

**An independent
investigation into the care
and treatment of a mental
health service user, Mr E,
by Northumberland, Tyne
and Wear NHS Foundation
Trust**

**Commissioned by NHS England
(Northern Region)**

March 2015

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EXECUTIVE SUMMARY

NHS England's Single Operating Model¹

In March 2014 NHS England (North) commissioned Niche Patient Safety to conduct an independent investigation into the care and treatment of Mr E and to review the events that led up to the death of a young boy at the home of Mr E's mother on 1 March 2011.

This case met the following criteria for the commissioning of an independent homicide investigation as set out in NHS England's Single Operating Model:²

*"When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach of specialist health services in the six months prior to the event."*³

The purpose of this investigation is to investigate the care and treatment of Mr E; to assess the quality of Northumberland, Tyne and Wear NHS Foundation Trust's (NTW) internal investigation, which took place following the incident; to review the implementation of the action plan that arose out of the findings of the Trust's internal review and to establish whether any lessons can be learnt for the future which could prevent similar incidents from occurring. The investigation was also to determine whether or not the events could have been predicted⁴ or prevented.⁵

This report was written with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis Guidance. Root Cause Analysis (RCA) methodology has been utilised to both review and analyse the information obtained throughout the course of this investigation.

Summary of the incident on 1 March 2011:

On the evening of the incident, it was reported⁶ that the victim (ND) and Mr E had a heated argument over the use of a mobile phone. At approximately 11pm Mr E's mother heard raised voices. She went downstairs to find ND crying, saying that Mr E had twisted his arm. In order to defuse the situation, she removed the SIM card from the phone and told ND to go to her bedroom. Mr E remained in the kitchen area and it was reported that he said, "I need

¹ NHS England Delivering a Single Operating Model for Investigating Mental Health Homicides (2013)

² NHS England Delivering a Single Operating Model for Investigating Mental Health Homicides (2013), p7

³ NHS England Delivering a Single Operating Model for Investigating Mental Health Homicides (2013), p7

⁴ Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. <http://dictionary.reference.com/browse/predictability>

⁵ Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.

<http://dictionary.reference.com/browse/predictability>

⁶ Police interview transcripts

five minutes to calm down.”⁷ A short time later Mr E went into the bedroom and repeatedly stabbed ND.

The Sunderland Serious Case Review Panel met on 17 March 2011 where it was decided “*there would be no benefit of doing a Serious Case review or Management review due to agencies having no involvement or previous concerns*”⁸ regarding the victim. The rationale for this decision was verified to Niche’s investigation team.

Background:

It was repeatedly being documented that Mr E was reticent about discussing both his early life and the circumstances that initially brought him to the attention of mental health services in 2010. However, through the course of our investigation, we were able to build up a fairly comprehensive picture of Mr E’s life history. At the age of 15⁹ he was admitted to hospital following an overdose. A psychiatrist from the Child and Family Psychiatry Unit¹⁰ noted that Mr E had, at that time, a significant history of behavioural problems which included smoking cannabis, fighting, burglary and a conviction for arson after he set light to his father’s car.

Information we obtained from the police indicates that from 1994 to 2010 Mr E was arrested, charged and at times convicted on nine different occasions for either Section 47 Assaults¹¹ or Battery.¹² Several of the incidents involved domestic disturbances and assaults on members of Mr E’s family, and on one occasion he attacked a minor.¹³ Members of the family reported¹⁴ that Mr E’s alcohol consumption was often a significant factor in such incidents. They also reported that on regular occasions they had to remove Mr E’s child from his care, as they were concerned about the child’s safety when his father was drinking. Mr E’s A&E notes also indicated that Mr E had been admitted on numerous occasions having himself been a victim of violent assaults.

Mr E was the father of four children, although based on the information we were able to obtain, it appears that whilst he did not maintain contact with three of these children, he assumed the role of a single parent for seven years to his youngest child. In 2009¹⁵ this child witnessed an incident of domestic violence and was removed from Mr E’s care. The child was placed first with his paternal grandmother and then with his mother.

On 2 May 2010 Mr E was arrested and subsequently charged with a Section 18 offence¹⁶ after his girlfriend had been attacked and sustained significant injuries which required surgery. This case was pending at the time of the incident on 1 March 2011.

⁷ Information obtained in police interview, p12

⁸ SI report ,p4

⁹ 1994

¹⁰ Letter to GP from Child and Family Psychiatrist, 7 February 1994

¹¹ Section 47 Assault: actual bodily harm (ABH)

¹² Battery: battery involves unlawfully touching another person; no physical injury is necessary

¹³ 23 May 2009

¹⁴ Police interviews

¹⁵ 17 November 2009

¹⁶ Section 18: wounding with intent or causing grievous bodily harm with intent

Involvement of NTW's mental health services:

Mr E first came to the attention of NTW mental health services on 6 May 2010 when he presented in A&E following two episodes of self-injury whilst reportedly being under the influence of alcohol. Mr E repeatedly maintained that the reason for his mental health difficulties was the loss of custody of his son and his impending court case for the assault of his girlfriend. It was assessed that Mr E was at high risk of self-injury, and as he refused the crisis team's support, he was admitted to the inpatient psychiatric unit, initially on a voluntary basis. However, following an incident on the ward he was placed on a Section 2¹⁷ of the Mental Health Act (1983). This was regraded to a Section 3¹⁸ at a subsequent Mental Health Tribunal.¹⁹ It was recommended at the Tribunal that a forensic and psychological assessment should be undertaken.

Mr E spent from 6 May to 9 July 2010 on the inpatient unit and during this period he absconded seven times. On one of these episodes, police reported to the ward staff that Mr E had been seen in the vicinity of his girlfriend's accommodation, which broke the terms of his bail conditions.

On numerous occasions during his inpatient stay Mr E returned to the ward intoxicated. On one of these occasions²⁰ he assaulted another patient, and on another he damaged property and was verbally abusive to the ward staff. During Mr E's admission the ward staff were made aware that there were MARAC²¹ proceedings taking place with regards to the incident of domestic violence (2 May 2010).

At the point of Mr E's discharge from the inpatient unit (9 July 2010), he was diagnosed with an Impulsive Personality Disorder. His discharge medication was Carbamazepine 200mg²² and Mirtazapine 45mg.²³ It was reported²⁴ by family members that from the point of Mr E's discharge from the psychiatric inpatient unit, although he continued to collect his prescriptions he did not take his psychiatric medication but was storing it in the homes of members of his family. They reported that he did this as it was his intention to use his mental health diagnosis as a defence in his court case.

Mr E did not engage with community services and on 11 October 2010 his CPA²⁵ status was downgraded to a non-CPA programme. He was to continue to be seen by a psychiatrist in the outpatient clinic. Mr E was last seen at this

¹⁷ Section 2 of the Mental Health Act (1983): detained for assessment and treatment for up to 28 days

¹⁸ Section 3 of the Mental Health Act: detained for treatment for up to six months. Treatment might be necessary for the patient's health or safety or for the protection of other people. On discharge, patients are entitled to Section 117 aftercare (free aftercare from the NHS and social services)

¹⁹ 14 June 2010

²⁰ 18 May 2010

²¹ MARAC: Multi Agency Risk Assessment Conference

²² Carbamazepine is an anticonvulsant and mood-stabilising drug used primarily in the treatment of epilepsy and bipolar disorder

²³ Mirtazapine is an antidepressant used to treat major depressive disorder

²⁴ Police interviews

²⁵ The Care Programme Approach (CPA) is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs

clinic on 17 January 2011. At this appointment his antidepressant medication was changed to Escitalopram²⁶ 10mg.

On 20 October 2010 Mr E sustained a serious head injury²⁷ and spent several days in the intensive care unit. After his discharge, both he and his mother reported that he was experiencing some cognitive difficulties relating to his short-term memory. He also moved back into his mother's house, as he was having difficulty managing living alone. At the time of the incident, Mr E was in the process of being referred for a neuropsychological assessment.

Summary of findings:

During the course of our investigation we identified the following issues (please note that the findings that were also identified within NTW's SI report are marked with (S)):

- The forensic and psychological assessments that were recommended in the Mental Health Tribunal did not occur (S).
- Despite it being known that MARAC²⁸ proceedings were underway, that there were safeguarding concerns about his son and that Mr E was on bail for a serious assault, successive FACE Risk Profile Assessments²⁹ did not adequately document or consider his known historical and current risk factors.
- Despite being in regular contact with the police the ward staff failed to obtain any information regarding Mr E's forensic history.
- It was not documented if Mr E was offered access to psychological therapies³⁰ either during his inpatient stay or by community mental health services.
- Despite the fact that there were repeated incidents when Mr E returned to the ward intoxicated, the extent of Mr E's alcohol use was not consistently identified as a significant risk or contributory factor.
- Mr E was discharged from the inpatient unit without the appropriate Section 117 planning (S).³¹
- There were no discharge plans in place when Mr E was discharged from the inpatient unit. Therefore, community services only had minimal information about both his risk factors and support needs (S).
- Neither the head injury unit nor community mental health services communicated with each other with regard to Mr E's post-head-injury symptoms or treatment plans.
- Mr E's psychiatric medication was changed at a significant point, when it was unclear if his reported symptoms were due to his head injury or his mental health.

²⁶ Escitalopram is used for treating depression and generalised anxiety disorder

²⁷ Right-sided subdural haemorrhage

²⁸ MARAC: Multi Agency Risk Assessment Conference

²⁹ Risk assessment tool

³⁰ As recommended in NICE guidelines for the treatment of personality disorders

³¹ Section 117: imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under Section 3 of the Mental Health Act. A patient should be allocated a care coordinator and have multi-disciplinary care planning and review meetings and a written care plan. Aftercare should be planned with the patient, their family and carers, as well as professionals, looking at both health and social care needs

- Apart from Mr E's parents attending several ward meetings, it is not documented if either the primary or secondary mental health care services actively sought to obtain information from Mr E's family.
- Despite it being known by both community mental health services and the head injury unit that Mr E's mother had assumed the role of significant carer to her son after his head injury she was not offered a carer's assessment.

NTW's Post Incident Investigation (SI) and implementation of the SI's recommendations:

We concluded that the SI report provided an extensive chronology and details of Mr E's involvement with secondary mental health care services in the nine months preceding the incident. However, in our opinion there were some omissions within the SI report that we would like to draw the Trust's attention to in order to improve future SI investigations.

- The SI panel requested and received a brief summary from the GP of their involvement with Mr E. We would suggest that it would have been helpful to have tried to obtain access to Mr E's primary care notes.
- The primary care service reported that they had not received any feedback from the Trust's SI, nor were they invited to attend a post-incident feedback event.
- The authors of the SI report did not approach the police to access Mr E's forensic history.
- The authors of the SI report did not seek to gain access to hospital 3 (head injury unit) notes or interview staff from the head injury unit where Mr E was treated.
- The National Patient Safety Agency's RCA Investigation Evaluation Checklist directs that an Executive Summary must include care and delivery issues, root causes, contributory factors and lessons learnt. None of these areas were documented within the Executive Summary.
- Despite making several requests to the Trust to gain access to the witness statements etc. from the SI report, we were informed that they were unable to be located. It was also unclear exactly who within the Trust was responsible for their safe storage. Therefore, we concluded that both the authors of the SI report and NTW failed to comply with the National Patient Safety Agency's RCA Investigation requirements with regard to the safe storage of interview transcripts.
- Based on our investigation we concluded that there were certain areas to which the authors of the SI report failed to give adequate consideration; namely the significance of Mr E's head injury, the lack of liaison between NTW and hospital 3, and the potential significance of the change to Mr E's psychiatric medication³² just prior to the incident.

With regard to the SI's recommendations and the Trust's subsequent action plan, it was evident that all the recommendations had an action plan(s)

³² 24 January 2011

identified and it was reported to us that by May 2012 all the actions had been fully implemented. However, one clinician we interviewed commented that the SI action plans had been somewhat superseded by NTW's Transforming Services Programme, which has significantly changed both community and inpatient services.

Predictability and preventability:

Throughout the course of this investigation we have been mindful of the requirement, within NHS England's Terms of Reference, to consider if the incident which resulted in the killing of ND was either predictable or preventable. A significant amount of information regarding Mr E's criminal background has only come to light during the course of this investigative process. Therefore, it was not available to either the primary or secondary health care services who were supporting Mr E or to the authors of the SI report. In our consideration of the predictability and preventability of this incident, one of the questions that we have asked ourselves was if it was reasonable to have expected agencies and individual clinicians to have taken more proactive steps to obtain a comprehensive profile of Mr E. Additionally, based on the information that was known at the time did clinicians take reasonable steps to assess and manage Mr E's risks? The benefit of hindsight³³ has been useful, as it has enabled us not only to develop a more comprehensive account of the events that led up to the incident itself but also to highlight issues within the treatment and management of Mr E by primary and secondary health care services.

Predictability:

Bearing in mind that one definition of a homicide that is judged to have been predictable is where "*the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.*"³⁴ We concluded that, even based on the partial information that was known at the time there was significant evidence to indicate that Mr E had extremely high risk factors of violence towards others and that he had few protective factors in his life. We concluded that all involved agencies failed to adequately identify his high risk of reoffending or to take the appropriate steps to obtain further information to inform their risk assessments and clinical judgments. Furthermore, based on Mr E's previous offences, it was highly predictable that he would have been involved in another impulsive violent incident. However, in our opinion it was not predictable that the victim would have been a young man who was living in the household.

³³ *Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)*

³⁴ *Munro E, Rungay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000), 176: 116–120*

Preventability:

We found that it was more difficult to definitively conclude whether the incident itself was preventable. As we have already concluded, it was evident that Mr E had a significant history of violent and unprovoked incidents which resulted in the victim at times suffering significant injuries. Mr E was also consistently either unwilling or unable to engage in any meaningful rehabilitation programme, including compliance with prescribed psychiatric medication. During the course of our investigation, we have identified many occasions where secondary mental health services failed to obtain significant information from both other agencies (police and probation) as well as from Mr E's family. This information would have enabled a more accurate assessment of Mr E's risk factors but also would have alerted agencies to the potential risks and support needs of members of Mr E's household. However, we concluded that even if more informed risk assessments had been undertaken, it was unlikely that the events of 1 March 2011 would have been preventable.

Concluding comments:

We concluded that based on the evidence that we obtained during the course of this investigation, it was clear that Mr E had complex needs and a significant history of violence, including towards vulnerable females, members of his family and on one occasion a minor. These incidents were often associated with alcohol. Mr E was well known to the police but only came to the attention of mental health services when he had lost the custody of his son, who was a significant protective factor for him. What our investigation has highlighted is that in the assessment, management and treatment of a patient such as Mr E, who was consistently resistant to disclosing information or engaging with services, what is required is an integrated multi-agency approach to risk assessments, information sharing and support planning. This clearly did not occur as Mr E's risk assessments were based on information that was self-reported. During the course of our investigation, it became increasingly evident that Mr E was an inconsistent and often unreliable self-historian. Finally, it was also evident that Mr E was not provided with the recognised treatment³⁵ that was in place at the time for a patient with a diagnosis of a Personality Disorder. However, it is acknowledged that Mr E was consistently resistant to engaging with any therapeutic or treatment programme that was offered to him.

³⁵ NICE guidelines

Recommendations:

Niche's investigation team believe there are lessons to be learnt from their investigation and have made the following recommendations.

Recommendation 1.

Where multiple health care providers are involved in the treatment and care of a patient, the discharging service should seek the permission of the patient to send discharge summaries to all involved agencies.

