INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF MR S

JUNE 2017

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1. INTRODUCTION

1.1 The incident

1.2 On the morning of 2 June 2010, following a telephone call from a neighbour who had overheard screaming, Derbyshire police attended a house in Holbrook, Belper, to find the bodies of a man and a woman. On the floor next to the bodies was a severely injured toddler.

1.3 Victim 1 and Mr S were pronounced dead at the scene. The cause of death in both cases was multiple stab wounds. The child, their two year old son (Victim 2) was pronounced dead on arrival at the Royal Derby Hospital, as a result of multiple stab wounds.

1.4 The Coroner's Inquest

1.5 In 2013, a Coroner's Inquest was convened. The Coroner's verdict was that the deaths of Victim 1 and 2 were unlawful killings. It was held that Victim 1 and Victim 2 had been stabbed to death by Mr S in their home, following which Mr S had then used the knife to commit suicide.

1.6 Background

1.7 In 2010, Mr S was 44 years old. He had been involved with Mental Health Services since his diagnosis of depression in December 2007. At the time of the deaths, Mr S was living in the community whilst on conditional bail following criminal charges of Threat/Conspiracy to Murder he had made against Victim 1, his estranged partner, less than a week earlier. One of the stipulations of his release on bail was that he was to have no contact with Victim 1. Although Victim 1 had ended their relationship by late 2008, she still interacted with and saw Mr S several times a week, and was essentially his "carer" throughout the relevant period.

1.8 Mr S had an appointment to discuss changes to his depression medication at 09:00 on the day of the incident, which he attended.

1.9 The involvement of the police

1.10 In the week preceding the deaths, Mr S had been detained by police twice on two consecutive days. Firstly, on 26 May 2010 for the purposes of a mental health assessment under s136 of the Mental Health Act (1983) following an episode of "unusual" behaviour, for which he was discharged the same day.

1.11 The second occasion was the next day, 27 May 2010. Mr S was then interviewed by the police and at 14.50 released from custody, pending further investigation for the offence of "*threats to kill*".

2. PURPOSE OF REPORT

2.1 In the period between 5 December 2007 and 2 June 2010, Mr S was in contact with Derbyshire Primary Care Trust, the Primary Care Mental Health Service for Guildford and Waverley, and the Primary Care Mental Health Service for Surrey and Borders Partnership NHS Trust.

2.2 As a result, NHS England have commissioned an Independent Investigation in order to unlock learning for the NHS which can improve the delivery of mental healthcare services for individuals such as Mr S and those connected with them.

2.3 "Hindsight bias"

2.4 "Hindsight bias" is a paradigm that promotes the belief that adverse events were more foreseeable and more avoidable than they actually were. Moreover "errors" in the chain of events can assume greater importance with the knowledge of the outcome. To a retrospective observer, all the lines of inquiry can point to the end result, but those individuals who were involved at the time did not have the benefit of foresight.

2.5 In order to ensure that proportionate and meaningful learning is achieved, the Independent Investigation Team has taken into account the notion that knowledge of the outcome can colour ideas of how and why an adverse incident occurred when making its judgements.

2.6 Desired outcome of the report

2.7 The Independent Investigation Team hopes that this report will allow care providers an opportunity to reflect upon the care which Mr S received, with a view to making improvements for future service users and those who come into contact with them.

2.8 In this way, it is intended that some benefit can be gained from these tragic events, and a degree of comfort achieved for those whose lives were affected by the victims' deaths. This is of particular importance to the victims' families.

2.9 The Terms of Reference of the Investigation, Team Membership, Methodology and the Chronology prepared during the course of the investigation can be found at Appendices 1 to 4.

2.10 Evidential Considerations

2.11 Mr S committed suicide at the time of the killings. As a result, there was no criminal trial. This has created a number of evidential issues for those undertaking the Independent Investigation. In particular, there are fewer verifiable facts regarding Mr S's life, history, versions of events etc. than would have been available had there been a trial. As a result, the Coroner's Inquest, convened in 2013, proves the single most authoritative inquiry into the "facts".

2.12 The lack of information available to the Independent Investigation Team concerning Mr S's history is compounded by the fact that Mr S did not present to services with any mental health problems to services prior to December 2007, by which point he was already 41 years old. This raises its own difficulty in terms of formulation of diagnoses and the way in which he presented with his condition.

2.13 In addition, as Mr S lived in both the US and Spain for a period of many years prior to his return to England in the lead up to the incident, much of the information relating to his career, employment, previous relationships and behaviours, is nebulous at best and unverifiable.

2.14 The Independent Investigation Team has borne these limitations in mind in performing this investigation and the drafting of this report. As a result, it has attempted to minimise speculation and hypothesis as much as possible.

3. EXECUTIVE SUMMARY

3.1 This section is intended to provide an overview of the key findings of the Independent Investigation Team. The detail supporting these findings is contained in the main body of the report which follows. The Independent Investigation Team has highlighted two areas where additional learning can be unlocked for the NHS as a result of these tragic events.

3.2 The missed opportunities in following an informal Care Programme Approach (CPA)

3.3 There was evidence of the various professionals and agencies involved in Mr S's care acting together in relation to view Mr S's care; a CPA was 'loosely' applied. However, the CPA was not formally applied in this case, and the CPA was not recorded as a 'formal' process.

3.4 As a result, information sharing between the various services involved in the care of Mr S was not as efficient as it could have been, resulting in delays in diagnoses and treatments. Also missed was the opportunity to fully collaborate with those who knew Mr S best over a longer term, namely Victim 1 and Mr S's sister, in the building of an essential longitudinal understanding of his personality and illness, as well as any potential safeguarding issues.

3.5 A formalised care plan, including Victim 1's recognition as a "carer", could have potentially provided an opportunity for services to explore Mr S's mental state and background further, pursuant to a thorough, correctly applied CPA strategy as envisaged at the inception of the CPA model, as outlined later in this report. This is more fully discussed in Juncture 1.

3.6 The missed opportunities regarding utilising those closest to Mr S in his care

3.7 Throughout Mr S's illness, he had considerable involvement with Victim 1. Whilst she was not formally a "carer", she had an in depth and personal knowledge of Mr S by virtue of her interactions with him on a virtually daily basis, and was even assessed for the role of "carer" (although the reasons for her failing to satisfy this standard are not clear from the notes).

3.8 Mr S and Victim 1 had ended their romantic relationship in 2008. However, Victim 1 remained closely involved during his illness, repeatedly contacting services with increasing frequency and on matters of increasing concern. Services did not actively seek her input into formulation of a care strategy, as will be discussed in Juncture 2.

3.9 In addition to Victim 1, services also missed opportunities in relation to Mr S's sister to increase their knowledge of Mr S, particularly longitudinally, and therein the risks he may have posed. At the time of the offence, involvement of personal individuals known to service users in providing mental health

services with potentially crucial information regarding service users was not part of the culture of the organisation at this time.

3.10 It is of fundamental importance that the professionals who work with individuals with disabling conditions take account of the experience and knowledge of those people involved closely with the person in their care.

3.11 The reason for this is to ensure that the opportunity which carers and families represent for clinicians (as a resource and means of significant knowledge in relation to the individual who is ill), can be fully utilised in developing meaningful care strategies.

3.12 In failing to actively seek the input of Victim 1 or Mr S's sister in the formulation of a care strategy, services missed a significant opportunity to utilise knowledge that was not reliant on details hidden in case notes or presented by Mr S himself, which in turn could have been of diagnostic and therapeutic benefit for Mr S, Victim 1 and services.

4. RECOMMENDED REACTION TO THE INCIDENT BY HEALTHCARE PROVIDERS

4.1 In order to provide an insight into the direction of this report at a glance, an overview of the Independent Investigation's Recommendations is as follows:

Recommendation 1 – Ensuring formal adherence to the Care Programme Approach:

1. Whilst the Independent Investigation Team acknowledges services were responsive (providing Mr S with both psychology and admission whenever required), they did not follow a formalised CPA process and were not able to obtain as full an understanding of Mr S as they might have.

2. The ethos of the CPA should be reflected and strengthened in the training programmes staff are required to attend, and the priorities identified in individual and group supervision.

3. Caseload management supervision should include routine review of all cases to ensure the appropriate applications of the principles and ethos of the CPA have been addressed, and to enable corrective action to be taken if required.

4. The implementation of this Recommendation should be monitored by periodic audit.

5. The Trust's CPA policy and auditing of that policy should ensure that CPA Care Plans reflect the ethos of CPA in order that current psychiatric, social, family circumstances and risk characteristics of service users are addressed, and that individual service user centred care can be delivered.

6. Management supervision of caseloads and coordination via the CPA must be enforced effectively. CPA and caseload reviews must be undertaken regularly. These pre-existing processes must be used more effectively. The effective implementation of this Recommendation should be monitored.

Recommendation 2 - Working with carers (and family members, where applicable):

1. "Consent to share" information should be updated regularly to promote effective communication between the practitioner, the service user and carers/family members. Protocols and policies should be introduced to secure this.

2. Those closely involved in care should always be given a contact point to access the mental health system in a crisis. Communication should be established as early as possible.

3. The Trust reviews its policy for identifying carers and making it more flexible in its assessment and easier for individuals like Victim 1 to be recognised and therein supported as “formal” carers.

4. Collateral histories should be taken from carers/family members to secure a greater insight into a service user’s situation and those of the carers/family members themselves.

5. In order to obtain a comprehensive understanding of the service user’s current psychiatric, social and family circumstances and risk characteristics, the Trust’s Quality Assurance Programme should be revised to ensure that Teams are required to actively seek carers/family members’ involvement and views.

6. The standard practice of clinical teams in relation to this Recommendation should be monitored by periodic audit.

Recommendation 3 – Improving liaison with families after adverse events:

1. The Trust must take steps to demonstrate greater awareness of the knowledge levels of family members of victims, their specific backgrounds and insights, and their interactions with the Trust post incident.

2. The Trust implements and enforces policies to ensure that, in homicide/suicide cases such as this to ensure that the families of the victims are supported, continuously apprised of developments post incident, and generally made to feel as though they are ‘involved’ in the process and not ‘just forgotten about’.

5. VICTIM IMPACT STATEMENTS

5.1 The death of the victims was a catastrophic event which has had a continuing effect upon those most closely involved with it, and lies at the heart of this Independent Investigation. In order to give them a voice in the Investigation and to allow members of their families to express how their deaths have had an impact upon their lives, the Independent Investigation Team has asked the victim's relatives to explain their loss. Extracts from their response are set out below.

5.2 Victim 1 and 2's family

"The loss of Victim 1 was awful. No one has really spoken about Victim 2, so awful, a child killed by a father.

We lost the opportunity of getting to know our nephew as well as the idea of having a new one. We didn't know Victim 1 was pregnant at the time of the incident. We learned this shortly after, which added to the trauma.

Our youngest son was doing his A-Levels at the time. Our other son was doing his university finals and our daughter was in the middle of her finals at vet school. It was a crazy time. We were in a traumatised state.

We had to get on with looking after Victim 1's mother. We inherited Victim 1's role of looking after her. Victim 1 had been holding it all together".

5.3 Victim 1's mother

"Her life is now a mere existence from day to day. She constantly dwells on the loss of her daughter and grandson and reflects on how things used to be when she saw them almost every day and the frequent outings they had together.

She has lost all confidence, especially for doing things alone. She now relies on others taking her shopping, paying bills and for appointments.

Her social life has reduced significantly and now centres around her son's visits on two weekends each month.

She is frequently depressed, does not bother to eat properly and her physical health has deteriorated greatly".

5.4 Victim 1's brother

"The death of his sister and nephew occurred at a time when he was working his redundancy period.

With all the ensuing activities and the need to quickly find a job he accepted a temporary contract job some 3 levels below his previous employment. He has since moved to a permanent role but again at a significantly lower level that requires less stress and commitment involved which has enabled him to attend to legal matters following the deaths, clearance and sale of the cottage where the deaths occurred and frequent visits to his mother in Derbyshire.

He does not believe he has been affected by what has happened but others have noticed ..."

5.5 Victim 1's Sister in Law

"I remember shaking; I shook for two days, even during sleep. I wasn't sleeping for about a year, and waking at 2am shaking. It was like a PTSD reaction.

I worked at the time at a local primary school until two years ago. After a year or two, I couldn't focus as much as usual at work. A constant drain in the background was always there. I couldn't do the job anymore. It lasted until I gave up my job. It was overwhelming".

5.6 Victim 2's aunt (Mr S's sister)

"The terrible and tragic events that unfolded on the morning of 2nd June 2010 have changed my entire life forever.

The loss of my brother, nephew and amazing friend has me in a desperate and lonely situation. My life has changed forever and I can never pick up the pieces from this and move on.

My brother was my only sibling and Victim 2 my only nephew and have been taken away from me …."

5.7 Victim 1 and 2's family has asked that the Independent Investigation Team include the following statement

"We would like to know on what criteria would Victim 1 have been formally assessed as a carer and whether a lack of such an assessment was because services were merely going on what Mr S told them…..Victim 1 felt very frustrated by, and frequently complained to us about the lack of action by the services despite them "listening" to her information...

…We query whether mental health services are aware of relevant indicators of risk as regards domestic violence, particularly those pertaining to fatal domestic abuse? (For example, mental health issues, relationship break-up, pregnancy etc) If not at the time, are these links made now...

….it might be a good idea to question mentally ill patients about these risk factors when they are assessed e.g. recent relationship break-ups, pregnancy of partners/ex-partners…Even a pro-forma for use by a mental health professional could pick up the existence of e.g. narcissistic personality disorder. Assessors would then be alerted to the associated risks of murder-suicide as regards domestic abuse…"

6. PREDICTABLE/PREVENTABLE

6.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether the victims' deaths were "*preventable"* or "*predictable"*.

