



REPORT TO NHS ENGLAND (NORTH)
OF THE INDEPENDENT INVESTIGATION
INTO THE HEALTH CARE AND TREATMENT OF
PATIENT 2009/3245 COMMISSIONED BY THE FORMER
NORTH EAST STRATEGIC HEALTH AUTHORITY
JANUARY 2014

CONTENTS	PAGE
1. Introduction	3-5
2. Panel Membership	6
3. Terms of Reference	7
4. Chronological Narrative of Key dates and Events	8-34
5. Assessment and Management of Risk	35-49
6. Treatment, Care and Implementation of the Care Plan	50-92
(i) Care Programme Approach	50-56
(ii) Section 117 Mental Health Act 1983	57-63
(iii) Diagnosis	64-74
(iv) NICE Guidelines	75-78
(v) Organisational changes	79-92
7. Standard of Record Keeping and Communication	93-110
8. Interface between Mental Health Services & other Agencies	111-116
9. Executive Summary	117-123
10. Recommendations	124-126

1. INTRODUCTION

On the 3 or 4 April 2009, Patient 2009/3245 attacked and killed his girlfriend, Victim A, with a blow to the head using an iron, strangling her with an electric cord and stabbing her with a pair of scissors. He was subsequently charged with her murder to which he pleaded guilty at Teesside Crown Court. On 7 October 2009, he was sentenced to life imprisonment with a minimum term of 12 years to serve. He was aged 49 years old at the date of the index offence and had been known to Mental Health Services since the age of 7.

It is against this factual background that the panel was appointed in March 2011 by the North East Strategic Health Authority (“NESHA”) to enquire into the health care and treatment of Patient 2009/3245 and to deliver a report, to include findings and recommendations. The investigation was established under the terms of the Health Services Guidance (HSG) (94) 27 as amended in June 2005.¹

Not only would the panel like to express its gratitude to the Tees, Esk and Wear Valley NHS Foundation Trust (“the Trust”) for their cooperation in the investigation, but also to the NESHA for affording the panel the necessary facilities to conduct its inquiry.

The panel’s independent coordinator was Mr Chris Piercy, who the panel wish to thank for his invaluable assistance in the administration of this investigation.

During the course of the inquiry, the panel had access, (with 2009/3245’s consent), to all known relevant documentation detailing his involvement with Health, Police, Local Authorities including Social Services, Probation, and New Horizons(Teesside), the charitable housing organisation. All the agencies cooperated in producing records.

¹ Independent Investigation of Adverse Events in Mental Health Services, Health Service Guidance, (94) 27, 15th June 2005.

www.webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthserviceguidelines/DH_4104914

In addition, the panel had access to the inquest documentation from Teesside Coroners Court and the criminal trial transcripts from Teesside Crown Court. A review of the prosecution and defence psychiatric reports prepared pursuant to the criminal legal process has also been completed.

Policy documents and protocols have also been requested, received and considered by the panel.

The panel has had access to the Trust's Internal Investigation report dated 22 January 2010 as well as its evidence file which included but was not limited to transcripts of interviews of witnesses.

The documentation to be considered in the course of this enquiry has been vast. This is especially evident given 2009/3245's lengthy history with Mental Health Services. To consider such documentation, analyse the key issues and discuss recommendations the panel has met on 22 occasions.

The panel has interviewed 2009/3245 at the Roseberry Park site, Teesside as well as interviewing eighteen other witnesses in the course of the investigation. The witness's evidence was transcribed and then checked by each of them for factual accuracy.

The objective of this inquiry was to endeavour to identify the events that led to the death of Victim A and to highlight areas where practice could be improved. It is not the purpose of this report to attribute blame to individuals. For this reason and to encourage uninhibited contributions to the inquiry, professionals who were directly/indirectly involved with 2009/3245's care have not been identified by name.

Despite the investigation coordinator's best efforts, it was impossible to interview all the witnesses selected due to retirement and moving abroad and therefore conclusions about their work with 2009/3245 have had to be drawn from other documented evidence provided.

The panel wishes to express its thanks to all the witnesses who were faced with the unenviable task of recollecting past events and circumstances which they were involved in and where judgements perhaps were made some years ago. All the witnesses were helpful in providing additional evidence and supplementary documentation to fully explain the implementation of the Trust's policies, management structures and/or providing detailed factual accounts leading up to the index offence.

The panel has considered the history of 2009/3245's involvement with Mental Health Services in its entirety. Such an overview has also involved the panel being appreciative of the pressures of the working environment which professionals can frequently face. This is in contrast to the panel's somewhat artificial consideration of issues in isolation with the benefit of hindsight.

3. TERMS OF REFERENCE

The purpose of the investigation was as follows:-

- to examine the circumstances surrounding health care provision and treatment of Patient 2009/3245, in particular;
- the quality and scope of his health care and treatment, in particular the assessment and management of risk;
- the appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary Care Programme Approach and the assessment or risk in terms of harm to himself and others;
- the standard of record keeping and communication between all interested parties;
- the extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health;
- to prepare a report of the findings of that examination for, and make recommendations to the North East Strategic Health Authority.

4. CHRONOLOGICAL NARRATIVE OF KEY DATES AND EVENTS

Birth to 1985,First admission

1. Patient 2009/3245 was born in Peterlee on 3 December 1959. His parents' marriage lasted 5 years, resulting in two children (2009/3245 and his elder sister).The couple separated in 1961 when 2009/3245 was 2 years old. 2009/3245's mother filed for divorce in 1963 on the grounds of desertion, mental cruelty and adultery.
2. From that point on, 2009/3245 had no contact with his natural father, except for a brief stay with him in 1964 when his mother was taken into hospital. After 3 days, his father was unable to control 2009/3245 (who was then 5 years old) and so he placed him in a children's home in Stockton until his mother was fit to return home.
3. On the 8 March 1967, aged 7, 2009/3245 was referred by the school medical officer to the outpatients in the Department of Child & Family Psychiatry where he was said to be having problems mixing with other children and coping with school practices. He had been excluded from Newport Infant School due to his unacceptable behaviour of spitting at a dinner lady, biting the head teacher's hand and sticking a pair of scissors into another child's leg. By that time, 2009/3245 had attended four different schools and was said to have a high IQ of 129. There appeared to be no delays in reaching any of his age appropriate milestones.
4. He was assessed whilst attended the Child Psychiatry Day Unit as a day patient. The assessment described him as being very insecure and that he was handling anxiety in an aggressive attention seeking manner. The contemporaneous clinical notes recorded behaviour problems which consisted of over activity and of him being a disruptive influence.
5. Following separation from his father, 2009/3245's mother had a series of relationships with men who either moved in with her and her children or she moved with or without her children to be with her partner. She cohabited with one of her partners for over 8 years from 1962 and had a further four children with that partner.

6. In 1971, the family moved from Teesside to Chatham, Kent. However, by late spring of that year, the mother's relationship with her partner had broken down and he left the family home taking with him the two eldest children and putting up the two youngest children for adoption. 2009/3245 and his sister were placed by his mother into what in the clinical records was referred to as private foster care in Stroud. His mother failed to pay any maintenance payments for the children and therefore on 6 December 1971, 2009/3245 and his sister were taken into care under Section 1 of the Children's Act 1948.
7. Whilst in foster care, 2009/3245's behaviour deteriorated. He was said to have bouts of temper smashing up ornaments in the foster home. This resulted in his removal from the foster home in January 1972 and his transfer to Gatland House, a Remand Reception Centre. There he was described as being disruptive. He attacked a house mother and had to be restrained by three members of staff, resulting in him being moved to Greenacres Boys Remand Home in Rochester in September 1972.
8. At the age of 12, in October 1972, 2009/3245 committed his first criminal offence of theft by stealing a purse resulting in a disposal care order to Kent County Council. There he was assessed by a Consultant Psychiatrist as being maladjusted and recommended for a placement in a residential school. He was transferred to Aycliffe Training School, Teesside in February 1973. At that point, his mother had returned to Teesside with his sister and it was decided that 2009/3245 should be reunited with his family in the North East.
9. At Aycliffe Training School, 2009/3245 was assessed as constantly seeking adult attention and his mother was viewed as having little interest in him and not wanting him home. By March 1973, 2009/3245 had been convicted of his second criminal offence of trespass and burglary.
10. In a case review at Aycliffe Training School in October 1973, 2009/3245's then social worker stated that she was going to exercise "her policy of attempting to tie the mother down to face up to her responsibilities as she has on numerous occasions for many years given her children away and then accepted them back". There appeared to be evidence of repeated promises of visits to 2009/3245 from his mother which were frequently broken.

11. By December 1973, 2009/3245's mother had re married and consequently regular weekend contact with 2009/3245 resumed whilst he remained at Aycliffe Training School. Throughout 1974, 2009/3245 repeatedly absconded from Aycliffe Training School.

12. In October 1974, when 2009/3245 was aged 14, his mother and her new husband moved to Windsor with a view to enrolling on a 6 month training course in the licensing trade leaving 2009/3245 at Aycliffe Training School and his sister homeless and having no alternative but to be taken into care. 2009/3245's contact with his mother by this time was very infrequent.

13. In a care assessment dated 13 November 1974 carried out by 2009/3245's then social worker, she recorded that his mother was agreeable when the situation was going well, but rejected 2009/3245 in times of crisis.

14. By January 1975, due to 2009/3245's disruptive behaviour which included committing offences of theft, Aycliffe Training School were no longer prepared to allow him to remain with them until he had undergone strict training in a secure environment. Following a number of court appearances, 2009/3245 was admitted to the Open Adolescent Forensic Unit at Winterton Hospital, Sedgefield (David Westbury Centre) for assessment on 14 February 1975. The staff reported that their assessment showed that 2009/3245 had suffered from gross insecurity and severe rejection almost from birth and had in most settings pushed the tolerance of the caring staff to the point of rejection.

15. 2009/3245 absconded from the Open Adolescent Forensic Unit on a number of occasions and committed offences whilst he was absent. As a result in July 1975, it was felt that 2009/3245 was not willing to accept the treatment available in the Open Forensic Adolescent Unit and recommended Borstal training as 2009/3245 needed both treatment aimed at tackling his emotional immaturity as well as a structured setting to prevent him from absconding. He was sentenced in July 1975 to Borstal training following twenty criminal offences having been taken into consideration. From 1975 onwards, 2009/3245 repeatedly offended committing theft, burglary and driving offences.

16. In the subsequent years, 2009/3245 was sentenced to a period of Borstal training. He received five Borstal sentences and in 1982, two non-custodial sentences. It was recorded that during the period following the non-custodial sentences being imposed, he offended again and was sent to prison.
17. In June 1980, (aged 20), 2009/3245 married his first wife. She had one child from a previous relationship. His wife appeared inconsistent and during the period of 2009/3245's imprisonment in 1983, she neither visited nor wrote to him. Following a visit (encouraged by his probation officer), 2009/3245's wife apologised and again promised to visit and write, but failed to subsequently do either. 2009/3245 tried to escape from prison in 1983 and ended up losing remission and was transferred to HMP Manchester.
18. Around this time, it transpired that his wife was expecting another man's child and when 2009/3245 was released in 1984 he was effectively homeless. Subsequently, his estranged wife allowed him to stay with her and he remained with her until he again was sent to prison in January 1985.

COMMENTARY

2009/3245's clinical notes from this period were fairly scant. The Social Services notes and the Aycliffe Training School notes were the most comprehensive, providing case reviews of 2009/3245's behaviour and providing some insight into his childhood and upbringing. There were no known records available between 1975 – 1984. Apart from the nursing records and some letters to the Courts, the panel found very little information relating to 2009/3245's admission to the David Westbury Centre, Winterton Hospital.

There was evidence from subsequent clinical notes (circa 1985 onwards) that whilst 2009/3245 was admitted to David Westbury Centre, he was diagnosed with a Juvenile Personality Disorder although there was no reference to this in the contemporaneous notes.

It appeared to the panel that from an early age, 2009/3245 developed behavioural problems of being disruptive, challenging and seeking out the attention of others. This conduct appeared to have gradually deteriorated in his

early teenage years with him committing crimes of dishonestly and subsequently being convicted of numerous theft and burglary offences.

There appeared to be a severe lack of stable attachment to anyone and he was moved from place to place with an absence of any established home life and frequent changes of schools and routines.

He appeared to have been rejected by his mother who only wanted to be part of his life when he was “not letting her down”. There seemed to be an absence of any responsible and regular parental support to 2009/3245.

There was evidence of him having persistently absconded whilst both at Aycliffe Training School and at the Forensic Child Psychiatry Unit. It was also recorded that he had poor interpersonal skills, but there did not appear to be any contemporaneous evidence of any formal psychiatric illness.

The panel was not able to find the evidence for the assessment of his IQ at 129 in the documents made available to them, although the figure is mentioned in the letter from the senior school medical officer to the Child Psychiatrist. A subsequent assessment of 2009/3245's IQ, conducted at Aycliffe Training School in 1973 gave a verbal IQ of 95, a performance IQ of 103 and a full scale IQ of 99.

When 2009/3245 married in 1980, it appeared that his wife was unable to provide the consistency or support that he may well have needed – in many ways her attitude towards him appeared at times to mirror that of his mother's inconsistent behaviour towards him.

One issue that subsequently became apparent in later consultations was that 2009/3245 suggested some family members and staff from two of the care establishments he resided at sexually abused him from the age of 11. Although not raised by 2009/3245 at the time, it was first documented in his clinical records from July 1988 when he was 29 years old. This was an issue which appeared not to have been investigated further by treating clinicians of 2009/3245 and the panel could not find any evidence as to the reason for the lack of further investigation of that decision at that time.

There was the suggestion in one of the case summaries from Aycliffe Training School that 2009/3245 was ill treated by one of his mother's partners but there was no suggestion of any sexual abuse of him.

Subsequent entries in the clinical notes in 1991 also suggested that 2009/3245 was aware of his natural father being violent towards his mother and that he physically attacked her.

Overall, the panel was impressed at the efforts made by the professionals to try and assist 2009/3245 at this time. Health, Social Services and Education staff did recognise the issues that he had and did attempt to help him often on a repeated basis. Had there been, as there are now, locked Forensic Adolescent services available, the panel believed this may have been a better way to have attempted to help 2009/3245. It was clear that he was not willing to use the help available at the Open Adolescent Forensic Unit and by repeatedly offending and absconding; the panel could see the issues that arose for the staff at the time.

First admission, 1985 – 1990

19. On 4 January 1985, 2009/3245 was sentenced at Teesside Crown Court to 3 years imprisonment at HMP Durham having committed the offences of theft, burglary and a breach of the bail conditions. Twenty-three criminal offences were also taken into consideration.

20. On 28 May 1985, 2009/3245 was transferred under a Governor's warrant and subsequently by Section 47 of the Mental Health Act 1983 ¹ to the Regional Secure Unit ("RSU") at the Hutton Centre, St Lukes Hospital from HMP Durham for a period of just under 6 months until 20th November 1985.

21. Whilst in the Hutton Centre, 2009/3245 was under the care of a Consultant Forensic Psychiatrist 1, ("CP1"). A week prior to his transfer he was said to be exhibiting bizarre behaviour of refusing to eat or drink. He was dehydrated and had to spend a week in Middlesbrough General Hospital for intravenous fluids and for investigations to determine whether his presentation had an

¹ Mental Health Act 1983.

www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actandbills/DH_4002034

organic basis. He was incoherent, uncommunicative and was said to be suffering with a genuine psychotic episode which may have been “toxic” in origin.

22. Although there was no evidence of a precipitant of that episode or a previous Psychosis, 2009/3245 admitted to taking cannabis whilst in prison prior to being ill. CP1 made a provisional diagnosis of Schizophrenia possibly induced by drugs. Medication prescribed was Fluphenazine Decanoate 25mgs every two weeks. Following the treatment, he improved significantly and was well enough to be returned to prison in November 1985. He was seen in prison for reviews by the medical staff from the RSU. 2009/3245 failed to continue taking this medication once discharged from prison in January 1987.
23. 2 years later CP1 subsequently re-visited the issue of 2009/3245’s diagnosis and stated with hindsight 2009/3245 was suffering from an organic illness rather than Schizophrenia.
24. In January 1987, 2009/3245 was released from prison only to re-offend in July the same year when he broke into his estranged wife’s house and threatened to kill her with two carving knives. She fell backwards out of the bedroom window sustaining head injuries. Prior to sentencing he was seen by CP1 and nursing staff from the RSU. He was said to be free of any signs of mental illness. He was convicted and sentenced in December 1987 to 5 years imprisonment for aggravated burglary and assault.
25. In May 1988, 2009/3245 was admitted, initially under a Governor’s warrant under Section 47 of the Mental Health Act 1983 again to the Hutton Centre from HMP Durham under the care of CP1. He was said to be exhibiting paranoia, flights of ideas, delusional beliefs and pressure of speech. The deterioration in his mental health appeared sudden. There was again some debate by the treating care team as to his diagnosis. It was thought that there was a strong paranoid component, although it was also raised as to whether there was any organic basis.

26. He was treated with neuroleptics and there was an improvement in his condition in the first week in the RSU. Subsequent changes had to be made to his drug regime as he continued to have delusional ideation. It was felt that there was an affective component to his illness, (his mood was noted to be flat and he was troubled with early morning wakening) and this led to him being given eight Electro Convulsive Therapy sessions (“ECT”) which brought about what was described as a massive improvement in his mental state. CP1 made a diagnosis of a Bipolar Affective Disorder in respect of 2009/3245 and prescribed mood stabilizing medication; Lithium Carbonate 1250mg per day for the first time.

27. CP1 sought to offer 2009/3245 a rehabilitation programme within the Hutton Centre, but this was interrupted when 2009/3245 absconded in November 1988 and consequently, he was transferred back to HMP Durham.

COMMENTARY

Following the application of the transfer direction made under Section 47 of the Mental Health Act 1983, Section 117 aftercare applied when 2009/3245 ceased to be detained in prison. The adherence to Section 117 after care will be dealt with in greater detail at chapter 6, pages 57-63 of this report.

It was evident that between 1985–88, there was a lack of consensus amongst the treating clinicians as to 2009/3245’s psychiatric diagnosis. This was a recurring theme throughout his contact with Mental Health Services and which will be discussed at chapter 6, pages 64-74 of this report.

2009/3245’s a typical presentation and possible uncertainty about whether the 1985 admission was drug related was not well documented in the clinical notes. The panel considered that 2009/3245’s atypical presentation should have been discussed to a greater extent in his medical notes/discharge letters.

The absence of any clarity about whether there were any illicit substances found in 2009/3245’s urine made the issue of diagnosis difficult to evaluate.