Recommendation 2.

Risk assessments undertaken by NTW's mental health inpatient and community services must ensure that historical and current risks are being consistently documented and appropriately assessed.

Recommendation 3.

When it is known that a patient has a forensic history NTW's clinicians must seek to obtain information from the police and probation service in order to inform both risk assessments and support plans.

Recommendation 4.

NTW's mental health inpatient service's Discharge Summaries should provide both a narrative description and the context of a patient's risk, protective factors and triggers.

Recommendation 5.

The Executive Summary of SIs should include care and delivery issues, root causes, contributory factors and lessons learnt.

Recommendation 6.

The authors of SI reports and the Trust must ensure that information gathered as part of an investigation is securely stored for future reference.

Recommendation 7.

The authors of SI reports should always refer to the relevant NICE guidelines, both those that were in place at the time of the incident and any subsequent revisions, when reviewing a patient's treatment plans.

Recommendation 8.

NTW should undertake an evaluation of the impact of the changes that were introduced as a direct result of the SI's recommendations.

Niche Patient Safety's condolences to the family of the victim:

The Independent Investigation Team would like to offer their deepest sympathies to the family of the victim. It is our sincere wish that this report does not contribute further to their pain and distress.

Publication:

The outcome of this investigation will be made public. The nature and form of publication will be determined by NHS England. The decision on publication will take account of the views of the relatives and other interested parties.

Acknowledgement of participants:

The investigation team would like to acknowledge the contribution of the staff from Northumberland, Tyne and Wear NHS Foundation Trust, Newcastle upon Tyne Hospital Trust and Northumberland Police Authority.

Anonymity:

For the purpose of this report:

- the identities of all those who were interviewed have been anonymised and they will be identified by their professional titles;
- services have been anonymised and are referred to by their service type only;
- the patient is referred to as Patient E; and
- the victim is referred to as ND.

1. Introduction

NHS England's Single Operating Model:

1.1 Prior to 2013 the Health Service Guidance (94) 27 (amended in 2005) placed the responsibility on former Strategic Health Authorities to commission independent investigations into mental health homicides and serious incidents. From 2013 this function was transferred to NHS England, who assumed overarching responsibility for ensuring that *"the NHS delivers better outcomes for patients within its available resources and upholds and promotes the NHS Constitution and the NHS Mandate."*³⁶

1.2 In January 2014 NHS England introduced a Single Operating Model³⁷ which identified the following criteria with regard to what now prompts the commissioning of an independent homicide investigation:

*"When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach of specialist mental health services in the six months prior to the event. To examine the care and treatment of patients and establish whether or not a homicide could have been predicted or prevented and if any lessons can be learnt for the future, to reduce the chances of reoccurrence of a similar incident."*³⁸

1.3 The purpose of such an investigation is to:

*"Increase public confidence in statutory mental health service providers. Another reason for undertaking independent investigations and publishing their reports is to ensure that Trusts/providers implement the reports' recommendations and action plans."*³⁹

1.4 The intention of the Single Operating Model is:

- to ensure that there is a uniform and consistent approach to managing independent patient safety investigations;
- to develop expertise and a body of knowledge; and
- to reduce *"the organisational risks of running multiple systems by removing local variations."*⁴⁰

1.5 In March 2014 NHS England commissioned Niche Patient Safety to undertake an independent investigation into the homicide of ND.

³⁶ NHS England, *Single Operating Model for Investigating Mental Health Homicides*, 2013, p5

³⁷ NHS England, *Single Operating Model for Investigating Mental Health Homicides*, 2013, p5

³⁸ NHS England, *Single Operating Model for Investigating Mental Health Homicides*, 2013, p5

³⁹ NHS England, *Single Operating Model for Investigating Mental Health Homicides*, 2013, p7

⁴⁰ NHS England, *Single Operating Model for Investigating Mental Health Homicides*, 2013, p6

Purpose and scope of the investigation:

- 1.6 The purpose of this investigation is to investigate the care and treatment of Mr E; to assess the quality of the internal investigation that took place following the incident; to review the implementation of the action plan that arose out of the findings of the Trust's SI report and to establish whether any lessons can be learnt for the future which could prevent similar incidents from occurring.
- 1.7 We will also consider whether the incident on 1 March 2011, which led to the death of ND, was predictable⁴¹ or preventable.⁴²
- 1.8 The Terms of Reference that were agreed with NHS England are located in Appendix B.

Profile of Niche and the Investigation Team:

- 1.9 Niche Patient Safety is a leading national patient safety and clinical risk management consultancy which has extensive experience in undertaking complex investigations following serious incidents and unexpected deaths. Niche also undertakes reviews of governance arrangements and supports organisational compliance with their regulatory frameworks across a range of health and social care providers.
- 1.10 For this investigation Niche's investigative team was led by Senior Investigator Grania Jenkins and specialist psychiatric advice was provided by Dr Ian Davidson.
- 1.11 The report has been peer reviewed by Carol Rooney, Senior Investigations Manager, and Nick Moor, Niche Director.
- 1.12 For the purpose of this report the investigation team will be referred to in the first person plural and Niche Patient Safety will be referred to as Niche.

Approach and methodology utilised throughout the investigation:

- 1.13 This report was written with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis Guidance.⁴³ Root Cause Analysis (RCA) methodology has been utilised to review the information obtained throughout the course of this investigation.
- 1.14 RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that lead to an incident. It is an iterative⁴⁴

⁴¹ Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. <http://dictionary.reference.com/browse/predictability>

⁴² Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.

<http://dictionary.reference.com/browse/predictability>

⁴³ National Patient Safety Agency (NPSA) Root Cause Analysis Guidance

⁴⁴ Iteration is the act of repeating a process with the aim of approaching a desired goal, target or result

structured process that has the ultimate goal of the prevention of future adverse events by the elimination of latent errors.

- 1.15 RCA provides a systematic process for conducting an investigation, looking beyond the individuals involved and seeking to identify and understand the underlying system features and the environmental context in which an incident occurred. It assists in the identification of common risks and opportunities to improve patient safety and informs recommendations regarding organisational and system learning.
- 1.16 The prescribed RCA process includes data collection and a reconstruction of the event in question through record reviews and participant interviews.
- 1.17 As part of the investigation process we have utilised an RCA Fishbone diagram to assist the investigative team in identifying the influencing and multiple contributory factors which led to the incident (the Fishbone is located in Appendix A).
- 1.18 We referred to relevant national and local policies and guidelines, to the various Department of Health's (DH) Best Practice⁴⁵ guidelines and to the relevant NICE⁴⁶ guidance.
- 1.19 As far as possible we have tried to eliminate or minimise hindsight or outcome bias⁴⁷ in our investigation. We analysed information that was available to primary and secondary care services at the time. However, where hindsight informed our judgments, we have identified this.

Interviews:

- 1.20 During the course of the investigation it became apparent that due to the fact that the incident occurred in 2011 most of the individuals who were involved in the care of Mr E had either left their post or were on long-term sickness leave. However, we were able to locate two practitioners who were involved in Mr E's care after he was discharged from the inpatient unit in 2010.
- 1.21 We also undertook a series of interviews with senior operational and managerial staff from Northumberland, Tyne and Wear NHS Foundation Trust (NTW).
- 1.22 We interviewed a practitioner from the head injury unit at hospital 3 and two GPs from the primary health care practice where Mr E was registered.
- 1.23 We also interviewed the Director of Nursing and the Joint Commissioning Lead from Northumberland, Tyne and Wear Clinical Commissioning Group (CCG).

⁴⁵ DH (March 2008), *Refocusing the Care Programme Approach Policy and Positive Practice and Code of Practice Mental Health Act 1983 (revised)*

⁴⁶ NICE: National Institute for Health and Care Excellence

⁴⁷ *Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)*

- 1.24 Interviews were managed with reference to the National Patient Safety Agency (NPSA) Investigation interview guidance.⁴⁸ We also adhered to the Salmon/Scott principles.⁴⁹
- 1.25 We accessed transcripts from the police's interviews with members of Mr E's family.

Involvement of Mr E and members of the victim's family:

- 1.26 As part of all Niche's investigations we always try to obtain the views of the patient and the families of both the victim and the perpetrator, not only in relation to the incident itself but also their wider thoughts regarding where improvements to services could be made in order to prevent similar incidents from occurring again. Their involvement, we would suggest, is essential in order for the investigative team to be able to develop a comprehensive understanding and analysis of the incident itself and also to inform the final recommendations.
- 1.27 Mr E was invited to take part in this investigation but he declined. His medical records were released using the Caldicott Guardian principles.⁵⁰
- 1.28 NHS England invited the family of the victim to take part in this investigation but they declined.
- 1.29 Both Mr E and the family of the victim will be offered the opportunity to be provided with feedback on the findings of this investigation.

2. Summary of events that led up to the incident (1 March 2011) (information regarding the day of the incident has been obtained through police interview transcripts and was not available to the authors of the SI report):

- 2.1 At the time of the incident Mr E was 32 years old and was unemployed.
- 2.2 Mr E first came to the attention of NTW's mental health services on 6 May 2010 when he presented in A&E following two episodes of self-injury whilst reportedly being under the influence of alcohol.
- 2.3 On admission Mr E disclosed that he had been a single parent for seven years but he feared that he was going to lose custody of his son, as he had been arrested and charged with Section 18 Assault.⁵¹ The victim was his girlfriend. Mr E also reported that he had been arrested for being drunk in charge of his son. He believed that he would be given a custodial sentence and for this reason he had felt suicidal.
- 2.4 As Mr E refused the crisis team's support and as it was assessed that he remained at high risk of self-injury he was admitted to the inpatient

⁴⁸ National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*

⁴⁹ The 'Salmon Process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere

⁵⁰ Caldicott Guardian principles: access to patient identifiable information should be on a strict need-to-know basis

⁵¹ Section 18 Assault: wounding with intent or causing grievous bodily harm with intent

- psychiatric unit, initially on a voluntary basis, then under a Section 2⁵² and subsequently a Section 3⁵³ of the Mental Health Act (1983).
- 2.5 On discharge from the inpatient unit Mr E was diagnosed with a Depressive Episode and an Impulsive Personality Disorder. His medication regime was Carbamazepine 200mg⁵⁴ and Mirtazapine 15mg.⁵⁵
- 2.6 After his discharge Mr E failed to engage with either the crisis resolution or the community treatment teams. Due to Mr E's lack of engagement with support his Enhanced CPA⁵⁶ status was downgraded (11 October 2010) to a non-care programme. He was to continue to be under the care of the psychiatrist in the outpatient clinic.
- 2.7 Mr E was last seen by the psychiatrist on 17 January 2011. At this appointment his antidepressant medication was changed to Escitalopram 10mg⁵⁷ with a programme for the reduction of Mirtazapine.
- 2.8 The other noticeable event in the months leading up to the incident was on 29 October 2010 when Mr E sustained a significant head injury during what was thought to have been an assault at his home. He was diagnosed with a right-sided subdural haematoma⁵⁸ and spent several days in ICU.⁵⁹ He was sedated and intubated with an intra-cranial pressure monitoring bolt inserted, which was to monitor the pressure within his brain.
- 2.9 Following his discharge from the neurosurgical ward Mr E's mother reported that her son had come to live with her and although his physical symptoms had begun to improve, he was struggling with both short-term memory issues and reduced confidence.
- 2.10 Mr E was last seen by a specialist nurse on 18 February 2011 when he and his mother attended an outpatient appointment. Due to his ongoing difficulties he was referred for a neuropsychological assessment. At the time of the incident he was awaiting this appointment.
- 2.11 On the day of the incident (1 March 2011) it was reported⁶⁰ that the victim, ND, aged 14 years, had gone to school as usual. When Mr E's mother returned home, at approximately 12:45pm, Mr E was out of bed, and after borrowing £10 he went to his sister's house. He remained there for several hours, where reportedly he borrowed some more money.⁶¹

⁵² Section 2 of the Mental Health Act (1983): detained for assessment and treatment for up to 28 days

⁵³ Section 3 of the Mental Health Act: detained for treatment for up to six months. Treatment might be necessary for the patient's health or safety or for the protection of other people. On discharge patients are entitled to Section 117 aftercare (free aftercare from the NHS and social services)

⁵⁴ Carbamazepine is an anticonvulsant and mood-stabilising drug used primarily in the treatment of epilepsy and bipolar disorder

⁵⁵ Mirtazapine: antidepressant

⁵⁶ The Care Programme Approach (CPA) is a system of delivering community mental health services to individuals diagnosed with a mental illness. The approach requires that health and social services assess need, provide a written care plan, allocate a care coordinator, and then regularly review the plan with key stakeholders, in keeping with the National Health Service and Community Care Act 1990. Enhanced CPA are for individuals with complex and multiple support needs

⁵⁷ Escitalopram: prescribed for treating depression and generalised anxiety disorder

⁵⁸ A subdural haematoma is a collection of blood outside the brain

⁵⁹ ICU: intensive care unit

⁶⁰ Police interview transcripts

⁶¹ Information obtained in police interview, p3

- 2.12 Both Mr E and ND returned to the house about mid-afternoon. It was reported that the early evening passed without incident, with the members of the household following their usual patterns of activity. Mr E was mostly in the kitchen, drinking alcohol and smoking.
- 2.13 At about 7:30pm Mr E lent his mobile phone to ND. At approximately 11pm Mr E's mother heard raised voices. She went downstairs to find ND in Mr E's bedroom crying, saying that Mr E had twisted his arm. Mr E's mother reported that it was evident that both her son and ND were angry, so in order to defuse the situation she removed the SIM card from the phone and told ND to go to her bedroom.
- 2.14 Mr E remained in the kitchen area and it was reported that he had said "*I need five minutes to calm down.*"⁶² It was documented that he made a phone call after his mother went upstairs.
- 2.15 A short time later Mr E came into his mother's bedroom. At first she reported⁶³ that she did not see that he was carrying a knife. She then recalled that Mr E "*did not speak but almost growled*"⁶⁴ at ND. He then began to repeatedly stab ND. Mr E's mother called the emergency services at 12:15am.
- 2.16 ND attempted to get away from Mr E and the attack continued onto the landing area. Mr E told his mother to fetch a towel so that he could stop the bleeding. By the time the police arrived Mr E had placed the knife on the floor and put a towel around ND's neck area. The victim was still conscious when the paramedics arrived. ND was taken to hospital where he was pronounced dead at 1:45am.
- 2.17 Mr E's mother reported that she did not recognise the knife that her son had used in the attack.
- 2.18 At the trial (23 September 2011) Mr E admitted the killing but despite it being argued that his "*abnormality of the mind diminished his responsibility.*"⁶⁵ Mr E was convicted by a majority verdict of the murder of ND. He was given a life sentence.
- 2.19 The judge is reported to have stated that Mr E was "*a highly dangerous man*"⁶⁶ who would have to serve 22 years before he would be considered for parole.
- 2.20 The Sunderland Serious Case Review Panel met on 17 March 2011 where it was decided "*there would be no benefit of doing a Serious Case review or Management review due to agencies having no involvement or previous concerns*"⁶⁷ regarding ND. This rational for this decision was confirmed by NTW's Safeguarding Lead to Niche's investigation team.