6.2 Many Independent Investigations identify failings, missed opportunities or gaps in the care with which an individual was provided. However, this does not mean that a homicide could have been either predicted or prevented. The following tests are commonly applied to determine whether a homicide could have been predicted or prevented.

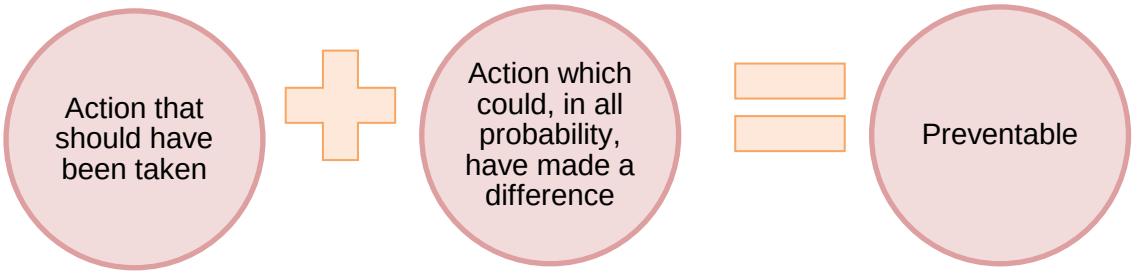
6.3 Predictable

6.4 A homicide is "*predictable"* if *"there was evidence from the service user's words, actions or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had been un-noticed or misunderstood at the time it occurred"*.

6.5 Preventable

6.6 A homicide is "*preventable"* if *"there were actions that healthcare professionals should have taken, but which they did not take, that could in all probability have made a difference to the outcome.*

6.7 *Simply establishing that there were actions that could have been taken, or opportunities which were missed would not provide evidence of preventability, as there are always things that could have been done better*".



Comment One

This report specifically considers the risks that Mr S posed when ill, services' response to these risks, and therein the correlation between those risks and the predictability and preventability of the incident. However, in summary:

Predictability

The Independent Investigation Team's view is that the deaths of Victims 1 and 2 were not predictable by mental health services. Risk assessments were performed which were consistent with each other and raised no significant risks of harm to others.

The Independent Investigation Team does however, consider it predictable that Mr S could have come to some harm himself when in the throes of a crisis (in which case he was always offered and received a response).

What could not be predicted was the type of reaction and incident which occurred. Based on Mr S's risk history, it was likely his reaction would be one of withdrawal and rapid deterioration in mood and self-neglect.

This is based on the information that the care team had at the time, and it is the Independent Investigation Team's view that the only mention of any significant risk pertaining to any history of self-harm came from Mr S himself, and could not be externally verified.

Preventability

It is difficult to comment on preventability in any case.

The Independent Investigation Team has considered whether there were *"actions that healthcare professionals should have taken, but which they did not, that could in all probability have made a difference to the outcome",* as per the test of "preventability" as set out at paragraphs 6.6 – 6.7 above.

The Independent Investigation Team considers that even though:

1. The Trust missed opportunities by not following a formal CPA; and,
2. Missed opportunities to sufficiently involve/seek insight from Victim 1 and Mr S's sister in developing understanding of Mr S;

under the test of "preventability" as above, even if services had performed some, or even all of these actions, the homicides and suicide of 2 June 2010 were still not "preventable" by mental health services.

7. DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

7.1 The origins of the Trust

7.2 Derbyshire Healthcare NHS Foundation Trust was established on 1 February 2011 when Monitor (the independent regulator of health services in England), authorised Derbyshire Mental Health Services NHS Trust to become a "Foundation Trust".

7.3 An overview of Derbyshire Healthcare NHS

7.4 The Trust provides mental health**,** learning disabilities and substance misuse services in Derby City and Derbyshire County. It currently employs over 2,400 staff based in 90 locations across Derbyshire. Across the county and the city, the Trust serves a combined population of approximately one million people. It operates within a budget of £132 million and provides 311 inservice user beds.

7.5 The Trust is led by a unitary Board (meaning all participants have equal legal responsibility for the management and strategic performance of the Trust). Since February 2011 when it gained foundation status, the Trust leadership has been in transition, with three Chairmen and three Chief Executives having held office.

7.6 Revisiting the Trust's internal investigation

7.7 The Independent Investigation Team acknowledges that there were positives to be taken from the internal investigation;

- It is comprehensive in its scope;
- It included the requisite expertise;
- It drew valid learning; and
- It was conservative in its recommendations.

7.8 As mentioned above, the Independent Investigation Team is conscious of the ease with which "hindsight bias" can enter into perceptions of events after the fact, and this has been borne in mind when considering the internal investigation.

7.9 The Independent Investigation Team also acknowledges that since the Incident, the situation in relation to service users such as Mr S has changed on a national level; we now have the Care Act (2014), the Duty of Candour and revised national guidance on serious incident investigations.

7.10 However, the findings of the Independent Investigation Team are that:

- There was a lack of consideration of child safeguarding issues; and,

- There was a lack of consideration of interactions between Mr S and Victim 2 regarding contacting the health visitor and making them aware that Mr S was in hospital and that Victim 2 was visiting.

8. LEARNING FROM PREVIOUS INQUIRIES IN THE NHS

8.1 The following Inquiries are helpful at this point in framing the incident of 2 June 2010 in a broader context of mental health homicide.

8.2 2015 National Confidential Inquiry into Suicide and Homicide

8.3 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015[1] has calculated that in the years 2003-2013 there were an average of 57 homicides per year, involving 61 victims, committed by individuals in receipt of mental health care.

- 6% of individuals in the period 2005-2013 were under crisis resolution/home treatment teams at the time of the homicide.
- 17% of individuals had been non-adherent with drug treatment in the month before the homicide.
- 29% of individuals with schizophrenia had been non-adherent with drug treatment in the month before the homicide, an average of 5 per year.
- 39% of individuals with schizophrenia missed their final service contact before the homicide, an average of 6 per year.
- In total 57% of individuals with schizophrenia were either non-adherent or missed their final contact with services.
- 89%, (excluding those with an unknown history), had a history of either alcohol or drug misuse or both, an average of 49 homicides per year.

8.4 The Ritchie Inquiry

8.5 On 17 December 1992, Christopher Clunis killed Jonathan Zito, in an unprovoked attack at a London underground station. Clunis had a long history of psychiatric illness, including previous displays of violent behaviour.

8.6 The NHS sought to learn from the care of Mr Clunis. His care was described as a *"catalogue of failure and missed opportunity"*, by the Ritchie Inquiry which was tasked with reviewing his care.

8.7 The Ritchie Inquiry was instrumental in the development of the Care Program Approach (CPA), which aims to ensure that there is a coordinated approach to the care and treatment of individuals with long term mental health needs where numerous professionals and agencies are involved. A core purpose of the CPA is to provide a framework for care planning which recognises the needs of the individual.

8.8 The landscape of mental health provision is far more complex than when the Ritchie Inquiry was written. Significant changes have been made to the legal framework governing mental health and there have also been changes in the manner in which services are delivered. However, analysis of mental health

[1] England, Northern Ireland, Scotland and Wales, July 2015 (University of Manchester).

homicide reports since the Ritchie Inquiry into Mr Clunis' care show that the issues highlighted in that Report remain relevant.

8.9 The Care Programme Approach (CPA)

8.10 The CPA was introduced in England in 1991, and by 1996 had become a key component in supporting and facilitating long-term care. It was introduced in order to provide a framework for the delivery of effective mental health care, partly in response to the Ritchie Inquiry.

8.11 The main elements of the CPA are:

a) Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
b) The formation of a care plan which identifies the health and social care required from a variety of providers;
c) The appointment of a "care co-ordinator" to keep in close touch with the service user and to monitor and co-ordinate care; and
d) Regularly review and, where necessary, agree changes to the care plan culminating in regular CPA meetings between all parties involved, including the service user and their carers[2].

8.12 As will be shown throughout this report, and particularly in Juncture 1, the CPA was of significance in relation to Mr S's care.

8.13 The Francis Inquiry

8.14 The Francis Inquiry report was published on 6 February 2013 and examined the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report made 290 recommendations. Key themes were identified as being important to allow patient centred care to be delivered including:

- Patient-centred values throughout the system;
- Openness and transparency about how the service is performing and candour about harm to patients;
- Strong patient-centred health care leadership;
- Accurate, useful and relevant information allowing all to understand how safe, effective and good the service is.

[2] "Refocusing the CPA" (DH, 2008).

8.15 The relevance of the above inquiries in Mr S's case

8.16 The Independent Investigation Team recognises that the incident took place prior to the conclusion of the Francis Inquiry. The Independent Investigation Team is also aware that a homicide inquiry, in relative terms, is a rare event when considered against the broader scope of day to day NHS operations

8.17 However, Francis and Ritchie are nonetheless relevant to this case to the extent that they represent a commitment to greater openness and candour with families involved in incidents, to developing a culture dedicated to learning and improvement that continually strives to reduce avoidable harm.

8.18 The Independent Investigation Team considers the relevance of the Ritchie to Mr S is that, in this case, there could have been a more meaningful and multi-disciplinary CPA involving Mr S and those involved in his care.

8.19 Francis' relevance here pertains to the ethos of the Trust. In this case, it is the view of the Independent Investigation Team that there was a minimal sense of openness and transparency about how the service is performing and candour in relation to the Trust interactions with the families of the victims post incident, as will be discussed later in the report. This is of relevance to the cultural shift in the past few years regarding working with families, and being open and accountable to those families.

9. PROFILE OF MR S

9.1 This chapter will provide an overview of Mr S's background, his relationship with Victim 1, and his historic interaction with mental health services, to set the scene for analysis in the Junctures of this report.

9.2 Mr S had a vague history of mental health problems. It is the view of the Independent Investigation Team that Mr S's lack of history of involvement with mental health services made it more difficult for mental health services at the time to identify and combat the increased demand for attention from Victim 1 which ultimately progressed until the incident.

9.3 Mr S's background

9.4 Mr S was born in North West England on 12 January 1966. Having reportedly achieved 8 "O – Levels" and 4 "A – Levels", he studied Graphic Design at a School of Art. After travelling and living in various countries, at some point in the 1980s, Mr S moved to California in the United States to work in the golf industry. Here he met an American make-up artist, who became his partner of 12 years.

9.5 In 1999, Mr S moved to Andalusia, Spain, and bought a barn which he converted and opened as an art gallery. His partner did not come with him, remaining in the United States, although, according to reports and media references, she held a share in the art gallery, despite the relationship having ended by this point. Although it was never actually confirmed, it is reported that Mr S and his partner had married and divorced. Mr S had later stated that at some point in 1999, he had considered throwing himself from a rooftop in Rotterdam.

9.6 Mr S was reported to have been very close to his mother. She died on 31 January 2002, and Mr S's medical notes cite numerous references from Mr S himself stating that he never properly recovered from her death, and that his mental health started to decline from this point forth (note however, there are references in his medical notes to the onset of his mental health problems dating back to 1999).

9.7 Mr S's relationship with Victim 1

9.8 In 2004, whilst in Spain, Mr S met Victim 1. They became involved, and the art gallery closed in 2005. In the summer of 2005, Victim 1 returned to England, living with a friend in Greenwich. Mr S remained in Spain, and between 2005 and 2007, Victim 1 would visit Mr S in Spain. In late 2007, Victim 1 became pregnant. At some point between December 2007 and January 2008, Mr S returned to England, initially living in Guildford. It was during this time that Mr S first presented to services with mental health concerns on 5 December 2007.

9.9 In February 2008, Mr S moved in with Victim 1, who was living alone in Wessington Derbyshire, where Mr S's mental state continued to decline and his involvement with mental health services continued to increase. On 15 July 2008, Victim 2 was born.

9.10 Mr S continued to present with self-neglect, withdrawal and crises, and shortly after Victim 2's birth, Mr S and Victim 1 separated, although at some point in December 2008/January 2009, Mr S, along with Victim 1 and Victim 2, moved in to live with Victim 1's mother, and as of Spring 2009, Mr S was no longer living with Victim 1 and Victim 2.

9.11 Mr S continued to have regular contact with Victim 1 and Victim 2. Indeed, between the period August 2008 and June 2010, Victim 1 was so involved in the day to day care of Mr S as his mental condition teetered back and forth, repeatedly stabilising and then declining, that she was even assessed for a role as his permanent "carer". However, it was decided that she did not qualify.

9.12 Mr S's mental health began to decline from January 2010 forward. By this time Victim 1 had commenced a relationship with a new partner, although she was still involved with Mr S, as both the father of their child (Victim 2) and as an individual for whom Victim 1 had assumed caring responsibilities.

9.13 Even after their "separation" and until 26 May 2010, Victim 1 continued to drive Mr S to appointments, buy groceries and other such items for him, contact services on his behalf in relation to getting help for Mr S, arranging appointments etc. and generally tending his care needs.

9.14 At some point between 14 and 26 May 2010, Victim 1 informed Mr S that she was pregnant with her new partner's child. The tragic incident at which she, Victim 2, and Mr S died occurred shortly later on 2 June 2010.

9.15 Overview of Mr S''s contact with mental health services

9.16 Mr S was in contact with mental health services between 19 December 2007 until 2 June 2010, a period of less than 3 years.

9.17 A full timeline of Mr S's contact with services, pursuant to the Independent Investigation Team's Terms of Reference for this report, can be found at Appendix 4.

9.18 It is the view of the Independent Investigation Team that an overview of Mr S's most significant interactions with mental health services would be usefully highlighted below.

9.19 Services involved in Mr S''s care during the relevant period

9.20 In addition to his involvement with primary health care services, Mr S had involvement with various secondary services:

- Derbyshire Mental Health Services (DMHS) provided mental health services to Mr S between April 2008 and 2 June 2010, during which Mr S was treated by various different professionals and teams.

- Clay Cross – Community Mental Health Team (CMHT) service in Alfreton - legitimately discharged Mr S in November 2008 as he was supposed to be moving back to Spain, but took over 4 weeks to review him. Mr S's transfer to Amber Valley was arranged, but done without a CPA.

