the Coroner identified flaws in the referral system. The duty of the Trust to respond to the Coroner's comments, included details of action taken or proposed. This response had to include a timetable of the action.

7.3.7 The subsequent 2014 Verita follow up review spent considerable time examining how well the services interfaced with each other. This review

included the process of how the service managed the flow of clients from one service to another.

- 7.3.8 In the scrutiny which the independent panel undertook of the relevant documents they noted that the 2014 Verita report's authors were able to comment positively with regard to their detailed review of the case notes.
- 7.3.9 The case notes provided evidence that the clinicians were actively addressing the challenges, including a good interface between the services.
- 7.3.10 In summary, the 2014 review examined five complex cases. This revealed that amongst those cases one person who had a recognised need and motivation to receive psychotherapy had this provided by the Trust. Of particular importance was that the Verita review team was able to see evidence of clear communication between the psychotherapist and the clinical team if and when vulnerability and/or risk increased. Of the remaining four cases the records clearly highlighted when the patients' situation deteriorated and risk increased.
- 7.3.11 During the period 2012 to 2014 key organisational changes occurred which assisted the service to meet the challenge of patients who may have deterioration in their mental health and become a risk to themselves or others.
- 7.3.12 The main organisational changes which may have altered the possible treatment pathway available to Mr RS during his two contacts with the service were:
- the relocation of the IAPT to the Wellbeing service. This removal of IAPT resulted in a clearer remit for the secondary care ATS and Recovery services; and
 - the integration of the Access/Recovery services. This resulted in the removal of the block which existed in 2012 between the two service components and facilitated a care coordinator to be appointed if necessary at the referral stage.
- 7.3.13 The independent panel were able to evidence from their scrutiny of records followed by interviews with managers, GPs and practitioners that the triage of referrals to ATS had improved in the years following the contact which Mr RS had with the service.
- 7.3.14 As could be expected during an organisational restructure, there were initial barriers to progress. Those barriers were located in the increased demand for services, rather than in the actual design of the services. The demand coincided with a "skill shift" from the Assessment and Treatment Service to the

Wellbeing service. It took time then for active recruitment to the ATS and Recovery services to make a positive impact.

- 7.3.15 During this time period (2012 to 2013) the acute mental health services were working over capacity. Further, the primary care service tended to expect the urgent four hour assessment through the BURS to be available at all times. Such an expectation led to additional pressure on the ATS teams to provide alternative urgent assessments.
- 7.3.16 It was against this mental health service backcloth that the events in the weeks immediately prior to the homicide and assault took place. These are described in Section 3.1 (Chronology) above.
- 7.3.17 As part of the review the independent panel were able to establish with Dr TH, the GP, his level of concern that the situation with Mr RS could possibly escalate in terms of his expressed thoughts regarding his parents. Dr TH held an expectation that his referral would result in Mr RS being examined and assessed in relation to his mental state by a consultant psychiatrist.
- 7.3.18 During this review the independent panel were able to confirm and elaborate on this criticism. This aspect is reflected earlier in their view regarding care planning and risk assessment.
- 7.3.19 The independent panel were able to examine contemporary evidence of progress as it pertained to those areas of criticism. This included a revised flow diagram which was designed to simplify the information required around the procedure for implementing triage. The independent panel spoke with the GP who made the urgent referral in 2012 and he was aware of this flow chart, as were other practitioners in the service.
- 7.3.20 Significant work has been undertaken by the service to produce Brief Referral Guidance for the ATS. This concise document commences with instruction and advice on how agencies can contact the ATS triage service for support regarding any referral issues.
- 7.3.21 It was useful to test this more recent guidance and criteria alongside some of the complex presentation of Mr RS during 2012. Had the more contemporary guidance been used in 2012 then the following signs may have triggered the need for comprehensive assessment by a psychiatrist. These signs include:

1. Complex presentation and co-morbidities:
 - a relapse of psychosis;
 - co-existing mental health condition or developmental disorder (such as autism or Asperger's syndrome) requiring assessment and multi-disciplinary treatment;
 - multiple mental health and social care needs; and
 - a requirement of multi-model intervention of an integrated therapeutic approach to any treatment.
2. Psychiatric diagnosis:
 - the referrer is fairly clear that the person has symptoms of a severe mental health condition that requires diagnosis and treatment.
3. Significant disability caused by mental health condition requiring the support of a multi-disciplinary team:
 - loss of work as a result of their mental health condition; and
 - social isolation as a result of their mental health state.