⁶² Information obtained in police interview, p12

⁶³ Information obtained in police interview, p12

⁶⁴ Information obtained in police interview, p13

⁶⁵ www.dailymail.co.uk/news/article-2041140

⁶⁶ www.dailymail.co.uk/news/article-2041140

⁶⁷ SI report .p4

3. Mr E's childhood and family background

- 3.1 Mr E was the middle child of five children. In a Care Plan Review⁶⁸ it was documented that both Mr E and his mother reported that during his time at primary school Mr E was “*outgoing with friends*” but that from the age of eight years he started to “*get into trouble for fighting.*”⁶⁹
- 3.2 In a letter, dated 7 February 1994, Mr E's mother was reported to have stated that during his time at primary school her son had problems and she described him as a “*bully.*”
- 3.3 During his first year in secondary school Mr E's parents separated due to reported incidents of domestic violence.⁷⁰ After the separation Mr E and some of his siblings lived with the father. Mr E was convicted of arson after he set fire to his father's car and he then went to live with his mother. Mr E's mother reported that after her son moved in with her his behaviour worsened as he had “*got into the wrong crowd.*”⁷¹
- 3.4 The medical notes from Mr E's adolescence document that from the age of 13 he began drinking alcohol and was experimenting with illegal drugs and solvent abuse. In 1994 Mr E's GP noted that Mr E was drinking “*in the region of 12 units a day.*”⁷²
- 3.5 In 1994 a psychiatrist from a Child and Family Psychiatry Unit⁷³ noted that Mr E had a history of behavioural problems which included smoking cannabis, fighting and burglary.
- 3.6 On 29 January 1994 Mr E, aged 14, was admitted to a paediatric A&E after having taken an overdose of paracetamol and antibiotics. It was recorded that this incident occurred following an argument with his mother.
- 3.7 Mr E was reviewed by a child psychiatrist, who assessed that the family was in “*crisis.*”⁷⁴ The psychiatrist noted that he would offer family therapy but he was “*pessimistic*”⁷⁵ about the outcome as the family wanted Mr E to be placed into care.
- 3.8 Mr E and his family attended an assessment appointment at the child and adolescent outpatients' clinic. It was assessed that Mr E had a mild conduct disorder and that since the divorce of his parents his “*conduct had moved into the severe end of the spectrum, resulting in his family rejecting him.*”⁷⁶ It was also documented that if the current dynamic within the family remained Mr E's prognosis was poor, as he had already committed significant criminal offences and he was “*likely to end up being dealt with by the criminal justice system.*”⁷⁷
- 3.9 The treatment plan was to provide the family with both crisis and long-term support but neither Mr E nor his family attended any further

⁶⁸ Care Plan Review, 21 June 2010

⁶⁹ Care Plan Review, 21 June 2010

⁷⁰ Care Plan Review, 21 June 2010

⁷¹ Care Plan Review, 21 June 2010

⁷² Letter from GP to Paediatric medical consultant, 22 November 1994

⁷³ Letter to GP from Child and Family Psychiatrist, 7 February 1994

⁷⁴ Hospital 1 clinical inpatient notes, 29 January 1994

⁷⁵ Hospital 1 clinical inpatient notes, 29 January 1994

⁷⁶ Letter to GP from Child and Family Psychiatrist, 7 February 1994

⁷⁷ Letter to GP from Child and Family Psychiatrist, 7 February 1994

appointments. They were discharged from the service on 10 March 1994.

- 3.10 Mr E's mother remarried in 1991 when Mr E was 11 years old. During 1996 Mr E's mother reported that her son's relationship with his stepfather had deteriorated to such an extent that both were refusing to live in the family home together. She felt that she "*had to choose between her husband and her son.*"⁷⁸ She approached social services requesting that her son be placed into care. They refused and Mr E remained in the family home.

Education:

- 3.11 Between 1991 and 1992 Mr E was placed in a special school. He reported that this was due to him being "*out of control.*"⁷⁹
- 3.12 He then returned to the family home and presumably to mainstream schooling.
- 3.13 During Mr E's brief involvement with child psychiatric services (1994) it was noted that he had "*dropped out*"⁸⁰ of secondary school but that his "*greatest desire was to be rich and to live by himself.*"⁸¹ He also spoke of his aspiration to attend art college to obtain a degree, as he felt that he was talented in this subject.

Parental responsibilities:

- 3.14 Secondary care notes document that Mr E had one son who was born in 2003. From our review of the police records it appears that the mother of this child was the victim in the domestic violence incidents in 2004 and 2008.
- 3.15 When the relationship ended Mr E took custody of this child. They initially went to live with Mr E's grandfather and then they moved into his own accommodation. Mr E looked after this child until the child was seven years old. On 17 November 2009 Mr E was arrested for an assault on his girlfriend. His son was a witness to this incident and Children's Services became involved. The son was initially placed into the care of his paternal grandmother, with Mr E only being allowed supervised access.
- 3.16 After Mr E was arrested and charged with a serious assault on his girlfriend and the child was placed in the care of his mother.
- 3.17 A member of Mr E's family reported⁸² that after he lost the custody of his son his drinking increased and that his supervised visits to his son at his mother's house significantly reduced.
- 3.18 It was also reported⁸³ that Mr E continued to drink a considerable amount of alcohol whilst he was responsible for the care of his son. During Mr E and his girlfriend's repeated prolonged bouts of drinking

⁷⁸ Letter to GP from Child and Family Psychiatrist, 7 February 1994

⁷⁹ Care Plan Review, 22 June 2010

⁸⁰ Care Plan Review, 22 June 2010

⁸¹ Care Plan Review, 22 June 2010

⁸² Care Plan Review, 22 June 2010

⁸³ Police interview transcripts

the family reported that they would remove the child from his care as *“they were so drunk they couldn’t have possibly looked after him.”*⁸⁴

Comments and analysis:

- 3.19 We noted that during several of the police interviews it was reported that Mr E also had two other male children and a daughter from different relationships. From the evidence that we reviewed during the course of this investigation it appeared that no agency was aware of these other children. It is also unclear if Mr E had contact with them.
- 3.20 Up until 2010 we were also unable to identify if any agency were aware of the fact that Mr E was a single parent or if there was social services involvement in supporting Mr E.

Employment:

- 3.21 From 1995 it was documented, within various A&E admission forms, that Mr E was unemployed.
- 3.22 The only reference that we have been able to ascertain regarding Mr E’s employment history was within the SI report which noted that since leaving school he had few positions. His last known employment was in 2002 when he was a painter and decorator.

4. Mr E’s forensic history:

- 4.1 A Care Plan Review⁸⁵ documented that both Mr E and his mother reported that from the age of 14 he had been involved in minor criminal activities and that on several occasions he had been sentenced to periods of detention in juvenile institutions.
- 4.2 Mr E also reported⁸⁶ that in 1999 he had been convicted of fraud and deception and had received a seven-month prison sentence.
- 4.3 However, from information obtained by the investigation team from the police⁸⁷ a more extensive picture is revealed of Mr E’s forensic history. From 1994 to 2010 Mr E had on nine different occasions been arrested, charged and at times convicted for either Section 47 Assaults⁸⁸ or Battery.⁸⁹
- 4.4 There were a number of violent incidents involving his family members. On 20 November 1998 Mr E, then aged 19, *“attempted to gouge his father’s eyes out.”*⁹⁰ During his arrest Mr E also assaulted the arresting police officer. Following his arrest Mr E spent seven months on remand awaiting his trial. In 1999 he was found guilty of Section 47 Assault⁹¹ and was given community service.

⁸⁴ Police interview transcripts

⁸⁵ Care Plan Review, 22 June 2010

⁸⁶ Care Plan Review, 22 June 2010

⁸⁷ Bad Character Summary, 10 March 2011

⁸⁸ Section 47 Assault: actual bodily harm (ABH)

⁸⁹ Battery involves unlawfully touching another person; no physical injury is necessary

⁹⁰ Bad Character Summary

⁹¹ Section 47 Assault

- 4.5 On 1 November 2001 police were called to a domestic disturbance where it was alleged that Mr E had assaulted his mother.
- 4.6 On three separate occasions between 2004 and 2008 (30 March 2004, 2 July 2004 and 16 February 2008), the police were called to incidents of domestic violence that involved Mr E physically assaulting the mother of his son. On each occasion Mr E was arrested for Section 47 Assault but apart from one occasion, on 2 July 2004 when the case went to court but was dismissed, no further action (NFA) was taken by the police.
- 4.7 We noted that on 23 May 2009 police were called to a residential address where it was reported that Mr E had “*head butted*”⁹² a 15-year-old occupant. He was arrested and received a caution for Battery. It is unclear if Mr E was related to this victim.
- 4.8 On 17 November 2009 Mr E was arrested after he assaulted his girlfriend. His son, aged six, had witnessed this incident. Mr E was later convicted at the Magistrates Court for Battery (31 March 2010).
- 4.9 On 2 May 2010 Mr E was arrested for Section 18 Assault⁹³ after he attacked the same girlfriend in her home. She was hospitalised and required surgery for a ruptured bowel. At the time of the incident in March 2011 the Crown Court case was pending.
- 4.10 On 17 May 2010, whilst Mr E was an inpatient at the psychiatric unit, he was arrested and charged with Common Assault for attacking a fellow patient and causing facial injuries. Again this case was pending at the time of the incident.
- 4.11 Due to the number of incidents where the police were called to Mr E’s accommodation, members of the family reported⁹⁴ that the council decided to rehouse him in a different area.
- 4.12 During a police interview a family member reported that they did not think that Mr E had “*ever been arrested when he wasn’t under the influence of drink*.”⁹⁵ They also recalled that they had witnessed many incidents where Mr E was physically abusive, both towards the mother of his children and in a subsequent relationship. They also reported that in this later relationship the couple would consistently binge drink over weekends, which often led to physical violence. Such were the frequency of these incidents of Mr E’s continued ‘binge’ drinking that a member of the family reported that they avoided contact with Mr E when he was with his girlfriend and that they would not allow their children to have contact with him.

Comments and analysis:

- 4.13 Apart from the last two arrests, information regarding the full extent of Mr E’s criminal activities was not known by secondary care services. We noted that there were many occasions, whilst Mr E was an inpatient on the psychiatric unit (hospital 2), where the ward staff were in direct

⁹² Information obtained from police records prepared for CPS

⁹³ Section 18 Assault: wounding with intent or causing grievous bodily harm with intent

⁹⁴ Police interview

⁹⁵ Police interview

contact with police and the safeguarding team. We would suggest that these were opportunities where significant information regarding Mr E could have been obtained. Such information would have enabled both a comprehensive picture of Mr E's history and more informed risk assessments to have been developed.

5. Mr E's physical health history:

- 5.1 The investigation team accessed Mr E's primary care notes from 1978 where it was documented that, apart from normal childhood illness, Mr E's physical health was unremarkable. Up until his discharge from hospital 2 (9 July 2010) he rarely attended his GP surgery.
- 5.2 However, what we did note was that from the age of 16 Mr E was presenting on numerous occasions to various A&E departments for the treatment of injuries that he had sustained during physical fights or assaults. Frequently it was noted that alcohol was a significant factor in these incidents.
- 5.3 On several occasions Mr E was brought into A&E by the police for the treatment of minor injuries. There were occasions where Mr E claimed that he had been assaulted by the police either during an arrest or whilst he was in custody.

Incidents where Mr E sustained head injuries:

- 5.4 We noted that, prior to his head injury in October 2010, Mr E had been admitted to hospital with head injuries on four separate occasions between 1998 and 2009. On 14 November 2000 Mr E was admitted to A&E reporting that he had been assaulted. He sustained a left parietal⁹⁶ skull fracture and was admitted to hospital for observation. On 9 February 2009 Mr E reported that he had sustained a head injury whilst he was drinking, but he denied that he was assaulted. He reported that he had been vomiting, experiencing blurred vision and on several occasions since the injury had lost consciousness. He was admitted to hospital but absconded the same day. Police located him at his home address and he agreed to return to the ward, where it was assessed that as he had capacity there were no concerns about him discharging himself.
- 5.5 At the physical examination, which was undertaken when Mr E was initially admitted to the psychiatric inpatient unit at hospital 2 (19 May 2010), he reported that he had partial deafness in his left ear following a violent incident where he had sustained a skull fracture.
- 5.6 The most significant head injury that Mr E sustained occurred on 20 October 2010. After he failed to arrive at a pre-arranged meeting, a member of his family went to his flat, where they discovered him unconscious and lying in "*a pool of blood.*"⁹⁷

⁹⁶ Parietal bones: bones in the human skull which, when joined together, form the sides and roof of the cranium

⁹⁷ Police interview transcripts

- 5.7 There was some evidence to indicate that there had been an altercation in his flat but Mr E consistently maintained that he was unable to recall what had occurred.
- 5.8 Mr E was initially taken to the local A&E where, after an initial CT scan, he was diagnosed with a right-sided subdural haematoma.⁹⁸ He was sedated, intubated⁹⁹ and then transferred to the neurosurgical ICU¹⁰⁰ at hospital 3, where an Intra Cranial Bolt (ICP) was inserted¹⁰¹ to relieve the pressure in his skull.
- 5.9 After four days the ICP was removed and Mr E was transferred to the neurosurgical ward before being discharged on 5 November 2010.
- 5.10 At the point of discharge it was documented that Mr E was experiencing poor short-term memory. Also it was noted that his mother had “*a good understanding*”¹⁰² of her son’s injury and was aware of possible post-head-injury symptoms.
- 5.11 When Mr E and his mother next visited the GP (18 November 2010), it was documented that since his discharge from hospital Mr E was staying with his mother, as he did not want to go back to his accommodation.¹⁰³ He also reported that he had been experiencing intermittent headaches.
- 5.12 On 17 January Mr E, accompanied again by his mother, attended a psychiatric outpatients appointment. Mr E’s mother reported that her son had sustained a significant head injury and was now living with her as he was unable to go out alone. It was also documented that she had reported that his “*short term memory was dreadful*”.¹⁰⁴
- 5.13 At this appointment, in response to Mr E reporting symptoms of insomnia and his continued “*upset*”¹⁰⁵ feeling, which he insisted were both related to the loss of custody of his son, it was agreed that his antidepressants were to be changed to Escitalopram 10mg (see section 6 for our analysis of this change in medication).
- 5.14 Mr E was last seen on 18 February 2011 at the outpatient head injury clinic,¹⁰⁶ where both he and his mother reported that although his physical symptoms had improved, he continued to be experiencing poor short-term memory and a significant loss of confidence. His mother also reported that her son had “*changed since his injury*”¹⁰⁷ and that he was now withdrawn and was no longer socialising with his peers. It was agreed at the appointment that Mr E would be referred for a neuropsychological assessment.