- Amber Valley – CMHT service in Ripley – Mr S came here when he returned from his short-lived relocation to Spain in December 2008. The process of referral to Amber Valley was not efficient. Mr S was not seen by Amber Valley until 24 February 2009. It seemed to take a considerable period of time for Amber Valley to assess and take him on.

- Derbyshire Community Health Services (DCHS) was a team providing health visiting services to families following the birth of a child, and were not therefore, *directly* involved in Mr S's care during the relevant period. Instead, they provided care to Victim 1 during both pregnancies, the birth of Victim 2 and the relevant post-natal care.

  This team was relevant in relation to safeguarding and information sharing to the other services directly involved in Mr S's care.

- Derbyshire Health United (DHU) is an organisation providing out of hours GP services, contacted by Victim 1 seventy times between April 2008 and March 2009 (the last contact they had regarding Mr S) in an attempt to seek help with Mr S. They also had 4 out of hours telephone contacts with Mr S and Victim 1.

9.21 An overview of Mr S's significant interactions with mental health services

DATE	EVENT
19 December 2007	Mr S's first interaction with services in relation to his mental health – primary care, GP Surgery in Guildford – depression for the last 4 years as a result of the death of his mother.
April 2008	Mr S assessed by Surrey Primary Care Mental Health Services, relocated to Derby (on waiting list to see a psychologist at this time).
15 April 2008	Attended first appointment at a Derby GP surgery
17 April 2008	Assessment appointment with psychologist.
21 April 2008	Mr S seen in psychology clinic, referred to mental health services.
16 May 2008	Derby – first interaction with secondary services – Mr S assessed and referred for Crisis Resolution Home Treatment Service (CRHTS).
15 June 2008	Mr S informally admitted to Hartington Unit for a 3 week period of assessment following a worsening of depression. At the end of the period, he was discharged, categorised as "low risk of suicide" and placed on a waiting list for psychotherapy. FACE risk profile completed. He continued to have follow- up in the community by the Clay Cross CMHT.
25 June 2008	Mr S discharged from Tansley Ward.
7 July 2008	Discharged from CRHTS due to improvement in symptoms of depression and denial of suicide ideation.
8 July 2008	Saw locum Consultant Psychiatrist.
15 July 2008	Birth of Victim 2.
	Mr S separated from Victim 1.
October 2008	Mr S started 10 week 'emotion focused' psychotherapy course with the Clay Cross CMHT.
11 November 2008	Reviewed at Clay Cross
	Mr S relocated to Spain.
	Mr S returned from Spain.
26 December 2008	Despite the relationship ending at some point between August and September, Victim 1 took Mr S to the Hartington unit stating that she could not cope with him. Mr S refused to get out of the car. Victim 1 contacted the police stating she felt unsafe, at which point Mr S agreed to be assessed by the Mental Health Liaison Team. Their assessment declared "*no evidence of mental illness*" Mr S declined mental health service intervention.
2 January 2009	Mr S registered with different Surgery.
24 February 2009	Assessed by a CPN with the Amber Valley Community Mental Health Team – information of assessment was sent over to care coordinator.
	Mr S changed address.
3 June 2009	Accepted for home treatment.
17 June 2009	Mr S discharged from home treatment by virtue of relative stability and lack of acute mental illness.
13 August 2009	Mr S referred to the crisis team because of a deterioration in his mental health.
21 August 2009	Mr S underwent voluntary admission for assessment as a result of severe depression and significant retardation. During the assessment, indicated that Mr S may pose a (low) risk of violence to himself or others. Victim 1 present.

1 September 2009	Mr S discharged from Hartington Unit on Duloxetine, with recommendation for daily crisis team input, ongoing psychotherapy input and anxiety management.
12 October 2009	Mr S reviewed at hospital outpatient clinic.
26 January 2010	Mr S was visited at home by care coordinator. A dramatic deterioration in Mr S's self-care was noted.
5 March 2010	Mr S did not answer door to CMHT.
8 March 2010	CMHT visited Mr S at home and observed movement in his residence but no response was obtained.
9 March 2010	Victim 1 and Mr S's sister visited his home with Mr S's care coordinator but were refused entry.
11 March 2010	CMHT and GP visited Mr S at home. He was assessed under the Mental Health Act and a recommendation was made that Mr S be detained under the Act if he failed to comply with the Derbyshire Mental Health Services monitoring and intervention.
18 March 2010	Mr S cancelled his appointment.
22 March 2010	Mr S stormed out of a clinic with Dr. Dr considered an additional diagnosis of narcissistic personality disorder in addition to Mr S's depression.
20 April 2010	Crisis Team visited Mr S but were unable to gain access.
27 April 2010	Services visited Mr S at home. However, contact was refused.
4 May 2010 onwards	Mr S refused access to professionals and was discharged from clinic on this basis. Mr S continued to engage with the rest of the psychiatric team and still saw the psychologist.
	Victim 1 informed Mr S of pregnancy with second child to new partner.
25 May 2010	Mr S discharged by crisis team as a result of lack of contact.
26 May 2010	Mr S referred to crisis team following learning of Mr S's knowledge of Victim 1 new pregnancy to her new partner. Mr S arrested under s136 and assessed and discharged. Victim 1 telephoned saying he was suicidal.
27 May 2010	Mr S arrested as a result of threats to kill.
28 May 2010	Mr S arrested and released on conditional bail. Police identified Victim 1 as "high risk".
2 June 2010	Mr S's final contact with services at a GP appointment.

9.22 Mr S's last contact with NHS services

9.23 On 1 June 2010, Mr S called his GP surgery complaining again of headaches and looking to re-book an appointment which he had missed when in police custody on 28 May 2010. During this phone call, Mr S informed the surgery that he was speaking to the press about how badly he felt he had been treated by the mental health team. An appointment was arranged for 09.00 the following day, 2 June 2010.

9.24 Mr S attended his appointment at surgery at 09.00 on 2 June 2010.

9.25 During the course of this appointment, Mr S apologised and stated that the reason he had missed the appointment booked for 09.10 on 28 May 2010 because he *"had been forced to go to the hospital with severe headaches*".

He made no mention of his arrest, charge or bail conditions. In evidence at Inquest, it was stated that the surgery was unaware of Mr S's arrest.

9.26 At the time of this appointment, the surgery was aware of the s136 assessment and its outcome, by virtue of the faxed assessment report sent through to the surgery on 27 May 2010.

9.27 Mr S's threat

9.28 Upon presenting at the appointment, Mr S was noted to appear agitated, anxious and was hyperventilating. Records note that Mr S's overriding thoughts during the appointment were of not being able to see his son, and Mr S stated that Victim 1 was not allowing him access. Mr S informed the GP that *"these are going to be the most important days of your career".* Mr S's GP challenged him on this, asking whether or not it was a threat, at which point Mr S instantly apologised and informed him it was not at all a threat. Mr S's GP took it as a professional threat against his career, given his knowledge that Mr S had reported that he had to have spoken with the press.

9.29 Discussion concerning Medication

9.30 Mr S stated that he wished to stop taking his medication. Mr S was advised not to stop taking the medication "*cold turkey*", but instead to gradually reduce it. In his evidence at inquest, Mr S's GP stated that this was a matter he had planned to discuss after the appointment with the mental health team, as he feared there was a risk of Mr S's mental health deteriorating if he were to simply cease his medication entirely.

9.31 According to the GP's evidence at inquest, Mr S then appeared to settle during the appointment, to the extent that his GP felt *"encouraged because Mr S was showing evidence of the fact that he was thinking about the future".* Mr S's GP felt *"there was insufficient reason for him to be concerned about the risk of harm to others at that time".* On the information he had available to him at the time of that appointment, Mr S's GP stated he felt Mr S presented "*no risk*". He also stated that he would have immediately contacted the crisis team if he had found himself concerned Mr S "*was suffering from overt mental illness, or presenting risk".*

9.32 Mr S's GP was not in the surgery the following week. However, the GP wanted Mr S to come for a follow up appointment. Accordingly, he made arrangements with another GP over the phone whilst Mr S was in his presence, for him to see her the following week instead. An appointment for this meeting was even booked whist Mr S was seeing his GP. Mr S's GP also informed Mr S he would also chase up an earlier Cognitive Behaviour Therapy (CBT) referral that seemed to have gone missing, and would also contact the crisis team to discuss the recent events in terms of his care plan going forward.

9.33 According to Mr S's GP, Mr S left the appointment on a positive note, then *"popped his head back in, confirmed the treatment plan, and apologised again for the remark about "most important days".*

10. THE DIFFICULTY IN MANAGING Mr S'S CONDITION

10.1 Mr S had a history of depression, dating back to at least 2007. However, according to self-reports made by Mr S, this began as early as 2001, with the death of his mother. His records suggest it may even have gone back as far as 1999. He was described by mental health professionals as *"a moderately resistant patient who avoided emotion".*

10.2 Over the course of his interaction with services, Mr S's described his symptoms as including:

- Low mood.
- Not eating.
- Not leaving the house (although he had food in the house on one occasion).
- Not shaving/self-caring.
- Suicidal thoughts – sometimes described, more often hinted at.
- Anxiety.
- Checking of locks and windows.
- Dismissal of help offered to him.
- Pre-occupation with finances, relationship with Victim 1, relationship with Victim 2 and concerns over the health of his father.
- Sister and Victim 1 would not/could not understand his illness
- Rapid recovery once in a 'caring' environment (e.g. hospital)
- Lying.

10.3 These symptoms could be consistent with depression, anxiety, obsessive compulsive disorder (OCD), dysthymia and adjustment disorder. It should be noted that these symptoms had not necessarily always been observed by others.

10.4 Mr S's presentation

10.5 Mr S presented with self-neglect, withdrawal and suicidal ideas whenever his immediate needs were not met. It is the view of the Independent Investigation Team that his movement between Guildford, Chesterfield, Clay Cross and Amber valley made it more difficult to see this repetitive pattern of behaviour.

10.6 Mr S's diagnoses by services

10.7 Mr S suffered from both depression and a narcissistic personality disorder. The diagnosis of narcissistic personality disorder only started to emerge in late 2009. Mr S did not present to health services with any indication of mental illness until he was diagnosed with depression in 2007, by which point he was already 41 years old. However, this is of less of a surprise when remembered that Mr S had spent many years of his earlier life overseas.

10.8 As a result, Mr S's history of interaction with mental health services only goes back to this point. As will be discussed, this caused further difficulties in his diagnosis and treatment, particularly in light of the fact that Mr S's underlying personality disorder would have started early in life and developed over a long period of time. In addition, despite his apparent grief following the death of his mother, Mr S relocated to Spain, bought a house, established a new business venture and instigated a new relationship with Victim 1. These behaviours are not necessarily consistent with having a major mental illness.

10.9 These difficulties were further compounded by the fact that he disengaged once it looked as though a diagnosis of personality disorder was going to be made. It is the finding of the Independent Investigation Team that it took longer to diagnose Mr S as a result of this lack of longitudinal history.

10.10 Difficulties presented by Mr S's lack of longitudinal history in relation to his diagnostic process

10.11 As a result of the fact that Mr S had lived much of his earlier life overseas and did not first present to NHS mental health services formally until 2007, at the time of that first presentation, there was virtually no longitudinal history of Mr S's mental health problems.

10.12 The Investigation Team considers that services were therefore at a disadvantage from the beginning of their interactions with Mr S in 2007 as a result of his considerable lack of contact with NHS services prior to that time in relation to his mental illness.

10.13 In relation to Mr S's narcissistic personality disorder, this lack of prior history proved particularly troublesome. The complex, longstanding nature of this condition requires a longstanding and comprehensive overview of as many potentially relevant facts and life events as possible.

10.14 Difficulty in diagnosing personality disorders

10.15 Diagnosing personality disorders is difficult by virtue of the fact that it requires knowledge of a sustained pattern of repetitive maladaptive behaviours. It is the view of the Independent Investigation Team that there is often a reluctance to diagnose personality disorder formally. This can be for a number of reasons including the stigma associated with the diagnosis, the difficulties attached to treatment and the fact that depressive illnesses can 'worsen' symptoms of personality disorder, which then resolve once the underlying illness is treated.

10.16 When diagnosing a personality disorder, it is not sufficient to simply diagnose on the basis of an observation of the way in which the individual appears to behave in a certain situation, for example, under stress, or at one certain point in time, for example, when they are actually presenting in crisis. There also needs to be an understanding of the individual's developmental history in their

formative years. It is a diagnosis that would develop from an individual's late teens onwards.

10.17 The notes relating to Mr S's behaviours as a child, at school, other relationships, inter familial relationships, parental relationships, information relating to the beginnings of his golf career, the extent of his progression within that career, the end of that career, the details surrounding his travelling and living in America are not detailed. This is the sort of information that can be obtained from a relative/informant who has known the service user over many years in the absence of clinical notes.

10.18 Mr S occasionally talked about the death of his mother in 2002 which appears to coincide with the beginning of his difficulties. However, there remained a lack of depth about the origins of his problems, given that parents inevitably die and yet this does not of itself cause their children to become ill. As a result, more history regarding the reason why his parent's death caused him to become ill was required. Mr S's notes are not detailed in terms of his broader, longer term historical psychological development.

10.19 <u>NICE Guidance on Personality Disorder</u>

10.20 The National Institute for Mental Health in England published guidance on the development of services for those with personality disorder in 2003[3]. That report recommended the setting up of 8 development centres, which would act as a source of information, training and networking. Feedback from pilot services was not scheduled until 2007.

10.21 The National Institute for Health and Clinical Excellence guidance on two types of personality disorder, borderline personality disorder[4] and antisocial personality disorder[5] was only published in 2009. Narcissistic PD was covered in DSM-5 (which would have been DSM-IV in 2010[6]).