7.3.22 Alongside the above advice sheets for ATS referrals was the criteria for BURS. This was based on the periods of response times i.e.4 hours, ATS 5 day priority referral and ATS standard 28 day referral.

7.3.23 The most recent guidance for initiating BURS is well defined, and in the case of Mr RS as he presented in 2012, its application would not have been likely to have made any difference as the time scales for engagement with the service were reasonable and the recommendation of the referring GP was carried out.

7.3.24 The weakness in the process for Mr RS was, rather, due to the poor application of the assessment and associated identification of risk or relapse indicators.

7.3.25 The table below summarises the information provided by the Trust regarding implementation of the recommendations. This table also includes the independent panel's judgement of the Level to which the recommendations have been implemented.

7.3.26 In order to facilitate this analysis the independent panel adapted a framework of measurement similar to that utilised by the National Health Service Litigation Authority (NHSLA). This framework uses a set of risk management standards within health care organisations. There are three standards and the principle applied to each level can be aligned with the action plan progress. These standards are:

- Level 1: Policy: evidence has been described and documented

- Level 2: Practice: evidence has been described, documented and is in use
- Level 3: Performance: evidence has been described, documented and is working across the organisation(s) as appropriate.

Recommendations and Actions	Evidence provided and Level of implementation
First medical appointments, particularly those with complex presentation to be assessed by consultant or experienced doctor.	A consultant is always present at triage; following triage referrals are sent to the appropriate consultant/trainer who allocates them according to complexity, based on knowledge of the trainee's experience, skills and need for learning; trainees also have access to senior doctors with years of experience. When trainees do an assessment they go straight to discuss it with a consultant. Level 2
Available information from families should be followed up and taken into account.	Documentation seen that addresses thoroughness of assessment, preparation for assessment; work is currently ongoing in refreshing CPA policy in the Trust. Level 1
A system so that all new assessments performed by psychiatric trainees can be discussed with a consultant psychiatrist at the time of assessment and the consultant psychiatrist to review the patient if needed accordingly.	New Clinical Risk Assessment and Safety Planning/Risk Management Policy and Procedure ratified in December 2014; confirms requirement to work collaboratively with service users and their carers. Level 1
Consider all risk indicators, including historical, at all appointments and seek more expert advice immediately if concerned	Clinical Risk Assessment and Safety Planning/Risk Management Policy and Procedure as above, comprehensive cover of risk factors. Risk practice is audited yearly; since the 2013/14 audit there has been a decline in compliance and action plans to address areas of particular concern have been drawn up. New training on risk assessment has been rolled out. In addition to the risk assessment forms there are a number of meetings at which risk gets discussed – clinical meetings, zoning meetings, formulation meetings, supervision. Minutes of meetings provided. Level 3

<p>Take all presenting factors into consideration. In this case this would have included how Asperger's syndrome effects how a patient presents</p>	<p>A specialist nurse post (Asperger's, ADHD) has been funded and a person appointed. The nurse does training, telephone advice and support but she is being overloaded; a second post is to be funded. Level 2</p>
<p>Training for frontline staff regarding the effects of drugs including 'legal highs' and regular updates.</p>	<p>A dual diagnosis care plan has been developed and evaluated. It was not really implemented, because it was a stand-alone document outside of the clinical information system so staff had to complete two care plans: the CPA care plan now reflects dual diagnosis so the information and plans are all in one place for people with a diagnosis of mental health needs and substance misuse. Dual diagnosis recovery workers will be co-located with the adult team. Training is being provided. Level 1</p>

Recommendation 5

As part of its ongoing monitoring and evaluation of the implementation of the recommendations made by the internal review, the Trust should include stakeholder feedback – to answer the question: are these changes making a difference to service users, carers and staff?