⁹⁸ A subdural haematoma is a collection of blood outside the brain. As blood accumulates, pressure on the brain increases

⁹⁹ Intubate: to put a tube in, commonly used to refer to the insertion of a breathing tube into the trachea for mechanical ventilation

¹⁰⁰ ICU: intensive care unit

¹⁰¹ Patients with a traumatic brain injury would be transferred to the inpatient neurosurgical unit if it was thought that they may potentially require surgery

¹⁰² Hospital 3 clinical notes and admission assessment from 29 October 2010

¹⁰³ GP notes

¹⁰⁴ Letter from Speciality Doctor to GP, 24 January 2011

¹⁰⁵ Letter from Speciality Doctor to GP, 24 January 2011

¹⁰⁶ It was reported to the investigative team that the post-discharge care pathway for patients with head injuries was that they are reviewed in the Head Injury Outpatients’ Clinic at the 8 to 12-week post-incident stage. This allows for a period where the natural recovery process occurs and for any issues/problems to be identified

¹⁰⁷ Hospital 3 notes and interview with specialist nurse

Comments and analysis:

- 5.15 In our review of Mr E's clinical notes from this admission to the neurosurgical ward it was documented that Mr E was drinking "to excess"¹⁰⁸ and that he was "using cannabis and speed."¹⁰⁹ It was also documented that Mr E had a diagnosis of "impulsive personality disorder."¹¹⁰ It was not, however, apparent to us where this information was obtained from, as we could not locate any evidence of communication between the unit and the community mental health team (CMHT).
- 5.16 There was evidence to indicate that the neurosurgical team did have some communication with Mr E's GP with regard to his pre-admission psychiatric medication. It was also documented that Mr E was to be discharged with only two weeks' medication "as per GP instruction."¹¹¹
- 5.17 There were three different NHS Foundation Trusts and a primary care service involved in the care of Mr E's head injury and in his psychiatric treatment. We were informed that each Trust has their own patient record systems which are not accessible to each other. Therefore, all information regarding Mr E's psychiatric and head injury treatment plans were reported in written summaries which were only addressed to Mr E's GP. All agencies were reliant on self-reporting from either Mr E or from his mother, who accompanied her son to his outpatient appointments after his head injury.
- 5.18 It was reported to us that the management of Mr E during his hospital admission for his head injury would not have been different if his mental health history was known. However, it was suggested that this information would have been helpful to the neuropsychologist at the point of their initial assessment.¹¹²
- 5.19 During our interviews, both the head injury team member and the outpatient psychiatrist from CMHT agreed that it would have been helpful to them to have had more information about Mr E's treatment from the respective teams. However, each reported that they felt that it was the other agency's responsibility to have initiated this communication.
- 5.20 A very different picture is described by several of Mr E's family, during their police interviews, regarding the level of difficulties that Mr E was experiencing after his head injury. In their police interview a family member recalled that after the head injury Mr E initially stopped drinking and that "I didn't see any aggression in him. There were no arguments or fighting. He displayed no unusual behaviours and he was quieter and more mellow if anything."¹¹³ However, "as the weeks went on he began to drink again, even though the Doctors advised against this. He was still picking up his prescribed medicine but he was only taking Codeine for pain relief as he still suffered with headaches."¹¹⁴

¹⁰⁸ Hospital 3 clinical notes and admission assessment from 29 October 2010

¹⁰⁹ Hospital 3 clinical notes and admission assessment from 29 October 2010

¹¹⁰ Hospital 3 clinical notes and admission assessment from 29 October 2010

¹¹¹ Hospital clinical notes and discharge summary

¹¹² Interview with nurse

¹¹³ Police interview

¹¹⁴ Police interview

- 5.21 They also recalled that he was telling both the head injury team and the CMHT's psychiatrist "*that he couldn't go anywhere alone and that he always needed someone with him*" but that "*this was not true.*"¹¹⁵ They suggested that he was trying to portray a picture of a very disabled person who had significant physical and mental health problems so that it could be used as mitigation in his impending court case.

Recommendation 1

Where multiple health care providers are involved in the treatment and care of a patient, the discharging service should seek the permission of the patient to send discharge summaries to all involved agencies.

6. Involvement of psychiatric services from 2009

The details of both inpatient and community mental health services' involvement are fully outlined within the chronology located in Appendix C. Therefore, it is our intention not to repeat this information but rather to focus on the issues and events that we felt that the SI report did not adequately address. We will also discuss information that has come to light during the course of our investigation that was unknown at the time to either the clinicians or the authors of the SI report.

- 6.1 Up until 2009 there was no indication that Mr E had any involvement with adult mental health services.
- 6.2 On 26 February 2009 Mr F was admitted to A&E having taken an overdose of paracetamol, Tramadol¹¹⁶ and codeine. After it was assessed that there was no suicidal intention and that Mr E had not intended to harm himself he was discharged.
- 6.3 The next contact Mr E had with mental health services was on 6 May 2010 when a member of his family took him to A&E after he had lacerated his wrists. He disclosed that he had drunk three quarters of a bottle of vodka prior to the incident. This incident was four days after he had been arrested for the assault on his girlfriend.¹¹⁷
- 6.4 The initial Care Co-ordination Assessment, which was completed when Mr E was in A&E, noted that he was on police bail for a Section 18 with Intent charge and that he had a "*long history of violent behaviour.*"¹¹⁸ It was also documented that whilst in A&E his "*behaviour became difficult as he was under the influence of alcohol*"¹¹⁹ and that he had lacerated his arm with a broken saucer. Security had to be called to manage the situation.
- 6.5 Mr E reported to the A&E self-harm team that he believed that he was going to lose custody of his son as he had been arrested for two alleged assaults on his girlfriend. Mr E refused the support of the crisis

¹¹⁵ Police interview

¹¹⁶ Tramadol is a fully synthetic opioid pain medication used to treat moderate to moderately severe pain

¹¹⁷ 2 May 2010

¹¹⁸ Assessment summary hospital 1, p1

¹¹⁹ Assessment summary hospital 1, p1

team, and as it was assessed that he continued to present with ongoing suicidal ideation, that he lacked any protective factors and that he was at significant risk of further self-harm, he was admitted to the psychiatric inpatient unit.

- 6.6 The Care Co-ordination Assessment and the FACE Risk Profile which were carried out whilst Mr E was in A&E were only partially completed. There was also no narrative within the assessments that identified either present or historical risks and it was not signed by the assessor.
- 6.7 Mr E spent from 6 May to 9 July 2010 in the inpatient unit. During this period he absconded seven times. At times he expressed some remorse regarding his behaviour and the ward staff tried, on several occasions, to negotiate a leave plan with Mr E and his family. However, this pattern of behaviour continued throughout his inpatient stay, with Mr E reporting that he was going AWOL as he was feeling “*frustrated*” or that he had to attend to his affairs, e.g. visiting his flat or family. The police reported to the ward that on one of these episodes Mr E had been seen in the vicinity of his girlfriend’s accommodation, which broke the terms of his bail conditions. After this episode the ward agreed to inform the police when Mr E left the ward, either when he went AWOL or when he was on planned escorted leave, so that they could alert his girlfriend.
- 6.8 After Mr E assaulted a patient,¹²⁰ he was arrested and assessed at the police station under the Mental Health Act (1983) and placed under a Section 2.¹²¹ A subsequent Mental Health Tribunal¹²² (14 June 2010) decided that due to his “*recent impulsiveness and going AWOL*”¹²³ his section should be regraded to a Section 3.¹²⁴ The Tribunal recommended that Mr E should undergo a forensic and psychological assessment.
- 6.9 On 9 July 2010 Mr E’s Section 3 was removed as it was assessed that there was “*no clear evidence of mental illness.*”¹²⁵ He was immediately discharged from the unit. His final diagnosis was Impulsive Personality Disorder.

Inpatient risk assessments:

Alcohol:

- 6.10 A full FACE assessment¹²⁶ was undertaken on Mr E’s admission to the inpatient unit. It was documented that he had experienced six months of social stress factors with increasing alcohol consumption. Mr E reported that he was regularly consuming eight to 12 cans of lager at

¹²⁰ 18 May 2010

¹²¹ 28 days’ assessment period

¹²² 14 June 2010

¹²³ Mental Health Tribunal notes

¹²⁴ Section 3: detained for up to six months for the purpose of treatment

¹²⁵ Multi-disciplinary meeting notes, 9 July 2010

¹²⁶ The FACE (Functional Analysis of Care Environments) risk profile is part of the toolkits for calculating risks for people with mental health problems, learning disabilities, substance misuse problems,

- weekends. His CAGE¹²⁷ score on admission was assessed as 0 out of 4.¹²⁸
- 6.11 In the first inpatient Risk Management and Contingency Plan it was documented that “*individuals to be aware of possible risk of violence if [Mr E] is under the influence of alcohol.*”¹²⁹ Yet we noted that this concern was not highlighted in any other assessments, although the Interim Discharge Summary¹³⁰ documented that Mr E had been advised to abstain from alcohol.
- 6.12 The First-tier Tribunal Report,¹³¹ which was prepared in Mr E’s absence as he had absconded from the ward, concluded that based on the information available, Mr E continued to be at “*high risk of violence to himself and others and self-neglect through alcohol misuse when stressed.*”¹³²
- 6.13 On several occasions Mr E returned to the ward intoxicated. On one of these occasions¹³³ he assaulted another patient and was arrested for a Section 47 Assault. On his return he was initially placed on the PICU.¹³⁴ The other occasion was two days before he was discharged, when he verbally abused a patient and caused minor damage to property. On this occasion he was not arrested but was transferred to another ward; on his return he was verbally abusive to the ward staff.
- 6.14 It was documented that after these incidents Mr E would appear contrite, reporting that he would refrain from drinking and going AWOL but these behaviours continued throughout his admission.

Comments and analysis:

- 6.15 The CAGE is a self-assessment process that relied solely on information that was self-reported by Mr E. On no occasion was information obtained from family members with regard to his drinking. The information supplied by family members during several police interviews after the incident would indicate that Mr E’s drinking habits far exceeded those which he was reporting. We would suggest that it would have been helpful to have obtained information from the family.
- 6.16 There was ample evidence documented that alcohol was a disinhibiting factor in relation to both Mr E self-harming and his impulse control, which resulted in significant violence towards others. The First Tier Report commented that “*it would be beneficial for him to attend drug and alcohol services,*”¹³⁵ but this did not occur.
- 6.17 It was well documented that Mr E continued to consume alcohol, on a regular basis, whilst he was an inpatient and that this drinking precipitated many of the events on the ward. But his drinking was not identified or considered as an ongoing or contributory risk factor.

¹²⁷ CAGE Substance Abuse Screening Tool

¹²⁸ A total score of two or greater is considered clinically significant

¹²⁹ IP Risk Management and Contingency Plan, 9 May 2010

¹³⁰ IP Interim Discharge Summary, 6 July 2010, p2

¹³¹ First-tier Tribunal Report, dated 25 May 2010 (social circumstances report)

¹³² First-tier Tribunal Report, dated 25 May 2010, p3

¹³³ 18 May 2010

¹³⁴ Psychiatric Intensive Care Ward

¹³⁵ First-tier Tribunal Report, dated 25 May 2010, p3

- 6.18 There was no indication within any of Mr E's care plans or clinical notes to indicate that he was either offered support to reduce his alcohol consumption or referred to the drug and alcohol service.

Risk assessments and management plans:

- 6.19 After Mr E was admitted to the inpatient unit, staff completed an initial FACE Risk Profile.¹³⁶ This assessment identified that Mr E's risk to others was 1 (low apparent risk). This was despite the fact that it had been documented within the assessment undertaken in A&E that he had both a historical and a recent risk history of physical harm towards others.
- 6.20 His risk of self-harm and suicide was assessed as being 0, despite the fact that he had just been admitted following a significant episode of self-injury.
- 6.21 During Mr E's initial assessment period on the inpatient unit, it was documented within the 'Any History of Offending' form¹³⁷ that he had "*numerous arrests ranging from theft-violence-drink behaviour. 7-8 periods of imprisonment.*"
- 6.22 After Mr E was arrested for a Section 47 Assault,¹³⁸ a further FACE Risk Profile was undertaken. This identified that Mr E's risk of violence and harm to others was a 4 (serious and imminent risk). However, we noted that in the subsequent FACE Risk Profiles, from 28 May 2010 to 2 July 2010, this risk had been downgraded to a 1 (low apparent risk). There was no rationale documented as to why his risks had significantly reduced within such a short space of time.

Comments and analysis:

- 6.23 It was evident to us that the FACE risk assessments were only documenting and considering the immediate risks that Mr E was presenting. Despite quite extensive information regarding Mr E's forensic history being documented within the 'Any History of Offending' form it was apparent that all the risk assessments were repeatedly failing to either document or consider Mr E's risk in relation to his known past and recent forensic history.
- 6.24 We referred to NICE guidelines with regard to the management of risk in patients with Unstable Personality Disorder; "*the history of previous violence should be an important guide in the development of any future violence risk management plan.*"¹³⁹ Given Mr E's known historical and recent offences and that it was documented that he was at "*high risk of domestic violence incidents,*"¹⁴⁰ combined with his continued alcohol use. We would have expected Mr E to have been scored consistently as a 3 (serious apparent risk) with regard to risk of violence to others. Additionally, risk management and contingency plans should have

¹³⁶ 6 May 2010

¹³⁷ Completed 19 May 2010

¹³⁸ Section 47 Assault: causing actual bodily harm (ABH)

¹³⁹ NICE clinical guideline 77 (2009)

¹⁴⁰ 27 May 2010, Clinical notes

- been developed alongside each assessment and also at the point of his discharge. We were unable to locate any risk management or contingency plans within Mr E's inpatient or community notes.
- 6.25 Additionally, throughout the course of this admission, ward staff were in regular contact with the police but they failed to utilise this as an opportunity to obtain further information. We would suggest that the ward staff's consistent failure to liaise with the police was a significant missed opportunity whereby a more comprehensive profile of Mr E could have been obtained.
- 6.26 It was also well documented that the inpatient staff were aware that MARAC proceedings were being actioned and that such were the concerns regarding the safety of Mr E's girlfriend and children that they had been relocated to another city. It was also known that his son had witnessed an incident of domestic violence.
- 6.27 We were concerned that despite it being documented in all three Risk Factor and Warning Signs Forms¹⁴¹ completed by the inpatient unit that there were identified current and historical child protection issues, none of the FACE Risk Assessments identified that there was any risk to children. It was only when the community mental health team undertook a FACE Risk Assessment¹⁴² that it was assessed that there was a level 1 risk (low risk) to a child.
- 6.28 We would suggest that based on the information that was known by the inpatient unit, it should have been consistently assessed that the risk to children was a 3 (serious apparent risk).
- 6.29 We also noted that both the Interim and the Full Discharge Summary only documented numerical scoring relating to Mr E's risk factors. There was no narrative or details of either his current or his historical risk indicators. They also failed to identify Mr E's risk factors associated with violence towards others or the link between his alcohol consumption and violent incidents. The investigative team would question the usefulness of communicating merely a numerical score to community or primary care teams. We would suggest that it is essential that discharge summaries provide information regarding the context of the risks assessed, as well as protective and risk factors.

Diagnosis, treatment and care plans:

- 6.30 Mr E's final diagnosis was a Depressive Episode and an Impulsive Unstable Personality Disorder.¹⁴³ At the Formulation and Mental State Assessment it was documented that Mr E did have insight into his social stressors but was "*unable to reflect on what part he [had] played in the recent assault.*"¹⁴⁴
- 6.31 After Mr E's admission to the inpatient unit he was immediately prescribed Mirtazapine (15mg nocte)¹⁴⁵ and then Carbamazepine

¹⁴¹ 6 May 2010, 19 May 2010, 7 July 2010

¹⁴² 20 July 2010

¹⁴³ Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. Final diagnosis reported in Full Discharge Summary, 22 July 2010

¹⁴⁴ Mental State and Formulation and Summary of Assessment, 19 May 2010

¹⁴⁵ Mirtazapine is an antidepressant used to treat major depressive disorder

- (100mg).¹⁴⁶ At the point of discharge Mr E's medication regime was the same, although his Carbamazepine had been increased to 200mg.
- 6.32 His care plan identified that he was to receive twice-weekly one-to-one sessions from his named nurse.¹⁴⁷
- 6.33 At the Mental Health Tribunal Hearing¹⁴⁸ it was argued that the continuation of Mr E's Section 2 of the Mental Health Act (1983) was necessary in order to provide "*the structure and stability*"¹⁴⁹ to enable a forensic assessment to be undertaken and to engage him in rehabilitation treatment.
- 6.34 A total of nine Care Plan Reviews were undertaken whilst Mr E was an inpatient. On two occasions¹⁵⁰ Mr E's mother was present at the review meetings, where she provided some information regarding both Mr E's early life and the current situation regarding the custody of his son. No member of the family was present at the last care plan review,¹⁵¹ where it was decided to discharge Mr E on that day.
- 6.35 As the SI report correctly notes, the required Section 117¹⁵² meeting was not convened in order to discuss Mr E's discharge plans. It was documented that Mr E left the ward immediately after this meeting, refusing to wait for his discharge medication.