10.22 <u>Narcissistic Personality Disorder 301.81</u>

"A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

[3] NATIONAL INSTITUTE FOR MENTAL HEALTH FOR ENGLAND (2003) *Personality Disorder: no Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder*, Gateway Reference 1055. London: NIMH(E).
[4] NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE. *Borderline personality disorder: treatment and management*. CG78 January 2009.
[5] NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE. *Antisocial personality disorder: treatment, management and prevention*. CG77 January 2009.
[6] Personality disorder is not described in ICD-10, the UK diagnostic classification, but is described in the American diagnostic manuals, both DSM-IV and the post incident DSM5 (May 2013).

(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
(4) requires excessive admiration
(5) has a sense of entitlement, i.e., unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations
(6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
(8) is often envious of others or believes that others are envious of him or her
(9) Shows arrogant, haughty behaviours or attitudes[7]".

10.23 Difficulties Faced by Services in Historically Evaluating Mr S

10.24 It is important that the Independent Investigation Team is mindful of the information that the clinicians had to hand at the time these events were occurring. Someone presenting as low in mood, self-neglecting and overwhelmed by circumstances after a series of negative life events, is presenting as someone who maybe suffering from depression. Mr S presented this way repeatedly.

10.25 It is of critical importance to attempt to avoid "hindsight bias". Looking back, knowing the events that transpired, the behaviour relating to Mr S's making Victim 1 take him to Accident & Emergency, his behaviour on arrival at A & E, the passive-aggressive nature of all his interactions with the hospital, the attention he received there and the fast improvement he consistently showed, usually resulting in him being discharged within 2 – 3 days, all fit very appropriately with a narcissistic profile.

10.26 All of the above supports the statement that there was never performed a historical evaluation of Mr S from a reliable third party. The question therefore becomes one of the ways in which this lack of longitudinal information in relation to Mr S's past was fed into the care that he did get. In addition, whether there were other avenues that the information could have been obtained.

10.27 It is the view of the Independent Investigation Team that it is always desirable to obtain a collateral history, backed by documentary evidence if at all possible. However, in the first instance, talking to Victim 1 or Mr S's sister may have revealed something about his life in Spain and early childhood.

[7] American Psychiatric Association: *Diagnostic and statistical manual of mental disorders (5th edition) (DSM-5).* American Psychiatric Association 2013.

10.28 The implications of Mr S's personality disorder

10.29 Mr S was not happy with the treatment he received, despite being offered a number of therapies, including those he had requested. However, it is the view of the Independent Investigation Team the teams offered him at least a standard level of care, which he did not then choose to pursue.

11. THE CARE MR S RECEIVED

11.1 Mr S's treatment

11.2 Mr S received psychotherapy that was based on providing him with coping skills to handle the situation at the time of the therapy's application on an ad hoc basis.

11.3 The emphasis of treatment was on providing Mr S with the necessary psychological tools to address a depressive illness on a day to day basis, with the goal of reducing the likelihood and frequency of Mr S finding himself in situations of crisis. It is the view of the Independent Investigation Team that this was a reasonable and proper approach to take when treating Mr S presenting as someone suffering from depression.

11.4 It is also the view of the Independent Investigation Team that this was a reasonable treatment over the longer term for a person presenting as narcissistic, in Mr S's case, the narcissistic personality disorder element of his issues. The alternative treatment for this disorder is the use of psychodynamic psychotherapy.

11.5 Mr S's depression was treated according to NICE guidance, and there is no NICE guidance with respect to the Narcissistic personality disorder.

11.6 Medication

11.7 There is no medication that treats personality disorders. Medication can be useful in managing short-term symptoms and assisting in crises, so long as it does not then become the only tool used by the patient. Intercurrent depressive episodes should be treated according to NICE guidance. There is no evidence that antidepressants worsen the outcome.

11.8 It is the view of the Independent Investigation Team that if Mr S had a depressive illness, then antidepressants were appropriate and safe given the information available at the time. Antidepressants were prescribed sensibly and in therapeutic doses. The difficulty with a retrospective review is that it appears that there was probably not a full-blown depression, rather a withdrawal when things were not going Mr S's way followed by a rapid recovery.

11.9 The Independent Investigation Team could not find any evidence that Mr S ever showed a sustained low mood for as long as two weeks. However, in a clinic, assessments must be based on what clinicians are told and what was stated must be believed unless proven otherwise. At the time therefore, prescription of medication was reasonable.

11.10 On the evidence available, it is the view of the Independent Investigation Team that it was unlikely that Mr S was taking medication as prescribed when he was not in hospital. Mr S had stated that he did not like it and had reported

side-effects, including a note on a questionnaire from his earlier interactions that fluoxetine provoked seizures. In the final weeks leading up to the deaths of Victim 1 and Victim 2, Mr S was aggressively avoiding services so would be unlikely to comply.

11.11 Rapid withdrawal of antidepressants can precipitate a withdrawal syndrome, which would be possible with duloxetine but is less of a concern with mirtazapine. It can also lead to a recurrence of the original depression.

11.12 In relation to Mr S, it is the view of the Independent Investigation Team that neither of these was a concern. It was unlikely that there was a biological depression to recur. In the event that there had been, this would have become clear before 2 June 2010. Mr S clearly was not markedly depressed when he saw his GP. It is the view of the Independent Investigation Team therefore that Mr S was likely not taking the medication consistently enough to withdraw from it.

11.13 Treatment options for narcissistic personality disorder

11.14 There is no widely accepted evidence-based treatment for narcissistic personality disorder. NICE has not published any guidelines. Treatment of personality disorder depends on a shared understanding of the condition. It is essential therefore that professionals work in partnership with people with personality disorder to develop their autonomy and promote choice by;

- Ensuring they remain actively involved in finding solutions to their problems, including during crises.
- Encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make.

11.15 There is evidence that this approach had been commenced with Mr S. It is harder to apply this approach in cases of narcissistic personality disorder than with other types of personality disorder, as the collaboration involves doing what the patient wants, and there is little scope for reflection from the patient.

11.16 Psychotherapy

11.17 When treating narcissistic personality disorder, the prudent approach would be to request an assessment as to the individual's suitability for psychotherapy, which is the treatment most commonly given. Ideally, once psychotherapy is commenced, extreme caution must be taken not to delve too deeply as there is a real chance of non-engagement, resulting in making matters worse.

11.18 The most recent edition of the Oxford Textbook of Psychiatry (2012)[8] states:

[8] Carrasco JL & Lecic-Tosevski D. Chapter 4.12.3: Specific types of personality disorder *et al*. *In* New Oxford Textbook of Psychiatry Second Edition. Eds: Gelder MG, Andreasan NC, Loez-Ibor Jr JJ and Geddes JR. *Oxford University Press:* 2012

"Individual psychotherapy is aimed to the analysis of idealizing transference `and interpretation of self-grandiosity. However, during the first stages only supportive therapy is recommended with interpretations delayed until confident and integrated attachment with therapist is achieved.

The treatment of narcissistic individuals inevitably arouses serious countertransference problems, because of the detachment, demanding behaviour and devaluative actions of narcissistic patients. The therapist should have worked through his or her own narcissism and retain an empathic and non-judgmental attitude."

11.19 NICE guidelines state that personality disorders should be treated in the Community Mental Health Teams. However, it would also be prudent to seek an expert assessment and advice regarding management.

11.20 Usually, a narcissist would not be suitable for long-term psychodynamic psychotherapy. However, this should not preclude an attempt being made. This would be a very individual, personalised assessment. Here the clinical psychologist gave an opinion on Mr S's suitability for different types of psychotherapy and the different psychological approaches to be taken.

11.21 A difficulty presented by the nature of Mr S's condition and personality disorder for care providers was the nature of the treatment to provide him with. Mr S suffered from both depression and a personality disorder of the narcissistic variety. These presented in both short term crises, requiring crisis response for each episode on an ad hoc basis, and a more longitudinal personality disorder, requiring an attempt to address the cause of this on a longer term basis.

11.22 Whilst Mr S did not have anti-narcissistic personality disorder therapy, he did receive a considerable amount of help. It is the view of the Independent Investigation Team that the help which was given was appropriate.

11.23 <u>Risks of psychotherapy</u>

11.24 Generally, psychotherapists are reluctant to treat narcissistic personality disorders using psychodynamic psychotherapy. This is because there is little evidence that it actually improves the condition. In addition, there is considerable evidence that it actually worsens it. Mr S's notes themselves state Mr S appeared to deteriorate following the psychotherapy.

11.25 Often the common assumption is that discussing a problem and going deeper into it, will ultimately make the problem better. However, the chance of this happening in relation to Mr S was remote. It is more likely in the case of Mr S that doing this would actually have made matters worse.

11.26 Although, on the evidence available, the Independent Investigation Team cannot confirm that this was the approach taken by the psychologist, it is a

possibility that a CBT, rather than a psychodynamic, type approach was taken.

11.27 It is the view of the Independent Investigation Team that it is likely that had Mr S been referred for psychodynamic psychotherapy, the recommendation would have been an acceptance of the fact that he had a narcissistic personality disorder. However, it is possible that there would have been a refusal to apply the therapy in any event on the basis that it was too risky.

11.28 The ease of access to a psychotherapy opinion is a factor to be considered. The psychotherapeutic response nationally is varied. An issue to be considered would be staff availability for such specialist treatment. For the internal treatment, Mr S was seen relatively quickly. In most, if not all situations, Mr S seemed to have considerable involvement and continuity.

11.29 <u>Conclusions on the care Mr S received</u>

11.30 Psychiatric diagnosis is an active process in which symptoms and behaviour are evaluated against standardised criteria to arrive at a “best match”. In complex cases, the information needed to make a diagnosis is often incomplete, or requires a period of longitudinal evaluation. Further, a patient’s symptoms or presentation may change over time. Diagnosis, therefore, should be dynamic and be regularly reflected upon, reviewed, and refined.

11.31 The extent of the knowledge is that Mr S had a happy upbringing, was a professional golfer who lost his career and set up an art gallery. This gallery then failed around the same time he left his partner. Further, very little is known about his first partner.

11.32 Upon the realisation by care services of the possibility of Mr S suffering a personality disorder, greater effort could be made to define that disorder at the point of first detection. Services could have more thoroughly planned the options regarding treatment of the disorder. The disorder should be used as the driving force behind the management plan, and therefore, would require information and evidence to defend the diagnosis going forward. As a result, that diagnosis needs to be robust and well researched from the beginning.

11.33 Services did not seek information from third parties about Mr S. This may have been because they were only beginning to realise the need for such information. Services had not had the opportunity to formulate a plan. As will be discussed more fully in Juncture 1, a formalised CPA could have been helpful here, as could referral to the personality disorder service for advice and/or intervention. This would have been dependant on the existence of such a service in the area at the time.

11.34 The opportunity to obtain additional information could have taken place during the inpatient admissions. There is more flexibility in such a setting to contact relatives and carers.

11.35 There is no evidence of any instance in which Mr S sought help and was refused. In the instances where Mr S found himself in crisis, he received a response. Psychological treatment was offered. However, Mr S withdrew as he was beginning to be challenged by the psychologist.

11.36 It is the view of the Independent Investigation Team that Mr S received more treatment than many patients with personality disorders would have received. He had an appropriate response to crises. He was offered symptom focussed psychotherapy rather than analytical psychotherapy which was most likely the correct course of action to adopt. This treatment could have proven effective had Mr S taken advantage of it and engaged.

11.37 However, given that Mr S did not engage, there would be no point in taking it any further. It is therefore the view of the Independent Investigation Team that the care providers did not overlook the personality element relevant to Mr S's diagnosis.

11.38 <u>Good practice by services</u>

11.39 There is evidence of good practice by health services during the course of Mr S's care.

- Mr S received in-patient stays whenever he needed them.
- Alternative diagnoses were considered.
- There was a crisis team response.
- Mr S was offered appropriate medication.
- He was offered the chance to have psychotherapy.
- Attempts were made to engage him constructively between crises. It is likely more common that an individual would perhaps not receive much help in between separate crises.
- He was seen by a full trust consultant, not a locum visiting consultant.
- Mr S had multiple chances to engage where there was a formulation of his behaviour when in crisis - an individual in crisis would usually get only one chance to engage, and if they actively refuse it, as Mr S did, they are then unable to access services again because of the pressure on services.

11.40 Doing the absolute maximum for every patient could result in multiple second opinions and the situation can become confused. It is the view of the Investigation Team that Mr S received a good service overall in terms of care from the NHS.

12. THE RISKS MR S POSED WHEN ILL

12.1 The correlation between risk, predictability and preventability

12.2 The Independent Investigation Team has applied the paradigms of predictability and preventability set out at paragraphs 6.4 to 6.7 above to the events of 2 June 2010.

12.3 Predictive factors

12.4 The Independent Investigation Team recognises that if an individual has a history of violent actions then they are more likely to commit violent acts in the future. In most cases, the violence exhibited by an individual is likely to mirror the way in which they had been violent or aggressive before. This includes the group of individuals to whom the violence is directed.

12.5 Preventability

12.6 Care must be taken to try and avoid hindsight bias by attempting to imagine the position of one of the practitioners treating Mr S at the time, before the deaths occurred. Narcissists do not handle change well, or being moved down the hierarchy of importance. In this case, Mr S felt at the bottom of that hierarchy – the relationship had ended and there was a child on the scene, reducing Mr S's significance.

12.7 It is therefore, the view of the Independent Investigation Team that the deaths were neither predictable nor preventable.

12.8 What is of significance is what the police said regarding the presence of any risk to Victim 1 and Victim 2. The Independent Investigation Team considers that "using past behaviour as a predictor of future behaviour", it could be argued that it could have been predicted the news of Victim 1 being pregnant by her new partner would have produced some form of reaction in Mr S.

12.9 Judging risk in light of Mr S's lack of history

12.10 In situations where services are faced with a lack of history as to the individual's longitudinal mental health state, there is an increased likelihood of misjudging risk factors. This presents as the risk of care services viewing the individual's behaviour in terms of "that's just how he is", rather than "it's his depression".