7.3.27 Since this serious incident and the associated internal review, revisions have been made in the Trust's approach to internal reviews. The independent panel were informed that internal review panels are multi-disciplinary, involving more members and reviews are more rigorous. Internal reviews and reports are more intensive, staff carrying out reviews are better trained and reports are vetted by a number of individuals and groups. The 'Incident and Serious Incident Reporting Policy and Procedure' (2014) indicates that Trust takes seriously its responsibility for identifying lessons and implementing recommendations, through a range of groups and committees, up to and including the Trust Board, which receive a quarterly report analysing data and drawing out themes from incident data. The independent panel also note that the current policy on reporting serious incidents includes as a 'key point' that all staff involved in the review should be given 'the opportunity to receive feedback in a supportive setting'.

8. Was the incident predictable or preventable?
 - 8.1 After careful deliberation, the independent panel have concluded that the incident was neither predictable nor preventable. The professional view is that a direct cause and effect relationship between the failings identified and the outcome cannot be demonstrated. The independent panel do not feel that there is a guarantee that if he had been seen by a consultant on 20 September 2012, the subtleties of his presentation would necessarily have been identified.
 - 8.2 However, the independent panel acknowledge that the family do consider that if he had been seen by an experienced doctor the incident might well have been prevented. The independent panel feel it is important that the family's views are reflected in this report.

9 Summary of findings and conclusions

- 9.1 The independent panel reviewed relevant local and national policies, procedures, guidance and research. The independent panel interviewed key staff, including members of Mr RS's current care team. Importantly, the independent panel were able to interview members of his immediate family (who were also relatives of the victim of homicide and included the victim of assault) and both his former partners. The independent panel agreed with the findings and conclusions of the internal review team, although the independent panel would strengthen one of the recommendations. The independent panel identified a number of additional issues, notable practices and areas where improvement is required, leading the independent panel to identify eight additional lessons learnt and to make five additional recommendations.
- 9.2 The following are additional points of notable practice – the positive response of the IAPT service in bringing forward Mr RS's appointment for screening and assessment at the request of his GP; the fact that both the BURS team and the SHO recognised the limits of their competence when assessing his presentation, and referred him for review by a consultant psychiatrist. Sadly, he committed the offences before the date of the new appointment.
- 9.3 Care and service delivery problems, contributory factors, and root causes can be summarised as:
- significant sections of assessment forms (IAPT and BURS) either not completed or erroneously completed;
 - systemic problems in the IAPT service;
 - reliance on self-reporting;
 - failure to involve either his family or former partners;
 - the complex presentation of Mr RS and his denial of intent to do harm to his parents;
 - the triage decision for a 'routine medical assessment';
 - the structure and capacity of the BURS service; and
 - weaknesses in the BURS risk assessment and management plan.
- 9.3 The additional lessons learnt emphasised:
- the importance of involving families;
 - the importance of rigorous needs and risk assessment and management;
 - careful allocation of junior doctors;
 - proper completion and use of assessment forms;
 - archiving of interview and witness documentation gathered as part of internal reviews; and
 - providing comprehensive feedback and support to staff who are interviewed as part of a serious incident review.

- 9.4 Despite the failings noted above, the independent panel concluded that the incident could not have been predicted or prevented – there is no guarantee that if an experienced consultant had seen him, the full subtleties of his presentation would have been identified.
- 9.5 The internal report was competent, although the independent panel thought the report was more descriptive than analytic. For various reasons neither family nor former partners were contacted: in the independent panel’s view this was a missed opportunity to gain a much more comprehensive picture of Mr RS, his presentation, social circumstances and behaviours. The recommendations did flow from the findings and conclusions; and work has progressed on implementing the action plan. The independent panel did however find two staff whose practice had been criticised in the review reported that they were unaware of this criticism (one remembered having feedback and one did not). Therefore, they could not have been supported specifically in relation to this negative feedback.