Again, in relation to the second admission, there was no known record of any urine drug screen taken and while the response to ECT may well have been more in keeping with an Affective Disorder, a better summary of the key features would have assisted subsequent clinicians when reviewing the evidence in arriving at an appropriate diagnosis for 2009/3245.

Indeed, there was very little use of a formulation to bring together the various different strands of information, regarding the medical, personality and social issues of 2009/3245. This is dealt with in greater detail in chapter 6, pages 63-73 of this report.

From 1988 onwards, 2009/3245 started on Lithium Carbonate and this formed part of his medication regime for 20 years until a reduction in that medication by CP15 in November 2008.

During admission to the Hutton Centre in 1987, (age 27), 2009/3245 self-disclosed about being assaulted as a child. He also expressed thoughts of killing staff within the RSU.

Whilst at the Hutton Centre, it was also recorded that 2009/3245 appeared to be apprehensive about returning to prison.

Between 1990 – 1995

28. 2009/3245 was released from HMP Durham in late 1990 and within a matter of 2 weeks was charged with a burglary offence.

29. He was given two mental health outpatient appointments which he failed to attend in November and December 1990.

30. On 17 January 1991, he was arrested for criminal damage at the Swallow Public House and taken to Stockton Police Station. There at the request of the police surgeon, CP1 assessed 2009/3245 and admitted him for assessment to the Hutton Centre under Section 2 of the Mental Health Act

1983. He was said to be exhibiting pressure of speech, flight of ideas and grandiosity. The Section 2 was subsequently converted to a treatment order under Section 3 of the Mental Health Act 1983 on 13 February 1991.

31. Whilst at the Hutton Centre, 2009/3245 demonstrated verbal and physical aggression. He was physically abusive to staff and threatened to kill his sister and repeatedly broke the fire alarm glass. He was treated with neuroleptics and his Lithium Carbonate continued and there was an improvement in his mental health.

32. In March 1991, he attacked a member of staff at the Hutton Centre by punching him. He also injured two others whilst they attempted to restrain him. In addition, 2009/3245's visitors brought cannabis on to the RSU which he admitted to having smoked. At that time, it is recorded in the clinical notes that 2009/3245 was secreting his medication.

33. By mid-March 1991, (aged 31), he embarked on a relationship with a female patient at the Hutton Centre. He became very preoccupied with her quickly and had high expectations of the relationship, even making suggestions that they should move in together and get married after a short period of time. He stated that if he could not live with her, his life was not worth living.

34. In early June 1991, 2009/3245 brought alcohol on to the RSU and gave it to his girlfriend. This resulted in CP1 considering whether to discharge 2009/3245 as his mental illness did not appear to be a significant problem. At that point 2009/3245 was re-graded to informal status.

35. On 8 June 1991, 2009/3245 seriously attacked his girlfriend when she tried to end the relationship. He kicked and punched her and had to be restrained by nursing staff. She believed that had the nursing staff not intervened, she would have been killed. Although the incident was reported to North Ormesby Police, charges were subsequently dropped.

36. As a result of the attack, 2009/3245 was accompanied by the police to leave the RSU. His property was collected for him and a sharpened piece of metal

was found under a towel in his room. CP1 added that if 2009/3245 was ill again he may need to be admitted to a Special Hospital.

37. On 12 June 1991, CP1 wrote to Consultant Psychiatrist 2, ("CP2") to ask him to take over 2009/3245's care. 2009/3245 failed to attend his appointments with CP2.
38. On 17 December 1991, 2009/3245 presented himself at the Hutton Centre demanding admission. He barricaded himself into the reception area and destroyed fixtures and fittings resulting in him being restrained by six policemen.
39. Whilst at the Hutton Centre reception area, he made threats to kill CP1 and CP2 as well as the staff at the Hutton Centre. He was arrested and charged with threats to kill, criminal damage and actual bodily harm. Consequently, he was taken to Middlesbrough Police station. There, CP2 saw him and made a diagnosis of manic depression. He was described as a grave imminent danger to the general public and in need of treatment in conditions of maximum security.
40. CP2 was aware that 2009/3245 could not be admitted to the RSU but completed a Section 48 application that meant although he was remanded to HMP Durham, arrangements were subsequently made for 2009/3245 to be transferred to Ashworth Special Hospital.
41. 2009/3245 was admitted as an emergency patient to Ashworth Special Hospital where he remained from 23 December 1991 to 13 January 1992. During an interview with Consultant Forensic Psychiatrist 3, ("CP3") he repeatedly stated that he did not want to return to prison.
42. As his mental health improved during his admission at Ashworth, CP3 felt that the statutory grounds to detain him were no longer met and he was taken to his court hearing on 13 January 1992 with a report confirming exactly that. At court, he was granted bail and returned to reside in Middlesbrough. He was subsequently convicted of criminal damage.

43. On 19 August 1992, there was contact with Middlesbrough Social Services who raised possible child protection issues concerning 2009/3245. This was because his then partner's 9 year old son was too frightened to go home because 2009/3245 was living there.
44. Over a 4 year period from late 1992 to March 1996, 2009/3245 was living in the community but exactly where and how is unclear. CP9 in a subsequent case review indicated that between 1992 and his referral to CP4 in 1996, 2009/3245 behaviour was regulated by his medication namely, Lithium Carbonate as well as his GP supervising his healthcare.

COMMENTARY

Following his re-admission to the Hutton Centre in 1991, (aged 30), the contemporaneous clinical notes suggested that 2009/3245 was exhibiting more affective symptoms, although the panel could find little in the way of a documented detailed discussion about the change in his diagnosis from 1985. Furthermore, there was no overall formulation evident in the clinical notes.

Throughout 1991, 2009/3245 was exhibiting disturbing behaviour traits. He was both physically and verbally abusive and was openly aggressive. He was also manipulative of others, secreting mediation and abusing alcohol. It was therefore not surprising that CP1 viewed 2009/3245 at that time as a patient who could become ill very quickly with serious complications.

The events which took place between March–June 1991 illustrated 2009/3245's tendency to become over involved in relationships per se, to the point of unhealthy pre occupation. He appeared to elevate the seriousness of the relationship in an unrealistic way and then became aggressive when rejected by his partner.

Despite the incident in June 1991, it was noticeable that in the discharge summary at that time, there was no mention of him being a potential risk to females with whom he had a relationship.

Another recurring feature was 2009/3245's reluctance to return to prison. He repeatedly viewed his admission to hospital as a means of avoiding being transferred to prison. This was evident previously and was also documented in the brief psychiatric report by CP3 which was dated the 7 January 1992.

When seen in police custody in December 1991, he was described as being manic with pressure of talk and flight of ideas. It was possible that this was precipitated by him failing to comply with taking his medication -Lithium Carbonate. He self-disclosed to CP3 that he believed this was the cause of his mental deterioration. An alternative explanation was his misuse of drugs which precipitated the episode in December 1991.

However, the panel did not see any evidence in the clinical notes of a urine drug screen result or any evidence of a serum Lithium Carbonate level result to verify either.

The episode which led to 2009/3245's admission to Ashworth Special Hospital was not well documented in the clinical notes. 2009/3245 did alert his GP to the fact that he felt that his mental health was deteriorating. However, the absence of any clear follow up arrangements suggested that there was not any agreement about how this would be dealt with.

There was an absence of specialist psychiatric follow up or after care once 2009/3245 was discharged from prison in 1992. This was surprising given 2009/3245's previous detention under the Mental Health Act 1983, his forensic history and his admission to Ashworth Special Hospital.

Such an admission, the panel believed, should have triggered off not only a major review about his care, but also about the aftercare he should have received when he was back in the community. It was concerning to the panel not to be able to ascertain the quality of aftercare he was given at that time. In addition, the lack of any clearly recorded risk assessment was also of concern.

For the first time in 2009/3245's history, there also appeared to be concern regarding 2009/3245's risk of violence towards children with Middlesbrough

Social Services raising the alarm about his then partner's son. The panel could not find any subsequent clinical assessments identifying this as a repeated area of concern in relation to 2009/3245. However, it was apparent from paragraph 57 (page 23) of this report that there were other examples where 2009/3245 had threatened his partner's children.

1996 –January 2004,Release from Prison

45. From March 1996 there followed a series of attempts by 2009/3245's GP to refer him for psychiatric treatment. Initially the GP referred 2009/3245 to Consultant Psychiatrist 4, ("CP4") at Parkside. Although 2009/3245 had in the preceding years from 1992 been able to manage his symptoms on his medication of Lithium Carbonate, it was apparent to his GP that his psychiatric condition had started to deteriorate. It was reported that he was suffering with panic, anxiety and feelings of aggression.
46. CP4 was aware of 2009/3245's clinical and forensic history and consequently took the view that it would be inappropriate for 2009/3245 to be seen at the community mental health centre. As an alternative, he advised that 2009/3245 should be assessed at the Hutton Centre where they could offer secure facilities. He assessed 2009/3245 on the 20 March and referred him to a Forensic Psychiatrist 5, ("CP5"). CP4 in his referral emphasised that he felt "2009/3245 was potentially a very dangerous man in view of his tendency towards violence and lack of clarity about his diagnosis".
47. CP5 saw 2009/3245 on the 25 April 1996. The interview was terminated prematurely when 2009/3245 walked out of the assessment as a result of being asked "silly questions". Based upon the information given to him by 2009/3245 and without regard to 2009/3245's forensic notes, CP5 assessed 2009/3245 as having no major mental illness and stated that he was returning his care management to CP4 and his GP.
48. 2009/3245's GP then referred 2009/3245 to another Consultant Psychiatrist 6, ("CP6"). He declined to interview 2009/3245 given he was also treating 2009/3245's partner as a patient. He recommended that the GP contacted Consultant Psychiatrist 7, ("CP7"), at the Hutton Centre. CP7 did not consider Forensic Services to be appropriate for 2009/3245 and agreed with CP5's assessment of him as having no major mental illness.

49. At the beginning of July 1996 and at the request of CP4, 2009/3245 was eventually seen by Consultant Psychiatrist 8, ("CP8") and he made a diagnosis of a Bipolar Affective Disorder – and that he was suffering from a major depressive episode which required hospital treatment.
50. A case conference was called to try and resolve disagreements between the Consultants as to 2009/3245's diagnosis. CP9 and CP4 were invited but neither of them attended. Minutes were taken and distributed to those who attended and to CP8. As a result, 2009/3245 was admitted informally on 29 July 1996 to the Hutton Centre. A period of 5 months had lapsed since the date of the initial referral by the GP.
51. 2009/3245 had a period of in-patient care at the Hutton Centre where he was also assessed by Consultant Forensic Psychiatrist 9, ("CP9") who carried out a comprehensive review of 2009/3245's previous history and risk factors. He covered the diagnostic issues as well as recording the triggers that he felt were relevant to 2009/3245's dangerousness. These included aspects relevant to his psychiatric illness, illicit drug usage and relationship issues. Relevant personality factors of 2009/3245 were also considered.
52. 2009/3245 was transferred from the Hutton Centre to the Bristol Special care unit and then onto Trent ward and subsequently to the Parkside inpatient unit, St Lukes Hospital prior to his discharge in October 1996. He then moved from central Middlesbrough to Guisborough in November 1996. As a result CP4 transferred 2009/3245's care to the new sector Consultant Psychiatrist 10, ("CP10").
53. Whilst under the care of CP10, 2009/3245 was seen/reviewed on a regular basis by CP10 and the Community Psychiatric Nurse ("CPN"). At the Care Programme Approach ("CPA") meeting in September 2007, 2009/3245's stability and compliance with medication was confirmed as satisfactory and a decision was made to re-grade 2009/3245 from Enhanced CPA to Standard CPA. His medication at this time was maintained at Lithium Carbonate 1200mgs, Carbamazepine 400mg, Chlorpromazine 200mg and Fluoxetine 20mg (daily dose).

54. 2009/3245 was then referred to the Lead Consultant at the Contraception and Reproductive Health Service, Middlesbrough in March 1999 as a result of sexual health problems. Consequently, he was prescribed Viagra for erectile dysfunction.
55. In November 1999, (aged 39), 2009/3245 was arrested following a domestic dispute in which he threatened his partner's daughter with a carving knife and slapped her in the face. He was detained in a police cell where he was said to be physically and verbally violent, "howling like an animal and smearing faeces". Police were required to enter his cell with shields in order to try and control the situation.
56. A psychiatric opinion was obtained from CP10 who visited the police station with an approved social worker and confirmed that 2009/3245 was not suffering at that point from an acute relapse of his mental disorder and did not need hospital treatment. He did however conclude he was at considerable risk of violence given his personality and past history.
57. 2009/3245 attacked his then girlfriend of 7 weeks in September 2000. He threatened to burn her eyes out with cigarettes and kill her two children. 2009/3245 was bailed but breached those conditions and a Public Protection meeting was arranged for 16 October 2000. 2009/3245 was charged with threats to kill, common assault, battery and affray.
58. Before the Public Protection meeting on 16 October 2000, CP10 decided to discharge 2009/3245 into the care of his GP in Middlesbrough for a number of reasons namely: given his move to that area which meant that he was moving out of CP10's catchment area, his reluctance to be seen by Parkside community mental health care team which was the community team for the area he was now living in, and that in his opinion he had been without mental health symptoms for 3 years.
59. CP10 expressed that he had serious doubts that 2009/3245 had manic depression and attributed the previous episodes of illness to episodes of drug induced Psychosis and said he felt that the diagnosis was of a Personality

Disorder of psychopathic type. He also recommended gradual reduction of Lithium Carbonate by 200mgs every 2 months.

60. At the Public Protection meeting on 16 October 2000, no Consultant Psychiatrist attended, although 2009/3245's CPN did. The police reported nine incidents of domestic violence in the past which confirmed 2009/3245 was potentially dangerous towards any female he formed a relationship with. He was placed on Teesside Probation Services and Cleveland Dangerous Persons Register.

61. 3 months later the second Public Protection meeting was held on 24 January 2001, and again only the CPN attended. The outcome was for 2009/3245 to remain on the register with enquiries to be made as to what medical assistance he was having.

62. 2009/3245 attended his new GP in January 2001 and stated that his depression was getting worse as a result he was referred to Consultant Psychiatrist 11, ("CP11"). 2009/3245 was then sent two outpatient appointments to attend Parkside, (5 March and 29 June 2001), both of which he failed to attend. 2009/3245 was imprisoned for 45 months from March 2001 until he was released on licence to a bail hostel in January 2004.

COMMENTARY

It was evident that prior to March 1996, 2009/3245 had not presented to Forensic Services for 4½ years with either a mental illness or serious violence. He basically self-medicated with the assistance and support of his GP.

From March through to July 1996, 2009/3245 had very little by way of mental health support other than from his GP. It appeared that only through the persistence of his GP did 2009/3245 eventually receive the treatment he needed in 1996. This could have been highly problematic had 2009/3245 re-offended whilst waiting to be assessed.

However, the issues were resolved and a plan devised which allowed 2009/3245 to be initially assessed in the Hutton Centre and which allowed the general

psychiatry staff to be reassured about the risk. It was perhaps very unfortunate that despite being invited, the General Psychiatrist did not attend the case conference held at the Hutton Centre in July 1996, nor sent a representative.

Once admitted to the Hutton Centre, 2009/3245 was assessed by CP9 who carried out a very detailed review of 2009/3245's history and treatment up to that point, and identified risk factors leading to a deterioration of his symptoms. It provided the clearest account of 2009/3245's history of contact with Mental Health Services and covered issues about his diagnosis, his dangerousness and the static and dynamic factors that could have affected this. The review findings could have been used as an invaluable tool as it summarised many of the issues concerned. Subsequently, it could have been used by treating Consultant Psychiatrists had they been aware of it. The panel considered the assessment by CP9 an example of good practice.

The CPA reviews that followed clearly identified risk issues which needed to be looked at particularly, 2009/3245's failure to comply with his medication or follow-up and drugs misuse. However, they failed to identify correctly the Section 117 aftercare entitlement.

Throughout 1997 to 2000, 2009/3245 had regular appointments with CP10 and CPN, most appointments with the CPN were taking place at his home which did not continue once his care was transferred to Parkside.

In October 2000, when 2009/3245 was discharged into the care of his GP by CP10 he did so partly because 2009/3245 did not want to be seen at Parkside. The decision by the CP10 to discharge 2009/3245 back to his GP was one which the panel considered. On the one hand CP10 had not seen any evidence of significant mood swings. The one occasion where his mental state had changed significantly was not thought to be related to mental illness. This appeared to make CP10 believe that the diagnosis of a Bipolar Affective Disorder was incorrect and the most likely diagnosis was that of a Personality Disorder of psychopathic type.

CP10 additionally indicated that he felt that the previous episodes of more psychotic behaviour were more than likely drug induced even though there was

nothing in the clinical notes to indicate that this was categorically the case. CP10 completed a relatively brief rationale for discharging 2009/3245 back to his GP's care and did not look at the issue of future antisocial behaviour in any significant way.

The panel accepted that there were similar diagnostic issues that faced CP10 as there had been for the previous Consultants treating 2009/3245. However, in trying to simplify things to make a single diagnosis, the panel felt that the complexity of 2009/3245's presentation was lost. This will be dealt with in more detail in chapter 6, pages 64-74 of this report.

The fact that 2009/3245 could suffer from a mental illness which appeared relatively well controlled on his medication and personality difficulties did not seem to have been addressed by CP10. The decision to discharge 2009/3245 with the advice that he should stop taking his Lithium Carbonate medication was of grave concern to the panel as was the failure to inform his GP of the warning signs that would indicate a health deterioration which would require an urgent re referral of 2009/3245 to the Mental Health Services.

The panel felt that whilst discharging 2009/3245 back to his GP's care may have been appropriate, the complexities of 2009/3245's care should have been summarised more comprehensively. A full risk assessment should have been documented and a clear plan given to the GP about what the recommendations were for future care if 2009/3245's health should deteriorate.

The panel accepted that due to 2009/3245 having changed addresses on several occasions it was perhaps not feasible for CP10 to continue to look after him and as he was declining follow up care in the area to which he had moved, CP10 was put in a difficult position to provide regular supervision of 2009/3245's health care.

2004 to 2009, Index offence

63. On 14 January 2004, a Multi-Agency Public Protection Arrangement ("MAPPA") meeting was organised (pre-release) by the Probation Service. 2009/3245 was assessed as high risk. The risk strategy included alerting the GP and for referral back to Mental Health Services.