12.11 This in turn can lead to the thinking of there being no actual cure for the condition, which, if communicated, can then further worsen the individual's sense of hopelessness.

12.12 Mr S's Risk to Others

12.13 The internal investigation notes the lack of response Victim 1 received in relation to her concerns when she stated that she did not feel safe with Mr S in December 2008 and would not let him look after Victim 2. This was not explored further, either in relation to her safety and her concerns relating to Victim 2, nor in relation to obtaining more info regarding a broader picture of Mr S's mental state.

12.14 That said, the Independent Investigation Team was of the view that over a ten year period, it was possible to envisage a situation that when Mr S was experiencing a crisis that he would commit or threaten to commit an act of self-harm. However, that level of foreseeability of risk could not be extended to an act of double homicide than a suicide because Mr S presented more with peculiarity than malice.

12.15 Further, there is no information on record of Mr S ever engaging in violence against another, or that he attempted to include another with him as part of a suicide attempt. Mr S had no forensic history of violence, weapons offences or stalking etc. until the deaths of Victim 1 and 2.

12.16 Risk to Victim 1

12.17 Victim 1's continued involvement with Mr S after their break up may have increased the risk to her, posing more danger to her than would have been if they had split up wholly. It may have been the case that Victim 1 was fearful, and wished to let down Mr S gently. In the week prior to the incident, Mr S had made threats against Victim 1, and was denied access because of those threats.

12.18 In many situations, people coerced by threats of suicide will accede for fear of feeling responsible for the consequences if they do not. This factor is exacerbated in this case because Mr S is the father of Victim 1's child, as it then brings in consideration of the child's needs.

12.19 The issue of safeguarding others applies in relation to Victim 1 as regards to the arrest information of two days after the s136 assessment. The police assessed Victim 1 to be at "high" risk of homicide on 28 May 2010. Victim 1 was not told of this.

12.21 Risk to Victim 2

12.22 As will be discussed later in this report at Juncture 1, it is the view that the lack of a formalised CPA in relation to Mr S was detrimental to the ability of the services involved in Mr S's care to share information, particularly that relating to risk and safeguarding issues.

12.23 The Independent Investigation Team has found evidence of instances (also depicted in the Trust's own internal investigation) as to situations where there was a lack of consideration relating to potential safeguarding in relation to Victim 2

- On **6 May 2008**, Mr S presented to his GP surgery with low mood, and was prescribed fluoxetine. He was referred to the CMHT and seen by them thereafter, before ultimately being referred to the CRHTS. Whilst there was no apparent deficiency in this chain of referrals, from a safeguarding point of view, it is concerning that the visiting midwife involved in Victim 1'a antenatal care was not made aware of any of the mental health problems that Mr S was experiencing.

- Similarly, in **June 2008**, Mr S was admitted to hospital for three weeks for assessment and treatment as a result of his increasing depression. The Independent Investigation Team could find no evidence in the records that those involved in the antenatal care of Victim 1 (and therein, Victim 2) had any knowledge of this.

- The health visitor involved both antenatally with Victim 1 (and therein victim 2) and *post*natally as of **July 2008** was never made aware by other services involved with Mr S of his mental illness. It is therefore conceivable that had the visitor been aware of this, safeguarding issues in relation to Victim 2 would have been raised.

12.24 The Independent Investigation Team considers that such contact could have raised awareness of potential problems for Victim 1, and given her the opportunity to express any concerns for her safety, and therein, that of Victim 2.

12.25 <u>Limitations of formalised risk assessments</u>

12.26 FACE assessments do not include the impact that personality traits have on risk. In cases of individuals who are emotionally closed, narcissistic or feeling they are special, the risk profile is changed, and yet FACE format of risk assessment does not capture or recognise the differences caused by this.

12.27 FACE forms run the risk of turning the assessment into a tick-box exercise, rather than the intended consideration of aspects of personality. According to the tick-box FACE form, with the exception of citing some suicidal thoughts and the incident of climbing a building in Spain and threatening to jump (which he stated he could not remember), Mr S presents as low risk.

12.28 As will be discussed later in the report, nowhere are the features identified by the police for bringing Mr S for the s136 assessment identified. Secondly, there is the question as to whether services were aware that Victim 1 had informed services Mr S was going to go into the lake.

12.29 This was again, information that was not picked up on prior to the Mental Health Act assessment on 11 March 2010. There was a suicidal ideation when Mr S presented to casualty at that time. The section 2 did not proceed because he came in informally. This admission was on the basis of profound self-neglect.

12.30 It is the view of the Independent Investigation Team that FACE-type risk assessments, if correctly completed, can provide a rapid, 'at a glance' indication of areas to explore if a service user is being assessed by unfamiliar professionals, but they do not take into account the dynamic aspects of the patient's circumstances: the social, cultural, financial, emotional and domestic circumstances surrounding the feared/predicted action.

12.31 Conversely, if those elements are incorporated into the risk assessment, it can become so cumbersome that it is not utilised.

12.32 Suicide risk to Mr S

12.33 More information regarding the collateral history and more narrative in relation to his personal history and lifestyle would have been helpful. The care services did consider the situation and note it. Overall, Mr S was most likely an individual of moderate risk to himself.

12.34 The Independent Investigation team considers that the internal enquiry's criticism of the decision to inform Mr S he would not be having further therapy, on the basis that it "should have been predictable" and he would react badly, is ill-founded.

12.35 It was conceivably reasonable to explain to Mr S the decision to desist with the psychotherapy given his difficulty engaging with it. It is also reasonable that this was done clearly and explicitly to avoid misrepresentation.

12.36 The issue of safeguarding Mr S himself is also relevant, in relation to the issue of self-harm and suicide risk, although the "safeguarding" issues in their truest form apply to Victim 2 and Victim 1.

12.37 Conclusions

12.38 The Independent Investigation Team has concluded that it was predictable that Mr S could carry out an act of self-harm in the midst of a crisis. This possibility was highlighted in Mr S's records regarding the rooftop incident in Spain, and alluded to in relation to the "note" he allegedly wrote and incident at the lake. Consequently the Independent Investigation Team believes that an act of self-harm was predictable should Mr S go into crisis and fail to engage with services.

12.39 However, the Independent Investigation Team is of the view that an attack such as that carried out upon the victims could not have been predicted.

13. THE DIFFICULTY IN APPLYING A LONG-TERM PERSPECTIVE OF CARE

13.1 Mr S had a complex presentation which required the involvement of a number of services. The complexity of Mr S's presentation suggested that his need for care would endure, and that a number of services would need to be involved.

13.2 It is the finding of the Independent Investigation Team that Mr S generally received a good standard of treatment from services. One of the principle difficulties in the treatment of Mr S was that the nature of his engagement with services made it very difficult to plan his treatment over a long term basis, which in turn, had the effect of denying services the opportunity to fully explore the personality disorder with which he presented.

13.3 The NHS approach to managing "complex" individuals

13.4 Within NHS provision, individuals with complex health issues may be managed across multiple services throughout their episodes of care. The involvement of multiple teams in the provision of mental health care has increased greatly in recent years with the development of functional teams (e.g. Home Treatment Teams, Acute Inservice User Care Teams and different types of Community Mental Health Teams, including Community Drug Teams) that focus on a particular stage of the service user's care and treatment.

13.5 Whilst this has advantages, (for example it allows a greater number of service users to receive the appropriate level of specialised care to meet their needs), there is a danger that it can lead to a loss of a long-term, "overview" perspective in care delivery, with each team concentrating on the particular function of that part of the service, and not considering the overall course of care over the endurance of the service user's illness. Simply put, the cog, so busy with its own performance, does not know the overall function or purpose of the machine.

13.6 The additional disadvantage is that information is not brought together in order to a allow a "joined up approach" to be taken towards the individual's recovery.

13.7 Mr S's Care Programme Approach

13.8 In this case, Mr S was receiving an offer of psychological help between crises, as well as the immediate crisis response, which, the Investigation Team considers would be the correct response. The correct format would be to respond to the crisis to hand, give sufficient time for things to settle down in relation to the aftermath of that crisis, and then engage in longer term work to attempt to prevent the likelihood of the crisis occurring again in future.

13.9 When Mr S was self-neglecting, low in mood and at his most distressed, considerable effort was made to assist him in the form of liaison teams, crisis

teams, consultant psychiatrists and admissions. There was an attempt to strike when the iron was cold and assist after he had come out of crisis, offering him reasonable psychological input.

13.10 Mr S's history of abrupt "disengagement" from services

13.11 Throughout Mr S's history, there were periods of disengagement from services, most recently from March 2010 onwards. It is the view of the Independent Investigation Team that Mr S's refusal to engage in his treatment and repeated tendency to disengage from services throughout the course of his treatment severely limited the options available to mental health services in terms of treating his condition.

13.12 Services made good attempts to engage within the confines of the mental health legislation, and when services reached impasses as a result of Mr S's disengagement, thorough letters soliciting contact and defining the end of his care due to non-engagement were issued.

13.13 The missed opportunity to utilise those close to Mr S in the management of the CPA

13.14 It is the view of the Independent Investigation Team that one of the systemic missed opportunities of care services in the treatment of Mr S was the lack of formal involvement of Victim 1 and Mr S's sister in the management of the CPA, as will be considered in Juncture 2.

13.15 This lack of formal involvement of Victim 1 and Mr S's sister in consideration of Mr S's presentation during a time when that presentation was deteriorating was absolutely crucial. Victim 1 and Mr S's sister had valuable information and insights into his mental state which would have warranted exploration, had that information been elicited.

13.16 The Independent Investigation team considers it would have been useful to have more narrative about Mr S and his past, and also to have substantiated this more with information by speaking to individuals who knew him closely, and over a term of years.

13.17 This is further highlighted by the fact that two months prior to the deaths, during a time when services were attempting to reformulate Mr S's care, his sister had contacted the community team attempting to speak with them about Mr S, but was never called back. This could be viewed as a missed opportunity, although a call back would raise issues of confidentiality.

13.18 Good practice

13.19 Services should be commended on the flexibility with which they approached elements of Mr S's care during this period as he received a virtually immediate crisis response whenever he required one.

13.20 It is the view of the Independent Investigation Team that the problem in this case is that Mr S did not engage between crises. No "remedial work" was capable of being performed in between crises, and this was more a case of Mr S refusing the help being offered, than the help not being there in the first place.

14. THE SECTION 136 ASSESSMENT

14.1 Approximately one week before the tragic events of 2 June 2010, Mr S's mental state was assessed by services under section 136 of the Mental Health Act. The purpose of this assessment was to ascertain whether or not Mr S was *legally capable* of being detained at that point, following unusual behaviour.

14.2 At this assessment, Mr S was found incapable *at law* of being detained under the Mental Health Act, having failed to meet the requisite standard proscribed by the legislation.

14.3 Background

14.4 On 26 May 2010, services directed that a joint assessment be performed the next day. The Independent Investigation Team considers that this may be viewed as a risk when there is no prior knowledge of the individual.

14.5 Victim 1 had made a telephone call informing that Mr S had "been by the lake", had gone into the lake, and had alleged it was too shallow, but that he could not cope any longer and wanted to end his life. Victim 1 also informed that Mr S had stated he had written a suicide note. He then refused to get out of her car, at which point Victim 1 had called the police.

14.6 The intervening s136

14.7 At approximately 17.00 on the evening of 26 May 2010, Mr S was brought, by car, to the car park of the police station by Victim 1. Victim 1 had concerns for Mr S's mental health given her knowledge of his history of mental illness, things he had said to her that day (i.e. that he had written a suicide note and gone to the lake), and his refusal to get out of the car, prior to them attending the police station.

14.8 Mr S was taken by the police to hospital for the assessment under s136 of the Mental Health Act.

14.9 Section 136 assessments

14.10 A section 136 Assessment is an emergency response Mental Health Act assessment, and is, by its nature, done in a hurry. Whilst it is always preferable to access notes and scrutinise history before any Mental Health Act assessment, there could be repercussions if this accessing of information were to delay the s136 assessment.

14.11 The nearest relative of the patient would be legally defined in any event, and carers and other potential sources of collateral history information are not always available at the immediate time of the assessment, for example, if the

assessment were to occur at 03.00. As a result, it is not realistic to expect a full collateral history at a section 136 assessment; it is an emergency response.

14.12 The procedure to be followed for a s136 Mental Health Act assessment

14.13 The main purpose of s136 Mental Health Act assessment is to determine whether the patient is suffering a mental illness which *warrants a section 2 application* for their detention under the Mental Health Act. It is a 2-stage assessment:

Stage 1:

- Patient is arrested in “public place” and brought to “safe place/place of assessment”. 72 hour detention clock starts running.
- S136 form completed by arresting officer on arrival at the “place of safety”, signed by the officer, and then countersigned by the “bleep holder” at the place of safety, effectively receiving the patient handover from the police officer.
- Approved Medical Professional meets patient, explains it is an assessment under s136 and what that constitutes. The “Mental Status Exam” commences the moment first contact is made with the patient.
- Patient informed of purpose and nature of assessment. Patient given a leaflet informing them of their rights. Patient is made aware the assessment could result in an application for mandatory detention.
- S1 & s12 Approved Psychiatrist; AND, an Approved Mental Health Worker (AMHP - formerly “social worker”) – perform joint assessment. The psychiatrist performs the assessment and makes a *recommendation* to detain, the AMHP observes, notes and determines whether or not to make an *application to* detain, based on the psychiatrist’s assessment – they have different roles in assessment. The AMHP is not bound by the opinion of the psychiatrist in making their decision. Usually, the psychiatrist does not make notes of the assessment. The AMHP would complete the AMHP sheet, as required under the Act.
- The assessment must follow statutory criteria to consider how the patient’s mental health is “presenting” *at that time*, and examines appearance, grooming, eye contact, speech, motor function and retardation etc. amongst other things.