10 Recommendations

3.118 10.1 The independent panel agreed with the recommendations produced by the internal review and do not intend to replicate these. The independent panel do not intend to duplicate recommendations which the Trust is already addressing. The independent panel would, however, add the following recommendations:

3.119

1. The Trust-wide Risk Panel should develop a reliable method for systematically and comprehensively obtaining the views of family members where appropriate when screening for risk.
2. The Trust should ensure that all staff fully understand the limits to confidentiality, particularly in relation to risk of harm to self or others, and ensure that practice is in line with legal, professional and Department of Health guidance.
3. The Trust should ensure that all medical staff receive sufficient support from colleagues and peers who are available to them. For trainees, this should include supervision by consultants and for consultants, peer group learning. Reflective practice should be embedded into the supervision process, into continuing professional development and into organisational practice.
4. The Trust Board should consider signing up to the 'Triangle of Care' or similar systematic and comprehensive approach to involvement of families, significant others and carers. The objective is to support culture change to promote full engagement of carers, to include carers as partners, along with service users and professionals, in all aspects of the appropriate delivery of care and services.
5. As part of its ongoing monitoring and evaluation of the implementation of the recommendations made by the internal review, the Trust should include stakeholder feedback – to answer the question: are these changes making a difference to service users, carers and staff?

Appendices

Appendix One: Trust reports, policies and protocols reviewed

Referrals into the Assessment and Treatment Service – flowchart
Referrals into specialist services – flowchart
Service Specification – Brighton Urgent Response Service, May 2011
Operational Policy: Adult Community Mental Health Service, June 2011
Brighton Urgent Response Service, May 2011
Enhanced Model for Urgent and Out of Hours Support, January 2013
Enhanced BURS Operational Protocol and Service Specification, January 2013
Brighton and Hove Assessment and Treatment Service (undated)
Briefing: Update as to the Clinical Risk Assessment and Safety Planning/Risk Management Policy, Risk Tools, Risk Training, Trust Risk panel, Trust Audit
Assessment and Treatment Service Triage Flowchart (undated)
Model 'Care Programme Approach' Care Plan
Brief Referral Guidance for Assessment and Treatment Service
ATS Leadership meeting minutes
Incident Reporting and Management Policy and Procedures, December 2010
Serious Untoward Incident (SUI) Policy and Procedure
Incident and Serious Incident Reporting Policy and Procedure, December 2014
Checklist for the investigation of SUIs
Sussex Multi-agency policy and procedures for safeguarding vulnerable adults, June 2007
Sussex safeguarding adults policy and procedures, 2015
Being Open, 2010

Appendix Two: National guidance and research reviewed.

Table 1: National policy guidance and legislation

Coroners and Justice Act, 2009
Department of Health, Promoting Quality Care. Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services, Department of Health, 2010
Department of Health, Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosures, Department of Health, 2010
GMC (2012) Continuing Professional Development: guidance for all doctors, General Medical Council
NHS, Realising the Benefits. IAPT at Full Rollout, Department of Health, 2010.
NHS England, Serious Incident Framework, March 2015.

Table 2: Literature reviewed.

R Hannan, P Rooney, A Worthington (2013) The Triangle of Care. Carers included: a guide to best practice in mental health care in England. The Carer's Trust.
J Langen and V Lindow.(2004) Living with risk: Mental health service user involvement in risk assessment and management The policy press, Joseph Rowntree Foundation
A review of themes identified during the independent investigation into the care and treatment of Mr B, Verita, 2014
L Vail, A Adams, E Gilbert, A Nettleingham, C D Buckingham, (2012) 'Investigating mental health risk assessment in primary care and the potential role of a structured decision support tool, GRiST', Mental Health in Family Medicine, 9 57-67
M McCroskerry (1999) 'Asperger's syndrome: A Developmental Puzzle'
National Institute for Neurological Disorders (2014) 'Asperger's Syndrome Factsheet'
Royal College of Psychiatrists (2008) 'Rethinking Risk to Others in Mental Health