64. A second MAPPA meeting was held on the 1 April 2004. Given that the risk factors included but were not limited to violence and drug abuse, 2009/3245 remained as a high risk.
65. 2009/3245 was released from prison on licence on 29 January 2004 and both his CPN from the Custody Division Scheme (who monitored 2009/3245 in the probation hostel) and his GP referred 2009/3245 for psychiatric review. He was not seen by the Senior House Officer ("SHO") to Consultant Psychiatrist 12, ("CP12") until June 2004.
66. When 2009/3245 was seen by the SHO to CP12 in June 2004, he was said to have no signs of mental illness and a diagnosis was made of Psychopathy. The doctor accepted that he had not seen 2009/3245 before, but did indicate that he had reviewed the clinical notes and based his diagnosis on the absence of any mental illness at the time he saw him and previous written comments from CP10. The assessment was made that he should be weaned off Lithium Carbonate which 2009/3245 was clearly anxious about. He self-disclosed at the appointment that he had concerns about running out of his medication, as he felt he could not do without it.
67. There followed a third MAPPA meeting on 23 June 2004 where 2009/3245 was assessed as high risk as he was said to be unable to recognise his inability to cope well with change and his reliance on drugs and alcohol.
68. The proposal by the SHO to see 2009/3245 on one further occasion in supporting the removal off the Lithium Carbonate was discussed at the MAPPA meeting on the 23 June 2004. It was highlighted that 2009/3245 had a long forensic history and that periods of change, including alterations to his medication were apt to cause extreme anxiety and had previously precipitated a deterioration in 2009/3245's mental health. They asked for additional support to 2009/3245 during the critical period that he was weaned off Lithium Carbonate, to ensure his mental health was regulated and monitored adequately.
69. In any event, 2009/3245 failed to attend his next appointment and was then seen briefly in July and then in September 2004 when Consultant Psychiatrist

13, ("CP13") took over his care. He took the decision to allow 2009/3245 to continue taking his medication. This seemed strongly influenced by patient preference and not for any confirmed diagnostic reason. There was no evidence of current mood disorder and 2009/3245 made it known that he was not ready to stop taking Lithium Carbonate yet. 2009/3245 was to be reviewed on a 3 monthly basis.

70. 2009/3245's MAPPA status was changed at a meeting held on the 13 September 2004. He was reclassified as medium risk rather than high and deregistered.

71. There was no Health or social care representation at the MAPPA meeting in September 2004, the decision was taken by the Police and Probation Service representatives.

72. 2009/3245 healthcare was transferred to Consultant Psychiatrist 14, ("CP14") in April 2005; this appeared due to 2009/3245 moving to Bed & Breakfast accommodation (B&B) in Park Road North, Middlesbrough and changing catchment areas. CP14 assessed 2009/3245, 3 months later as having no other risk factors than his medication being changed. His current medication was maintained.

73. In late 2005, 2009/3245 was suffering with anxiety and panic. He was asking for additional support through a CPN during consultations with CP14. He was severely concerned that he would have another breakdown. Part of that anxiety related to his preoccupation with his medication, in that he continuously carried a quota of 7 days' supply of his medication with him. He also admitted to smoking £5 of cannabis per day. Despite these concerns being aired at the consultation with CP14 on 11 August 2005, no risk factors were flagged up.

74. 2 months later, 2009/3245 was further reviewed by CP14. He self-reported that he was smoking cannabis most days and now wanted to come off his medication. 2009/3245 was then seen on 7 March 2006 by CP14 again and reported he was having some paranoid thoughts. In a clinic letter these were described as "weird thoughts" which resulted in 2009/3245 physically fighting

with others. He was still smoking cannabis three times per week. Despite this, the next review was set for 3 months where again he was still smoking cannabis albeit at a self-reported reduced rate.

75. On 16 October 2006, a telephone call was made to the acting duty manager at Parkside. 2009/3245 appeared to have developed an unhealthy attachment to a female member of staff at the B&B where he was staying and was said to become irritable if other men were around her. There appeared to be a return telephone call to the member of staff at the B&B, informing her that Parkside were aware of these issues.

76. 2009/3245's next appointment was in January 2007 having missed two earlier ones. This was his first appointment with his new Care Coordinator. She indicated that she would carry out a thorough review of his experience of the Mental Health Services and complete a new core assessment and risk assessment of him.

77. 2009/3245 was seen on 10 May 2007 by his Care Coordinator, he indicated a reluctance to change his medication. There was a risk review section in the letter in the clinical file. It was also documented that he had a very serious past history of violence towards women, as well as to staff and the general public. Problems were said to lie in relationships with women particularly when they wanted to end the relationship. There was a recognition that a full forensic history had to be corroborated as well as a need to update the core assessment.

78. 2009/3245 was reviewed at 3 monthly intervals. By August 2007, the Care Coordinator felt that the risks were so low, 2009/3245 could be reviewed every 6 months. The next review was in April 2008.

79. 2009/3245 was reviewed on 17 July 2008 where he expressed concern that he might "go berserk". He actually asked to be kept under psychiatric review because of his past history. He also had a deep seated fear that he would once again relapse in a "spectacular manner". Despite this, there were said to be by the Care Coordinator no risks in any areas and he was to be reviewed in 6 months' time.

80. 2009/3245 applied for supported housing through the charitable organisation New Horizons (Teesside). The application was completed by 2009/3245's Care Coordinator.
81. Around the same time, 2009/3245 was diagnosed with Type 2 diabetes and his GP had concerns regarding his high creatinine levels and spoke to CP14 on two occasions regarding this. This resulted in 2009/3245's Lithium Carbonate being reduced and 2009/3245 being reviewed by Consultant Psychiatrist 15, ("CP15") on 19 November 2008. At that appointment 2009/3245 indicated he was concerned about his sexual performance. He had also moved into new accommodation.
82. CP15 decided to reduce 2009/3245's Lithium Carbonate further. He had been on 1200mg per day, but this was reduced by his GP following consultation with CP15. By the time of the next clinic appointment it was 250mg Bis Die. At the clinic it was agreed that the Lithium Carbonate was to be reduced to 250 mgs for one week and then stopped. CP15 discussed with 2009/3245 the options to replace Lithium Carbonate. It was to be replaced by Aripiprazole. The review for this process was 2 months.
83. At the appointment in November 2008, 2009/3245 expressed concern he may relapse or "flip" as he had done in the past. Despite this the Care Coordinator recorded in the clinical notes that there were no risks.
84. Prior to the 2 months review, 2009/3245 was seen by the Care Coordinator on 15 January 2009. A CPA review was completed. He was said not to be in any close relationship at that time and there were no risks evident. He was to be reviewed in 3 months' time.
85. 2009/3245 had his final review pre incident with CP15 on 29 January 2009. Again, he was complaining of sexual health problems. An entry in the clinic letter said there were no cross sectional risks and a 3 month review date was arranged. This was the last contact that 2009/3245 had with specialist Mental Health Services.

86. The index offence was committed on 3rd or 4th April 2009.

COMMENTARY

From the probation file, it was clearly apparent that they had an offender screening assessment which identified that 2009/3245 had limited ability to deal with relationship problems and that attention had to be given to his mental health. Whilst on probation his medication and relationships were to be monitored to avoid trigger situations arising. Such identifiable triggers and rigorous monitoring procedures were not followed by the care team.

The positive practice of organising a MAPPA meeting pre-release was recognised although the decision to re classify 2009/3245 was taken in the absence of any active Health or Social Care involvement.

The panel was concerned that a patient with 2009/3245's lengthy and complex clinical and forensic history was followed up by a SHO to CP12. The complexity of the issues in 2009/3245's case appeared not to have been documented and there was no risk assessment in the notes for this period (June 2004).

The transfer letter dated 21 April 2005 from CP13 to CP14 appeared inadequate. It was handwritten and was of limited value in identifying the risk factors that would have indicated deterioration in 2009/3245's mental health.

During 2005-2006, the notes suggested that 2009/3245 was suffering with symptoms of panic, anxiety and that there was substance abuse. Despite this, 2009/3245 was not monitored any more closely and there appeared to be no evidence of consideration as to the best approach in dealing with his use of Cannabis. He himself was asking for additional help and was concerned about having a breakdown, yet he was assessed as having no risk factors.

The lack of any review and reassessment of the risks and the management of 2009/3245's care at this time was of concern to the panel. Despite his history, it

did not appear that any “alarm bells” were being sounded within the services involved with his care. There was evidence of there being symptoms of 2009/3245 possibly relapsing and suggestions by him of physical aggression to others by getting into fights, but this appeared to have been ignored.

When 2009/3245 took an unhealthy interest in a member of staff at the Park View Guest house there did not appear to be any follow up at all by the care team. There was no linkage with 2009/3245's previous history of violence towards women. Despite the fact there was a known risk to women with whom he formed an attachment. The action after it was simply to phone the female concerned and to inform her that they were aware of those issues.

There was no meeting with 2009/3245 where this appeared to be discussed and 2009/3245 was not actually seen formally again until at the Team Led Clinic some 4 months later in January 2007. 2009/3245 appeared to have missed two appointments since the last review in June 2006, but there was little by way of evidence of Parkside chasing this up in light of what occurred in October 2006. There was no evidence that this information caused any concerns and neither was there any evidence of any review/reassessment of any current or future behaviour.

In the space of a few years, 2009/3245's had clinical contact with fifteen different Consultants. Many of those transfers occurred either due to 2009/3245 having moved address or because of service change, resulting in his care being passed onto a different team. There did not appear to be a single summary document that succinctly, but comprehensively gave an overview of 2009/3245's history, apart from that of CP9's.

There was no clear formulised risk assessment being passed on from Consultants. For any new doctor meeting 2009/3245 for the first time, they would have had to refer back to the assessment produced by CP9 in 1996 when 2009/3245 had been in the Hutton Centre for them to find a comprehensive review of his care.

In addition, it was evident to the panel that Consultants CP11 to CP15 were only involved with 2009/3245 for a relatively short period of time. Also Consultants

CP13, CP14 and CP15 had trained overseas and even if 2009/3245 had indicated that he had been a patient in Ashworth Special Hospital, it was not necessarily the case that this would have enabled those Consultants to be aware of where this hospital was and/or what type of facility it was.

There was the possibility that his Care Coordinator, (an experienced mental health practitioner) might have been able to identify the issues and provide guidance to the Consultant who was responsible for 2009/3245's care. It was clear that information about 2009/3245's past history was not passed on verbally between the Care Coordinator and the Consultant. This will be dealt with in chapter 7 at pages 93-110 of this report.

At the final CPA review on 29 January 2009 between CP15 and 2009/3245, the entire focus appeared to be on 2009/3245's medication. There was no in-depth enquiry into any other risk factors. This was surprising to the panel given 2009/3245 again expressed concern with his sexual health. This did not appear to prompt any questioning into whether he was having a relationship with anyone or the status of any potential new relationship.

What was clear from the post incident assessments of 2009/3245 was at the time of the index offence neither of the Prosecution and Defence Psychiatrists who subsequently examined him felt that he was suffering from an acute episode of mental illness and consequently, he was given a life sentence.

The fact that 2009/3245 indicated that he had no recollection of the events on the day of the offence made it even more difficult to ascertain whether it would have been possible to act in a way that would have prevented the offence occurring.

In the panel's view, it certainly was not predictable that 2009/3245 would act in the way he did on the day in question. However, there were clear signs for a risk of violence towards women with whom he was having a relationship as this had clearly been evident in his past and this was not necessarily related to relapses in his mental health, although he had shown that aggression towards others could occur as part of a deterioration in his mental state. It was clear that he had not confided in the statutory mental health team about his new relationship. It was

always possible that if more probing questions had been asked, more information would have been available about that relationship.

5: ASSESSMENT AND MANAGEMENT OF RISK

The panel viewed the assessment and management of risk by the Trust as one of the central issues when considering the quality and scope of health care and treatment provided to Patient 2009/3245. In looking at risk assessments, the investigation focused on the Trust's policy for risk assessment that was operating prior to and leading up to the index offence. Then subsequently, how and to what effect that policy was applied to Patient 2009/3245 by the treating clinicians.

By definition, risk management is the identification, assessment, and prioritisation of risks followed by a coordinated and economical application of resources to minimise, monitor, and control the probability and/or impact of the realisation of those risks.

The panel reflected that even with the most comprehensive contingency planning, risk could not be entirely eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risks in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of factors underlying a person's behaviour.¹

The panel considered this was indeed the case for Patient 2009/3245. Even if CP15 and the Care Coordinator had discharged their obligations vis a vis risk assessments to Patient 2009/3245 in compliance with the Trust's Clinical Risk Assessment and Management Policy (2008), the index offence could still have occurred. Although the panel recognised risk management as a core function in a clinical setting to reduce or avoid the frequency of negative outcomes, in practice, such risk assessments would not totally remove the possibility that the incident could have occurred in any event.

For the Trust, their interpretation of risk management was and still is enshrined in an agreed policy for clinical risk assessment for Mental Health Service users which was referred to as the Clinical Risk Assessment and Management Policy. Such policy was ratified in October 2008 and in force at the time of the serious untoward event in April 2009.

¹ Rethinking risk to others in Mental Health Services, June 2008. Royal College of Psychiatrists.

The policy aimed to:-

- clarify the scope and methods of clinical risk assessment;
- clarify the standards of clinical risk assessment and clinical risk management practice;
- set standards for the documentation and communication of clinical risk assessment and clinical risk management plans;
- describe the training requirements for staff;
- outline the systems by which clinical risk models and clinical risk assessment tools used in services are authorised and registered by the Trust

The policy applied to all staff with direct contact with service users (clinical practitioners where competency in clinical risk assessment, formulation and management was required as integral to their role).

It also applied to other staff that had regular contact with service users, their families and carers. They were required to have an awareness of clinical risk issues and its importance in the care of service users. Also practitioners who worked with service users, their families and carers through partnership agreements, inter-agency integrated working arrangements, service level agreements, honorary contracts and educational placements were required to adhere to the principles and standards in the policy and to access the Trust's training programme for risk assessment.

The policy regarded clinical risk assessment and clinical risk management as an ongoing, dynamic process, which should be kept under constant review. Risk assessments were not to be viewed as an isolated once only activity but instead a regular review which was constantly evolving.

Consequently, formal clinical risk assessments were to be completed on a patient's initial contact with new services, throughout the service user's involvement with

mental health and then reviewed at regular intervals. Any changes were to be recorded and acted upon.

Clinical risk assessment, clinical risk formulation, clinical risk management planning was to be completed and reviewed at “critical points” in the service user’s journey of care. All assessments, reviews, plans and changes to plans were to be documented in the service user’s clinical record together with supporting evidence justifying the change.

The minimum of critical points were identified in the policy as:-

- on initial contact with the service;
- following any incident during contact with Trust services;
- any significant change to the service user’s presentation, physical or mental state;
- change or transfer of care responsibilities e.g. change of community practitioner; admission to an in-patient setting; in handovers of periods of enhanced engagement and observation in in-patient settings;
- prior to and return from any leave from in-patient residential services;
- multi-disciplinary team review or any review of care provision;
- change in legal status;
- change in life events (e.g. loss);

- movement to less or more restrictive environments;
- at the request of a service user, their carer and/or families;
- prior to and post discharge from in-patient services, on arrival and pre discharge from community or Trust services;

The policy stipulated that clinical risk assessment was to be based on a thorough collection of information from all available sources and to cover all aspects of the service user's early life experiences. This included cognitive, emotional, psychological, physical, behavioural and social factors. Details of historical risk factors and behaviours as well as recent risk behaviors were to be taken into account. This included looking at the severity, frequency, pattern, and effect and planned intent of such risks and behaviours.

An integrated clinical risk management plan was to be drafted to identify the risks the service user could present, through their behaviours, cognitions, physical state and disability. The plan had to identify which situations and organisational contexts the risks were likely to present. It was also to identify all the actions or interventions that were to be implemented to address those risks. In addition, it also looked at the goal or aim of those actions/interventions and who would act/intervene and when.

The type of action/intervention was to be congruent with the clinical risk identified and consistent in intensity with the level of clinical risk.

A record of the progress and outcomes of the clinical risk management plan was to be documented in the service user's core contemporaneous progress sheets in the clinical record, together with a review and evaluation of the plan and the evidence and rationale for any changes.

Evaluations and reviews were not to be made on the clinical risk management plan itself. This was to avoid an incomplete contemporaneous progress record. If specialist clinical risk assessment and management models/tools required the completion of reviews and evaluations on specialist documents, then a summary

note was to be made in the core contemporaneous progress sheets to provide a complete record.

It was the responsibility of the clinical practitioner to ensure that the clinical risk assessment, formulation and clinical management plan were communicated to all involved in the service user's care and that they were recorded in the specialist risk assessment section of the service user's clinical record and on the appropriate corporate electronic record keeping system.

The policy identified standards of record keeping and documentation. All clinical practitioners were required to record clinical risk assessment findings and formulation findings with clinical risk management planning outcomes on their service specialist local clinical risk assessment and management documentation which would be held in the service user's clinical record.

All service users were required to have a clearly identifiable clinical risk assessment and management plan. No documents were to be used that were not registered with the Information Governance systems.

A summary of the clinical risk assessment and clinical risk management plan was to be recorded on the Trust's corporate electronic recording systems, PARIS (as well as the paper contemporaneous record) as part of the local CPA systems. This would ensure access to contemporary clinical risk assessment and clinical risk management plans for all on-call and out of hours staff.

The policy set out the expected standard for risk assessment. It recognised that the use of clinical risk assessment models and tools were part of the process to aid recognition and rating of clinical risk to the service users, their families and carers, staff and the general public.

Given the Clinical Risk Assessment and Management Policy in place, it seemed to the panel that the Trust in theory, demonstrated a robust, well researched, evidence based framework for clinical practitioners to undertake clinical risk assessment and formulate risk management care plans.

A significant amount of evidence that was considered by the panel pre dated the

policy that was in operation at the time of the offence. The panel viewed the principles of good practice contained in the policy relating to risk assessment and risk management to predate the policy operating at the time of the incident.

Prior to the introduction of the 2008 policy, the panel identified from reviewing 2009/3245's clinical notes, historical evidence of risk assessments which were of varied and inconsistent completion with a number of differing formats. There was an absence of a uniformed approach to risk assessments by consecutive clinicians. They ranged from a comprehensive summary of risk that demonstrated holistic understanding of repeated aggressive and offending behaviour, particularly towards women, to examples of risk assessments that lacked any depth or comprehensive understanding of Patient 2009/3245's behavioural risks.

The panel heard in evidence how risk assessment was integral to the CPA. The CPA is examined in chapter 6 at pages 50-56 of this report and will be dealt with in more detail in that chapter. Under the CPA, risk assessments utilising the clinical risk assessment FACE tool were to be carried out as part of the initial comprehensive assessment then at least at every CPA review.