14.14 If the patient *does not* meet the statutory criteria for detention -

- In the event that the AMHP feels that the patient does not meet the standard proscribed by law for detention, the patient cannot be detained under the Act. However, a number of other things may follow anyway, including a care plan or referral onto other services. The AMHP can immediately refer people to the crisis team if deemed necessary, or own care team, or tranquilisers.

Stage 2 - if the patient *does* meet the statutory criteria for detention at stage

- If the AMHP decides that the patient does satisfy the criteria required by law for detention, they will then go onto make an application to detain under s2 of the Mental Health Act. In this event, the Psychiatrist who performed the assessment completes a history sheet, noting their findings in assessment, and makes a recommendation as to whether the patient is to be detained under section 2 or 3 of the Mental Health Act. It is at this point, and only at this point, a second Psychiatrist, also S1 & S12 approved, must also assess the patient (as required by s2(3) MHA 1983), and, upon the application to detain by the AMHP, and the concurrent opinion of this 2nd Psychiatrist, the patient may be detained as per the mental health act.

14.15 Mr S's s136 Mental Health Act assessment

14.16 Mr S was informed of his rights and the possibility that the assessment may result in his detention. Services performed a formal "assessment of mental status examination", as per s136.

14.17 In evidence given at the Coroner's Inquest, Mr S appeared "kempt", acted appropriately to introductions, and did occasionally maintain eye contact. Mr S

"appeared calm, co-operative and articulate, and did not appear agitated. His speech was normal in tone, volume and rhythm, and there was no reaction time. Mr S stated he was not happy, but appeared of "normal" (euthymic), not high or low, mood. There was no psychomotor retardation".

14.18 The lack of risk background at the s136

14.19 At the s136, services decided events were not seen to be a "serious suicide attempt", which therefore contributed to the decision not to detain.

14.20 It is entirely conceivable that Mr S underwent a thorough, robust assessment which considered all factors and concluded he was not suicidal. This is consistent with much of Mr S's behaviour – he said he was going to kill himself to Victim 1 and then changed his mind, or, he never intended to anyway.

14.21 Focus would be given to the nature of the planning and the intent. Therefore, there needs to be considerable inquiry into the events surrounding the planning of the incident (although it is always possible that an individual of an impulsive disposition can commit suicide with very little planning in the heat of the moment). More important would be the intent and the motive behind the actions, in which instance care providers should be exploring feelings of hopelessness and future planning.

14.22 Also considered would be “final acts” – evidence of the individual closing their affairs and then spending time planning an attempt in which they would never be discovered, demonstrating the belief that nothing can change their mind, and that the future is dreadfully hopeless. The individual then makes an attempt and has a near miss. This kind of behaviour would be analysed as a serious attempt. Therefore factors considered in a thorough and competent assessment would be things like features of the mental state, features of the history of the attempt, changes from previous attempts etc.

14.23 <u>The results of the s136 mental health act assessment</u>

14.24 Services felt that Mr S did not meet the stipulated statutory criteria required to then go on and make an application to detain under s2 of the mental health act, and Mr S was discharged as he was classified as “not detainable”. As the statutory criteria were not made out during the assessment, Mr S could not be lawfully detained, and therefore the AMHP could not make an application to detain. A patient cannot be detained on “risk” alone.

14.25 Because no application to detain was made as a result of the s136 assessment, there was no requirement to invoke the use of a second Psychiatrist to perform an examination pursuant to s2, as per the Mental Health Act.

14.26 As soon as the assessment was completed, and Mr S was found “not detainable” and discharged, the AMHP proceed to write up his assessment notes. This was approximately 19.00. In his report, he noted that neither he, nor the Doctor, felt there was any evidence of a “significant risk” present (as per the Children Act), to make the matter one of child protection or social services (N.B. both made clear that had there have been any such evidence, they would have immediately involved the relevant services by telephone)

14.27 Further, as a result of their observations during the assessment, they did not feel any further immediate action was required to be completed at that time, although the AMHP did make reference to the fact that the s136 assessment was something services needed to be aware of in relation to the broad overview of Mr S’s care plan going forward.

14.28 It is the view of the Independent Investigation Team that the internal investigation was correct in its finding that the s136 team did not need to take any further action.

14.29 <u>The dissemination of the s136 assessment conclusion</u>

14.30 Once the AMHP had completed the s136 assessment form that evening, as per practice, he did not immediately fax his findings on (faxes at night time are not used because it presents confidentiality issues re faxes lying on recipient fax machines overnight), but instead left the report along with instructions to

fax it first thing in the morning. This was done the next morning, and the results of the s136 assessment were sent to:

a) The Amber Valley Team.
b) Mr S's GP Surgery.
c) The crisis team (which the AMHP also informed in person the next day as he was working with them).

14.31 Conclusions

14.32 Whilst the section 136 assessment represented a point in time at which a very clear demarcation line in Mr S's behaviour and a shift in his stance took place looking back with hindsight, at the time of that assessment, services cannot be faulted for not being aware of information contained in police records that had not yet even been written.

Comment two

A practitioner would need to be sure not to admit Mr S, and therefore it is conceivable, given the fact that the 2 practitioners present were very experienced, there would need to be a good reason not to admit.

The fact that the s136 documentation has no *proviso* to make a recommendation on the appropriate form of follow up could be construed as a deficiency in the pro forma documentation. Here, the management plan section stated "no follow up" by the Crisis Team.

The s136 assessment was, in terms of Mr S's mental healthcare, absolutely pivotal - Prior to the assessment, whilst difficult to treat, his behaviour is something of a nuisance more than anything else. After the assessment, his behaviour begins to change significantly. His presentation changes; then the threats to kill appear, followed by the deaths.

It is the view of the Independent Investigation Team that the s136 pro forma documentation is potentially deficient. One of the consequences of this was a failure to trigger the appropriate community package of care, or even modify the community package of care.

15. JUNCTURES

15.1 As has been shown, Mr S was an individual who had repeated involvement of crisis engagement, but then only engaged beyond the crisis service on his terms. This behavioural pattern posed a number of challenges for those involved in his care, including Victim 1 and his sister, as a result of his significant psychological and social needs.

15.2 As mentioned above, the Independent Investigation Team was asked to construct a timeline of Mr S's care from December 2007, as at Appendix 4.

15.3 The Independent Investigation Team used that timeline to identify a number of "junctures" or significant factors in Mr S's care, some of which could potentially have taken a different path, had organisations/clinicians made different decisions. This is intended to act as a prompt to allow reflective practice and unlock learning.

16. JUNCTURE ONE – MISSED OPPORTUNITIES AS A RESULT OF THE LACK OF A "FORMAL" CARE PROGRAMME APPROACH

16.1 Whilst Mr S was clearly subject to a form of CPA, i.e. he had a care coordinator, there were some CPA meetings, there was evidence of inter service communication etc., the Independent Investigation Team does not consider that the CPA was *formally* followed in relation to Mr S. This represented a missed opportunity in relation to Mr S's care in several regards.

16.2 Specifically, and most significantly, there was no formal CPA meeting on communication between the various services involved in Mr S's care, which not only resulted in a lack of a consistent long term management plan, but detrimentally affected information sharing between services, and therein, potentially affected risk analysis.

16.3 Furthermore, there was no evidence of formalisation of a CPA in relation to Victim 1's role and potential utility as a formal "carer", or in relation to Victim 1 and Mr S's sister as valuable sources of information.

16.4 This Juncture will consider the missed opportunities in the CPA paradigm in Mr S's case in their own right, but will also highlight the way in which the other Juncture in this report interconnects with that flawed application of the CPA ethos.

16.5 <u>The Care Programme Approach (CPA)</u>

16.6 The CPA is a national framework for mental health services' assessment, care-planning, review, care-co-ordination, and service user and carer involvement focused on recovery.

16.7 If used as it was intended, i.e. to work with service users and carers to make an assessment, establishing care and support needs, it can be a significant asset to the delivery of care. However, if followed incorrectly, the CPA can become a meaningless exercise. In this case, whilst teams were communicating, the CPA lacked the formal elements.

16.8 Contained within Mr S's medical records is a volume of documentation generated by the CPA process which is intended to ensure that the essential aspects of the CPA are included in his care.

16.9 <u>The method of the Care Programme Approach</u>

16.10 The entire ethos of the CPA is recognition of the fact that in complex individuals, various and multiple services will be needed, and will need to work to the same plan and with the same objective.

16.11 Care of people with complex mental health needs requires consistent and coordinated working between agencies and disciplines, including criminal justice, primary and secondary care.

16.12 Mr S's Care Programme Approach

16.13 It is the view of the Independent Investigation Team that an *informal* CPA was followed in relation to Mr S. Mr S had a care coordinator, and was receiving "coordinated" care. He had named workers from CMHT, housing, general practice, and psychology, and all were in regular contact with Mr S and Victim 1. Liaison between services was generally good here, and they were tackling a primary diagnosis of depression. The team did seem to have full Multi-Disciplinary Team (MDT) CPA meetings, including Mr S and Victim 1.

16.14 The appropriate teams engaged him to the extent that resources allowed for with someone who did not want to engage and could also present as "well". Furthermore, CMHT records show a consistent attempt by services to engage, and Mr S received hospital care and psychological input when he wanted to engage.

16.15 It therefore, cannot be said that services did not adhere to a CPA. However, it is the view of the Independent Investigation Team that a failure to pursue a formal adherence to the ethos of the CPA was evident. For example, Mr S had no CPA care plan, which is clearly an instance of a lack of a formalised CPA.

16.16 The failure of adherence to the ethos of the formalised Care Programme Approach in Mr S's case

16.17 It is the view of the Independent Investigation Team that by failing to apply a formalised CPA, services missed opportunities to adhere to the ethos of the CPA throughout the care of Mr S.

16.18 Examples of the missed opportunities for CPA policy tasks and structure that were missed:

- Involve the person in agreeing and writing the care plan as much as possible.
- Give them an opportunity to sign their care plan.
- Give them a copy of their care plan, review notes etc.
- Ensure that a systematic assessment of the person's health and social needs is carried out initially, and again when needed (including an assessment of risk and any specialist assessments)
- Be familiar with past and current records about Mr S, both paper and electronic.
- Ensure that a care plan is produced and sent to all concerned, including Mr S and G.P. For lead professionals, this will be in a letter.

- Ensure that crisis and contingency plans are formulated, updated and circulated as part of the care plan. For those who do not need CPA, this may be a “contact card”.
- Identify any informal carers providing support, ensure their needs are assessed if necessary, and review this at least annually (see the Carers’ Assessment Policy for more information).
- When organising a review, making sure that all those involved in Mr S’s care are told about them, consulted, and informed of any outcomes.

16.19 It is the view of the Independent Investigation Team that this lack of “formality” in the pursuit of a CPA resulted in a series of missed opportunities for services in relation to his care;

16.20 Information sharing and safeguarding

16.21 It is the view that the lack of a formalised CPA in relation to Mr S was detrimental to the ability of the services involved in Mr S’s care to share information, particularly that relating to risk and safeguarding issues.

- On **6 May 2008**, Mr S presented to his GP surgery with low mood, and was prescribed fluoxetine. He was referred to the CMHT and seen by them thereafter, before ultimately being referred to the CRHTS. Whilst there was no apparent deficiency in this chain of referrals, from a safeguarding point of view, it is concerning that the visiting midwife involved in Victim 1’a antenatal care was not made aware of any of the mental health problems that Mr S was experiencing.

- Similarly, in **June 2008**, Mr S was admitted to hospital for three weeks for assessment and treatment as a result of his increasing depression. The Independent Investigation Team could find no evidence in the records that those involved in the antenatal care of Victim 1 (and therein, Victim 2) had any knowledge of this.

- The health visitor involved both antenatally with Victim 1 (and therein victim 2) and *post*natally as of **July 2008** was never made aware by other services involved with Mr S of his mental illness. It is therefore conceivable that had the visitor been aware of this, safeguarding issues in relation to Victim 2 would have been raised.

- On **1 June 2010** (the day before the incident), Victim 1 contacted the Amber Trust to update them on the involvement of the police and the threats to kill. The Independent Investigation Team could find no evidence that this information was ever shared with other services. This may have altered recognitions and designations of the risk Mr S posed at that time, had it been shared, although it is impossible to speculate on the likelihood of this occurring within a 24 hour period.

16.22 Mr S's multiple sets of notes and lack of formal Care Plan

16.23 Mr S had seven different sets of notes compiled between various services. As a result of an informal CPA, there was never produced a formalised written care plan. The consequence of this was increased difficulty in compiling information between the services and extensive duplication.

16.24 It is the view of the Independent Investigation Team that not only would a unified set of notes and written Care Plan, pursuant to a formalised CPA, have reduced the chance of potentially important information (for example that regarding safeguarding issues), being overlooked, but may also have improved services' responsiveness in terms of a review of diagnosis.

16.25 Victim 1's recognition as a "carer"

16.26 The National Carer's Strategy[9] defines a "carer" as;

"someone who spends a significant amount of their life providing unpaid support to family or potentially friends, caring for a relative, partner or friend who is ill, frail or disabled or has mental health or substance misuse problems",

16.27 whilst the Care Standards Policy and Procedures and CPA of the Trust recognise that;

"Informal carers who provide substantial and regular care for mental health service users will be identified and supported appropriately".

16.28 As described previously in this report, even after their *romantic* involvement ended in late summer 2008, Victim 1 continued (for a period of over 18 months) to act in a support role for Mr S in many regards. Victim 1 transported Mr S around, provided him with groceries, allowed him to stay with her when he was without accommodation and repeatedly and consistently contacted services in relation to his wellbeing regarding his mental health.

16.29 It is the view of the Independent Investigation Team that, on the evidence, Victim 1 should have qualified as a carer under the above definition. However, Victim 1 was never formally designated Mr S's carer. As a result, she and her needs for assistance in this capacity were never formally assessed, and therefore, never met.

[9] 2008.