Comments and analysis:

- 6.36 The locum inpatient consultant psychiatrist, who was interviewed as part of the SI report, reported that the aim of Mr E's hospital admission was to undertake an assessment and to provide pharmacological and psychological support.¹⁵³ However, we noted that when Mr E was initially admitted to the inpatient unit, he was immediately prescribed Mirtazapine (15mg nocte) and then Carbamazepine (100mg). Therefore, there was no time given to assessing Mr E's current presentation and risk factors or to obtaining a more detailed account of his issues from either his family or himself.
- 6.37 With regard to psychological support, the only evidence that we were able to ascertain of support being offered to Mr E was twice-weekly one-to-one sessions with his named nurse.¹⁵⁴ We only located five sessions; each one was facilitated by a different nurse.
- 6.38 It was also documented that Mr E did not attend two of these sessions as he was either on planned leave or was AWOL from the ward. There was no indication that he was offered an alternative session when he was on planned leave.

¹⁴⁶ Carbamazepine is an anticonvulsant and mood-stabilising drug used primarily in the treatment of epilepsy and bipolar disorder

¹⁴⁷ Care Plan, 6 May 2010

¹⁴⁸ Mental Health Tribunal records of hearing, 4 May 2010

¹⁴⁹ Mental Health Tribunal records of hearing, 4 May 2010

¹⁵⁰ 4 and 21 June 2010

¹⁵¹ 9 July 2010

¹⁵² Section 117: imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under Section 3 of the Mental Health Act. A patient should be allocated a care coordinator and have multi-disciplinary care planning and review meetings and a written care plan. Aftercare should be planned with the patient, their family and carers, as well as professionals, looking at both health and social care needs

¹⁵³ Noted in NTW's Internal Report, p19

¹⁵⁴ Care Plan, 6 May 2010

- 6.39 Neither the lack of one-to-one sessions nor Mr E's non-attendance was identified by either the MDT¹⁵⁵ or his care planning meetings.
- 6.40 In the sessions Mr E did attend there was no indication of any structured therapy being offered to Mr E. The sessions appeared to be entirely focused on his day-to-day concerns about his son and his frustrations about being on the ward.
- 6.41 We again referred to the NICE guidelines (2009)¹⁵⁶ that were in place at the time Mr E was an inpatient and also reviewed the current NHS guidelines¹⁵⁷ regarding the management and treatment pathways for patients with a diagnosis of a Personality Disorder. Both indicate that a course of psychological therapy is the recognised treatment pathway and that any therapeutic intervention should normally last at least six months, often longer, depending on the severity of the condition and other co-existing problems. However, the guidelines also advise that the frequency of this therapy should be adapted to the person's needs and the context of their living situation.¹⁵⁸ Also that brief psychological interventions of less than three months' duration are not advisable for this disorder.¹⁵⁹ Clearly Mr E was not offered psychological therapy either as an inpatient or in the community, nor does it appear to have been discussed in the MDT meetings as a possible treatment option.
- 6.42 There is currently no medication licensed for the treatment of a personality disorder. However, NICE recommends that medications may be prescribed to treat associated problems such as depression, anxiety or psychotic symptoms.¹⁶⁰
- 6.43 Despite the recommendation by the Mental Health Tribunal that a forensic assessment should be undertaken, this did not occur. Neither ourselves nor the authors of the SI report were able to ascertain any satisfactory explanation as to why this had not occurred or why psychological therapy was not provided during Mr E's inpatient care (refer to section 7 of this report regarding the interview notes from the Trust's Internal Report).
- 6.44 Given that neither the forensic nor any psychological assessments occurred and that there was no form of therapeutic engagement, we do question the rationale for the initial and continued decision to place Mr E on a Section. It appeared to us that it was being used solely as a means of attempting to control his behaviour rather than establishing and engaging him in the appropriate treatment programme.
- 6.45 With regard to Mr E's Care Planning Review meetings, we noticed a number of issues at the meeting that followed the two incidents where Mr E returned to the ward intoxicated, assaulted another patient, was verbally abusive to staff and damaged property. There was no reference made of these incidents. Indeed, after the incident on 18 May

¹⁵⁵ MDT: multi-disciplinary meeting

¹⁵⁶ <https://www.nice.org.uk/guidance/78> (2009)

¹⁵⁷ <http://www.nhs.uk/Conditions/Personality-disorder/Pages/Treatment.aspx>

¹⁵⁸ Psychological therapies: psychotherapy is a treatment that involves discussion of thoughts, emotions and behaviours with a trained professional. The aim of all psychological therapies is to improve people's ability to regulate their thoughts and emotions. Some therapies focus on dysfunctional thoughts, while others focus on self-reflection and being aware of how your own mind works. Some therapies, especially group therapies, help people understand social relationships better. <http://www.nhs.uk/Conditions/Personality-disorder/Pages/Treatment.aspx>

¹⁵⁹ <https://www.nice.org.uk/guidance/78> (2009)

¹⁶⁰ <http://www.nhs.uk/Conditions/Personality-disorder/Pages/Treatment.aspx>

2010, at the next Care Plan Review Mr E is noted to have said that he “*had alcohol issues; however these are not an issue at present.*”¹⁶¹

There was no evidence that anyone at these meetings challenged Mr E’s behaviour or his account of his alcohol use.

- 6.46 There was no evidence of information being triangulated between the various documentation, assessments and care planning meetings.
- 6.47 Throughout his admission we noted that there was no discussion or consideration given in the Care Plan Review meetings to Mr E’s lack of engagement with any recovery programme.
- 6.48 As the SI report correctly identified, there were a number of concerning issues regarding the management of Mr E’s discharge planning; namely the failure to instigate the required Section 117 Aftercare¹⁶² arrangements programme at the point of his discharge. Mr E was discharged on an Enhanced Care Plan, but there was no care plan in place, nor was he allocated a Care Coordinator.
- 6.49 We again referred to the NICE guidelines¹⁶³ that were in place at the time regarding discharge planning for patients with personality disorders. They suggest that such a transition “*may evoke strong emotions and reactions in people with borderline personality disorders.*”¹⁶⁴ Therefore, the transition period will require careful and sensitive planning. The NICE guidelines also direct that a risk crisis plan must be formulated as part of the discharge planning, involving both the patient and, where appropriate, their family, and that such a plan should be shared with all agencies involved.¹⁶⁵ This did not occur in what clearly was very minimal discharge planning for Mr E.
- 6.50 Indeed, in our review of the chronology of events of Mr E’s discharge we noted that there was a failure to comply with the required CPA process (e.g. Section 117 planning). Although his immediate care package was in situ (Crisis Resolution Home Treatment Team (CRHT) and a seven-day psychiatric follow-up review), there was no long-term treatment or support plans identified on which the CRHT and community mental health services could base their initial assessment, treatment and support plans.

Post-discharge period (July 2010 to March 2011):

- 6.51 Mr E was visited by a CPN from the CRHT on one occasion.¹⁶⁶ However, as he did not see a role for this service he was discharged from their caseload.
- 6.52 Ten days¹⁶⁷ after Mr E was discharged from the inpatient unit he presented himself at A&E with self-lacerations. Again alcohol was

¹⁶¹ Care Plan Review, 28 May 2010

¹⁶² Section 117: imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under Section 3 of the Mental Health Act. A patient should be allocated a care coordinator and have multi-disciplinary care planning and review meetings and a written care plan. Aftercare should be planned with the patient, their family and carers, as well as professionals, looking at both health and social care needs

¹⁶³ <https://www.nice.org.uk/guidance>

¹⁶⁴ NICE clinical guideline 78 (2009)

¹⁶⁵ NICE clinical guideline 78 (2009)

¹⁶⁶ 12 July 2010

¹⁶⁷ 19 July 2010

identified as a contributing factor, as was the loss of custody of his son. It was assessed that there were “*no symptoms of mental health problems evident*”¹⁶⁸ and he was discharged. The crisis team contacted Mr E’s GP and requested that his Mirtazapine be increased to 45mg nocte.¹⁶⁹ However, there is no indication that they alerted Mr E’s community mental health team.

- 6.53 The Community Treatment Team (CTT) took over Mr E’s care on 19 August 2010, and their initial formulation plan was to obtain more background information before offering him an assessment appointment. On reviewing Mr E’s inpatient notes the allocated CPN identified that Mr E had a history of aggression towards others and it was decided that he would be visited by two CPNs.
- 6.54 At the meeting on 15 September the CPNs explained to Mr E the support they could offer, but it was noted that “*he could not see this as being helpful as he felt his problems were dependent on the outcome of his court case and trying to regain custody of his son.*”¹⁷⁰
- 6.55 Following a discussion with the psychiatrist the CPN informed Mr E’s GP that it had been decided that as Mr E’s mental health appeared to be “*relatively stable and appropriate given his social situation*”,¹⁷¹ he would be discharged from her caseload. The GP was also informed that there was to be a joint review on 11 October 2010, at which point Mr E’s CPA status was to be downgraded to non-CPA. It was also documented that Mr E “*was happy with this and not keen to engage in any treatment.*”¹⁷² It was agreed that Mr E would continue to be monitored in the outpatient clinic by the psychiatrist. Neither Mr E nor his GP attended this CPA review.
- 6.56 Mr E was next seen by community mental health services on 17 January 2011. Mr E attended this appointment with his mother, who reported that since her son’s head injury he had moved in with her. She also expressed considerable concern about her son’s loss of cognitive function and confidence since the injury.
- 6.57 The speciality doctor wrote to Mr E’s GP reporting¹⁷³ that in response to Mr E’s symptoms he made the decision to change his antidepressant Mirtazapine to Escitalopram 10mg, with the intention to review him again in two months. This was the last time Mr E was seen by community mental health services.

Comments and analysis:

In our review of Mr E’s post-discharge phase we noted a number of issues that require further consideration:

- 6.58 The inpatient unit’s failure to obtain a more comprehensive and accurate picture of Mr E’s historical and current forensic histories,

¹⁶⁸ Hospital 1 notes

¹⁶⁹ Nocte: at night

¹⁷⁰ Letter from CTT to GP, 15 September 2010

¹⁷¹ Letter from CTT to GP, 15 September 2010

¹⁷² Letter from CTT to GP, 15 September 2010

¹⁷³ Interview with speciality doctor

- combined with his continued reluctance to engage with services, resulted in the community mental health services basing their risk assessment on partial information.
- 6.59 Additionally, the failure of the inpatient unit to develop a discharge care plan or involve the community team in Mr E's discharge planning resulted in the community services having a very limited and incomplete profile of Mr E on which significant decisions were being made, for example to down grade him to a non-CPA status.
- 6.60 Despite the fact that in January 2011 Mr E's mother reported to the community speciality doctor that her son had sustained a significant head injury and that there had been significant changes in her son's behaviour since the injury. There was no documented intention on the part of the community mental health speciality doctor to liaise with either Mr E's GP or the head injury unit in order to obtain further information or to develop a joint care plan.
- 6.61 We were also concerned to note that despite it being evident that there had been significant changes in Mr E's situation, there was no consideration that a risk assessment may be necessary.
- 6.62 It was reported¹⁷⁴ to us that it was usual practice to undertake an assessment of risk during an outpatient appointment and to document this in the summary letter to the patient's GP. However, we noted that after Mr E's appointment in January 2011, the letter to the GP did not document any risk assessment, and it remains unclear to us as to why this did not occur.
- 6.63 It was also reported to us¹⁷⁵ that it was usual practice to advise a patient and the family members present at the appointment of what actions they should take if there were any concerns. We were informed that this would be documented in both clinical notes and in the summary letter to the GP. In the absence of any evidence to the contrary, we have to assume that this did not occur.
- 6.64 The rationale for changing Mr E's medication to Escitalopram was noted as being due to his "*presentation which was predominantly anxious*"¹⁷⁶ and the fact that he was reporting that he was suffering with acute insomnia. It was felt that if his levels of anxiety could be reduced, then his sleep pattern may improve.
- 6.65 We would like to mention a number of issues that arose in our investigation regarding the management and treatment by community mental health services of Mr E in his post-head-injury phase. Mr E had a diagnosis of an Impulsive Personality Disorder, which typically presents as impulse-control problems. It is a distinct possibility that his significant head injury may or may not have resulted in his impulse control being affected. Therefore, we suggest that information should have been sought from the head injury unit and that any change in medication required careful supervision. Given these factors, we would also suggest that consideration should have been given at the

¹⁷⁴ Interview with speciality doctor

¹⁷⁵ Interview with speciality doctor

¹⁷⁶ Interview with speciality doctor

- appointment with the speciality doctor in January 2010 to regarding Mr E's CPA status so that more regular monitoring could have taken place.
- 6.66 Additionally, there is always an increased risk for patients during any changeover period in their medication regime, e.g. possible side effects and increased symptoms. The community team was unaware of the extent of Mr E's head injury and his post-injury medication regime. Therefore, their assessments were based on information that was being self-reported by Mr E and his mother. Both were reporting that there had been a significant change in Mr E's presentation and lifestyle since the accident. We would suggest that given these significant changes, a more comprehensive risk assessment should have been undertaken and there should have been direct communication between the community mental health services and the head injury unit.
- 6.67 The other agency that was in the position to monitor Mr E during this complex time was his primary health care service. However, we were informed that patients with personality disorders do not currently meet the criteria for placement on GPs' mental health register. Therefore, such patients are not being reviewed on a regular basis for either their mental or their physical health and assessments are reliant on the occasions when they present themselves at the surgery. It was reported to us that it can be problematic to develop an ongoing relationship with this patient group, as they are often difficult to engage with. Therefore, at this practice, in order to maintain an overview of such patients' symptom management and well-being, they restrict the number of repeat prescriptions that are dispensed before the patient is required to attend an appointment. In Mr E's case, we noted that he was only able to obtain prescriptions for fortnightly amounts of medication. This was evidenced in our review of Mr E's primary care notes, as on two occasions, (25 October 2010 and 25 January 2011), the surgery refused to issue his repeated prescription and he was required to attend an appointment.
- 6.68 Clearly from the professional view it appeared that Mr E was regularly ordering prescriptions from his GP and that he was compliant with his medication regime. However, we now know that he was not taking his medication but was storing it in the homes of various members of his family, as he reportedly¹⁷⁷ did not consider that he was unwell. It was his intention to use his mental health diagnosis as a defence in his impending trial for the assault of his girlfriend. Although this is clearly anecdotal information, it does provide us with an alternative view of Mr E which does challenge his presentation, especially after he was discharged from the inpatient unit and during the post-head-injury phase. We would suggest that if services had seen members of Mr E's family without his presence, they may have accessed information which would have been helpful in their assessment of both Mr E's mental health and his risk factors.
- 6.69 It was also repeatedly being documented that Mr E's mother was a significant protective factor and that since the head injury her role had become one of a carer. We were concerned to note that neither

¹⁷⁷ Anecdotal information taken from police interviews

primary nor secondary services from two different Trusts offered Mr E's mother access to a carer's assessment.