For those at the time on Enhanced CPA, this would be a minimum of every 6 months. For those on Standard CPA, it would be annually. Additionally, the FACE clinical risk assessment tool was to be completed at the point of transfer of care responsibilities and to be kept under regular review.

Unfortunately, in the case of 2009/3245, annual reviews did not occur. In addition, the decision to place Patient 2009/3245 on Standard Care, from Enhanced CPA meant that he was not assessed at home and essentially his risk assessments were entirely based on self-report. Both CP15 and the Care Coordinator acknowledged in evidence to the panel that with the benefit of hind sight, 2009/3245 met the criteria of Enhanced CPA and therefore should have been subject to a more rigorous care plan, including risk assessment.

The clinical risk assessment model that was approved for use across the Trust was the FACE clinical risk assessment tool. Unless a clinical service or professional group identified another clinical risk assessment model or tool that was clinically more effective for use with their service user group, then the FACE clinical risk

assessment tool was to be used. The panel heard evidence that confirmed the FACE clinical risk assessment and management model was applicable to the Psychosis Service in Middlesbrough and therefore should have been used in conjunction with Patient 2009/3245.

The FACE risk assessment tool was incorporated into the Trust's electronic patient record (PARIS) on its implementation in July 2008. Prior to this, the FACE risk assessment tool had been recorded on a paper-based system. The panel could not find any evidence from the documentation reviewed that at the time of, or preceding, the date of the offence, a FACE risk assessment and care management plan had been completed for 2009/3245. The treating Care Coordinator, when giving evidence informed the panel that the FACE tool should have been used in relation to 2009/3245, but that it was not.

The panel heard evidence, that with the establishment of the Team Led Clinics, a proforma had been developed and used as a substitute for the FACE risk assessment tool. Included in the proforma, was a section on risk that could be used to prompt questioning to the service user on harm to others or self. This was adopted in place of the FACE risk assessment tool in Adult Services at Middlesbrough from 2005 onwards. It was used to risk assess Patient 2009/3245. It appeared to have been used exclusively by Middlesbrough Psychosis team. It was not evident to the Trust CPA Department until after the serious untoward event in April 2009.

The treating Care Coordinator saw the use of this proforma as a "pragmatic approach". She regarded the FACE risk assessment tool as laborious and which in her opinion took too long to complete (up to 3 hours). It was not perceived in evidence by her as being helpful and a narrative risk profile was viewed by her as being far better and quicker.

From the clinical notes, it appeared to the panel that the proforma consisted of general questions focusing on health and social care needs such as accommodation, physical health, finances, employment and an examination of the current risks. The theory was that the social issues needed to be addressed as a priority to start to facilitate Patient 2009/3245's recovery. The emphasis was on concentrating on the basic needs, then once dealt with, to move on to the clinical. All the information being populated by self-report only by 2009/3245 with no or little corroboration from any other source. This seemed to have been in direct

contravention of the Trust's own Clinical Risk Assessment and Management Policy. Not only was the FACE tool not being used, but the proforma was being used in its place and it failed to be a thorough review of past historical risks including 2009/3245's early life experiences from all sources.

Due to the focus being on current social needs, it seemed to the panel that past risks, and future behavioural triggers were largely being ignored by the care team treating 2009/3245. There was no attempt to identify situations or circumstances in which 2009/3245's historical risks would/could resurface and what action to take if they did. There was no evidence of a contingency plan in the event of a deterioration of 2009/3245's symptoms.

The panel considered narrative, proforma risk assessments to be descriptive and subjective rather than evidence based and measurable. The use of the proforma had also not been subjected to the rigours of the Trust's governance approval process. In respect of 2009/3245, there was no FACE risk assessment that supported a comprehensive approach to risk formulation and risk management planning. The standard of recording and documentation in the clinical notes reflected this. In this respect, neither the Care Coordinator or CP15 complied with the Clinical Risk Assessment and Management Policy in relation to Patient 2009/3245.

At a corporate level, governance systems prior to the index offence did not appear to monitor compliance with the Trust's Clinical Risk Assessment and Management Policy and to take remedial action in default. The panel were informed systems have subsequently been developed, to address this. Risk assessment is now seen as a key priority for the organisation and is included as part of Quality Accounts.

The panel were informed that the Trust, as part of the implementation plan for PARIS, required clinicians to include a retrospective summary of need, including risk, to be entered onto the PARIS system. This was seen as important information to ensure context, continuity and access for all those providing care. Evidence was heard that in some areas of the Trust some teams made a decision not to do this. In relation to 2009/3245, a historical summary of need was not completed at the time of the index offence.

Whilst there was a synopsis of 2009/3245 historical information dated 25 January 2007 on the PARIS system, it was confirmed by the Care Coordinator in evidence that this had been entered after the date of the index offence. At the time of the incident, this was not available to clinicians other than by accessing the paper file.

It seemed clearly evident to the panel from the paper case notes that the Care Coordinator was aware of Patient 2009/3245's past risks. She referred in evidence to the panel about his risks being "very loud". She was aware that Patient 2009/3245 could form unhealthy attachments to females, particularly when they rejected him. She confirmed in evidence that this was a definite trigger. The issue was however; that those past risks and future triggers were not documented or recorded in line with the Trust's Clinical Risk Assessment and Management Policy. Nor were they communicated by the Care Coordinator at all to CP15 or adequately communicated to the New Horizons team.

The panel heard that the Care Coordinator was unsure as to whether CP15 was aware of 2009/3245's historical risk associated with female attachment. She indicated that she would have expected CP15 to have read 2009/3245's case notes to develop his understanding and knowledge of 2009/3245's risks. Consequently, she failed to communicate those risks to CP15. Again, this seemed to depart from the Trust's Clinical Risk Assessment and Management Policy by failing to communicate to all involved in 2009/3245's care what his actual risks were.

There was evidence from the witnesses interviewed by the panel that a number of Consultant medical staff were not fully informed of 2009/3245's forensic history, including his referral to MAPPA and in particular the associated risks regarding female attachment. Care of 2009/3245 had been transferred, over a number of years, between several clinicians. During those years, there was clear evidence of a lack of summary information with a comprehensive risk history being transferred from Consultant to Consultant.

Patient 2009/3245's transition through services is documented throughout this report, particularly in chapter 4 dealing with the Chronological Narrative of Key Dates and Events (pages 8-33). The significant forensic and risk history, in particular 2009/3245 relationships with women, did not appear to have consistency or continuity of communication through his service transition. The information regarding risk which should have been passed from treating clinician to treating clinician had not been. As a result the potential significance of his risk history had

not been fully considered in formulating decisions relating to his care. This was a fundamental matter as one of the key indicators in determining future risk is past behaviour of the individual. This supported a perception of low/no risk issues being formulated in connection with Patient 2009/3245.

In addition to detailed information not being transferred between Consultants, neither did the past history appear to have been accessed by receiving Consultant medical staff. CP14 gave evidence to the panel that he had not been aware 2009/3245 had been in a RSU or the reasons he had been in prison. He had not accessed the previous case notes. He indicated that he had not seen 2009/3245 as having any significant risk issues.

The panel had concerns regarding the apparent apathy in relation to 2009/3245's historical risk factors and the failure to adequately record, share and communicate that information. As a result this inevitably reduced the ability of services to identify potential concern and agree risk management plans to mitigate such concern.

CP15 gave evidence that he only became aware of 2009/3245's history after the index offence. In evidence, he confirmed that he had no knowledge of 2009/3245's forensic history or involvement with MAPPA. He indicated there was no information on the PARIS system. Nor had any information regarding Patient 2009/3245's risk factors been passed to him by the Care Coordinator. His expectation being that it should have been.

In addition, CP15's view of risk assessments seemed very narrow. In evidence, he confirmed that he viewed risk assessments as dealing with 6 current issues only; risk of self-harm, harm to others, self-neglect, alcohol, drug abuse and exploitation. There appeared to be no appreciation by him that a risk assessment was in any way based on historical information. He referred to his approach to clinical risk assessment as being "blind".

CP15 explained in evidence that he had assessed risk solely through discussion with 2009/3245. Again, he departed from the Trust's Clinical Risk Assessment and Management Policy by assessing risk based on 2009/3245's self-report only. He confirmed at interview that the only risk he considered in connection with Patient 2009/3245 leading up to the index offence was drug abuse. It seemed to the panel

that this was partly due to his lack of understanding of 2009/3245's historical risk, a failure to appreciate the Trusts Clinical Risk Assessment and Management policy and partly due to his own perception of his own role as being to deal with patient medication issues only.

At the CPA review meeting on the 29 January 2009 no risks, other than continued use of cannabis, were identified. This was the last CPA meeting before the offence was committed. This was despite the fact that by that time Patient 2009/3245 had moved to new accommodation (October 2008), been diagnosed with diabetes (October 2008) undergone a reduction in his Lithium Carbonate medication (November 2008) which he had been dependent on since 1988, and was complaining of sexual health problems.

The panel believed that the whole issue of 2009/3245's historical risk was ignored by the treating clinicians at the time of the index offence. The Care Coordinator in evidence referred to complacency being adopted by the treating clinicians towards the historical risks of 2009/3245. The panel accepted that this appeared in fact to have been the case.

The panel could not find any evidence to suggest that the fact 2009/3245 had entered into a relationship with a female was highlighted at the last CPA review meeting prior to the offence. The only person, other than 2009/3245 himself, (and he was not asked) who was at the meeting and aware of the relationship being formed was the New Horizons key worker, who did not raise this as an issue. Evidence provided to the panel would indicate the monitoring of 2009/3245's behaviour in forming new relationships was exclusively by asking him and through his self-report only.

The panel viewed self-reporting, by interview and consultation as a very narrow approach as well as a departure from the Trust's Clinical Risk Assessment and Management Policy. Awareness of risk history, possible triggers or events occurring in the future would have enabled a far more comprehensive approach to assessment of the risks of 2009/3245.

The fact that the Care Coordinator was not aware 2009/3245 had entered into a close relationship with a female, prevented a wider discussion on risk. This did not

allow for assessing any changing risk status and identifying any interventions or actions to mitigate risks.

The panel heard evidence that New Horizons staff were aware of 2009/3245 forming a relationship with a female in early 2009. Between the 22 January 2009 and the time of the index offence, there were nine separate references in the New Horizons weekly logs that record 2009/3245 had formed a significant relationship (an example from the weekly New Horizons log dated the 16 March recorded “a happy man spent the weekend in Hemlington with girlfriend”).

In evidence, the care staff, including the key worker at New Horizons, indicated awareness of the history of 2009/3245 regarding violence towards women, particularly when rejected.

The fact 2009/3245 was in a relationship was discussed at the New Horizons internal review meetings of 2009/3245. There was conflicting evidence at interview as to whose responsibility it was to communicate this information to the Care Coordinator. The New Horizons key support worker indicated this should have been done through their line management structure whereas the line manager saw this as the key caseworker’s responsibility.

There was however, a view formed within the team at New Horizons that 2009/3245 was progressing well; there were no concerns (as his violence had been in the past). 2009/3245’s relationship with a female reflected their philosophy of promoting independence and as such they saw the developing relationship as positive. No link was made between his developing relationship and his historical risks.

The panel could find no evidence that the development of the relationship between 2009/3245 and Victim A was communicated wider than the New Horizons team.

Evidence provided was that New Horizons staff did not have internal transparent communication that allowed them to identify and understand the potential significance of this specific behaviour.

Referral to New Horizons required the completion of an application form by the Care Coordinator. That application included the requirement to share risk information. Indeed, the referral for supported accommodation was not complete without a care plan and risk assessment. In Patient 2009/3245's case, this consisted of a copy letter from the Care Coordinator to his GP dated 30 July 2008 which simply summarised the current position. In the said letter under "risk review" it was recorded that there were "no concerns".

The accommodation application on behalf of 2009/3245 lacked any behavioural detail and sought to down grade his historical risks. The risks were recorded as being past and that was exactly how they were then viewed by the New Horizons staff. In the past, with no bearing to the future.

Internal risk assessments were undertaken by New Horizons staff. This was documented within their case records. The documentary evidence suggested this did not have the benefit of a full and transparent history and as a result, this limited their effectiveness. The first risk assessment pertaining to 2009/3245 which was carried out by the New Horizons team identified a serious history of violence towards women. However, this was not identified as a continuing risk in subsequent risk assessments completed by his key worker. Nor was it therefore viewed as significant by New Horizons staff when Patient 2009/3245 entered in to a relationship.

The New Horizons team did not demonstrate an understanding of the significance of 2009/3245 entering into a relationship with regard to his risk history. They were in a key position to communicate this development in 2009/3245 changing behaviour. They all acknowledged in evidence to having had risk assessment training.

In the panel's opinion their receptiveness to this issue was influenced by two factors. Firstly, their level of knowledge and understanding relating to the risk history which had been communicated to them by the Care Coordinator. She acknowledged in evidence that if Patient 2009/3245 was in a relationship this could be a potential "trigger".

From her drafted synopsis dated 25 January 2007 she was well aware of the previous pattern of violent behaviour towards females when rejected. (His attack on

his estranged wife in July 1987, his attack on a female patient at the Hutton Centre with whom he was having a relationship in June 1991, in November 1999 when he was arrested following domestic violence towards his then partner and her daughter, and in September 2000 when he attacked his then girlfriend threatening to burn her eyes out and kill her children. Latterly, in October 2006, when he formed an inappropriate emotional attachment to an employee at the Parkview guesthouse and then subsequently, to his first female support worker at New Horizons).

Despite this level of knowledge by the Care Coordinator, this was not adequately communicated to New Horizons staff. Instead, the New Horizons team saw the behavioural risks of 2009/3245 as something in the past and not relevant to the present. This will be explored further in chapter 7 dealing with the Standard of Record Keeping and Communication at pages 93-110 of this report.

Secondly, New Horizons philosophy of care was based on “normalisation”. The fact 2009/3245 had started a relationship with a female was seen as normal by them.

In conclusion, it seemed to the panel that at the time of the index offence, the treating clinicians had departed from the Trust policy regarding Clinical Risk Assessments and Management. There was no comprehensive care plan in place. No FACE risk assessment was being used, instead in its place was a narrative proforma which failed to adequately record the significance of Patient 2009/3245 historical behaviour. Insufficient information was collated and it was based entirely on self-report from Patient 2009/3245.

It was clear from the handwritten notes and synopsis drafted by the treating Care Coordinator that she was fully aware of the historical risks associated with 2009/3245 but she failed to record this in compliance with the Clinical Risk Assessment Policy and she failed to communicate it to CP15 or to the New Horizons team.

2009/3245 was frequently transferred from clinician to clinician without a uniformed approach as to a transfer summary. Some treating clinicians of 2009/3245 did not even read the past notes to enable them to adequately assess the current risks. The panel considered it was not good practice to carry out a risk assessment without some knowledge of a patient’s past risks.

The panel viewed this undoubtedly as having impacted on the level of care given to Patient 2009/3245.

TREATMENT, CARE AND IMPLEMENTATION OF THE CARE PLAN

In looking at the treatment, care and implementation of the care plan for Patient 2009/32454, the panel focuses on the CPA, Section 117 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) and then considered the wider issues of 2009/3245's appropriate diagnosis, NICE Guidelines and organisational changes which were taking place in the Trust prior to the index offence and leading up to when the offence was committed.

(i) Care Programme Approach

The CPA is the national framework for the delivery of care in specialist Mental Health Services across multi disciplines and partnership organisations. It was first introduced in England in the 1990s and was latterly reviewed with the publication by the Department of Health in March 2008 of "Refocusing the Care Programme Approach, policy and position guidance".¹

The objective behind its implementation was to ensure uniformity of approach and effective communication between care providers, service users and their families. In practical terms, it meant a comprehensive health and social care needs assessment for the patient followed by a single written care plan that was to be reviewed regularly.

In response to the published 2008 guidance, the Trust and its Local Authority partners established a working group across the seven Local Authorities to review the CPA policy. The working group developed a revised policy referred to as the "Care Programme Approach Policy: A framework for multi-agency working in Mental Health and Learning Disability Service". This was ratified as a working draft on the 8th October 2008, and it was subsequently endorsed on the 1 April 2009.

The CPA policy defined its purpose as providing an effective and consistent care provision and resource allocation for patients who were the responsibility of the Trust and their Local Authority partner. To secondary mental health care, CPA meant

¹ Refocusing the Care Programme Approach: Policy and Positive Practise Guidance, 20th March 2008. www.dh.gov.uk/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

assessment, planning, coordinating and reviewing the range of treatment, care and support needs for those individuals with complex characteristics. The policy also covered responsibilities for those in contact with Mental Health Services not managed through CPA. This was referred to as Standard Care. This was considered to be appropriate for patients who were more independent with less risk and less complexity. CPA and Standard Care replaced the previous two levels of CPA which were Enhanced and Standard CPA.

The policy set out criteria for those patients who should be managed on a CPA as a result of being assessed as having more complex needs and consequently viewed as a higher risk. The criteria included but were not limited to:-

- severe mental disorder (including Personality Disorder) with a high degree of clinical complexity;
- current or potential risk(s) including harm to others (including a history of offending);
- current or significant history of instability;
- presence of non-physical co-morbidity, e.g. Substance Misuse;
- patients subject to Section 117;
- those experiencing disadvantage or difficulty

The policy emphasised that where there was a history of violence, dual diagnosis and unsettled accommodation, the default position for patients would normally be CPA rather than Standard Care.

The policy also provided a description of the expectations of what a service user should expect from the service. That was to include:-

- the support of a Care Coordinator;

- a comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks;
- an assessment of social care needs;
- comprehensive formal written care plan, including risk and safety/contingency/crisis plan;
- regular review at least every 6 months for CPA and every 12 months for Standard Care;
- access to advocacy;
- carers advised of rights to assessment

It also outlined the key role of the Care Coordinator and highlighted the importance of a proactive and coordinated approach in managing care. The core areas to be covered included:-

- to undertake a comprehensive risk assessment;
- risk assessment and management of the patient;
- crisis planning and management;
- assessing and responding to carer's needs;
- care planning and review;
- effective transfer of care or discharge

The CPA policy also signposted to other relevant policies of risk management including Section 117.

In considering the CPA policy, documentation made available to the panel and the witness evidence heard by the panel, it was apparent that in the case of Patient 2009/3245 he met the criteria for those individuals who were to be included on CPA rather than Standard Care. He was subject to Section 117 aftercare, there was a

history of violence, dual diagnosis and he had been unsettled in accommodation and therefore, the panel believed that the default position should have been adopted by his care team and consequently, Patient 2009/3245 should have been on a full CPA. Despite this, he was assessed on a Standard Care basis. This, the panel considered was incorrect. It led to a lower level of care being delivered to 2009/3245, than his history and presentation warranted.