16.30 Mr S's Care Programme Approach meetings

16.31 One of the essential functions of a CPA meeting is to make a service user feel that their needs are fully understood and the proposed care plan adequately addresses all those needs. The meeting ensures that all those involved in the care plan are aware of their individual roles and responsibilities. In addition, the purpose of a CPA meeting is to ensure a multi-disciplinary approach**.**

16.32 A CPA meeting with all involved parties therefore could have led to a number of opportunities for Mr S, Victim 1, his clinicians, alongside the police to review progress and address concerns. Whilst the Independent Investigation Team readily acknowledges that Mr S was indeed subject to at least one CPA meeting, the most recent was recorded as 30 June 2009, almost one year prior to the events of 2 June 2010.

16.33 The transfer between teams

16.34 The transfer from Clay Cross to Amber Valley was deficient. The transfer of a care coordinator from one team to another is usually done via the CPA, with a formal CPA meeting. That did not happen in this case (although the Independent Investigation Team does not consider that this deficiency affected the outcome).

16.35 The failings regarding Victim 1 and Mr S's sister's involvement in relation to Mr S's Care Programme Approach

16.36 It would have been encouraging to see the implementation of a plan to explore the relationship between Mr S, Victim 1 and Mr S's sister. This would have allowed an assessment of supports in a protected and non-judgemental environment as a means to better understanding Mr S's illness. Both Victim 1 and Mr S's sister were potentially excellent sources of information in relation to Mr S's present mental state and longer term history of presentation to services and reactions to life events.

16.37 This point will be discussed extensively in Juncture 2, although it is worthy of note here, as their lack of inclusion represents a missed opportunity stemming from services lack of a formalised CPA in relation their handling of Mr S's care.

Comment three

The components of the service clearly worked together pursuant to the informal CPA applied to Mr S, as discussed. However, as has been shown, it is the view of the Independent Investigation Team that a formalised adherence to the ethos of the CPA would have allowed services to develop a comprehensive management plan as envisaged by the CPA which would have addressed relapse prevention strategies, crisis planning, psychological approaches and support for the family.

In so doing, more harm reduction measures could have been employed, Victim 1 and Mr S's sister could have been involved better, and the risk to Victim 2 as raised in the SUI review could have been disseminated to the teams involved in Mr S's care.

Recommendation one – Ensuring *formal* adherence to the Care Programme Approach:

1. Whilst the Independent Investigation Team acknowledges services were responsive (providing Mr S with both psychology and admission whenever required), they did not follow a formalised CPA process and were not able to obtain as full an understanding of Mr S as they might have.

2. The ethos of the CPA should be reflected and strengthened in the training programmes staff are required to attend, and the priorities identified in individual and group supervision.

3. Caseload management supervision should include routine review of all cases to ensure the appropriate applications of the principles and ethos of the CPA have been addressed, and to enable corrective action to be taken if required.

4. The implementation of this Recommendation should be monitored by periodic audit.

5. The Trust's CPA policy and auditing of that policy should ensure that Care Plans reflect the ethos of CPA in order that current psychiatric, social, family circumstances and risk characteristics of service users are addressed, and that individual service user centred care can be delivered.

6. Management supervision of caseloads and coordination via the CPA must be enforced effectively. CPA and caseload reviews must be used. These pre-existing processes must be used more effectively. The effective implementation of this Recommendation should be monitored.

17. JUNCTURE TWO: MISSED OPPORTUNITIES TO PROPERLY INCLUDE VICTIM 1 AND MR S'S SISTER IN MR S'S CARE

17.1 It is the view of the Independent Investigation Team that there were missed opportunities in relation to the lack of a formalised CPA as shown in the previous Juncture.

17.2 However, arguably the most significant missed opportunity by services in relation to Mr S's care related to their utilisation of Victim 1 and Mr S's sister in obtaining information relating to him and his condition.

17.3 As has been described, notwithstanding Victim 1's knowledge of Mr S, his condition and his behaviours over a period of years by virtue of her historic *romantic* involvement with Mr S, even after this romantic involvement ended, Victim 1 still retained extensive insight into Mr S by virtue of her continued involvement with Mr S as, at the very least, an *informal* carer.

17.4 Mr S's sister, although not living in the locality during the relevant period, also had involvement with services in relation to Mr S, and was a potential wealth of information, so desperately lacking, in relation to Mr S's earlier life and longitudinal mental health history.

17.5 It is the view of the Independent Investigation Team that neither "source" of potentially vital information was used to their full potential in this regard in relation to Mr S's care, reflecting a missed opportunity by services to increase much needed knowledge of Mr S's longitudinal condition.

17.6 The challenges involved for "carers" of those suffering mental illness

17.7 Close involvement with an individual who has a severe mental illness can be challenging[10].

17.8 Following initial diagnosis, carers/families may be ill-prepared to cope, knowing little about what to expect, except for ideas based on unhelpful and stigmatising stereotypes. They have to learn as they attempt to deal with a variety of services in order to navigate the various pathways which can provide their loved one with the help and care they need[11]. However, this can be a difficult and at times frustrating process. The challenges can prove overwhelming and can be difficult for a carer to cope with.

17.9 The role of mental health services in assisting families

17.10 It is of fundamental importance, that the professionals who work with the carers of individuals with disabling conditions demonstrate a genuine understanding of what it is like to live with a severe mental illness, and try to connect with this experience when carrying out their duties.

[10] NICE guidance CG178 Ch 2.4
[11] NICE guidance CG178 Ch 2.4

17.11 The reason for this is to ensure that the opportunity which they represent for clinicians as a resource (and means of significant knowledge in relation to the individual who is ill), can be fully utilised.

17.12 <u>The potential value of familial input into a service user's care</u>

17.13 Carers/family members can play an important role in helping in recovery. In particular, the attitude of carers towards the person, and how they understand and react to the person's experiences are very important.

17.14 There are two important aspects to this. The first is that carers and relatives may find dealing with some of the problems that can be associated with mental illness experiences frustrating and difficult, and therefore require support.

17.15 The second reaction is that carers/families may find the problems experienced by their loved one to be very upsetting, and therefore they try to look after the person intensively. This also creates difficulties for the "carer" and the unwell individual.

17.16 <u>The "carer dynamic" in Mr S's case</u>

17.17 In this case, Victim 1 held vital information about Mr S's presentation that clinicians did not have. There was a correlation between declines in Mr S's mental health, and increased reporting of disharmony by Victim 1. She reported increased concern about Mr S at times when he was experiencing more notable symptoms.

17.18 Mr S's deterioration was closely correlated with the breakdown of his relationship with Victim 1, which further exacerbated his deterioration. This was brought to the attention of clinicians repeatedly by Victim 1, particularly in the early years of involvement with mental health services.

17.19 <u>The position taken by services in relation to the involvement of Victim 1 as a "carer"</u>

17.20 As shown above in the previous Juncture, services' failure to recognise Victim 1 as a formal "carer" was of potential significance. Throughout Mr S's illness, it was apparent to the Independent Investigation Team that he received considerable support from Victim 1; however the inclusion of carers (and potentially therefore, *where applicable,* family members) in the care of service users was not part of an embedded culture within the organisation.

17.21 It is clear that Victim 1's role as a "carer" was informally recognised. However, there was lack of clarity pertaining the criteria used for assessment, following which she was declined status as a *formal* carer, resulting in the absence of

any formal support network being put implemented Victim 1 to assist in this regard.

17.22 The position taken by services in relation to the involvement of Victim 1 as a source of information

17.23 It is the view of the Independent Investigation Team that services were involved with Victim 1, responding well when she contacted them, and engaging with her despite the fact she was not involved or living with Mr S. The Investigation Team is also cognisant of the fact that, as a result of Mr S's pattern of non and disengagement, contact between Victim 1 and services was sporadic.

17.24 However, whilst the CMHT notes show them to be in regular, good contact with Victim 1, and that she was not "shut out", it is also clear from a detailed consideration of Mr S's notes that, despite repeated instances of Victim 1 raising concern for Mr S's behaviour, little consideration seemed to be given to her views, nor was there any documented attempts by services to contact her.

17.25 It is acknowledged by the Independent Investigation Team that services "listened" to Victim 1 when she offered information. However, accounts given to clinicians by Victim 1 of Mr S's behaviour and its impact upon her and Victim 2's lives were not *actioned*. Statements made by Mr S at a time when he was clearly unwell were accepted as fact and no attempt was made by those responsible for his care to establish the true facts of the situation.

17.26 There is no evidence that there was any independent attempt to explore how Victim 1 was coping or what else she might add by way of corroboration to flesh out the picture. The logical thing would have been for Victim 1 to have been interviewed and then that would have given a lot of corroboration. Half an hour with her might give invaluable information.

17.27 The position taken by services in relation to the involvement of Mr S's sister

17.28 On 5 and 8 March 2010, services visited Mr S at his home, and observed movement inside his residence, but despite repeated attempts to communicate with Mr S, received no response from him and ultimately had no choice but to leave.

17.29 On 9 March 2010, Victim 1, concerned for Mr S, had called his sister, and they both attended on Mr S at his residence. Mr S refused them entry and would not speak with them. They attempted to communicate with Mr S through the letterbox, but he would not respond. Approximately 10 – 15 minutes later, the Crisis Team (accompanied by Mr S's care coordinator) arrived at the house. Mr S did not engage with them.

17.30 Mr S's sister introduced herself to the team and informed them that they all needed to make entry into Mr S's property. The crisis team informed her that they were legally unable to do that, and if Mr S would not engage with them or allow them entry, they could do no more in that instance. The crisis team then left.

17.31 Mr S's sister and Victim 1 then left Mr S's residence, went to a supermarket, bought a supply of groceries, returned to his residence, and informed him, through the letterbox, that they had left him food on the door step. Eventually, they left.

17.32 On 10 March, Mr S's sister called Mr S's care coordinator 3 – 4 times looking to speak with him regarding Mr S. Mr S's care coordinator was busy when Mr S's sister called, but Mr S's sister was informed that he would return her call when able. Mr S's sister, aware of the rules regarding patient confidentiality, informed services she did not wish to discuss "her brother", she wished to discuss her "*concerns about* her brother", i.e. provide information to services regarding Mr S. Mr S's sister's calls were never returned.

17.33 <u>The potential value of better involvement of Mr S's family</u>

17.34 Collateral histories are sometimes used to obtain information from family/carers at key points in a service user's care, in order to give clinicians an opportunity to formulate an accurate assessment of the individual's problems. There are no indications that anything other than a brief attempt was made to obtain the views of Victim 1 or Mr S's sister concerning his condition, which highlights some of the issues which can arise as a result of a failure to take a collateral history.

17.35 If the views of these individuals had been obtained prior to May 2010, then there would have been more insight into his mindset, clarification of previous indicators and the risks he might have presented as a result.

17.36 In addition to obtaining this practical information, a robust consultation of this nature would have also gone further towards ensuring that Victim 1 and Mr S's sister felt that they had a significant input into Mr S's care, and that they had had a chance to articulate the strain which they were under, and obtain appropriate offers of support.

17.37 <u>The adverse impact of services' approach to Victim 1 and Mr S's sister's involvement</u>

17.38 This appears to have impacted adversely upon how Victim 1 and Mr S's sister were heard and, indeed, regarded going forward. Given that they held vital information about changes in Mr S's behaviour, historical risks and indicators, this was disappointing.

17.39 In Mr S's sisters own words after the incident when speaking of her insight in relation to the assistance she could have afforded services;

"None of the people involved with my brothers case ever asked his family for an insight into Mr S, if they had they could of approached Mr S differently…I could have given them so much information about Mr S…

I tried on several occasions to speak with Mr S's care team not even a returned phone call …."

17.40 The information could have held important insight relevant to his ongoing care and potentially regarding ways to manage the threat which he posed to himself and others. It could also have provided information which would have allowed a greater degree of support for Mr S, Victim 1 and Mr S's sister as they coped with his disabling condition.

17.41 There is no evidence that those responsible for Mr S's care made any attempt to actively seek engagement with Victim 1 or Mr S's sister as Mr S's mental health was deteriorating. This is particularly remiss given that it was Victim 1 who had brought Mr S to the attention of services in virtually all instances of him going into crisis, and medical professionals were aware of these incidents.

17.42 Conclusions

17.43 In this case, Victim 1 and Mr S's sister were potentially part of the solution to understanding aspects of Mr S's presentation. There was a direct correlation between an increase in disharmony between Mr S and Victim 1, and a decline in his mental health. The evidence in Mr S's medical records would suggest that he reached his most susceptible point at those times in which significant events were taking place in his relationship with Victim 1; the birth of their son, her disengagement from the romantic relationship with Mr S, and finally, her notifying Mr S of her pregnancy to another man. This was brought to the attention of clinicians repeatedly.

Comment four

In failing to review the complaints from Victim 1 about disharmony in Mr S's mental state systematically, clinicians missed a significant opportunity to utilise knowledge which in turn could have been of diagnostic and therapeutic benefit for Mr S, Victim 1 and services.

There is a *caveat* here in relation to confidentiality and consent to share. It is the view of the Independent Investigation Team that services involved in the care of Mr S took what he said at face value, and did not include the views of Victim 1 or Mr S's sister. It may have been the case that services felt they were maintaining confidentiality by not including Victim 1 and Mr S's sister – this will require a very delicate balancing exercise.

Recommendation two - Working with family (or carers)

The Independent Investigation Team has highlighted a number of issues regarding a lack of inclusion of Victim 1 and Mr S's sister's views in the care of Mr S.

An essential requirement in the long-term care and treatment of service users is the development of an effective and collaborative relationship with carers/family. As mentioned, whilst Victim 1 clearly acted in the capacity of a "carer" for all intents and purposes, it is the view of the Independent Investigation Team that services missed an opportunity in relation to Mr S's care, and significantly, Victim 1's *ability to withdraw from that care*, by not formally recognising her as a "carer".