Services' CR150

K Sofronoff, J Lee, J Sheffield and T Atwood (2014) 'The construction and evaluation of three measures of affectionate behaviour for children with Asperger's syndrome'. Autism November 2014 vol. 18 no. 8903-913

['Statistics: how many people have Autistic Spectrum Disorders?', 2014](#)

Appendix Three: The independent review panel

Mr Anthony Thompson: F Inst LM, MA, B. Ed (Hons); RMN, RNLD, RNT, Cert. ED, DN (Lond), Lead Reviewer. A Senior Associate of Caring Solutions (UK) Ltd, he has led a number of independent review panels and brings many years of experience representing mental health and learning disability services within a multi-disciplinary context. His career has spanned senior positions in statutory services, higher education, NHS and the independent sector. He continues to work at an international level and is a Fellow of the Institute of Leadership and Management. He is currently a director of Bridge R&D International, a not for profit company, and a management consultant for Roefield Specialist Care Ltd.

Dr Ashok Roy: Consultant in the Psychiatry of Learning Disability in Solihull Community Services and Coventry and Warwickshire Partnership Trust. He is Medical Lead for the Learning Disability Assessment and Treatment Service for the Trust. He is the Chair of the Faculty of Intellectual Disability at the Royal College of Psychiatrists. He represents the Faculty at the Department of Health and at the Learning Disability Professional Senate. He is a Senior Clinical Lecturer in the Psychiatry Department at Birmingham University. His interests include clinical outcome measures, service development, access to primary care services, and ethical issues in Learning Disability. He was previously Medical Director of an NHS Mental Health and Learning Disability Trust.

Mr Alan Worthington: Formerly in science education, he 'retired' early to become a carer of twin foster sons who developed psychosis in 1988. Soon afterwards he was appointed, in Exeter, to develop support and education services for mental health carers becoming one of the first Carers' Support Workers in the country. This work involved identifying Best Practice and finding ways for its introduction into carer involvement. For several years he worked for both MIND and the National Schizophrenia Fellowship and organised training days and conferences for staff and carers. He has contributed to the Care Quality Commission's inspection standards; participated in the Royal College of Psychiatrists' Accreditation - Peer Assessment Schemes; both in the Inpatient (AIMS) programme and the Crisis-Home Treatment (HTAS) Scheme. In the latter he took part in the process of selecting Standards for Home Treatment and is currently involved in the HTAS Awarding process. He is a member of the DH National Mental Health Safety Advisory Committee which is currently looking at ways of applying the Safety Thermometer concept to the reporting of mental health risk. Previous experience of reviews of care and treatment include a review of five Serious Untoward Incidents in Cornwall and a Serious Untoward Incident Conference run by DH in Leeds in 2009.

Ms Maggie Clifton, MA, MCFI Review Manager: A Senior Associate of Caring Solutions (UK) Ltd, Maggie has managed and contributed to a number of independent review panels and to the review and audit of internal and independent Serious Untoward Incident review reports. She is social scientist, specialising in qualitative research in

health and social policy related areas; and a general manager with extensive experience in the voluntary sector of managing services for homeless people and for people with long-term mental health problems. She is currently an independent research and management consultant, specialising in quality assurance, mental health service development, and training and development for managers. She is trained in advanced investigation skills and in the use of the European Foundation for Quality Management Excellence Model.

All members of the review panel are independent of any of the organisations involved with the incident in and have had no involvement in any of previous reviews into this homicide.