The panel heard evidence from both CP15 and his Care Coordinator (at the time of the index offence) that they, with the benefit of hindsight considered that Patient 2009/3245 should have been assessed on a full CPA. Instead, 2009/3245 was not seen at the time by his care team as an individual who was high risk or had demanding needs despite his past. He was not seen as a clinically complex patient with a significant history of instability.

CP15 suggested in evidence that it was his responsibility to consider whether 2009/3245 should have been on CPA or Standard Care. His failure to put 2009/3245 onto CPA was according to CP15 due to his lack of knowledge of 2009/3245's past history which should in his opinion have been communicated to him by the Care Coordinator. Instead, CP15 based his assessment on self-report from 2009/3245, without having read any of the clinical records of 2009/3245 which were available to him.

As previously identified in the preceding chapter of this report, the panel viewed this approach to risk assessment as narrow and furthermore, inadequate. It appeared to the panel highly surprising that CP15, who shared responsibility with the Care Coordinator for 2009/3245's care management, could even begin the task of carrying out a thorough and full assessment of 2009/3245 when he had not read or reviewed his clinical notes and was therefore oblivious to his past behaviour and risks. This appeared to be a direct departure from the Trusts' CPA policy and ignored that policy's aim of providing effective communication and coordination between clinicians who were treating individuals.

Evidence from previous treating clinicians of 2009/3245 (such as CP13 who provided care to 2009/3245 from September 2005 to April 2006) reinforced the fact that 2009/3245 should have been on Enhanced CPA and not on Standard Care. This would undoubtedly have led to closer and more regular monitoring of 2009/3245 with a comprehensive multi-disciplinary approach.

Indeed, 2009/3245's Care Coordinator and CP15 both made the point in evidence, that had 2009/3245 been on CPA Care he would have been subject to home visits by members of the care team. They may then have become aware of his relationship with Victim A. As it was, the New Horizons key worker was the only person carrying out home visits to 2009/3245.

Evidence from the transcripts of the criminal prosecution of 2009/3245 following the index incident suggested the relationship had been on going from August 2008 and certainly the New Horizons support worker was aware of the relationship from at least January 2009.

The panel viewed the failure to place 2009/3245 on CPA Care as opposed to Standard Care as part of the overall lack of appreciation of the risks by the treating clinicians. 2009/3245's risks were downgraded and viewed as occurring in the past only. He was assessed as being relatively stable with little cause for concern. If he had been on CPA then he would have been monitored with increased regularity by his care team in the home environment and they would have been able to take a more informed approach when it came to making an accurate risk assessment of his social circumstances.

Patient 2009/3245's last contact with his Care Coordinator was at the CPA meeting held on the 29 January 2009. CP15 and his New Horizons key worker also attended this. The CPA policy identified the purpose of the review meetings as being to monitor the progress of care, and for complete and continual re-assessment of all aspects of the care plan as an on-going dynamic process, including risk. In the case of 2009/3245, this should have also included a formal review of Section 117 aftercare.

The evidence suggested the most significant issue addressed at that meeting was relating to 2009/3245's medication changes. Whilst the panel recognised medication management as being an important aspect of care, there was little evidence to suggest this was a comprehensive review having regard to all aspects of his care.

Around this time, 2009/3245 had undergone a number of significant changes in his personal life; a reduction in his Lithium Carbonate medication, diagnosed with Diabetes, formed a relationship with a new girlfriend, problems of sexual dysfunction,

and moved into new accommodation. There was no full review of these factors at the CPA meeting, nor was there any mention of him being subject to 117 aftercare or any social care input.

Clearly, the CPA review meeting on the 29 January 2009 and the resultant documentation from it did not represent a comprehensive approach in respect of the standards set out in the Trust CPA policy framework. The panel viewed this as falling significantly short of the thorough review of his care plan which should have taken place.

The panel did not undertake a detailed workload analysis. However, from the oral evidence heard the panel would question whether the community teams had the capacity to comply with the required standards of CPA in every single case within a reasonable time frame. This was explained consistently in oral evidence to the panel as predominately due to the volume of organisational changes which were occurring in the Trust from 2006 onwards and which will be dealt with in this chapter at pages 79-92.

Central to the CPA was of course the risk assessment. This was seen to be the clinical tool to risk management and care planning, encouraging crisis planning and effective transfer or discharge of care. It was felt by the panel that the failure to comply with the Trust's Clinical Risk Assessment and Management policy impacted on the level of care given to Patient 2009/324. This has already been discussed in chapter 5 of this report.

Overall, the evidence examined by the panel did not demonstrate a comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks of 2009/3245. The social care perspective was lacking with no Local Authority involvement at the time of the serious untoward event or since October 2000.

There was a clear departure from the CPA policy of involving multi disciplines and partnerships working together to provide a comprehensive care package. For 2009/3245, there was the Care Coordinator, CP15 and the accommodation providers – New Horizons (Teesside). The panel took the view that it may not have been necessary to involve other disciplines in supporting the provision of care of 2009/3245. If CP15 and the Care Coordinator had demonstrated adherence to the

CPA policy, they would have been able to correctly assess whether there was a definite need for other disciplines to be involved.

There was a clear absence of a written, comprehensive care plan covering crisis management and highlighting relapse signs. Furthermore, the documentation, which was introduced locally in Middlesbrough to support the Team Led Clinic by way of a risk assessment proforma, did not meet the standards required of the CPA policy.

Practitioners were not conducting a comprehensive assessment of need and entering the same on to PARIS, nor using the care documentation on the PARIS system. It seemed to the panel that less rigorous standards were being applied at a local level. Here, there was a failure to embrace the aim of the CPA policy which was to provide uniformity in the approach to care.

The panel recognised that the Trust policy complied with the revised Department of Health framework for CPA and set clear standards in relation to expectations of what service users should expect. However, in the case of Patient 2009/3245, he met the criteria for CPA but was not categorised appropriately. He should have been put on a full CPA.

The view of the panel was that this would have translated to a multi-disciplinary approach which included an assessment of social care needs. He should have had a formal written care plan which included a comprehensive assessment of risk. That did not happen, and was consequently viewed by the panel as a significant flaw by the treating clinicians in delivering treatment and care to 2009/3245.

The panel were satisfied from the witness evidence heard that progress has been made in the Trust since the time of the index offence to ensure compliance with the CPA policy, but felt it was important to reinforce the need for governance systems to identify noncompliance and rectify any subsequent deficits in both eligibility and compliance without any delay.

(ii) Section 117 Mental Health Act 1983 (as amended by the Mental Health Act 2007)

This part of the report considers the extent to which 2009/3245's care corresponded to the Mental Health Act 1983 as amended by the Mental Health Act 2007.

The Mental Health Act 1983 was reformed in 2007 with the changes becoming amendments to the 1983 Act, rather than legislating for a separate new Act. This statute provided the legal framework for both informal and compulsory care and treatment of patients with mental disorder including aftercare.

Section 117 of the Act relates to aftercare and applies to individuals who had been detained in hospital under a number of qualifying sections including, but not exclusively, Section 3 (admission for treatment) and Section 47 (transfer directions by the Home Secretary from prison to hospital).

Primary Care Trusts ("PCT") and Local Authority Social Services are legally responsible for the provision of aftercare under Section 117. The definition of what constitutes aftercare is not defined in the Act. It does however, relate to services provided or commissioned to meet assessed needs arising from a person's mental disorder including health interventions and social care.

The eligibility for after care starts when a person leaves hospital. It must be provided until such a time when the PCT and Social Services satisfy themselves that it is no longer needed.

By April 2009, within the Trust and Middlesbrough Social Services, there was a working draft Section 117 policy referred to as "Draft Section 117 Aftercare Policy". At the time of writing this report, this policy has yet to be ratified.

The draft policy set out the requirements of Section 117 and included the following:-

- an outline of eligibility;
- a definition of what constitutes aftercare;

- agency responsibilities;
- ending of entitlement;
- Operational guidelines for implementation.

The policy identified aftercare planning as the joint responsibility of the Trust and the relevant seven Local Authorities. It stated aftercare planning should take place within the CPA framework but required additional steps. These steps were specified as:-

- the need for comprehensive assessment to cover Health and Social needs (identifying those where need applies to Section 117 responsibilities);
- the care plan should also specify which elements are related to Section 117 entitlements;
- the review of Section 117 will take place within the CPA framework.

The panel were informed in evidence that the Section 117 policy was a working draft policy and had been so for a number of years. The explanation for this was the inability of the Trust to obtain a consensus agreement across the seven Local Authorities in partnership with the organisation. There was conflicting evidence heard regarding the current status of the Section 117 policy from senior health and social care staff. The panel considered it important to resolve any on-going concerns and to ensure the Section 117 policy was operational and carried the formal endorsement and approval of all stakeholders.

Prior to the draft policy being developed, guidance on Section 117 had been contained in the CPA policy guidance that had existed between February 2003 until October 2008.

In the case of 2009/3245, he was detained in hospital on three separate occasions. The first of those detentions was in the Hutton Unit in 1985. This initiated a legal responsibility for the provision of aftercare on the PCT and the local Social Services authority. This followed his Section 47 admission (transfer from Prison).

Two further admissions, where he was detained under sections of the Mental Health Act 1983, reinforced this entitlement. These were in 1988 (Section 47) and 1991 (Section 3). In addition, he had also been admitted to Ashworth Special Hospital in 1991 and informally to the Hutton unit in 1996.

The evidence reviewed in health and social care records indicated 2009/3245's eligibility for Section 117 entitlement was first recognised as part of a CPA review whilst in the Redcar and Cleveland community service in May 1997. The recognition of this responsibility continued until they transferred him in October 2000 following his relocation back to Middlesbrough in the June of 2000. There was no evidence to support the transfer of this aftercare responsibility at that time.

The Section 117 eligibility was not recognised again until January 2007 when the Care Coordinator, who was to remain the Care Coordinator up to the time of the index offence, noted this in 2009/3245's case records.

The Care Coordinator confirmed in her evidence to the panel her awareness of the status of 2009/3245 in being subject to Section 117. However, her compliance with the policy requirements was poor and the significance of this status did not appear to have been recognised by her. Indeed, in evidence to the panel, she was unsure as to whether 2009/3245's Section 117 status was recorded with the Mental Health Office.

The panel heard some evidence that indicated if Social Services had been aware of 2009/3245's Section 117 status, this would have made a difference to care planning discussions in that a social work perspective would have contributed to his care. The panel considered from the oral evidence, that Social Services lacked an awareness of patients who were subject to Section 117. There was little evidence of Social Services being pro-active in respect of knowledge of patients subject to Section 117.

CP14 and CP15 both confirmed in evidence that 2009/3245 should have been put on CPA rather than Standard Care given his Section 117 status, which would have led to much more regular reviews, in his home environment and with input from a social worker possibly as his Care Coordinator. This raised an issue as to whether 2009/3245's Care Coordinator should have been a social worker.

The Care Coordinator saw 2009/3245 as having continuing social care needs, and Section 117 as still being valid although there had not been any significant social work involvement in his care programme at any point in the recent or distant past leading up to the serious untoward incident.

The panel did not have access to any organisational policy that would have been applicable to the timeframe of 2009/3245 being placed within services during the period of his formal detentions in hospital. The acts or omissions by individuals at that time were therefore difficult to quantify in terms of policy. However, the substance of the Act remained unchanged with regard to Section 117.

In reviewing the historical and contemporary evidence, the panel considered the lack of specific social care involvement, within a structured approach to the delivery of Section 117 responsibilities, to have been detrimental to a holistic approach in the provision of aftercare, including the assessment of risk responsibilities across both Health and Social Care organisations. This led to significant periods of 2009/3245's care not having appropriate Health and social care involvement in aftercare planning and provision.

The panel heard evidence to suggest the tracking and management of service users subject to Section 117 was a wider issue not simply unique to 2009/3245. A consistent theme from witnesses was that the issue of Section 117 awareness and understanding was a longstanding problem leading to a confused picture regarding responsibilities.

The level of knowledge from clinical staff interviewed in relation to Section 117 in most instances was weak. There was limited understanding of responsibilities. Examples heard by the panel included views that saw the responsibility for Section 117 as solely a social care funding issue. Other examples included the panel being informed the only difference for a patient on Section 117 was that they would get registered on a central register when they were discharged from inpatient care; there were no other practical differences.

Senior clinical staff suggested there continued to be some uncertainty regarding Section 117 aftercare and awareness of what this status meant. They saw themselves as having a minimal role vis a vis Section 117.

The panel were informed there had not been any training in respect of Section 117 and the draft policy was not available on the Trust intranet although it had been sent out to teams. Consultant medical staff who had been employed from overseas confirmed their induction to the organisation had not covered Section 117 but had been more generic in covering mandatory areas such as fire safety, infection control and risk management. Additionally, senior social service managers had raised some concerns about Care Coordinators failing to have a level of understanding or in-depth knowledge of Section 117.

The panel considered the poor level of understanding and ineffective application of Section 117 responsibilities to be highly relevant to the level of care provided to 2009/3245. This impacted on the ability to consider a more comprehensive and holistic approach to aftercare taking into account the full history and all the risks and behaviours.

It also represented a failure to comply with the CPA policy. By virtue of his Section 117 status, 2009/3245 should have been on a full CPA and not Standard Care. This has been discussed earlier in this chapter at pages 50-56. The issue relating to 2009/3245 appeared to be representative of limited awareness as to the application of Section 117 across Health and social care agencies.

The panel sought evidence of the corporate governance arrangements relating to the monitoring of Section 117 arrangements. This included, where possible, the legacy issues through various organisational changes that had taken place over the time period of 2009/3245's contact with services.

The panel heard how historically there had been a Section 117 register operating in the Trust. Up until the introduction of PARIS this had consisted of a paper record held centrally. Regarding 2009/3245's care, the panel were informed that at the point of the Trust's merger there were also locality registers for Section 117 eligibility. In Social Services, a separate register was held; evidence was heard that this was less accurate than the information held by the Trust.

An exercise took place with the introduction of PARIS to update the system and populate it with accurate information relating to Section 117 entitlements. However, the panel were informed this was wholly dependent on the accuracy of the paper records/ local registers and that it was not possible to rely solely on PARIS, particularly for those older patients like 2009/3245 who had been detained some years ago.

Evidence was heard that progress had been made although the panel were informed there was the possibility of patients subject to Section 117 “slipping through the net”

A number of medical staff in evidence indicated they had discharged people and had not been aware they were subject to Section 117 as they had been detained under a qualifying section a number of years previously. One clinician described the Section 117 approach as “uncoordinated”. The panel heard conflicting evidence as to whether there had been changes to practice in this area.

Evidence was presented that the corporate governance arrangements had been revised since the time of the index offence. There was now a central administrative function managed through the Mental Health Act 1983 administration team that maintained an electronic Section 117 register.

Through PARIS internal notifications could be made which provided a tracking system for all patients on Section 117. CPA (inclusive of Section 117) was part of the Trust’s balanced scorecard that was reviewed monthly by the Director of Performance, Director of Finance and Operational Director. They reviewed a quality data report that included compliance levels relating to CPA reviews (including Section 117) within the standard time frames of 6 months (for CPA) and 12 months (for Standard Care). Training performance data, the panel understand is now also available on part of the workforce section of the performance indicators.

Since the introduction of the revised system, it has been reported that the problems that have been raised internally were ones of funding rather than compliance to delivery standards regarding Section 117. The revised tracking system was introduced in version 2 of PARIS (circa early 2010).

The panel considered that the corporate governance across Health and social care had, over a considerable period of time, lacked robustness in addressing compliance with the responsibilities relating to 2009/3245 Section 117 aftercare.

There was an open acknowledgement by witnesses interviewed by the panel, that in the case of 2009/3245 he was lost to the Section 117 register in both Health and social care. It was the opinion of the panel this was caused by a failure of individual practitioner(s) to notify changes both in terms of review and in terms of transition of care over a continuous period of time. Indeed, the Care Coordinator at the time of the index offence did identify the Section 117 status, but she failed to apply the diligence to the application of the policy requirements in this area.

Had she done so, then 2009/3245 would have been subject to a full CPA and been subject to much more rigorous reviews, a comprehensive care plan and home visits. The failure to observe the requirements of Section 117 in relation to 2009/3245 led to a standard of care being provided to him which was significantly less than his needs required or to which he was entitled.

At a corporate level, there was a legacy of inadequate monitoring systems across Health and Social Care in not having an effective framework to record and monitor their responsibilities. The system at that time was dependent on practitioners, to identify any non-compliance. This was not helped by a culture that reflected a lack of understanding at a clinical level. The robustness of the revised governance arrangements that were described as now being in place have not been scrutinised by the panel.

(iii) Diagnosis

It was evident to the panel on reviewing the clinical notes relating to 2009/3245 and hearing the evidence from the witnesses, that there were multiple entries and differing clinical opinions as to what was 2009/3245's appropriate diagnosis or diagnoses. This, the panel viewed as a significant issue given that the diagnosis would invariably be one of the factors that then dictated the type and level of care provided to 2009/3245.

With the advance of modern medicine, it is now possible to objectively verify diagnoses that have been suspected from the clinical presentation. Unfortunately, the position is not as straight forward in psychiatry. Most diagnoses in psychiatry are made on clinical grounds by comparing the symptoms that the patient has, with other patients that the clinicians have seen, and by an awareness of the diagnostic groups or classifications that have been produced.

As Kendal¹ indicates "diagnoses can only be made by the hippocratic procedure of comparing the patient's symptoms and signs with those of the stereotype and deciding whether the similarity is sufficiently close."

As a consequence, a psychiatric diagnosis can never be confirmed or refuted. The standard diagnoses are contained in two main publications ICD-10 (The International Classification of Diseases, 10th edition)¹ and DSM IV (The Diagnostic and Statistical Manual, 4th edition).²

The ICD classification gives a description of the type of presentation or symptoms likely to be seen in patients with different conditions while the DSM uses a more detailed checklist of the symptoms that have to be seen (and in some cases exclusion criteria) or lists a number of symptoms and that a certain number need to occur before the diagnosis can be confirmed.

1 Kendell RE –Chapter "Diagnosis and Classification"- in Companion to Psychiatric Studies. , Kendell and Zealley (1993) Churchill Livingstone.