The skills required to obtain information and formulate the service user's problems in an accurate and helpful way include the ability to work collaboratively with those people in close relationships with the service user. This requires training but also requires regular review and development in order to ensure that subjective judgements are not allowed to impact upon clinical information.

Whilst carers (and, where applicable family) views are subjective judgements, we invite them in precisely for that subjective quality.

Consulting those closely involved with the service user allows medical professionals to obtain crucial insight, which can reveal the extent of the illness and more information critical to a risk assessment. Additionally, it would alleviate the strain on carers/families themselves by ensuring their voices are heard, and that they have access to any support which they might need.

This would also give those closely involved with the service user a voice and a sense they are being taken seriously.

Recommendation 2 - Working with carers (and family members, where applicable):

1. "Consent to share" information should be updated regularly to promote effective communication between the practitioner, the service user and carers/family members. Protocols and policies should be introduced to secure this.

2. Those closely involved in care should always be given a contact point to access the mental health system in a crisis. Communication should be established as early as possible.

3. The Trust reviews its policy for identifying carers and making it more flexible in its assessment and easier for individuals like Victim 1 to be recognised and therein supported as "formal" carers.

4. Collateral histories should be taken from carers/family members to secure a greater insight into a service user's situation and those of the carers/family members themselves.

5. In order to obtain a comprehensive understanding of the service user's current psychiatric, social and family circumstances and risk characteristics, the Trust's Quality Assurance Programme be revised to ensure that Teams are required to actively seek carers/family members' involvement and views.

6. The standard practice of clinical teams in relation to this Recommendation is monitored by periodic audit.

18. COMMUNICATION WITH THE POLICE

18.1 Whilst commentary on or consideration of the involvement or otherwise of the police in the events of 2 June 2010 is outside of the Terms of Reference of this Independent Investigation, mention must be made of Mr S's mental health interactions *with* the police in relation to Mr S, particularly in relation to the information that was, or was not available to mental health services over the course of events.

18.2 Mr S's arrest of 27 May 2010

18.3 On 27 May 2010, Victim 1, worried about Mr S's volatility and stability at this point and fearing for her and Victim 2's safety from Mr S, had called the police in response to a threat he had made against her. At 22.30, officers attending her address attempted to issue Mr S with a harassment warning. When he refused to accept it, he was arrested on suspicion of threats to kill made against Victim 1.

18.4 He was taken to the police station, where the police were aware of his s136 detention and assessment the previous day (although there is no information in the Inquest transcripts as to the origins of this awareness, it is assumed it derives from their own arrest records in relation to the incident in the police station car park the previous day).

18.5 They were aware he had failed to meet the standard required by law to detain him under the Mental Health Act. Because of the assessment, the police decided they wanted to examine Mr S before the interview, to ascertain whether he was competent to be interviewed and charged.

18.6 Police interaction with services regarding this arrest

18.7 The police contacted services by telephone upon Mr S's arrival at the station for further information relating to the s136 assessment the day before and to acquire any relevant records.

18.8 They were informed that Mr S had been assessed pursuant to s136 the previous day (which they already knew) and that he was suffering from depression, but no "major" mental health issues. Services informed police that they felt he did not require any further input from them. The police were also made aware of the fact that Mr S had an appointment with his GP booked for 09.10 on the 28 May 2010, the next day (which he missed by virtue of being in police custody).

18.9 Pursuant to the confidentiality policy at the police station, the police did not tell services anything about the arrest or share information on Mr S's detention, but as above, they made them aware they were calling from the police station. The police ended the telephone call with the crisis team.

18.10 The Police examination of Mr S

18.11 The police examined Mr S and found him fit to be interviewed and charged. In evidence at inquest, Mr S at this point was described by the police as "*in no way sectionable*". They were also asked, on their knowledge of the events of the previous day's s136 assessment, was Mr S, in their opinion, capable of being sectioned, to which the police replied "*no*".

18.12 The "threats to kill" charge

18.13 Mr S was then interviewed by the police and at 14.50 released from custody, pending further investigation for the offence of "*threats to kill*", subject to the condition he had no contact with Victim 1, and that he returned to Ripley police station at 09.00 on June 18.

18.14 At 16.01 the same day, the police created a domestic abuse form categorising Victim 1 as "high risk". No further action was taken by the police in relation to Mr S. Victim 1 was never informed.

18.15 Upon his release on bail

18.16 Following his release from custody, Mr S then went to the GP surgery to apologise for missing the morning's appointment (when he was in police custody), and claimed he had not attended because *"he'd been at the hospital that morning complaining of severe headaches"*. He did not make any mention of his arrest.

18.17 At 19.07 that day, police received a telephone call from a neighbour of Mr S, who reported to the police that he had just been to her house. According to her, Mr S had informed her that he had been arrested, charged, and bailed, as well as the conditions of that bail. According to the neighbour, Mr S was also reported to have said that he *"feels like going round and taking the lad".*

18.18 Police officers made attempts to contact Mr S without success. They also contacted Victim 1 to check on her welfare and establish whether Mr S had been in touch with her. At 0145 hours on 29 May 2010, police visited Mr S and found no indication of him intending to harm himself or anyone else.

18.19 Police/Mental Health Liaison

18.20 The Independent Investigation Team did not identify any deficiencies with the liaison between the mental health services and the police. For instance, the procedure was followed for the s136 – he was picked up, taken to the correct place and the assessment was performed. The police responded to the A & E situation and transported him after the s136, all of which seemed good practice.

18.21 Furthermore, there was no particular delay in organising the s136. Nationally, there are very clear guidelines as to the procedure to be followed for a s136, i.e. the required composition of the SUI, the way in which the police must respond, the options available to them and the way it is supposed to travel through the emergency system.

18.22 There is no evidence to suggest that the police had not organised the s136 well, or did not continue involvement with the assessment itself, for example, the assessors actually came out and obtained further information from the police during the assessment.

18.23 Information from Police

18.24 The information regarding Mr S's second arrest and conditional bail two days after the s136 assessment was not made available to Mental Health Services.

18.25 As above at paragraph 18.1, commentary upon or consideration of the involvement or otherwise of the police in the events of 2 June 2010 is outside of the Terms of Reference of this Independent Investigation.

18.26 However, whilst the Independent Investigation Team is cautious not to enter into speculation of any kind, it must be noted that the opinion of the Independent Investigation Team is that had the police notified either Victim 1 herself, or mental health services of Victim 1 being considered to be at 'high risk' upon Mr S's release on bail on 28 May 2010, then events may have taken a different course. The Independent Investigation Team understands that the actions of the Police have been made the subject of a separate investigation.

19. RESPONSE TO INCIDENT BY HEALTHCARE PROVIDERS

19.1 It is hoped that this Report will have shown that services made an effort to engage, in a positive way, with a difficult individual who extremely guarded in the information he actually conveyed to others.

19.2 In hindsight, there were certainly areas in which the care of Mr S could have been improved by services, resulting in missed opportunities in that care, most specifically in relation to the strategy adopted in relation to the involvement of Victim 1 and Mr S's sister in his care and the lack of adherence to a formalised CPA.

19.3 However, as mentioned earlier, it is the view of the Independent Investigation Team that the events of 2 June 2010 could not have been either predicted or prevented, despite recognised instances where services could have "done better".

19.4 This section will depict the Independent Investigation Team's views on the learning to be gained from this investigation and the extent so far to which the Trust has made changes based on this learning.

19.5 Investigation of Mr S's Care

19.6 It is the view of the Independent Investigation Team that the Internal Investigation was, for the most part, thorough and robust. Given that the Investigation related to the death of a child, the internal investigation needed more on safeguarding – the implications of the safeguarding issues raised in this case should have been explored widely.

19.7 The Trust's response of 12 September 2016 to the Independent Investigation Team

19.8 The Trust has informed the Independent Investigation Team that three executive members now review all serious incidents in the Trust weekly. This review is conducted by the Medical Director, the Nurse Director and the Director of Operations, and includes all serious and catastrophic incidents. The Trust has informed the Independent Investigation Team that the purpose of this review is to give full insight into the service issues raised by the serious incidents.

19.9 The Trust have informed the Independent Investigation Team that the Trust executive clinical leads are scheduling a learning review with all staff involved, led by the "Safeguarding Adult's" Doctor, the Safeguarding Adult's named professional, and executive members. The Trust has informed the Independent Investigation Team that the purpose of this review will be to review this report, reflect on its findings, and agree shared solutions.

19.10 The Trust have informed the Independent Investigation Team that the outcome of this review will be presented at a Trust event and reviewed and managed at the Trust's safeguarding committee, which was put in place in April 2015 to drive forward performance in Think Family, Family inclusive practice, Safeguarding and learning from Homicide Reviews. The Trust has advised the Independent Investigation Team that the objective of this committee membership is to take forward the learning from this Investigation and ensure the recommendations are completed and actioned.

19.11 A proposed timescale for this review has not been given.

19.12 The Trust has informed the Independent Investigation Team that they have allocated some key staff to lead the learning review of safeguarding. The Trust has advised that this team has been instructed to be independent from the clinical areas. The Trust has requested their Safeguarding lead for Children facilitates the day, and that the Substance Misuse and Clinical Directors are part of the panel leading the learning review of safeguarding.

19.13 The Trust has informed the Independent Investigation Team that they use this methodology of learning events in relation to safeguarding children, and that they take a "no blame" approach. They have also stated that they expect the facilitators and nominated lead to present the plan to the Trust's Internal Safeguarding Committee. This would be done at a board level in an attempt to track progress with the team at "multi layers" of the organisation.

19.14 At the conclusion of the Investigation, the Trust confirmed its acceptance of the learning identified in the Independent Investigation Report. In addition, the Trust has confirmed that they will revisit that learning in order that they can ensure that it is embedded in current practice.

19.5 The Trust has provided the Independent Investigation Team with information relating to their progress with the implementation of the national policies since the incident, including:

- The "Duty of Candour and Being Open" Policy and Procedure (issued May 2015).
- The family liaison service document.
- The "Triangle of care" – "Think Family and Family inclusive practice" has been made a Trust quality priority
- A revised family and carers strategy was submitted to the safeguarding committee for ratification (2016).
- The Trust developed a SBARD communication tool for families and carers to raise concerns to alert staff to gain help with or without individual consent (2015/16).

19.16 Trust response to victim's families

19.17 The victim's families in this case, Victim 1's brother and sister in law, and Mr S's sister, are keen to ensure that "*something good for other people*" comes from the tragic events that resulted in the incident of 2 June 2010.

19.18 They described their dealings with the Trust after the incident;

"We were not offered any direct advice when it happened. The NHS did not make any effort to support. In the immediate aftermath, we felt we had been let down. We thought there would be something, expected it, nothing happened, nothing came. We wanted to personally seek support for Victim 1's mother, we got left…

There was no interaction with the NHS – the only contact was the "notification of internal review". We were sent a letter when it was completed, and given the option to meet to hear the results. We felt we didn't matter. A big thing had happened, people had died, and that's it, we will see what we did wrong for the people dead and that's it.

There was a pre inquest review in summer 2011 - by then we felt let down by mental health services.

Our experience told us if there was one thing, going forward, that needed addressing in cases like this is, after the incident, the Trust must check the family, check they're ok, offer assistance".

19.19 The Independent Investigation Team found that a crucial piece of learning that must be taken from this incident relates to the way in which the families of victims are handled by investigating trusts, in accordance with the duty of candour and the developments as a result of the Francis Report.

19.20 This learning must not only be applied to dealing with families in the immediate aftermath of an incident, but also, in the process of, and way in which a trust proceeds to handle the execution and delivery of their internal investigation report.

19.21 The Independent Investigation Team recommends a trust faced with a similar situation in future must treat the families of victims as individuals, and therein, acknowledge their personal knowledge levels of the case itself, the processes by which the NHS and mental health services operate, and place considerably more onus on the need for understanding and sensitivity to the traumatic events family members with whom they will be interacting in this unfortunate capacity have inevitably endured.

Comment five

The Trust informed the Independent Investigation Team on 12 September 2016 that it is able to provide, on request, evidence of the efficacy of the family liaison team in relation to the duty of candour via a reduction in the number of family complaints. They also state that as a mental health homicide has not occurred in the Trust since 2013, evidence to demonstrate rate the changes in their response is difficult to provide.

Recommendation three – improving liaison with families after adverse events

The Independent Investigation Team acknowledges that it has been informed during interview by senior executives that other measures have since been implemented, for example, family liaison. However, the Independent Investigation Team did not see any evidence that this had made an impact.

Recommendation 3 – Improving liaison with families after adverse events

1. The Trust must take steps to demonstrate greater awareness of the knowledge levels of family members of victims, their specific backgrounds and insights, and their interactions with the Trust post incident.

2. The Trust implements and enforces policies to ensure that, in homicide/suicide cases such as this to ensure that the families of the victims are supported, continuously apprised of developments post incident, and generally made to feel as though they are 'involved' in the process and not 'just forgotten about'.

20. GLOSSARY OF TERMS

1. AMHP - Approved Mental Health Practitioner.

2. “Section 136” – a procedure under the Mental Health Act allowing the police to take an individual to a place of safety (police station or hospital), for up to 72 hours, when they are in a public place, if they suspect the individual is suffering from mental illness. During this time, mental health professionals can arrange a Mental Health Act assessment to determine whether or not the individual can be detained in hospital pursuant to diagnosis and treatment of mental illness.

3. CMHT – Community Mental Health Team.

4. FACE – “Functional Analysis of Care Environments” risk assessment is a checklist style risk assessment used by services when calculating risk.

5. CBT – Cognitive Behavioural Therapy.

6. MDT – Multidisciplinary Team.

7. CRHTS – Crisis Resolution and Home Treatment Service.

21. APPENDICES

1. Appendix 1 – Terms of Reference of the Investigation.
2. Appendix 2 – Team Membership.
3. Appendix 3 – Methodology.
4. Appendix 4 - Chronology.