Appendix Four: Abbreviations and definitions

Advocate Depute	A senior advocate in the Scottish legal system at the time of Mr RS court case.
Assault to danger of life.	Offence under Scottish law. In this case it refers to the potential danger to his life arising from injuries sustained as result of the assault.
ATS	Assessment and Treatment Service
BURS	Brighton Urgent Response Service
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Team
Culpable Homicide	The equivalent of manslaughter in Scottish law
DISCO	Diagnostic Interview for Social and Communication Disorders
Functional alcoholic/high functioning alcoholic	A functional subtype alcoholic is categorized by being generally middle aged, have a stable home and work life and yet consume alcohol every day. Someone who is in this group is someone who is often not seen as an alcoholic. The individual hides the problem well, and often has a successful career that allows them cover up their alcoholic drinking. http://alcoholrehab.com/alcoholism/functional-alcoholic/
Hub	Geographical division of the Trust's mental health service.
IAPT	Improving Access to Psychological Therapies
Ideas of reference	"The misinterpretation that other people's statements or acts, or neutral objects in the environment are directed toward one's self when, in fact, they are not". Source: Farlex Partner Medical Dictionary © Farlex 2012
MHRRS	Mental Health Rapid Response Service
NAS	National Autistic Society

SI	Serious Incident
Triage	Originally used in the battlefield to identify priority of treatment, in mental health service the term describes a system for allocating priority and the appropriate form of care and treatment for a service user, based on the referral letter. In the Trust this is done by a group of health professionals, usually multi-disciplinary, and involving a consultant psychiatrist or experienced doctor.

Appendix Five: Anonymisation Index

Anonymisation	Position
Mr TS	Mr RS's father; victim of serious assault and widower of Mrs TS
Mrs TS	Mr RS's mother and victim of the homicide
Mr and Mrs VS	Mr RS's brother and sister-in-law
Ms WS	Mr RS's sister
Ms YT	Mr RS's former partner and mother of Ms WT
Ms WT	Mr RS's elder daughter
Ms AV	Mr RS's former partner and mother of Ms BV
Ms BV	Mr RS's younger daughter
Mr RS	Perpetrator
Ms ZE	CBT Therapist (carried out assessment for IAPT service in 2010)
Ms CW	CBT Therapist (carried out six CBT sessions in 2010)
Mr DX	Triage Social Worker
Mr EY	BURS CMHN
Mr FZ	Service Director
Ms GR	General Manager, Community Services
Dr HP	Senior Clinical Director, member of internal review team
Dr JO	Senior House Officer at the time of the homicide
Dr KN	Consultant Psychiatrist
Ms LM	Mental Health Officer, High Secure Psychiatric Hospital
Dr NL	Consultant Psychiatrist, Responsible Medical Officer, High Secure

	Psychiatric Hospital
Dr NK	GP who referred Mr RS to the IAPT service
Dr OG	Locum GP who referred Mr RS to the Assessment and Treatment service
Dr TH	GP who referred Mr RS to the BURS service
Ms TF	Speech and Language Therapist/Clinical Lead, Glasgow Autism Support Service
Ms VG	BURS CMHN
Dr WD	Glasgow GP
Ms YC	Triage nurse
Dr X; Ms Y; Mr Z	Senior personnel with allocated responsibility for implementing the Trust's action plan arising from the internal review of Mr RS's care and treatment.

Appendix Six: The Trust's Serious Incident Action Plan - Adult Services - Brighton & Hove

Report produced on 09 January 2015.

<p>Risk No: 6251</p> <p>SI034/12-13</p> <p>Findings</p> <p>First medical appointments, particularly those with complex presentation to be assessed by consultant or experienced doctor.</p>	<p>Action Status Closed</p> <p>Action, Lead & Target Date</p>	<p>Progress & Person Responsible</p> <p>Dr X</p>	<p>Directorate Team Setting</p> <p>AMHS ATS & Recovery (West) MVH Recovery Team</p>
<p>Findings</p> <p>Available information from families should be followed up and taken into account.</p>	<p>Action Status Closed</p> <p>Action, Lead & Target Date</p> <p>Dr X 31/03/2013</p> <p>Medic and ATS Team Leader to always be at present at Triage, to ensure all available information is assessed and followed through accordingly.</p>	<p>Progress & Person Responsible</p> <p>Ms Y</p> <p>08.01.15 - Consultant Psychiatrist attends daily triage meeting with Band 7 nurse and Team Leader. Triage have available all GP referral information and all records on electronic clinical recording system. Expectation that all assessors consider collateral information from</p>	<p>Team Setting</p> <p>AT & Recovery (West) MVH Recovery Team</p>
<p>Findings</p> <p>A system so that all new assessments performed by psychiatric trainees be discussed with a consultant psychiatrist at the time of assessment and the consultant psychiatrist to review the</p>	<p>Action Status Closed</p> <p>Action, Lead & Target Date</p> <p>Dr X 30/04/2013</p> <p>Consultant always present at Triage to ensure</p>	<p>Progress & Person Responsible</p> <p>Mr Z</p> <p>08.01.14 - All psychiatric trainees have access to their educational supervisor or alternative Consultant during assessment periods. Often</p>	<p>Team Setting</p> <p>ATS & Recovery (West) MVH Recovery Team</p>