2 ICD-10: The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (1992) World Health Organisation.

www.who.int/substance_abuse/terminology/icd_10/en/index.html

3 DSM-IV: Diagnostic and Statistical Manual of Mental Disorders (Diagnostic & Statistical Manual of Mental Disorders) (1994) American Psychiatric Association.

www.psychiatry.org/practice.dsm

There are many who when commenting on the use of diagnostic criteria in mental health consider that a diagnosis should not be made at all. They share the belief that a diagnosis conveys relatively little information and that few patients fit neatly into text book diagnostic categories. Also, that many psychiatric diagnoses have pejorative connotations and often influence people's behaviour towards the patient. Furthermore, that labelling individuals with a diagnosis creates a spurious understanding and encourages naive assumptions about disease entity.

There are those, who even if they accept that diagnostic classifications are helpful would rather that diagnoses were done on the basis of dimensions rather than categories. There is no doubt that for some conditions this may be extremely helpful. Defining people arbitrarily into a small number of categories depending on the results of their IQ assessment maybe less helpful than by rating people along a continuum.

However, few people can deal with the complexity of rating people along a continuum for more than one variable and the applicability of dimensional classifications is extremely limited for patients with psychiatric illnesses. So diagnoses in medicine and in psychiatry tend to be categorical ones.

In ICD 10, it is perfectly possible to record more than one diagnosis, but it is usually done against the firm principle that exists in medicine, which is that when possible a single diagnosis is made. This principle extends to psychiatry and has meant that adherence to a hierarchy has to apply. So for example for a patient who has mild anxiety symptoms and Schizophrenia; if a single diagnosis were to be used the patient would be given a diagnosis of Schizophrenia. Indeed, there is some empirical justification for this as the patient's treatment and prognosis is going to be determined far more by the Schizophrenia, rather than by the anxiety symptoms.

This however, does pose its own set of problems. In many patients it may be very difficult to consider a single diagnosis that really conveys enough information about the patient and the approach being taken to their care and management. Even if additional diagnoses are applied, this may not say a great deal more about the individual variations that will be seen between the patient and other people to whom the same diagnostic classification has been used. It remains a matter of clinical discretion about how many diagnostic categories to include when a diagnosis is given.

To avoid the limitations that giving one diagnosis or even two cause, a formulation has been used in psychiatry for some time. The word formulation in itself has been subject to some criticism as it can have a different meaning to different people. However, the core explanation is that the formulation is a brief summary which brings together all the relevant information about that patient. It may look historically at the factors that have influenced the patient's emotional development, whether

these are genetic and/or environmental. It may highlight any associated factors, be they in terms of the social environment that the patient exists in, their medical history or any other relevant issues that interact with the patient's psychiatric presentation. It allows the treating clinicians to take an overview about what has happened to that patient, and to consider more comprehensively what interventions may best be utilised to manage the patient's potential risks. In many cases, it is helpful for the patient to get a sense of what are the relevant factors particular to him. It may allow him to understand his thoughts and feelings and thus work in collaboration with the treating care team in order to achieve specific outcomes.

Table 1 on pages 66-67, provides an overview of the different diagnoses that were given throughout Patient 2009/3245's contact with Mental Health Services. It predominantly covers the period when he was being seen as an adult. Although, there was extensive documentation about 2009/3245 prior to 1985, this predominantly used descriptive terms to discuss his functioning rather than using specific diagnoses. There was one exception to this (see Table 1).

In the clinical notes, throughout his contact with Mental Health Services there was considerable documentation about his level of functioning and about his symptoms. There was much less about the precise diagnoses or differential diagnoses that were considered. Indeed, there was only one entry found (that was completed by CP9 in 1996) where a thorough review of his previous history was documented and an attempt was made to look at other factors such as his upbringing, his personality and his substance misuse which may have had a part to play in why he had presented as he did. This document was viewed by the panel as an extended formulation.

TABLE 1: DIFFERENT DIAGNOSES GIVEN THROUGH OUT PATIENT 2009/3245'S CONTACT WITH MENTAL HEALTH SERVICES

DATE	DIAGNOSIS GIVEN	ENTRY WRITTEN BY
1975	Immature personality characterised by conformity with the standards, values and behaviours of stronger people he will happen to be with.	Child Psychiatrist.
May 85	Acute Psychosis may be toxic in origin	Prison Medical Officer
June 85	Impossible to make a definite diagnosis, his illness seemed to be a mixture of Schizophrenic and manic symptoms.	CP2
Oct 85	Diagnosis appeared to be that of Schizophrenia.	CP1
Nov 85	I believe that he suffers from a Schizophrenic or possibly a Schizoaffective Disorder.	Senior Registrar to CP1
Nov 87	Schizophrenia, but may have been an organic illness. Aetiology remains obscure, could have been a drug induced Psychosis.	CP1
May 88	Manic illness.	CP1
Jun 88	Paranoid psychotic illness.	Registrar to CP1
Sep 88	Bipolar Affective Disorder.	Registrar to CP1
Mar 91	Hypomania	CP1
Jun 91	Bipolar Affective Disorder.	Registrar to CP1
Dec 91	Manic depressive illness.	CP1

Dec 91	No evidence of mental illness (currently).	CP3
July 96	Bipolar Affective Disorder (and personality issues).	CP9
Oct 96	Bipolar Affective Disorder (currently depressed with biological symptoms, but no psychotic symptoms).	Registrar
Nov 00	Seems to have a possibly drug induced Psychosis with some hypomanic features when in prison, but this is very brief..... I think the primary and most dominating diagnosis is that of Psychopathy.	CP10
Jun 04	Psychopathy	SHO to CP12
July 04	Personality Disorder.	CP12
Dec 04	Previously diagnosed as a Psychopathy, Bipolar Affective Disorder.	CP13
Nov 05	Bipolar Mood Disorder – previously diagnosed as Psychopathy.	CP14

The panel were aware that they had the benefit of being provided with information from numerous sources which had been recorded about Patient 2009/3245 over a period of 20 years or more. That amount of detail was unlikely to be something that clinicians treating 2009/3245 would have readily had access to but they could have requested it.

However, even with the availability of all this information, on review it was clear to the panel that there were gaps in the clinical notes. For example, when 2009/3245 was first admitted in 1985, he was on a medical ward because of concerns about his presentation. However, the panel did not see any documentation or any discharge summary from that admission (to the medical ward), nor was it clear whether any urinary drug testing was undertaken at that stage.

The panel were aware of the difficulties in coming up with a clear diagnosis. 2009/3245's initial presentation had been atypical with organic features and there was uncertainty as to whether the initial presentation was more in keeping with a Schizophrenic or an Affective Illness. (An organic basis was not found when he was assessed as an in-patient on the medical wards).

The panel appreciated that the diagnosis in 2009/3245's case was not an easy one to make— his presentation was atypical: like many patients he had a mixture of symptoms and while textbooks suggest that patients present in ways where differences between different diagnoses can be seen, clinical practice suggests that this is often not the case. It is well recognised that patients may present with symptoms thought to be part of an Affective illness but who later on subsequent follow up or on readmission have a clear diagnosis of Schizophrenia and vice versa.

As discussed above, for the purposes of returning information to the Department of Health a diagnosis using ICD classifications should be given – this does compel clinicians to decide which diagnostic category fits best while in other documents they may use a more descriptive account and talk about the diagnostic uncertainty that may exist.

However, the panel felt that a more detailed formulation would have been useful in looking at not only the presenting psychiatric illness, but also looking at the underlying personality of 2009/3245. Had this been done as far back as the late 1980s, it would have been far more beneficial for future staff dealing with 2009/3245. They would have had more detailed historic information to work upon. This could have allowed staff to assess how much certainty could be put on the diagnosis given and the interplay between other relevant factors such as his personality structure, his drug use and his social situation.

The fact that 2009/3245 care was under a number of different Consultants over a prolonged period of time, meant that the latter Consultants did not have personal

knowledge of 2009/3245's presentation some years ago. Indeed, CP13, CP14, CP15 when they gave evidence, confirmed that they had not even reviewed 2009/3245's case notes referring to his admissions in the past. Relying on the diagnostic category that the patient is said to be in will help to an extent, but in this case it did not enable detailed consideration to be given about what approaches would have been best to take.

With the exception of the summary document /formulation produced by CP9, most of the other clinicians decided what they thought was the correct diagnosis and recorded that – usually only one diagnosis was given. The one summary/formulation by CP9 was not updated by subsequent practitioners and this was problematic for two main reasons:

- Firstly, because 2009/3245's case was very complex. There was a complex interplay between his mental health, his personality, his substance misuse and social factors. Without there being a descriptive account the diagnosis alone could not convey this complexity, nor could it fully guide the next clinician into the most appropriate way of approaching 2009/3245 and responding to any issues that he came forward with;
- Secondly, the fact different clinicians saw 2009/3245 in different situations (some staff saw him when he was acutely ill and in hospital and some saw him when he was better and living in the community) meant that they focused more on the evidence that they saw through their direct clinical contact and contact with other members of the multidisciplinary team that they talked to. This was rather than review the previous clinical notes and cross reference the current features against what had been seen historically. A summary document would have allowed reappraisal to have taken place more readily. Furthermore, if a detailed summary/formulation had already been done it could have been added to, thus enabling a fuller picture to be built up over the time 2009/3245 was in contact with Mental Health Services.

Unless, there was information available at that time to the mental health professionals, but not available to the panel, it did seem that at times clinical assumptions had been made concerning 2009/3245 that were simply not supported by the facts. Thus for example, CP10 clearly thought the diagnosis was more of a Psychopathic Personality Disorder than somebody who had a major mental illness. He felt that the episodes were 2009/3245 had presented himself were likely to be drug related.

There did not seem to the panel to be any evidence to support those statements that the more severe psychotic episodes were drug related. There were no results from urine drugs screens to suggest that he had been tested as being

positive for illicit drug use and the duration of acute psychotic symptoms had been measured in weeks or months rather than a few days. The panel clearly saw that CP10 had known 2009/3245 over a number of years and had not seen any clear signs of him having symptoms of an Affective Disorder.

The panel felt that CP10 was quite right in looking at the personality components but it would have been better if he and subsequent colleagues had considered what was the relationship more closely between the affective symptoms (which may for a number of years have been controlled to some degree by the medication that 2009/3245 was receiving) and his personality structure which may have been so severe that a diagnosis of a Personality Disorder could have been made.

The panel felt there was a tendency by treating clinicians to focus on what they felt was the one correct diagnostic category to place 2009/3245 in. This was reinforced with the reconfiguration into functional teams under Service Redesign. This resulted in 2009/3245 being seen as either somebody who had a Personality Disorder whose affective symptoms could either be seen as part of their emotional dysregulation or part of a drug induced state. Or to view 2009/3245 as somebody who had a mood disorder and whose personality difficulties might become more pronounced when that illness became more symptomatic.

Many patients have both a major mental illness (such as a Bipolar illness) and personality difficulties of a severity that will allow a diagnosis of a Personality Disorder to be made. As indicated earlier, psychiatric diagnoses are not ones that can be confirmed by any laboratory tests or by any specific investigation. In 2009/3245's case it was felt by the panel that there had been episodes of a likely Affective Disorder.

He had had both manic and depressive episodes albeit with spells of recovery and remission between episodes. There was no evidence seen that showed that these were categorically drug related and the duration and the severity of the symptoms again suggested to the panel that a pure drug related aetiology was unlikely. The panel also felt that just focusing on what the psychiatric illness was omitted major, very relevant issues.

The evidence historically was that 2009/3245 had had significant difficulties in interpersonal relationships which did not appear to be explained purely on the basis of a Mood Disorder. So even if the diagnosis that the clinical team had arrived at of a Bipolar Affective Disorder was correct, it did not encapsulate all the issues that 2009/3245 was having to deal with (and which the clinical team should have been dealing with).

The panel did reflect on the issue of whether 2009/3245 might be said to suffer from a Personality Disorder. The panel recognised that making a diagnosis or differential diagnosis was not a task which was within the terms of reference but it was clear to the panel that the diagnosis of a Personality Disorder had been made by some of the clinicians who had treated 2009/3245 and consequently, the panel felt that some discussion about the issue of a diagnosis of a Personality Disorder was needed in this report.

The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organisation 1992), described Personality Disorders as:

“...these types of conditions comprise deeply engrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks and particularly relates to others. Such patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always associated with various degrees of subjective distress and problems in social functioning and performance. Personality Disorders differ from personality changes in their timing and in their mode of emergence: they are developmental conditions which appear in childhood or adolescence and continue into adulthood. They are not secondary to another mental disorder or brain disease although they may precede and co-exist with other disorders.”

The 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association 1994) defined a Personality Disorder in a broadly similar way:

“.. an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”

There are nine categories of ICD-10 Personality Disorders, one of which is called Dissocial (which includes the terms Antisocial and Psychopathic) and ten categories

of DSM-IV Personality Disorder. Each subtype is classified according to its predominant behavioural characteristics. The classification scheme however, is unwieldy as personality disordered patients rarely belong to just one category of Personality Disorder.

The diagnosis therefore, needs to be made based on a detailed understanding of the patient. It should look at a number of factors which may include:

- has there been evidence of this condition over a long period of time?
- is there evidence that this behaviour is not related to another condition such as episode of mental illness or substance misuse?
- is the behaviour that appears to suggest the diagnosis of a Personality Disorder seen in different environments or in different social situations?

The panel did not see any written evidence that a detailed evaluation had been made of the developmental history of 2009/3245. Nor, was it clear from the written documentation whether a detailed evaluation had been made to ensure that the behaviours being related to the presumed Personality Disorder were not actually shown, when he had been mentally ill or intoxicated.

The panel did see that 2009/3245 had had a pattern of problematic interpersonal relationships which went back to his childhood years. Furthermore, that 2009/3245 had exhibited violent behaviour to different partners at a time when there was no evidence of any mood disorder and this behaviour had occurred in the community and in the in-patient settings. So, while it was not possible for the panel to place a definite diagnosis or diagnoses, it could be seen how various different diagnoses could be applied.

Even if the clinical team had attached the diagnosis of a Personality Disorder this would not have, in the panel's view, added much unless they had gone on to include a formulation and tried to engage 2009/3245 in looking at how all these factors impacted on his life and his functioning.

This was because merely giving a diagnosis might have suggested what the likely behaviours and issues would be for a group of patients with this condition, but it

would not be so nonspecific that it would aid clinicians in dealing with 2009/3245. So it would not have indicated how 2009/3245 (because of his unique social situation, previous life experience and support systems) was likely to behave in specific circumstances.

Having a document which acted as a summary or formulation would undoubtedly have been of benefit in the panel's view, especially given 2009/3245's lengthy contact with Mental Health Services and the frequency with which the treating clinicians changed. A longer and more detailed document would have pulled together different strands of clinically useful information - it would have alerted staff to the fact that 2009/3245 had had issues when involved in close interpersonal relationships and when he formed a new relationship, or when it ended.

It would also have suggested that issues about changes or potential changes to his medication needed to be thought through and closely monitored, not only about the effects on 2009/3245's renal function, but also about the potential of a change affecting him psychologically. Consequently, focus would have been whether in a phase of change of treatment there was a need for a more intense monitoring period in case his mood deteriorated.

The panel accepted that his Care Coordinator had a good understanding of 2009/3245 and may well have had a well thought out cognitive formulation. However, this was something that was not recorded in a written format, nor communicated to CP15. This proved problematic, as the diagnosis alone (which was known to the treating Consultants) conveyed some information about what facts could affect patients as a group who had the same diagnosis. However, it did not inform staff enough about what could happen to 2009/3245 in certain scenarios.

A summary or formulation should have been available for the staff to look at. With the work of CP9, a lot of the relevant information had already been collected and while it did need to be updated, the time to do the work involved would not have been excessive.

(iv) NICE Guidelines

Bipolar Disorder

This part of the report deals with the issue of compliance with the National Institute for Health and Clinical Excellence (“NICE”)Clinical Guidelines for Bipolar Disorder (July 2006). ¹This is on the basis that 2009/3245 was diagnosed with a Bipolar Disorder, and prescribed Lithium Carbonate from 1985 onwards. All patients prescribed Lithium Carbonate should have an annual physical health review, (which is normally carried out in Primary care). The review should include:

- lipid Levels, including Cholesterol;
- plasma Glucose;
- weight;
- smoking and Alcohol status;
- blood pressure;

Appendix D of the NICE Guidelines for Bipolar Disorder provides a schedule for physical health care monitoring. The results of the review should be communicated to the patient and the professionals involved in providing care.

The panel could not find any evidence from 2009/3245’s GP records that demonstrated evidence of an annual physical health review being undertaken or communicated. From the evidence in the GP paper records, there did not appear to be a consistent approach to Lithium Carbonate monitoring.

- 1999-1 test
- 2000-1 test
- 2001-2 tests
- 2004-3 tests

¹ National Institute for Health & Clinical Excellence, Clinical Guidelines for Bipolar Disorder, July 2006.
www.guidance.nice.org.uk/CG38/NICEGUIDANCE/pdf/English

- 2005-2 tests
- 2007 – 2 tests
- 2008 – 4 tests

In the CPA review meeting on 29 January 2009, CP15 took the decision to discontinue 2009/3245's Chlorpromazine with immediate effect and agreed a review meeting within 3 months. NICE Clinical Guidelines for Bipolar Disorder state that any plan to discontinue a patient's anti-psychotic medication should be done gradually over a period of 4 weeks if there is any other medication involved and over a period of 3 months where no other medication is involved. It also states that the patient should be monitored closely over this time to identify any possible clinical deterioration.

Despite this, the panel saw no evidence of a written plan arising from that CPA meeting with a view to regularly review or monitor 2009/3245's mental state or any discussion between CP15 with the Care Coordinator that this should be done. There was nothing in 2009/3245's clinical notes around this time to identify any social or environmental triggers or early warning signs or symptoms of relapse that may indicate that 2009/3245's mental health was deteriorating following the change in medication. Nor was there any plan to identify the symptoms and indicators of a potential exacerbation of the disorder and how to respond.

When considering the long term management of Bipolar Disorder, the medical staff and Care Coordinator should have considered the use of psychological and psychosocial intervention including the development of a crisis intervention plan in collaboration with 2009/3245. The panel did not see any evidence of this being considered at all.

NICE Clinical Guidelines also state that any history of substance misuse should be highlighted in the treatment plan and joint work with the specialist services considered. Again, there was no evidence that this was the case, either by CP15 or the Care Coordinator. Retrospectively, when interviewed by the panel, 2009/3245 stated that he should not have been allowed by his care team to smoke cannabis with the frequency with which he did.

Furthermore, that he should have been monitored with thought being given to a referral to a drug and alcohol service. The panel have not examined what 2009/3245's motivation was to comply with such specialist services. However, it was evident in the contemporaneous clinical records that 2009/3245 was not asking for such a referral at that time.