Recommendation 2.

Risk assessments undertaken by NTW's mental health inpatient and community services must ensure that historical and current risks are being consistently documented and appropriately assessed.

Recommendation 3.

When it is known that a patient has a forensic history NTW's clinicians must seek to obtain information from the police and probation service in order to inform both risk assessments and support plans.

Recommendation 4.

NTW's mental health inpatient service's Discharge Summaries should provide both a narrative description and the context of a patient's risk and protective factors as well as potential triggers.

7. Northumberland, Tyne and Wear NHS Foundation Trust's Post Incident Report

As part of NHS England's Terms of Reference (TOR) for this investigation we have been asked to *"review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan."*¹⁷⁸

- 7.1 We benchmarked NTW's Level 2 Serious Incident Review (SIR) utilising the National Patient Safety Agency's RCA Investigation Evaluation Checklist.¹⁷⁹ We also undertook a telephone interview with the SI's investigation officer.
- 7.2 We concluded that the SI report provided an extensive chronology and details of Mr E's involvement with secondary mental health care services in the nine months preceding the incident. However, in our opinion there were some omissions within the SI report that we would like to draw the Trust's attention to in order to improve future SI investigations.
- 7.3 The SI panel did not access primary care notes but they did request and receive a summary from the GP which detailed their involvement with Mr E. It was reported to us by the primary care service that they had not received any feedback from the Trust's SI report, nor were they invited to attend a post-incident feedback event.
- 7.4 The SI's investigating officer informed us that they did not approach the police or access hospital 3 notes where Mr E was treated for his head injury.
- 7.5 It was reported to us that it is usual for the victim and perpetrator's family to be invited to take part in the SI. However, in this case they were neither invited nor received feedback on the SI's findings. The SI's investigating officer was unable to recall the reason for this.
- 7.6 The National Patient Safety Agency's RCA Investigation Evaluation Checklist directs that an Executive Summary must include care and delivery issues, root causes, contributory factors and lessons learnt. None of these areas were documented within the Executive Summary.
- 7.7 The other area where the authors of the SI and the Trust failed to comply with the National Patient Safety Agency's RCA Investigation requirements was in regard to the safe storage of its interview transcripts. Despite several requests that we made to the Trust to gain access to the transcripts, they were unable to locate them or identify who was responsible for their safe storage.
- 7.8 Many of the individuals interviewed as part of the SI investigation have now left their positions at NTW, and the lack of availability of their interview transcripts has resulted in Niche's investigative team being unable to verify some of the information that was identified within the SI report.
- 7.9 Based on our investigation we concluded that there were certain areas that the authors of the SI failed, in our opinion, to give sufficient

¹⁷⁸ TOR Appendix B

¹⁷⁹ National Patient Safety Agency (2008) "RCA Investigation: Evaluation, checklist, tracking and learning log"

consideration to in either the main narrative of the report or within its recommendations; namely the effects of Mr E's head injury; the lack of liaison between NTW and the head injury unit; the failure to obtain information from Mr E's family or offer his mother a carer's assessment and the change in Mr E's psychiatric medication just prior to the incident.

- 7.10 We also felt that the SI's authors focused mainly on processes and services rather than on the treatment plan of a patient who had a diagnosis of an Impulsive Personality Disorder. The SI made no reference to NICE guidelines in consideration of Mr E's clinical treatment plans as both an inpatient and an outpatient.

Recommendation 5.

The Executive Summary of SIs should include care and delivery issues, root causes, contributory factors and lessons learnt.

Recommendation 6.

The authors of SI reports and the Trust must ensure that information gathered as part of an investigation is securely stored for future reference.

Recommendation 7.

The authors of SI reports should always refer to the relevant NICE guidelines, both those that were in place at the time of the incident and any subsequent revisions, when reviewing a patient's treatment plans.

8. Northumberland, Tyne and Wear NHS Foundation Trust's Post progress on the implementation of the SI's recommendation

- 8.1 With regards to the SI's recommendations and the Trust's subsequent action plan, we noted that each recommendation had an action plan(s) identified. By May 2012 it was documented that all actions had been implemented.
- 8.2 However, we did note that evidence of completion was reliant on the self-reporting from the respective service managers. It is unclear if a monitoring and evaluation exercise has been undertaken, as prescribed within the National Patient Safety Agency's RCA Investigation framework, to assess the impact of the changes that have reportedly been implemented.
- 8.3 It was also reported¹⁸⁰ to us that many of the recommended changes have been "*somewhat superseded*" by the significant changes that have been implemented since this incident in the delivery of NTW's new community and inpatient services (see section 9). Therefore, it was difficult for us to evaluate the impact of the changes that were introduced based on the SI's recommendations.

Recommendation 8.

NTW should undertake an evaluation of the impact of the changes that were introduced as a direct result of the SI's recommendations.

¹⁸⁰ Interview with community services service manager

9. Profile of Northumberland, Tyne and Wear NHS Foundation Trust

- 9.1 NTW is one of the largest mental health Trusts in England, employing more than 6,000 staff, serving a population of approximately 1.4 million and providing services across an area of 2,200 square miles.
- 9.2 NTW's current vision statement is to "*Improve the well-being of everyone we serve through delivery services that match the best in the world.*"¹⁸¹
- 9.3 In 2010/11 the Trust instigated a comprehensive Service Model Review which brought together clinicians from across the Trust to undertake a whole system review of services. In July 2011 the NTW's Board of Directors accepted the recommendations from the Service Model Review, and the Trust's Transforming Services Programme was introduced.
- 9.4 To date, this programme has resulted in the following transformation of existing services and the development of additional care pathways:
- Single point of access (IRS): once a referral has been made IRS's role is to obtain further information and then refer the patient to the appropriate service.
 - Available care pathways include crisis service (rapid response crisis and home treatment service) inpatient unit and third sector and community mental services.
 - IRS also offers a primary care helpline, although it was reported¹⁸² that there is currently minimal uptake for this advice service.
 - There are four Principle Community Pathway Programmes.¹⁸³
 - Street Triage Service: where nurses and police work together on the streets and in A&E departments. The nurses have access to information from the police's PNC¹⁸⁴ records.
- 9.5 At the time of our investigation a new inpatient unit had just opened and after an initial 'soft launch', the full IRS programme had just been launched.
- 9.6 We were also provided with evidence that there was a more structured and integrated approach to the transitional points between hospital and community services. This ensures that there is no delay in the allocation of care coordinators before discharge from the inpatient unit, as well as greater communication.
- 9.7 Care plans now have clear recovery outcomes and there is now greater emphasis on providing episodic care. With the introduction of laptops and hot-desk working for community staff, there had been an increase in available patient face-to-face hours.
- 9.8 It was reported to us that as part of the NTW's Transformation Programme, there is now greater expertise and skills embedded within

¹⁸¹ Information taken from NTW's Annual Report 2013/14

¹⁸² Interview with Group Nurse Director for Planned Care

¹⁸³ Cognitive and functional frail, non-psychosis, psychosis and learning difficulties

¹⁸⁴ PNC: Police National Computer database

community services relating to drug and alcohol issues. There also continues to be separate specialist forensic and drug and alcohol services.

- 9.9 Both the clinicians and also senior managers, who were interviewed as part of this investigation, reported that the period of transition and redevelopment had presented many challenges and that the changes are still in the process of being embedded.

Comments and analysis:

- 9.10 A GP reported to us that they had a mixed experience of the new services. For example, previously CPNs had been based at the practice, and this enabled greater and more consistent communication than they are now experiencing.
- 9.11 The GP also reported that although they do get invited to CPA meetings and would like to attend, it would require employing a locum to cover their surgery time. As they do not get remuneration for this, the practice has to cover the financial cost. It was suggested that it would be helpful for CPNs to regularly visit the surgery to discuss patients with the GP and update them on CPAs etc.
- 9.12 During our review we asked the question as to whether Mr E's care would have been significantly different in the light of the new models of services now in place at NTW. It was suggested to us that he may have been identified earlier by the Street Triage team during his repeated admissions to A&E for alcohol-related injuries. As the team has access to the police database, this would have enabled them to obtain a detailed summary of Mr E's previous convictions, which could have enabled a more accurate assessment of his risk factors to have taken place. It would also have provided the inpatient unit with essential information.
- 9.13 Additionally, we were informed that had Mr E presented to NTW's new community care pathways, he would probably have been referred to the newly established Personality Disorder Hub Team.¹⁸⁵
- 9.14 The Personality Disorder Hub Team was commissioned by NTW's six clinical commissioning groups to provide direct care coordination, case management and treatment for patients who presented with Emotionally Unstable Personality Disorder (EUPD) who also have a high degree of complexity, co-morbidity and risk to self.
- 9.15 The draft service's criteria for inclusion are:
- a) self-harm and suicidality;
 - b) impulsivity – *“That is behaviours without adequate thought or consideration of alternatives or the consequences; a tendency to act without forethought or reflection. For example, impulsive spending, gambling, bingeing (food, alcohol or illicit substances), self-harm, terminating employment or relationship on a whim etc. Recent frequent examples of impulsive behaviours seen across a variety of situations;”*¹⁸⁶

¹⁸⁵ Service introduced in November 2014

¹⁸⁶ NTW's Personality Disorder Hub Team Referral Criteria and Process November 2014

- c) other risky behaviours;
- d) additional complicating factors; and
- e) 'risk to others', which we have been informed has now been included within the referral criteria.

10. Predictability¹⁸⁷ and Preventability¹⁸⁸

- 10.1 Throughout the course of this investigation, we have been mindful of the requirement, within NHS England's Terms of Reference, to consider if the incident which resulted in the killing of ND was either predictable or preventable. A significant amount of information regarding Mr E's criminal background has only come to light during the course of this investigative process. Therefore, it was not available to either the primary or the secondary health care services who were supporting Mr E or the authors of the SI report.
- 10.2 In our consideration of the predictability and preventability of this incident one of the questions that we have asked ourselves was if it was reasonable to have expected agencies and individual clinicians to have taken more proactive steps to obtain a more comprehensive and accurate profile of Mr E. Additionally, based on the information that was known at the time we have asked if clinicians took reasonable steps to assess and manage Mr E's risks?
- 10.3 The benefit of hindsight¹⁸⁹ has been useful as it has enabled us not only to develop a more comprehensive account of the events that led up to the incident itself but also to highlight issues within the treatment and management of Mr E by primary and secondary health care services.

Predictability:

- 10.4 In the months leading up to the incident, there were several significant events that were known to both primary care and secondary mental health services:
- Mr E had a diagnosis of Impulsive Personality Disorder and was consistently refusing to engage with community mental health services.

¹⁸⁷ Predictability is "the quality of being regarded as likely to happen, as behaviour or an event." We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. <http://dictionary.reference.com/browse/predictability>

¹⁸⁸ Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable, there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring <http://dictionary.reference.com/browse/predictability>

¹⁸⁹ Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

- Mr E had inflicted significant injuries on his girlfriend and this court case was pending.
 - Mr E suffered a significant head injury in November 2010 which had left him with cognitive difficulties and potential neurological problems.
 - His mother voiced her concerns to several clinicians about changes in her son's behaviour following his head injury.
 - Mr E's antidepressant medication had been changed in January 2011.
- 10.5 Despite these issues being known by mental health services in January 2011, they did not trigger a review of Mr E's risk assessment or support needs or prompt any inter-agency communication between the community mental health service and the head injury unit.
- 10.6 Additionally, at no point did secondary mental health services proactively seek to obtain information from Mr E's family. We would suggest that if they had spoken to the family, they would have obtained a more accurate and comprehensive picture of Mr E's issues, as well as gaining insight into both the dynamics and the support needs of his family.
- 10.7 Members of the family reported that they were acutely aware of Mr E's unpredictability and his potential for violent outbursts. They all identified that alcohol was often a significant factor in such incidents and that Mr E's mother had tried to limit her son's alcohol intake whilst he was in the house. From the information that we are now aware of it is evident that on the night of the incident, such was Mr E's mother's concern about her son's behaviour that she decided to remove ND to a place of safety, i.e. her bedroom, in order to defuse the situation.
- 10.8 Clearly Mr E had an extensive criminal history and a significant history of unprovoked violent attacks towards others, including members of his family.
- 10.9 Bearing in mind that one definition of a homicide that is judged to have been predictable is where "*the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.*"¹⁹⁰ We concluded that, even based on the partial information that was known at the time by services, there was significant evidence to indicate that Mr E had a combination of several extremely high risk factors and very few protective factors.
- 10.10 We concluded that all involved agencies failed to identify his high risk of reoffending or to take the appropriate steps to obtain further information that could have informed their risk assessments and clinical judgments.
- 10.11 We concluded that based on the information that agencies should have obtained it was highly predictable that Mr E would be involved in another impulsive violent incident. But in our opinion it was not predictable that the victim would have been a young man who was living in the household.

¹⁹⁰ Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000), 176: 116-120

Preventability:

- 10.12 We found that it was more difficult to definitively conclude whether the incident itself was preventable. It was evident that Mr E had a significant history of violent and unprovoked incidents which resulted in the victim at times suffering significant injuries. Mr E was also consistently either unwilling or unable to engage in any meaningful rehabilitation programme. We now know that he was non-compliant with his prescribed psychiatric medication.
- 10.13 Our investigation has identified some deficits and missed opportunities by both primary and secondary health care services where important information could have been sought from other agencies and Mr E's family. This information would have enabled a more accurate assessment of Mr E's risk factors and would have alerted agencies not only to the likelihood that he was going to reoffend. But also to the potential risks and support needs of the members of this household.
- 10.14 We concluded that based on Mr E's extensive history of violence, it was highly likely that he would commit further acts of violence towards others. However, in our opinion, even if more informed risk assessments had been undertaken it is unlikely that the events of 1 March 2011, which led to the death of ND, would have been preventable.

11. Concluding comments

- 11.1 We concluded that based on the evidence that we obtained during the course of this investigation, it was clear that Mr E had complex needs and a significant history of violence, including towards vulnerable females, members of his family and on one occasion a minor. These incidents were often associated with alcohol. Mr E was well known to the police but only came to the attention of mental health services when he had lost the custody of his son, who was a significant protective factor for him.
- 11.2 What our investigation has highlighted is that in the assessment, management and treatment of a patient such as Mr E, who is resistant to disclosing information or engaging with services, what is required is an integrated multi-agency approach to risk assessments, information sharing and support planning.
- 11.3 This clearly did not occur, which resulted in Mr E's support needs and risk assessments being based on information that was self-reported by Mr E. During the course of our investigation, it became increasingly evident to us that Mr E was an inconsistent and often an unreliable self-historian.

12. RECOMMENDATIONS

Niche's investigation team believes there are lessons to be learnt from their investigation and have made the following recommendations.

Recommendation 1.

Where multiple health care providers are involved in the treatment and care of a patient, the discharging service should seek the permission of the patient to send discharge summaries to all involved agencies.

Recommendation 2.

Risk assessments undertaken by NTW's mental health inpatient and community services must ensure that historical and current risks are being consistently documented and appropriately assessed.

Recommendation 3.

When it is known that a patient has a forensic history NTW's clinicians must seek to obtain information from the police and probation service in order to inform both risk assessments and support plans.