<p>Findings</p> <p>Consider all risk indicators, including historical, at all appointments and seek more expert advice immediately if concerned</p>	<p>Action Status Closed Action, Lead & Target Date Ms Y</p> <p>Review of all risk factors Discussion in MDT</p> <p>30/04/2013</p>	<p>Progress & Person Responsible</p> <p>08.01.14 - SPFT has undertaken an organisation wide risk assessment training and risk assessment documentation has been updated. Assessment & Treatment Services</p>	<p>Team Setting</p> <p>ATS & Recovery (West) MVH Recovery Team</p>
<p>Findings</p> <p>Take all presenting factors into consideration. In this case this would have included how Asperger's syndrome effects how a patient presents</p>	<p>Action Status Closed</p> <p>Action, Lead & Target Date</p> <p>Mr Z 30/08/2013</p> <p>Asperger's Awareness Training to be delivered</p>	<p>Progress & Person Responsible</p> <p>08.01.14 - CCG have commissioned Nurse</p>	<p>Team Setting</p> <p>ATS & Recovery (West) MVH Recovery Team</p>
<p>Findings</p> <p>Training for frontline staff regarding the effects of drugs including 'legal highs' and regular updates.</p>	<p>Action Status Closed</p> <p>Action, Lead & Target Date</p> <p>30/08/2013</p> <p>Training to use Drug Assessment Tool to be delivered by all assessing practitioners</p>	<p>Progress & Person Responsible</p> <p>Ms Y</p> <p>08.01.15 - Drug Assessment Tool used in the Assessment & Treatment Service. A dual diagnosis care plan was developed with the CCG as part of a local CQUIN. Substance Misuse Services have been retendered in Brighton & Hove. One aspect of the new provider will be to co-locate substance misuse colleagues</p>	<p>Team Setting</p> <p>ATS & Recovery (West) MVH Recovery Team</p>

Appendix Seven: Note on Asperger's syndrome.

Those with an expertise in assessing Asperger's syndrome recognise that it shares commonality with Autistic Spectrum Disorders (McCroskerry 1999) and akin to autism, shares symptoms: social and communication impairments, dogmatic habitual interests and physical incoordination.

Typical presentation of Asperger's syndrome includes social difficulties involve problems with non-verbal communications e.g. maintaining eye contact and reading body language: thereby contributing to a limited development of friendships with peers, trouble sharing in the interests of others outside their own and are thus compounded by an innate emotional isolation (Sofronoff, Lee, Sheffield and Atwood, 2014).

Therefore, whilst Asperger's syndrome is a similar disorder to autism in symptomology, it differs in as much as intellectual and language ability is considered normal.

Whilst classical autism has a prevalence of 1.1 % of the UK population ([The National Autism Society](#) 2014), the actual prevalence of Asperger's syndrome can only be estimated ([Neurological Institute for Neurological Disorder](#) 2014). Asperger's syndrome is a relatively recent medically diagnosable phenomenon. The condition has been broadened and grouped with other autistic spectrum disorders in an attempt to facilitate an accurate diagnosis, but also in respect of the fact that the condition is unique from person to person, with varying extremes and grades.