In addition, patients with a diagnosis of Bipolar Disorder should be included in the Practice (Primary Care) based Serious Mental Illness (“SMI”) register. The panel found no evidence of inclusion of 2009/3245 on a Practice based SMI register.

Patients with Bipolar Disorder and co-morbid Personality Disorder should receive the same treatment because Personality Disorder does not preclude the delivery of effective treatment for Bipolar illness. On the basis of a co-morbid presentation 2009/3245 received the same treatment.

Personality Disorder

The panel also reflected on the issue that at certain points 2009/3245 had been given a diagnosis of Psychopathy (see table on pages 67-68 of this report). The terms Psychopathy and Antisocial Personality Disorder are often used to refer to the same condition. Although guidelines have subsequently been produced by NICE for a range of clinical conditions, it was only in January 2009 that guidelines for the treatment of Antisocial Personality Disorder¹ were produced and by this time the diagnosis given to 2009/3245 had reverted to that of Bipolar Affective Disorder.

There had been publications about services for patients with Personality Disorder prior to this date such as: “Personality Disorder: No longer a diagnosis of exclusion - Policy implementation guidance for the development of services for people with Personality Disorder”.² This was published by the National Institute for Mental Health in England in January 2003.

This guidance was designed to ensure that once patients with a diagnosis of Personality Disorder were referred to Mental Health Services or for those who were found to have such a diagnosis, they should receive access to appropriate care. As things stood the report had found that people with a primary diagnosis of Personality

¹ National Institute for Health and Clinical Excellence, Clinical Guidelines for the treatment of Antisocial Personality Disorder January 2009.

www.guidance.nice.org.uk/CG38/NICEGUIDANCE/pdf/English

² Personality Disorder: No longer a diagnosis of exclusion – Policy implementation Guidance for the development of Services for people with Personality Disorders, 23rd January 2003.

www.webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/publicationsPolicyAndGuidance/DH_4009546

Disorder were frequently unable to access the care they needed from secondary Mental Health Services.

The report indicated few Trusts have dedicated Personality Disorder services. As such, the guidance was more for Trust and commissioners to look at the services they should be planning to develop although it also highlighted that it was no longer appropriate to exclude patients from services on the basis of the diagnosis of a Personality Disorder.

There was no evidence seen by the panel that 2009/3245 was excluded from services based on the diagnosis of a Personality Disorder – however it was not clear to what extent that the diagnosis was shared with 2009/3245 and in what way his care plan was altered in view of this change in diagnosis.

As has previously been highlighted the use of a particular diagnosis may help clinicians see what approaches may help a group of patients who have the same diagnosis. However, it will not help greatly in looking at what will happen to one individual patient which means an individualised care plan including an individualised risk assessment /risk management plan needs to be developed.

(v) Organisational Changes

At the same time that the revised Trust CPA policy and the Clinical Risk Assessment and Management policy were being implemented (2008), there were also a vast number of organisational changes that were occurring at local and national levels within the National Health Service. These are summarised in Table 2 on page 80.

The County Durham & Darlington Priority Services NHS Trust and the Tees & North East Yorkshire NHS Trust had merged to form Tees, Esk and Wear Valley NHS Trust (April 2006); the Trust achieved Foundation status (July 2008) which saw the introduction of a different business model with new regulatory procedures. PARIS, the new electronic patient record was being rolled out to the different cohorts, including Adult Services (October 2008). There was also a revision of the Mental Health Act (2007)¹, and the introduction of the Mental Capacity Act (2005)² which were being assimilated into practice. The Trust was therefore faced with a number of strategic challenges.

National structural changes were also underway as well with the drive for the New Ways of Working (“NWW”) (2005)³ and Service Redesign (July 2008). In Middlesbrough, this led to a move from geographical teams to one functional: a realignment from four community health teams (Linthorpe, Park, Lakeside and Town) to two: Psychosis (Parkside) and Affected Disorder (Lakeside).

¹ The Mental Health Act 2007.
www.legislation.gov.uk/ukpga2007/12/contents

² The Mental Capacity Act 2005.
www.legislation.gov.uk/ukpga2005/9/contents

³ New Ways of Working for Psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts, 31st October 2005.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationspolicyAndGuidance/DH_4122342

TABLE 2: ORGANISATIONAL CHANGES: OVERVIEW

EVENTS	APR/04	OCT/04	APR/05	APR/06	JAN/07	JUL/08	OCT/08	FEB/09
Paris								
Service Redesign								
Merger of Trusts								
Team Led Clinics								
Consultant	CP12	CP13	CP14				CP15	
MCA								
MHA (Amended)								
CPA								
Foundation Status								

Having reviewed all of the aforementioned changes, the panel accepted that it was impossible to establish with any degree of certainty that there was any causal link between the Trust's organisational changes and the index incident. However, the panel considered that it was necessary to place into context the care that was delivered to 2009/3245 and to review those changes and whether they affected the working environment and how clinicians could operate and provide an acceptable level of care to 2009/3245. In short, to focus on both the macro as well as the micro issues of care given to 2009/3245.

The accumulation of all those organisational changes within a very tight timescale undeniably had to have an impact generally on the delivery of front line Mental Health Services. Specific to 2009/3245 and the index offence, it meant that his Care Coordinator and the treating Consultant Psychiatrist were having to adjust and adapt (like many other staff delivering front line clinical services) to a high volume of rapid changes without in the panel's opinion having the capacity and support to be able to do so which consequently impacted on their ability to maintain the provision of an acceptable standard of care to patients within their control.

Service Redesign

One of the changes that were introduced was that of Service Redesign which had been successfully piloted in Hartlepool. The reasoning behind its introduction was that some of the traditional working practices in Mental Health Services were viewed as problematic especially for Psychiatrists and for their patients. There were examples of Consultant case load numbers being excessive, and they were working at times in relative isolation from other members of the mental health team.

Service Redesign was in keeping with the national approach of NWW. In essence, it was about utilising the skills, knowledge and experience of Consultant Psychiatrists to best effect by concentrating on service users with the most complex needs. It was felt that Consultants should be operating within multi-disciplinary teams, promoting delegated responsibility and leadership across the teams to achieve a cultural shift in services. It encompassed a willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated work force offering a high quality service. It was considered that NWW would lead to a reassessment of the needs of many patients, which would in turn identify a number of individuals whose needs could be met without them remaining in secondary services.

The panel heard in evidence that prior to these changes being brought about there were historically a large number of patients managed in the outpatient clinics where they would either see a junior doctor or be on the caseload of a Consultant Psychiatrist. It was clear from the evidence before the panel, that the junior doctors who routinely spent only six months working within a specific clinical team were not well placed to take long term treatment decisions and consequently possibly maintained patients in secondary care for longer than was actually needed.

Leading up to 2008, the Consultants were therefore being appropriately encouraged (in line with NWW) to review their caseloads, reduce them gradually and then to redistribute their remaining patients; either by discharging them back into the care of the GP or transferring them to other members of the community mental health team in readiness for reconfiguration under Service Redesign.

Practically, in Middlesbrough this meant that four Consultants transferred their outpatient caseloads to the two functional teams in or around June 2008 within a matter of weeks. The panel heard that this was in total approximately 600 cases transferred between the two teams. In addition, the two teams had to integrate cases from the four community care teams into the two functional ones alongside case management of their existing workloads. The panel heard that the task was further complicated by the fact that some of the Consultants in Middlesbrough had not in the 2 years lead in time reduced their outpatient caseloads in readiness for the transfer process, thus explaining the high number of cases transferred in Middlesbrough.

One of the main issues however, with the transfer of the Consultant case loads, was that it was completed without any formal handover process or transfer of comprehensive risk assessment/care management information. The panel heard evidence that there was not any guidance to staff concerning what or how such information should be departed or communicated at the point of transfer.

Consequently, it appeared that the community teams had in essence inherited new patients who they had no prior knowledge of, but who they now had a responsibility to risk assess and review their clinical paper records given their notes had not been entered onto the electronic patient record. In order to comply with the Trust CPA policy and the time frames set within it, they were then obligated to populate those details onto PARIS.

This was problematic given staff were having to learn to navigate their way around a new Information Technology system (PARIS) which they were wholly unfamiliar with. The panel heard evidence that the numbers and the complex nature of the cases transferred from outpatients made the task overwhelming. There was simply insufficient time to complete the risk assessments of all the patients, review the clinical notes and input the same onto PARIS. This created anxiety amongst staff

who simply lacked the capacity and support to adequately comply with those work demands.

The fact that hundreds of patients were being transferred across one team to another to staff that lacked any knowledge of them without any summary document was in the panel's view of significant governance concern. 2009/3245's Care Coordinator at the time of the index offence and who was also the manager of the Psychosis team at Parkside, in evidence confirmed that she did not know approximately half the patients transferred from the Consultants in terms of their background, diagnosis or treatment. She simply had to rely on self-report in the short term from the patient, as there was not adequate time to review the clinical notes. The end result was that risk assessments were not being completed or there was an inevitable delay in completing them.

2009/3245's Care Coordinator in evidence to the inquiry suggested it had taken up to 2 years post reconfiguration to complete and input the requisite care documentation on to PARIS. She referred to herself and staff being concerned about what was going to "explode" from the transferred case loads and not knowing who the patients were and yet being responsible for them, in addition to managing her existing workload.

The panel heard that pressure was placed on responsible practitioners to personally complete and enter the patient assessments on to PARIS within 24 hours of attendance on a patient, thus increasing their work burden. The panel listened to evidence that for every hour spent with the patient, it was taking 2 hours of PARIS time to effectively enter the data which staff were struggling to complete.

Incrementally, greater access was delegated to administration staff to enter patient data but with the caveat that it was validated by the clinician within 24 hours of being logged onto the system.

It struck the panel that the issue was one of capacity. 2009/3245's Care Coordinator at the time of the serious untoward event was clearly finding it difficult to balance management duties, on top of her own work load, a case load of transferred unknowns as well as learning to operate a new IT system with time pressures to populate. It was described by her in evidence as "daunting".

She raised such concerns with her Service Manager at management supervision who in turn repeated them at the General Manager level. The panel heard evidence that the Adult Mental Health General Manager of South Tees appointed in February 2009 received feedback from the Team Managers and Service Managers that staff were struggling with the transfer of paper records in deciding what was relevant and then the overwhelming task of having to actually transfer that data on to the electronic record. The staff consensus was there simply were not enough hours in the working day to do the job which was evidenced by staff coming in after hours to attempt to address the back log.

The panel also heard evidence that from the perspective of 2009/3245's Care Coordinator there was a lack of clarity about the Service Redesign process being adopted and what each individual team member's role was to be. There appeared to be uncertainty and confusion as to when and in what circumstances to request Consultant involvement. There were undoubtedly a lot of internal meetings for the 2 years leading to the changes, but the clarity about what was being planned, when the process would be implemented and clarification as to each individual team member's role appeared to the panel from the evidence heard to be lacking and not adequately communicated to the staff at ground level.

In addition, no specific training appeared to have been given to 2009/3245's Care Coordinator about the new role that she would adopt under the functional teams. In evidence, there was general concern from her about not being given specific training to take on the new role, nor adequate time within which to develop a specialist skill set. 2009/3245's Care Coordinator in evidence to the inquiry suggested that at the time of the changes she had generic skills concerning assessment and care planning but she did not have specific training relating to Psychosis of which she was the Team Manager. Indeed, the panel heard that the relevant psychological intervention training was not provided until some 2 years after the launch of the Psychosis team under reconfiguration.

In relation to 2009/3245's Care Coordinator at the time of the index offence, she gave evidence to the inquiry that she found all the changes that were taking place challenging. She was the Team Manager of the Psychosis team, a post which she felt she did not have the requisite specialist training for. She had a personal caseload of eighty patients, which she suggested in evidence was far too high and should have been closer to twenty. She also had managerial responsibilities including management supervision of twenty staff post the reconfiguration which involved between at least 1-1½ hours supervision per month for each supervisee.

The panel considered that her excessive case load, assessing patients she was unfamiliar with, dealing with the impact of the reconfiguration, coupled with managerial responsibilities and having to adapt to changes in a high pressured environment with specific deadlines set, meant that she was unable to comply fully with both the Trust's Clinical Risk Assessment & Management Policy and the CPA policy (see pages 35-49 and 50-56 of this report) and to deliver the standard of care that should have been given to 2009/3245.

Evidence was heard that it was only with the appointment of the new General Manager to South Tees in February 2009, that overtime was sanctioned for a month in order to assist staff to complete the necessary paper work. In addition, post the serious untoward incident, the same General Manager appointed two additional posts in Middlesbrough because he was concerned that the risk assessments were not being carried out contemporaneously.

Prior to this, 2009/3245's Care Coordinator voiced concerns in evidence to the inquiry that leading up to the index offence there were also budgetary restrictions with posts not routinely being filled once they had fallen vacant due to staff leaving or a delay in refilling them which drew further on the capacity of remaining staff and increased the general work load.

The fact that the PARIS computer system was being introduced at about the same time (within 2 months of the Consultant caseloads being transferred) invariably complicated matters for the clinical staff. Suffice to say that to the panel, there appeared to be very limited awareness by senior management in advance of these changes taking place that they would cause significant issues for the staff in respect of their ability to practically manage their work load on a day to day basis.

From the Consultant's perspective, the inquiry heard evidence that it was the totality of all the changes together which created such a drain on clinical capacity. This view echoed that of all the staff interviewed. The panel were informed these were major changes which occurred simultaneously and concurrently and which happened before staff appeared to be trained or were able to adjust and to adapt to them.

The overriding view amongst clinicians giving evidence was that there were simply too many major changes taking place at the same time. Consequently, the panel was concerned that the Trust at this time had limited appreciation in terms of the

impact on staff of a number of projects and changes running all at once with little allowance to stock take or monitor the effects on staff and the delivery of Mental Health Services to service users.

Evidence was heard that with the benefit of hindsight the problems of timing could have been avoided if there had been real visibility of project management at all levels. The panel understood that post PARIS, steps had been taken to introduce more cross transparency of projects with a project register and an established project management structure being introduced, which provided for an overview of projects running concurrently and the risks associated with them.

There now appears to be a much more rigorous approach by the Trust to project management. A project framework which was not in existence at the time of the implementation of the PARIS project has now been set up.

It seemed to the panel that although the Steering Development Group (“SDG”) had a system for improving change and making clinicians involved in decision making, there did not appear to be a structure for monitoring that. It appeared to the panel that with hindsight, PARIS should not have occurred concurrently with the reconfiguration.

Team Led Clinics

To handle the volume of cases which needed to be managed from the functional split and the transfer of Consultant’s caseload in Middlesbrough, the Trust did so with the aid of Team Led Clinics. These were nurse led review clinics with a Care Coordinator being the central pillar to the delivery of the service. The focus was perceived to be a much more robust holistic approach to care needs.

The Team Led Clinics were a local variation exclusive to Middlesbrough, a means by which Consultants’ and their juniors were refocused from seeing all patients and a move to empower other non-medical professionals to run a clinical case load and have the support of the Consultant when they needed it. Again, embracing the national ethos of NWW.

The panel saw the development of the Team Led Clinic as a pragmatic way of providing a degree of oversight to the care of the patients that had been transferred into the team. The panel were unsure as to the reasoning for the Team Led Clinics being solely introduced into Middlesbrough. Whether it reflected a more marked lack of preparation by the Middlesbrough services or a higher level of morbidity in the Middlesbrough population was not a question that the panel could answer. The panel considered that a more robust project plan which identified that issues were going to arise in Middlesbrough and which produced an action plan to resolve those issues would have been appropriate.

Evidence was heard that Team Led Clinics had existed in Middlesbrough prior to the move towards functionalisation of the teams within Service Redesign. They appeared to have started in 2006 (initially in the Park sector). They were viewed as being an appropriate method for delivering care for those patients that were seen as outpatients and that were stable in their mental health, posing no or little risk to themselves or others and at that time on Standard CPA.

According to his Care Coordinator, 2009/3245 fitted into that category; he was viewed as low risk due to being “stable” for 5 years and on Standard CPA care. He was therefore managed through the Team Led Clinic. With hindsight, his Care Coordinator recognised in evidence that there had been complacency exercised by her in relation to the historic risk and the inclusion criteria under the Trust’s policy, 2009/3245 should not have been placed in a Team Led Clinic.

In respect of 2009/3245, he was allocated by his Care Coordinator to the Psychosis team. One of the explanations for this heard in evidence was because of his “enduring mental illness”. As such 2009/3245 was to be seen every 3-4 months by his Care Coordinator, and at least once a year by his Consultant unless there was a need for him to be signposted to the doctor for medication or physical issues by the Care Coordinator or GP.

With the Team Led Clinic, despite the focus being more holistic and looking at the 2009/3245’s social care needs, there were no home visits to him by the care team. This, it appeared to the panel, was a failing in that had a wider approach been adopted to 2009/3245 and had he been seen at home it would have enabled the Care Coordinator to have a much more comprehensive view of his home environment and possibly awareness of him having entered into a relationship and the development of it.

This may have been achieved had 2009/2345's Care Coordinator had a more socially inclusive view which would have lent itself to a holistic approach enabling a social care assessment. A wider assessment with regular monitoring would also have been possible had 2009/3245 been placed on a full CPA as opposed to Standard Care. In those circumstances, he would not have been in a Team Led Clinic. This has been dealt with under the CPA section at pages 50-56.

To allocate 2009/3245 into the Team Led Clinic was something that was of significant concern to the panel. It seemed that there was a general lack of awareness of 2009/3245's history. CP14 had been the Consultant last involved with him prior to the move to the Psychosis team. When asked about the move to the team, CP14 indicated that he had not been involved in the decision to put 2009/3245 into the Team Led Clinic and it had been the Team Manager who had made that decision.

However, when this question was posed to the Care Coordinator, she in evidence suggested that the decision to place 2009/3245 into a Team Led Clinic was that of the Consultant and not hers. Either way, irrespective of the decision maker, the decision itself appeared to the panel entirely inappropriate given 2009/3245's past history as to risk.

It certainly was clear from the evidence given that CP14 had not been aware of the complexity of 2009/3245's history. He was not aware that he had been in a RSU and oblivious that 2009/3245 had been subject to MAPPA or Section 117 requirements. Without this information, he would not have been able to undertake an adequate risk assessment, and hence he would not have had the information to challenge the decision if it was made by the Team Manager to place 2009/3245 into the Team Led Clinic.