Recommendation 4.

NTW's mental health inpatient service's Discharge Summaries should provide both a narrative description and the context of a patient's risk and protective factors as well as potential triggers.

Recommendation 5.

The Executive Summary of SIs should include care and delivery issues, root causes, contributory factors and lessons learnt.

Recommendation 6.

The authors of SI reports and the Trust must ensure that information gathered as part of an investigation is securely stored for future reference.

Recommendation 7.

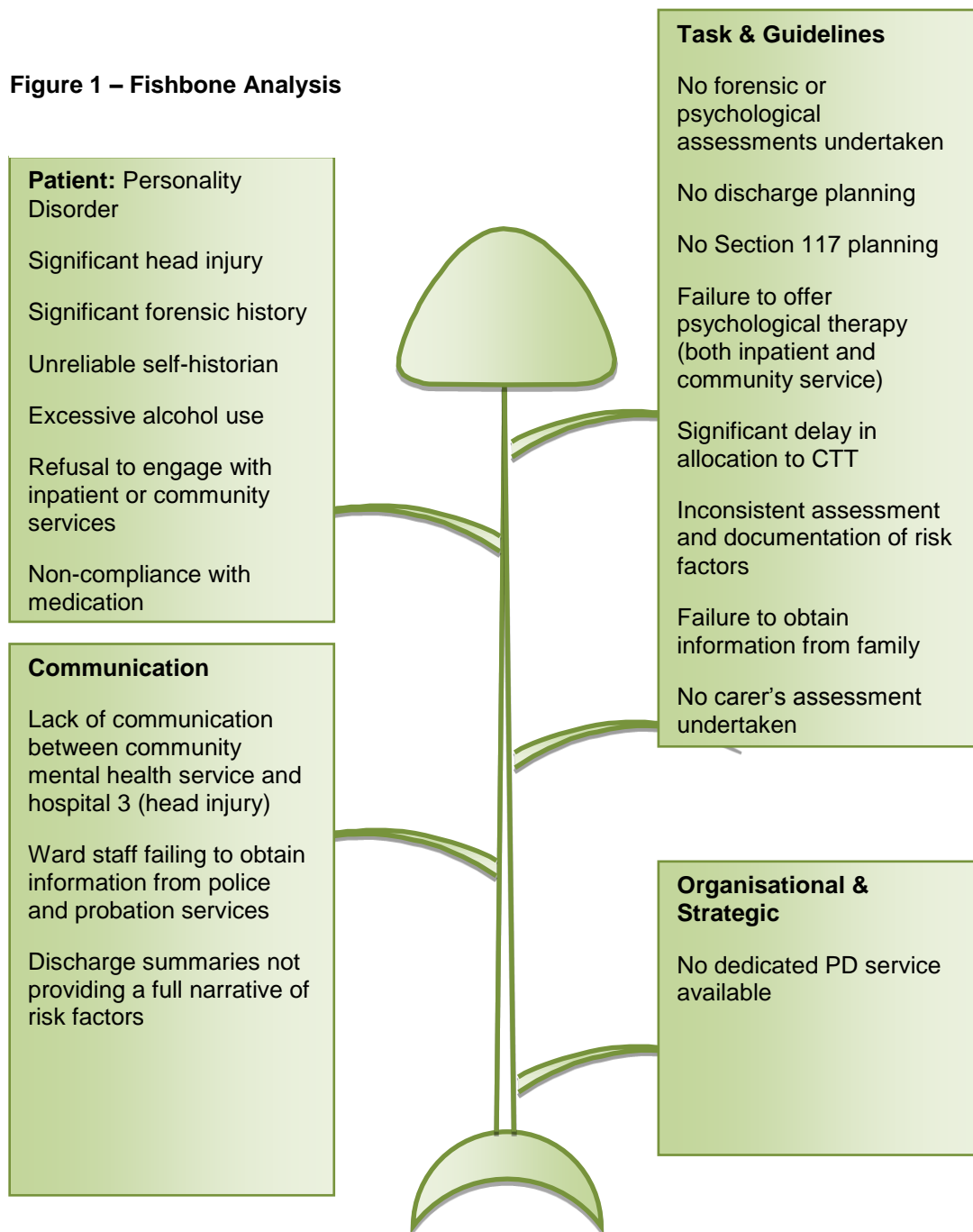
The authors of SI reports should always refer to the relevant NICE guidelines, both those that were in place at the time of the incident and any subsequent revisions, when reviewing a patient's treatment plans.

Recommendation 8.

NTW should undertake an evaluation of the impact of the changes that were introduced as a direct result of the SI's recommendations.

Appendix A: The Fishbone Analysis sets out the key issues identified.

Figure 1 – Fishbone Analysis



Appendix B – Terms of Reference

Core Terms of Reference for Independent Investigations under HSG (94) 27

- *“Review the trust’s internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- *Review the progress that the trust has made in implementing the action plan.*
- *Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user’s first contact with services to the time of their offence.*
- *Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.*
- *Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.*
- *Examine the effectiveness of the service user’s care plan including the involvement of the service user and the family.*
- *Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.*
- *Review and assess compliance with local policies, national guidance and relevant statutory obligations.*
- *Consider if this incident was either predictable or preventable.*
- *Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.*
- *Assist NHS England in undertaking a brief post investigation evaluation.”*

Appendix C – Chronology of Mr E’s contacts with primary and secondary care services and events leading up to the homicide. This chronology has been drawn up from medical records from primary care (GP), secondary mental health services and acute hospital notes as well as police interview transcripts.

Date	Source	Event	Details	Comment
29 January 1994	Primary Care Notes	Self-poisoning	Overdose.	Aged 15
February 1994	Primary Care Notes		<i>“Conduct Disorder unspecified.”</i>	
23 August 1994	Police records	Conviction for Section 47 Assault	No details available (Youth Court).	
4 October 1995	Hospital 1 and 2 notes	Fracture Clinic	Fracture of fifth metacarpal left hand. Noted that he sustained the injury following a fight.	Metacarpal: bone of the little finger
20 November 1998	Police records	Arrested	Police were called to a fight between Mr E and his father. Mr E assaulted his father by <i>“attempting to gouge his father’s eyes out.”</i> He also assaulted an officer. On remand for seven months.	Aged 19
25 November 1998	Hospital 1 notes	A&E admission	Mr E was admitted to A&E whilst in police custody with a head injury. Mr E claimed that he had been hit over the head with a chair.	
25 June 1999	Police records	Conviction for Section 47 Assault	Mr E was found guilty of Section 47 Assault and an assault of a police officer (incident on 20 November 1998).	Section 47 of the Offences against the Person Act is Actual Bodily Harm (ABH)

16 January 2000	Hospital 1 and police records	Arrested for Section 47 Assault A&E admission	Mr E and another male assaulted a police officer who was executing an arrest warrant. Case later dismissed in court. Mr E was admitted to A&E claiming that he had been assaulted by a police officer. Police reported that Mr E had head butted a wall and sustained laceration to head.	
12 May 2000	Hospital 1 notes	A&E admission	Mr E reported that he had a fight with his sister, lost his temper and punched a glass table. Sustained injury to his hand.	
14–15 November 2000	Hospital 1 notes	A&E admission	Alleged assault. Mr E reported that he had been hit with a metal bar. No intracerebral bleed. Left parietal skull fracture. Admitted to observation ward.	
1 November 2001	Police records	PNC entry	Entry related to Mr E assaulting his mother and “smashing her house up.” No charges.	PNC: Police National Computer
11 December 2003	Police records	Arrested for Section 47 Assault	Police were called to a disturbance. Fight between Mr E and other adult male. Mr E struck the male in face with a hammer causing injuries.	
30 March 2004	Police records	PNC entry	Entry relates to report of Mr E assaulting a female. No charges.	
2 July 2004	Police records	Arrested for Section 47 Assault	During a domestic incident Mr E reportedly grabbed a female around the neck and punched her in the face. Mr E was charged with Common Assault, but the case was later dismissed at court.	

11 October 2004	Police records	Conviction Section 47 Assault	Mr E was convicted, in Crown Court, of Section 47 Assault (incident occurred on 11 December 2003)	
16 July 2005	Hospital 1 notes	A&E admission	Mr E reported that he had been hit in the face with a fence post. Upper-lip injury.	
25 May 2007	Hospital 1 notes	A&E admission	Mr E fell down stairs following " <i>a day of drinking</i> ", fractured anterior tibia.	
16 August 2007	Police records	Arrested for Section 47 Assault	Mr E was arrested after he punched a male who sustained facial injuries.	
24 September 2007	Police records	Arrested for Section 47 Assault	Mr E was arrested for throwing a brick at another male, causing a facial injury. No charges brought by police.	
16 February 2008	Police records	Arrested for Section 47 Assault	Mr E was arrested during a domestic disturbance, allegedly striking a female with a small cheese knife. No charges brought by police.	Possibly the same victim as 30 March 2004 and 2 July 2004
26 February 2009	Hospital 1 notes	A&E admission	Mr E was admitted to A&E, via ambulance, having taken an overdose (10–12 tabs paracetamol, 10-plus Tramadol and 28-plus codeine. Mr E reported that he had drunk three quarters of a bottle of vodka and taken amphetamines prior to overdose. Noted that Mr E drank a similar amount every night. Assessed that he had no suicidal ideation and no intention to harm himself. He reported that he had wanted to " <i>get rid of things on his mind.</i> "	
23 May 2009	Police records	Arrested and cautioned	Police were called to a disturbance where Mr E head-butted a 15-year-old occupant at the address	

26 May 2009	Primary Care notes	Out-of-hours GP	Presented with swollen left leg which Mr E reported he had sustained during an " <i>altercation with the Police.</i> "	
9 November 2009	Hospital 1 notes	A&E admission	Mr E presented with a head injury that he sustained when he was out drinking. Denied that he had been assaulted. Reported that he had been vomiting, had collapsed several times since injury and reported blurred vision. Admitted for observation. Mr E absconded from hospital and police located him at his home. He returned to the ward to have his cannula removed. Dr assessed that he had capacity and did not meet the criteria for detention under the MHA.	MHA: Mental Health Act 1983
17 November 2009	Police records	Arrested	Mr E was arrested for an assault on his girlfriend. Six-year-old son witness to the assault. Social services became involved and son was placed in care of Mr E's mother.	
21 December 2009	Hospital 1 notes	A&E admission	Mr E found at the side of the road with lacerations to the head and face. It was thought that he had been hit with a glass bottle.	
6 January 2010		Multi-Agency Risk Assessment Conference	No details available to investigation team.	MARAC: Multi Agency Risk Assessment Conference
31 March 2010	Police records	Conviction for Battery	Mr E was found guilty in Magistrates Court of Battery re the attack (17 November 2009) on his girlfriend.	

2 May 2010	Police records	Arrested and charged with Section 18 Assault	Mr E attacked his girlfriend in her home. Sustained attack which took place in various locations around her house. She sustained significant injury (ruptured bowel) which required surgery.	<p>Section 18: wounding with intent or causing grievous bodily harm with intent</p> <p>Court case pending at time of the incident</p>
6 May 2010	Hospital 1 and 2 notes	A&E and hospital admission	<p>Mr E texted his mother to say "<i>he had had enough</i>". His brother took him to A&E. Presented with self-laceration to his arm whilst under the influence of alcohol. Security had to be called to manage his behaviour. Assessed by Self-Harm Team. Beck Score 12. Mr E reported that he was due to lose custody of his son, after being a single parent for seven years, following two alleged assaults on an ex-girlfriend. Mr E's mother was looking after the child and Mr E had supervised access. He believed he would be found guilty and given a custodial sentence. He would lose his accommodation and believed his son would be placed with the child's mother in Leeds. Assessed that he continued to be demonstrating ongoing suicidal ideation. The initial assessment identified that his self-harm risk was 3 (highest). He was admitted to hospital 2 after he refused Crisis Team Community intervention.</p> <p>Plan on admission was: Mr E on 15-minute intermittent observations. To be reviewed by own medical team. Ward staff to contact police to confirm bail appointment. FACE Risk Profile was completed. Scored: 1 for violence/harm to others, risk of deliberate self-harm, risk of suicide and risk of severe self-neglect. 0 for risk of adult abuse and exploitation.</p>	<p>Beck: Beck Depression Inventory</p> <p>Score 12: Mild mood disturbance</p>

7 May 2010	Hospital 2 notes	Care Plan	Care Plan developed: Mirtazapine 15mg nocte. Noted that Mr E not willing to go through his history again as he " <i>had already gone through it 3 times</i> ". Noted that he was drinking 8–12 cans a day and 70cl of vodka at weekends. Regraded to general observations and escorted leave in grounds with staff and brother.	Mirtazapine: antidepressant
10 May 2010	Hospital 2 notes	Care Plan Review	Unescorted leave granted. Working Diagnosis – Depressive Episode (F32 – ICD 10). Emotionally Unstable Personality Disorder (F60.3 ICD 10). Risk Assessment (not FACE): Suicide – Nil at present. Self-Harm – Nil at present. Harm to others – Nil at present. Self-Neglect – Nil at present. Noted that a review with family members to be arranged.	
12 May 2010	Hospital 2 notes	Absence from ward	Mr E left the ward without the knowledge of staff; police were contacted. He returned back to the ward later in the day (5:00pm). Staff contacted police to inform of his return. Mr E to be reviewed before any further leave agreed.	Leave and management of AWOL procedures implemented. IR1 Report (incident reporting form) not completed. AWOL: Absent Without Official Leave
13 May 2010	Hospital 2 notes	Leave and incident	Leave Plan agreed with Mr E. To be picked up by a family member. Police contacted ward to report that Mr E had been seen in the vicinity of his ex-partner's home. Police agreed to contact ex-partner when Mr E received leave. Mr E left ward. Ward staff contacted CID to report that he had left the ward. He later returned drunk and was verbally abusive to staff.	Second AWOL. AWOL procedure implemented. IR1 Report not completed.

14 May 2010	Hospital 2 notes	Review	Plan: escorted leave only. Agreed weekend leave escorted by family. Mr E to be searched for alcohol on return to the ward. If alcohol consumed then all his leave was to cease.	
17 May 2010	Police and hospital 2 records	Review and arrested for Common Assault	Review: Mr E agreed that staff contact the social worker to discuss the custody of his son etc. Agreed that his mother and stepfather would attend ward round the following week.	Court case pending at time of the incident
18 May 2010	Police and hospital 2 records	Arrested on ward. Sectioned and transferred to PICU.	Mr E assaulted a fellow patient whilst intoxicated on the ward and was arrested for a Section 47 Assault and taken into police custody. Patient sustained facial injuries. Assessed at police Section 2 applied and Mr E transferred to PICU. Initial PICU assessment: no evidence of currently suffering any depressive episode. Risk of alcohol use and associated violence. Assessed that he had capacity and insight.	Section 2 of Mental Health Act: 28 days for assessment PICU: psychiatric intensive care
20 May 2010	Hospital 2 notes	MDT review	MDT review on PICU: escorted ground leave. Transfer to open ward due to critical indicators not being present since transfer.	
21–24 May 2010	Hospital 2 notes	Transferred to ward	Mr E transferred back to open ward. Presentation: compliant with plan and appropriate on ward, presenting no management problems, with no overt symptoms of mood disorder or psychosis being noted. Mr E consistently denied experiencing depressive symptoms or significant mood fluctuations. Reported that he wanted to appeal against his detention under the Mental Health Act.	