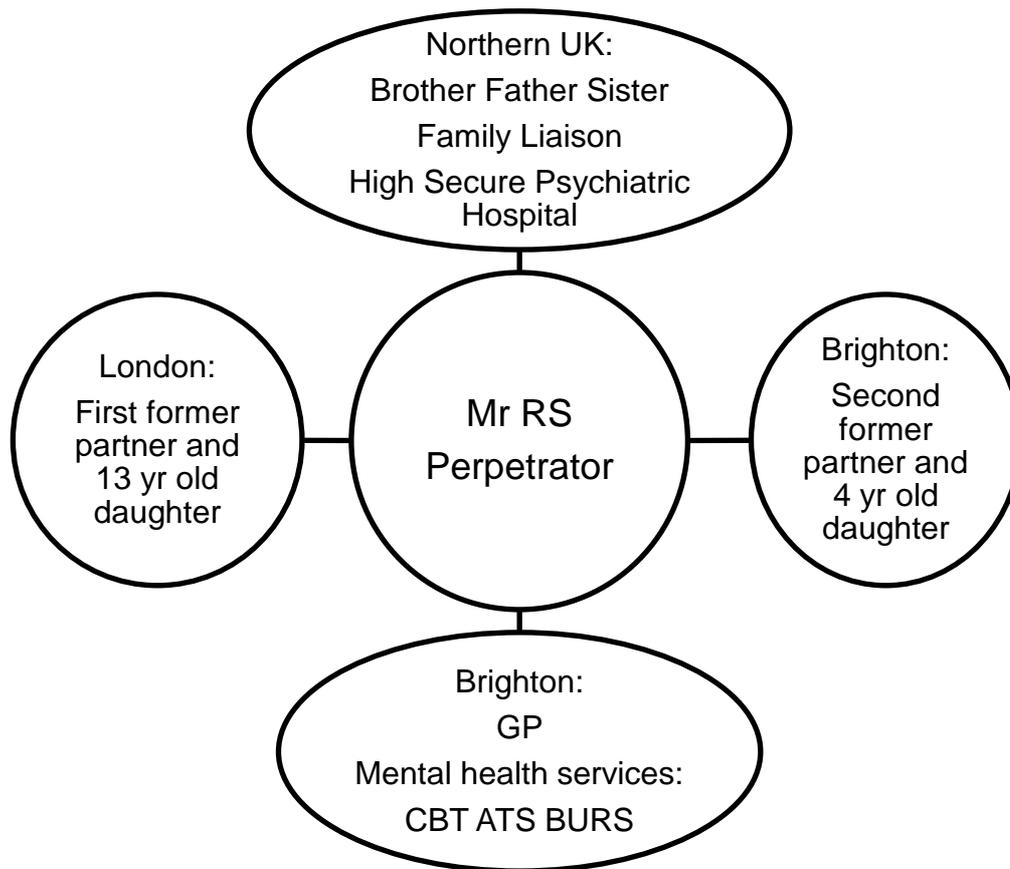
Conversely, the obstacle of comorbidities, such as schizoid personality disorder, schizophrenia, anxiety related disorders and communication problems all add to the immense challenge when clinicians attempt factual and accurate diagnosis of Asperger's syndrome.

However, from the literature there is a potential for violent outbursts that can only be mediated through understanding its provenance, extenuating comorbidities and differential diagnosis. This can range from anxiety to schizophrenia and potentially psychopathy.

Within the criminal justice system, a diagnosis of Asperger's syndrome can and has been used in part of a legal defence, in order to demonstrate diminished responsibility ([Coroners and Justice Act, 2009](#)). Such cases highlight that literature and empirical evidence pre-dates the precise diagnostics utilised in specialist units such as the one in Glasgow when Mr RS presented and was assessed.

If one is unsure of accurate diagnosis of Asperger's syndrome in the first instance, it follows that it is not possible to either confirm or deny a link between Asperger's syndrome as ascribed to Mr RS and his subsequent violent actions.

Appendix Eight: Mr RS Genogram



Appendix Nine: The family relationships of Mr RS