25 May 2010	Hospital 2 notes	Inter-agency communication AWOL	<p>Safeguarding Team contacted. Ward staff to inform that there was a MARAC meeting the following day to discuss the incident on 2 May. Mr E went AWOL (from 8:45am to 2:00pm). Police informed.</p> <p>On his return he reported that he had been to check on his flat. Medical report for mental health review tribunal completed: states a diagnosis of Emotionally Unstable Personality Disorder with psychopathic traits.</p> <p>Evidence of depressive episode, risk of alcohol use and associated violence, has capacity and insight.</p>	<p>MARAC: Multi Agency Risk Assessment Conference</p> <p>Third AWOL: IR1 Report not completed</p>
26 May 2010	Hospital 2 notes	MARAC Risk Assessment Conference	<p>MARAC meeting: agreed safety plan for victim. No actions for NTW. Ward received telephone call from North Yorkshire Police Safeguarding Unit requesting information of Mr E's discharge plan in order to safeguard his girlfriend and her children who had been relocated to another city. Assessed that Mr E was at high risk of domestic violence.</p>	
27 May 2010	Hospital 2 notes	Mental Health Tribunal	<p>Mental Health Review Tribunal Mr E to remain on Section 2</p>	
28 May 2010	Hospital 2 notes	MDT Review and one-to-one session	<p>Psychiatrist intended to speak to social worker. Mr E to sign consent form regarding disclosure of information. Mr E's mother and stepfather to attend next review. Mr E agreed to abstain from alcohol while on leave.</p>	

4 June 2010	Hospital 2 notes	MDT Review	Mr E's mother attended. Mr E's son had been removed from grandmother to the care of his mother. Psychiatrist informed Mr E that he would be applying for a Section 3 of the Mental Health Act.	Section 3: detention for treatment for up to six months
11 June 2010	Hospital 2 notes	Police contacted ward. AWOL.	Police contacted the ward asking when Mr E would be discharged, as the victim had seen him on a couple of occasions in shopping centre. Mr E did not return to ward after day leave. Police informed.	AWOL Absence Without Leave and management of AWOL procedures adhered to IR1 Report completed
12 June 2010	Hospital 2 notes	Mr E returned	Returned to the ward stating that he had received a text from his ex-partner and had stayed in a B&B. Smelled of alcohol on return and admitted having drunk two pints. Apologetic and stated he would not abscond from ward again. Police informed of his return.	
14 June 2010	Hospital 2 notes	Section 2 regraded to Section 3	Section 2 regraded to Section 3 of Mental Health Act due to Mr E's recent impulsiveness and going AWOL. Recommendation that Mr E should have a forensic and psychological assessment.	No evidence that either a forensic or a psychological referral/assessment took place Section 3: detention for up to six months for treatment
15 June 2010	Hospital 2 notes	MDT review	Reported that Mr E settled on ward and no further incidents of AWOL. Police informed staff that Mr E was due to answer bail on 14 July re. assault on ex-partner.	
16 June 2010	Hospital 2 notes	AWOL	AWOL from ward. Both police area commands contacted.	AWOL fifth occasion IR1 Report completed
17 June 2010	Hospital 2 notes	Return to ward	Mr E returned to ward with his stepfather. Stated that he absconded due to feeling frustrated on ward.	

19 June 2010	Hospital 2 notes	Referral for CPN	Mr E was referred for a CPN	CPN: Community Psychiatric Nurse
21 June 2010	Hospital 2 notes	MDT review	Mr E's mother and stepfather attended. More information regarding his childhood provided.	
22 June 2010	Hospital 2 notes	Community Treatment Team	Mr E allocated to CTT	CTT: Community Treatment Team
27–28 June 2010	Hospital 2 notes	Arrested	Police informed ward that Mr E had placed “ <i>rude</i> ” photos of his ex-girlfriend on social media/Facebook. Mr E was also arrested for sending his girlfriend texts of a harassing nature. Bailed to the ward with conditions that he does not have contact with ex-girlfriend and requested that he only leave the hospital if escorted by staff. Ward continued to offer day leave.	
29 June 2010	Hospital 2 notes	One-to-one session	Mr E stated that he did not want long-term involvement with psychiatric services, though he was happy to engage with the Crisis Resolution Team in the short term.	
2 July 2010	Hospital 2 notes	MDT review	Due to bail conditions (28 July) RMO would need to discuss discharge plans with police. Mr E reported that his ex-girlfriend had broken his window and that she had been arrested. It was at her arrest that she made the allegation regarding social media and text messages. Ward staff to contact CTT to check status of CPN allocation.	Delay in allocation RMO: resident medical officer

6 July 2010	Hospital 2 notes	AWOL	Mr E failed to return from scheduled leave at 3:30pm (both commands informed), returned of own accord at 7:45pm stating he had been to his sister's home and had been fixing a window at his flat (police informed)	AWOL sixth instance IR1 Report not completed
7 July 2010	Hospital 2 notes	AWOL and incident	Mr E absconded from ward (10:10pm) with another patient. Returned to ward (2:40am) by police. Intoxicated and verbally abusive towards staff on return, also threatening towards another patient who had also returned intoxicated. He was transferred to another ward to enable safe management of his behaviour until he was sober. Mr E picked up a table and threw it at a window. Police were informed at the time of going and returning from AWOL.	AWOL seventh instance IR1 Report not completed for AWOL IR1 Report completed for Inappropriate Patient Behaviour
8 July 2010	Hospital 2 notes	Ward transfer	Mr E transferred back to ward	
9 July 2010	Hospital 2 notes	MDT meeting	Agreed that there was " <i>no clear evidence of mental illness.</i> " Mr E advised that his Section would be removed and he was to be discharged that day. Diagnosis Impulsive Personality Disorder. Discharge Plan agreed, Section 3 to be removed. Discharged from inpatient services. Seven-day follow-up appointment with psychiatrist. Changed bail conditions with Northumbria Police. To continue with Carbamazepine 200mg BD, Mirtazapine.	No formal discharge planning and 117 meetings took place CTT not present

			Advised to abstain from alcohol. Seven-day follow-up to be arranged. In emergency to contact: 9–5 – GP/ Mental Health Matters / NHS Direct; and out of hours – Crisis Team / A&E / Emergency GP. Note that staff intended to chase up CPN referral.	
12 July 2010	Hospital 2 notes CRHT	Home visit	Mr E was seen at home. He could not see a role for CPN. After discussion with psychiatrist he was discharged from CPN caseload. Letter sent to GP.	CRHT: Crisis Resolution Home Treatment Team
19 July 2010	Hospital 2 notes	Contact with CRHT	Mr E telephoned CRHT. Noted that he appeared to be intoxicated and that he had been “ <i>out drinking</i> ”. Reported he felt upset that his son was going to live with his mother and had been packing up son’s belongings and found this difficult.	
19 July 2010	Hospital 1 and 2 notes	A&E admission	Mr E presented at A&E following an episode of self-laceration to arm. Reported that he felt that he could not cope with the loss of his son. Assessment by SHO: noted that Mr E had cut his arm whilst under the influence of alcohol “ <i>to deal with his feelings</i> ” regarding social stressors e.g. loss of his son. No thoughts of suicide or self-harm and “ <i>no symptoms of mental health problem evident</i> ”. Seen by Crisis Team and then discharged. Requested that GP increased Mirtazapine to 45mg nocte.	
21 July 2010	Hospital 2 notes	Allocation	Mr E was allocated CTT psychiatrist	CTT: Community Treatment Team

23 July 2010	GP and hospital 1 notes	Discharge summary	Full discharge summary received by GP	
16 August 2010	Hospital 2 notes	Allocation	Allocated to CPN at CTT. Formulation for his plan of care was to gather some background information from Mr E's health records and offer an appointment for assessment of his current needs.	
2 September 2010	Hospital 2 notes (CTT)	Cancelled appointment	Mr E cancelled appointment with CTT	
7 September 2010	Hospital 2 notes (CTT)	Liaison with Safeguarding Team	Contact with Safeguarding Team re. update of MARAC meeting that was held Informed there were no further action points to be followed up by NTW.	
8 September 2010	Hospital 2 notes	Outpatient appointment	Mr E attended his initial outpatient appointment with psychiatrist. Assessment identified no risk of self-harm or hurting others. No evidence suggestive of psychotic symptoms. Mr E reported being uncomfortable in crowded places.	
14 September 2010	Hospital 2 notes T/C interview with CPN	Assessment	CPN reviewed Mr E's notes, noted that he had a history of aggression towards others. It was agreed that due to this possible risk Mr E would be " <i>joint worked</i> " by two CPNs in assessment. It was agreed with Mr E that CPN would discuss this further with psychiatrist to consider if they would discharge him from CTT caseload.	

			Mr E reported that his problems are dependent on the outcome of his court case.	
11 October 2010	Hospital 2 notes T/C interview with CPN	Discharged from CTT	Mr E DNA'd his outpatient appointment. Discharged from CPN case but was to be offered another appointment with psychiatrist. CPA downgraded to non-Care Programme status.	
21 October 2010	Letter to GP CTT	CPN letter	Letter to GP informing him that Mr E had been discharged from caseload but would be seen by psychiatrist in outpatients' clinic	
29 October 2010	Hospital 1 and 3 notes. Interview with specialist nurse.	A&E and hospital 3 admission	<p>Mr E was found by his mother on the floor of his accommodation. He was unconscious with a head injury and multiple upper-body bruising. Taken to A&E. Thought to have been an assault. Diagnosed with right-sided subdural haemorrhage (unconscious).</p> <p>Sedated, intubated. After initial CT scan he was transferred to hospital 3 ICU. Noted that Mr E had a history of alcohol and drug abuse. ICP (intra-cranial pressure monitoring bolt) was inserted to monitor the pressure in his brain.</p> <p>Documented that police were involved. Noted that Mr E's family reported that he was "<i>known to have people he has issues with</i>", drank alcohol to "<i>excess</i>" and was using cannabis and speed.</p>	ICU: intensive care unit
31 October 2010	Hospital 3 notes	ICU	ICP removed. Transferred to ward. Police took a statement from Mr E.	

1 November 2010	Hospital 3 and GP notes Interview with nurse	Transferred to neurosurgical ward	Noted from GP information that medication was Carbamazepine 200mg and Mirtazapine 45mg. (Transferred to neurosurgical ward).	Mirtazapine: antidepressant used to treat major depressive disorder Carbamazepine: anticonvulsant and mood-stabilising drug used primarily in the treatment of epilepsy/bipolar
3 November 2010	Hospital 3 notes Interview with nurse	Reviewed by specialist nurse	Noted evidence of poor short-term memory. T/C with Mr E's mother noted that she had " <i>a good understanding</i> " of her son's head injury. Nurse outlined possible symptoms to expect and gave her contact details. Mr E to be reviewed in outpatients' clinic in three months.	T/C: telephone call
5 November 2010	Hospital 3 notes	Discharged	Noted that Mr E had " <i>impulsive personality disorder.</i> " Discharged with two weeks' medication " <i>as per GP instruction.</i> "	
18 November 2010	GP notes	Surgery appointment	Mr E attended appointment with his mother. Reported that he was staying with his mother as did not want to go back to his accommodation. Taking Tramadol, Nurofen and codeine (prn). Reported that he was experiencing intermittent headaches.	PRN: when necessary
17 January 2011	Hospital 2 notes	Outpatient clinic	Mr E, accompanied by his mother, attended outpatient's appointment with psychiatrist. Mr E's mother reported that her son had been assaulted and sustained a significant head injury. He was now living with her as he was unable to go out on his own. Psychiatrist discussed changing antidepressants to Escitalopram. To be reviewed in two months.	

24 January 2011	Hospital 2 notes	Letter to GP	Summary of appointment on 17 January. Requested change in antidepressants (slow withdrawal of Mirtazapine).	
10 February 2011	GP notes	Prescription	Escitalopram 10mg. Carbamazepine 200mg.	NB only entry on GP notes of these meds being prescribed
18 February 2011	Hospital 3 notes Interview with nurse	Outpatient Clinic	Reviewed by nurse in outpatient clinic. Noted that although Mr E's physical symptoms improving cognitively, he was " <i>struggling</i> " with poor short-term memory and reduced confidence. His mother reported that " <i>he has changed since his head injury.</i> " She described him as quite withdrawn. He no longer socialised with his friends and spent the majority of time with his mother. Nurse reported that she intended to refer him to consultant neurologist/psychologist for a neuropsychological assessment. She also gave Headway information. Mr E was discharged from clinic.	Headway is the UK-wide charity that works to improve life after brain injury Mr E did not see neuropsychologist as incident occurred Last seen by professionals
1 March 2011	Police interviews	Incident	Late afternoon: Mr E had returned to his mother's house with a number of cans of lager. The early evening passed without incident. 11:00pm (approx.): Mr E's mother went to bed and heard an argument between Mr E and ND about the phone. She intervened and told ND to go into her bedroom. Mr E rang a member of his family. Mr E's mother went down to the kitchen to talk to Mr E. Mr E told her " <i>I need five minutes to calm down</i> ".	

			<p>Mr E's mother and ND were watching TV in bed when Mr E entered.</p> <p>He then proceeded to stab ND multiple times in both the bedroom and on the landing.</p> <p>12:15 am. Mr E's mothers called the emergency services. When they arrived Mr E was using a towel to try and stop the blood loss.</p> <p>Mr E was arrested.</p> <p>ND was taken to Sunderland Royal Hospital and pronounced dead (1:45am).</p>	
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Appendix D – Documents Reviewed

National policies and research:

American Psychiatric Association, “*Practice guidelines for the treatment of patients with borderline personality disorders*”. 2005
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bpd.pdf

Department of Health, “*No health without mental health; a cross-government mental health outcomes strategy for people of all ages*”. February 2011
<https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

Department of Health, “*No health without mental health; implementation framework*”. July 2012
<https://www.gov.uk/government/publications/mental-health-implementation-framework>

Mind, “*Listening to experience: an independent inquiry into acute and crisis mental healthcare*”. 2011
http://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

National Institute for Health and Care Excellence, “*Quality standard for service user experience in adult mental health*”, quality statement 6, access to Services. December 2011
<http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14/quality-statement-6-access-to-services>

National Institute of Mental Health Borderline Personality Disorder (2005) <http://www.nimh.nih.gov/health/publications/borderline-personality-disorder/index.shtml>

National Patient Safety Agency, “*Being Open*”. 2004 (Updated Nov 2009)

National Patient Safety Agency, “*Independent Investigations of Serious Patient Safety Incidents in Mental Health*”. 2008

National Patient Safety Agency, “*RCA Investigation: Evaluation, checklist, tracking and learning log*”. 2008

National Patient Safety Agency, “*Root Cause Analysis Investigation Tools: Investigation interview guidance*”. 2008

NHE guidelines, “*Treating a Personality Disorder*”. 2015

NICE guidelines, “*Treating a Personality Disorder*”. 2010

<http://www.nhs.uk/Conditions/Personality-disorder/Pages/Treatment.aspx>

NTW policies:

- Care Coordination incorporating Care Programme Approach (CPA). 2010.
- MAPPA (Multi Agency Public Protection Arrangements) Policy. 2013.
- Personality Disorder Hub Team Referral Criteria and Process. November 2014.
- Prompting Engagement with Service Users. Policy on Non Compliance with Treatment/Difficult to Engage Service Users. 2009.
- Policy for Transitions between Services. 2009.
- Sunderland Planned Care Operational Policy.
- Incident Policy.