CP14 had not been given any clear summary when he took over 2009/3245's care and indeed, no good summary had been produced concerning 2009/3245 since the summary document that was produced by CP9 in 1996 when 2009/3245 was in the RSU. The fact that the Care Coordinator was transferred multiple patients of which she had no knowledge of, and a caseload of 80 patients, minimised the chances of her being able to quickly spot that 2009/3245 had been incorrectly placed within the Team Led Clinic given his history.

CP15 suggested in evidence that it would have been the Care Coordinator's responsibility to consider moving 2009/3245 from the Team Led Clinic to full CPA care. The panel saw no evidence that this had ever been considered by either his Care Coordinator or CP15.

It was quite clear to the panel, that 2009/3245 was not suitable for a Team Led Clinic; he had a previous history of violence (particularly towards women), substance misuse, subject to Section 117, and had been admitted to the RSU. He should have been placed on full CPA.

Various witnesses gave evidence to the panel that the Team Led Clinic was meant as a temporary solution to allow time to review the patients, and to establish a clear management strategy for them. Evidence was heard that this has now been accomplished and the Team Led Clinics have been withdrawn with patients being allocated to a Care Coordinator for assessment and review.

PARIS

Another major change within the Trust was that of the introduction of the new patient electronic record – PARIS.

The speed of PARIS' implementation within the Trust was dictated by the risk of the existing IT systems (PBIS and PIMS) being vulnerable to collapse. It seemed that there was a need for the Trust to effect a programme of modernisation and to quickly replace the redundant systems as the supplier of the old software were no longer prepared to provide support beyond March 2007, unless the Trust contracted to purchase an upgrade of it.

In addition, the panel heard evidence that the old IT systems were viewed as being fundamentally flawed and unsafe for running mental health, primarily because of questionable data quality. They also lacked the capacity to push through national strategies such as the CPA policy and the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

Given the Trust merger in 2006, it was also necessary to have one integrated software solution with a standardised computer system. It was untenable to function as one merged Trust but with two separate electronic clinical systems.

The Trust hoped that PARIS would deliver standard processes and improve the sharing and use of patient information which would in theory (and hopefully in practice) improve patient care. It was an opportunity to provide standardisation of letters, documents and systems, to allow access to a secure patient information out of hours and at any Trust terminal.

The panel heard that only limited information could migrate from PARIS' predecessors because the PBIS system was a patient administration system which provided brief information about patients' episodes of care. It was not a clinical care record. Due to the complexity of the data structures of the two legacy systems and PARIS, the only patient data it was possible to migrate was demographic.

More importantly for existing patients and particularly 2009/3245, there would not be a migration of previous patient case files containing documents, letters, risk assessments, care plans. PARIS was to simply create its own information base for each patient from day one of its implementation. The objective being that as time progressed, PARIS would build up documents, letters, care plans which would allow all clinicians and administration staff universal access to shared information concerning a patient.

The panel listened to evidence that to ease the implementation process, it was to be staggered over a number of months with three cohorts. The sequence being Older services (July 2008), Adult Services (October 2008), and Children services (December 2008). The implementation process being over a six month period. The panel heard evidence that there was little if any time to stock take after each cohort. There was no opportunity to delay the implementation process in order to allow staff to adapt to a major change in the IT system.

Mental Health Services Older People ("MHSOP") was the first cohort in July 2008 to undergo the transition to PARIS. The panel reviewed evidence in which the General Manager at MHSOP clearly identified significant issues arising from the

implementation of PARIS in Older services and which he regarded required attention prior to it being rolled out to Adult and Children Services.

Detailed concerns were raised by the General Manager of MHSOP to the Head of Information Strategic Projects and the Head of IT for the Trust. These ranged from inadequate PARIS training, lack of post “Go Live” support, failure to migrate all patient and staff lists, insufficient hardware, absence of “super users” and overall lack of functionality of PARIS. These matters were requested to be looked at prior to the transition to other directorates. It took 5 weeks for a response to those concerns and although there was some acknowledgment and improvement that the training had not gone into enough depth and repetition to allow the information to bed in, the transition process was not delayed and continued into Adult Services on the original timetable just over a month later.

In addition, the panel heard evidence that when PARIS was first rolled out by the Trust, its functionality was very limited. One clinician gave evidence to the panel which described it as “a massive compromise” and “not fit for purpose”. It was viewed as a “clunky” piece of software which was not intuitive. There was also no search facility, diary system or key/action dates to assist with the efficiency of providing patients care. All these points, although minor in isolation, when assessed in totality created a situation where staff were distracted from the main focus of providing care due to having to spend a significant amount of their working day operating a time consuming IT system that was labour intensive.

The panel have endeavoured in this chapter to address each significant individual change that they consider accumulatively impacted on the treatment and care given to 2009/3245 leading up to the serious untoward event. Thus, Service Redesign, the transfer of Consultant case loads, Team Led Clinics, and PARIS have all been examined and considered. The panel wish to emphasise again that they hold the view that it is not one individual change that was causally linked to the index offence but it was the totality of those changes that in turn impacted on the capacity and the work load of the mental health team treating 2009/3245 in 2008/2009.

The panel were concerned at the extent of the responsibilities being carried solely by 2009/3245's Care Coordinator in light of the volume of organisational changes and her ability to comply with Trust's policies and procedures in place relating to the provision of care to Patient 2009/3245.

Given the extent of her workload, not surprisingly, the Care Coordinator's perception of her role appeared to the panel to be self-limiting. She saw her role as focusing on social issues rather than the holistic needs inclusive of clinical issues. This narrow approach was mirrored by CP15 who viewed his main role as reviewing and suggesting changes to prescribed medication. Whilst these dual roles might have worked in a complementary way, in the case of 2009/3245, there was evidence of a complete lack of coordination.

Consequently, the panel has prioritised the need for the Trust to look at monitoring work load pressures taking into account individual practitioner's caseloads in order to prevent staff becoming overstretched, overloaded and ineffectual in their role when placed in the context of organisational changes which invariably impacted on the level of care and treatment provided to 2009/3245.

STANDARD OF RECORD KEEPING AND COMMUNICATION BETWEEN ALL INTERESTED PARTIES

This chapter has dealt with the standard of record keeping and then latterly with the level of communication between all interested parties, particularly with reference to information sharing between those parties.

(i) Standard of Record Keeping

The bench mark for record keeping within the Trust was enshrined in their Minimum Standards for Clinical Record Keeping policy which covered both clinical electronic and paper records and was ratified on 29 October 2008 and therefore in operation at the time of the index incident.

The policy made it clear that PARIS was to be the complete care record as from its implementation, with subsidiary paper records being maintained in specific circumstances. For example external correspondence which could not be scanned on to PARIS or specialist assessments which were not part of PARIS. It confirmed that summaries of what were currently recorded on paper needed to be inputted on to the electronic record.

One of the first criteria under the policy was for the clinician to ensure the patient's records were complete. Therefore, once a referral was accepted and a decision made to provide care the following had to be completed:-

- search for any separate health records;
- service users demographics;
- completed risk assessment eg. FACE;
- comprehensive assessment re capacity/competence;
- any alert protocol;

- regular and timely progress notes including summaries of paper based assessments;
- valid consent documentation;
- comprehensive care plan formulated from assessment and incorporating risk/crisis plan

The policy demanded that clinicians had to make their own entries in the case notes section of PARIS. In extenuating circumstances, a third party entry could be made but it needed to be counter signed by the clinician. All entries were to be validated within 24 hours.

All letters relating to the service user and generated by the Trust had to be held electronically on PARIS. The generation of paper held documentation had to be avoided. If correspondence could not be generated through the template provision on PARIS, then the existence of the correspondence had to be referred to on PARIS and its location for retrieval stated. The emphasis was that the recording of primary clinical information was to always be on PARIS.

In terms of organisation, the information in the paper records was to be arranged in chronological order according to filing instructions on the section dividers. Handwritten clinical notes were to be filed with the past history at the front of the section and the most recent at the back. Entries had to be legible.

Clinicians could be required to make more frequent entries for patients who presented with complex problems, show deviation from the norm, or were vulnerable or at risk of harm or abuse.

Significant risks had to be recorded on the risk alert sheet within the paper record. This was to be located in the comprehensive single assessment section. This was to be completed by the Care Coordinator. When a new volume was created the risk alert sheet was to be transferred to the new volume.

Records also had to document other professionals' involvement in the care of the patient. One of the boxes in the "additional clinical information/ notes" panel on the

front cover of the case notes had to be ticked to indicate the inclusion of other professionals to the client's care. If the panel showed input from other professionals not part of the multi-disciplinary team, then these professionals had to provide summary reports into the main care record.

There is a significant overlap in this chapter with the chapters which preceded this one. One of the key changes in the standard of record keeping was brought about with the introduction of the clinical electronic record - PARIS. This has been dealt with in some detail in chapter 6 at pages 79-92 of this report.

Although PARIS was to be the complete clinical record for the Trust, it could only become that over time given the limited migration of patient data. Therefore, initially treating clinicians were in the short term reliant upon the paper notes.

With existing patients and pertinent to 2009/3245, was the absence of transferred historical data to PARIS such as risk factors and forensic history which meant that PARIS would only bring any added value to treating clinicians over time. The panel heard evidence that there was a widespread knowledge of acceptance within the Trust that if as a clinician you wanted an appreciation of the past history of an existing patient, then you accessed the paper notes through archive in the medical records.

Any key information from the paper notes such as forensic history, risks should have been summarised onto PARIS or at the very least sign posted on PARIS with an indication of where that information was to be found in the paper records. This was in compliance with the Minimum Standards for Clinical Record Keeping policy. It seemed to the panel that this did not happen in respect of 2009/3245.

In the case of 2009/3245, the migrated legacy data on PARIS simply confirmed his last inpatient episode in 1996 and that he was under the care at that time of CP9. There was no sign posting to the comprehensive assessment carried out by CP9.

The panel found no record of the MAPPA involvement in 2001 and 2004 respectively on PARIS pre the index incident. The absence of an IT system transferring historical data meant that 2009/3245's past risks were lost in the PARIS migration process.

Given the lack of transferral of historical data through the IT system, it was then left to clinicians to input data reflecting 2009/3245's past risks post implementation of PARIS. The panel looked at what guidance other than the Minimum Standards for Clinical Record Keeping policy was given to staff in that regard.

The panel heard conflicting evidence as to what staff were told should be put on to PARIS from the paper notes by treating clinicians.

The panel listened to evidence from 2009/3245's Care Coordinator at the time of the serious untoward event that no guidance was disseminated as to what past data including risks were to be populated onto PARIS once it had been implemented in Adult Services. She suggested that there was simply no designated place specifically on PARIS to enter that type of information. Consequently, she confirmed that no summary of historical risk of 2009/3245 was entered on to PARIS in October 2008 or pre the index incident. The panel heard that now on PARIS there is a specific service user history icon in which clinicians can populate a patient's past social and medical history.

By contrast and in keeping with the Trust's Minimum Standards for Clinical Record Keeping policy, evidence was also heard that prior to the first review of a patient, a comprehensive assessment of needs should have been entered onto PARIS and that should have incorporated an assessment of historical risk. In the case of 2009/3245, the panel heard evidence that there should have been a core risk identified on PARIS regarding his past aggression towards women who he had had a relationship with.

The panel considered that at the very least, it would have been best practice for a historical summary to be produced or updated when any patient was reviewed or moved from one key individual, such as a Consultant or Care Manager to another. This should have then been entered onto PARIS for each existing patient including 2009/3245.

It seemed to the panel that in any event, under the CPA policy, there would be an obligation on treating clinicians to risk assess each patient within 6 or 12 months of PARIS being introduced and that would include a historic risk review identifying significant past indicators or markers. It was therefore anticipated that within that

time scale, all patient risk assessments would be completed and recorded on PARIS. It struck the panel that the Trust relied on the clinical process being followed rather than for example, building in an automatic fail safe prompt in the IT system to ensure this would actually happen. In 2009/3245's case, it clearly did not happen before the index incident.

Specific compliance with this did not appear to have been monitored until after the serious untoward event by the Trust's CPA department in early 2010. What was evident from that review was that irrespective of whether there was a clear direction or not, in Middlesbrough and specifically with regard to 2009/3245, this was simply not done. There was no compliance with the Minimum Standards for Clinical Record Keeping policy in ensuring a comprehensive care plan formulated from assessment and incorporating a risk/crisis plan. The panel heard evidence that this was either due to a capacity issue given the transfer of Consultant case loads and reconfiguration or simply due to a lack of IT skills and having to master an IT system which was viewed by the majority as not "user friendly".

2009/3245's case notes documented what was on PARIS post migration and pre index incident. In essence, this was a chronological narrative containing letters and attendances on 2009/3245. They dated from 31 October 2008. The panel saw on PARIS a total of three copy letters and two file notes between the migration of PARIS (October 2008) and the index incident. (April 2009—a five month period).

In none of the documents was there any summary of the forensic history or risks. What appeared to be missing was any summary of historical data or even any summary of any paper based assessment in compliance with the Minimum Standards for Clinical Record Keeping policy. The panel found this surprising given that the Care Coordinator at the time of the serious untoward incident had carried out a review of 2009/3245's file records and drafted a case synopsis incorporating historical risks in January 2007 which was not entered onto PARIS.

One of the prime objectives of PARIS was to enable staff to share patient information, yet in respect of 2009/3245, the limited information contained on PARIS meant that there simply was no information inputted to share. The Care Coordinator failed to populate PARIS with the key historical data regarding 2009/3245's risk history and CP15 failed to access that information from the paper records.

In the first letter dated 21 November 2008 contained in the PARIS case notes summary, CP15 confirmed that 2009/3245 had given a detailed account to him of his past history but there was no detailed record on PARIS as to exactly what that history was or what the risks or triggers were.

There was no FACE risk assessment, past forensic history or core risk assessments for 2009/3245 on PARIS between October 2008 and April 2009. There was no referral or sign posting to the paper notes or reference to past reports. More surprisingly, was that a case overview was only entered on to PARIS after the serious untoward incident on 13 April 2009. This was done by the Care Coordinator who was prompted to do so.

Therefore, anyone accessing PARIS before this date in relation to 2009/3245 would have been completely unaware of his history together with the risk factors associated with him unless they accessed the paper file.

There appeared to have been no alert for 2009/3245 on PARIS pre incident. This was concerning given his forensic history and mental health admissions. The panel understood that there was an alert system on PARIS by using a red exclamation mark and attaching it to a particular patient - this was the only risk facility available to clinicians at the inception of PARIS. The panel heard evidence that the risk facility has since been improved following the implementation of PARIS with it effectively flashing on the screen as soon as the patient details are accessed. This would however, be dependent on the alert being populated and activated in the first instance.

In addition, to an absence of historical data, there was and at the time of writing this report still is, no ability to scan any documents/ letters on to PARIS so that a complete clinical picture was not available to the clinicians treating 2009/3245 at the time of the index offence without accessing the paper file. The panel understood that the ability to scan documents/letters may be available in the next upgrade of PARIS.

The panel believed that the absence of transferred historical data relating to 2009/3245, the inadequate information which was recorded on to PARIS once

migration had been completed and the absence of any risk assessment on PARIS had to undoubtedly have an impact on the care delivered to 2009/3245.

PARIS was also to contain details regarding a patient's entitlements relating to Section 117 aftercare. However, the panel were informed in evidence this was wholly dependent on the accuracy of the paper records/ local registers and that it was not possible to rely solely on PARIS, particularly for those older patients like 2009/3245 who had been sectioned some years ago.

Indeed, in relation to 2009/3245, the paper notes were not comprehensive in respect of highlighting his Section 117 after care. This has been dealt with in some detail in chapter 6, on pages 57-63 of this report.

2009/3245's eligibility for Section 117 entitlement was first recognised in the clinical notes as part of a CPA review whilst in the Redcar and Cleveland community service in May 1997. The recognition of this responsibility continued and was noted until they transferred him in October 2000 following his relocation back to Middlesbrough in the June of 2000. There was no evidence in the clinical notes to support the transfer of this aftercare responsibility at that time.

The Section 117 eligibility was not recorded again until January 2007 when the Care Coordinator, who was to remain the Care Coordinator up to the time of the index offence, noted this in the case records, albeit those obligations were not complied with.

It was clearly evident that there was an absence of adequate recording of 2009/3245's Section 117 status in his clinical notes. The last two treating Consultant Psychiatrists (CP14 and CP15) leading up to the index offence, both suggested in evidence that they were totally unaware of his entitlement to Section 117 aftercare.

The panel heard how historically there had been a Section 117 register operating in the Trust. Up until the introduction of PARIS this had consisted of a paper record held centrally. Regarding 2009/3245's care, the panel were informed that at the point of the merger there were also locality registers for Section 117 eligibility.

In Social Services, a separate register was held which was reported in evidence to be less accurate than the information held by the Trust. Even the Care Coordinator in evidence remarked that the central recording at the Mental Health Office of Section 117 was very “hit and miss”. The recording of Section 117 entitlement appeared to have been unreliable. There was no definitive list of which patients were entitled to Section 117. The panel heard that this had the effect of clinicians failing to observe Section 117 obligations.

The impact of repeated failures to adequately record 2009/3245’s entitlement to Section 117 after care meant that instead of being subject to a full CPA, he was assessed on Standard Care only. This has been dealt with in chapter 6 at pages 50-56 of this report.

In relation to CPA, the panel also noted that the Care Coordinator failed to complete a FACE risk assessment in respect of 2009/3245. This has been dealt with at chapters 5, pages 35-49 and chapter 6, pages 50-56. There was a clear absence of a written, comprehensive care plan for 2009/3245 covering crisis management and highlighting relapse signs. Furthermore, the documentation, which was introduced locally in Middlesbrough to support the Team Led Clinic by way of a risk assessment proforma, did not meet the standards required of the Trust’s CPA policy.

Practitioners were not conducting a comprehensive assessment of need and entering the same on to PARIS, nor using the care documentation on the PARIS system. Not only was the FACE tool not being used, but the proforma that was being used in its place failed to provide a thorough review of past historical risks including 2009/3245’s early life experiences from all sources.

The panel recognised that the paper records of 2009/3245 were vast and ran to a number of files and were not centrally located. For any treating clinician it would have been a herculean task to review such documentation for one patient, let alone a number of patients in the case load who were seen for only a limited time slot at consultations.

Specific to 2009/3245, the panel found the clinical notes were not in any chronological order and difficult to navigate around. Some of the clinical notes were not legible, particularly some of the hand written notes. There also appeared to be

no dividers, filing instructions or risk alert sheets. There were no summary reports from New Horizons (Teesside) in the care records.

Although there was no policy to be applied before the Trust's Minimum Standards for Clinical Record Keeping policy, the panel considered the earlier clinical notes included good descriptions of how 2009/3245 was functioning. The records appeared to be complete and there were no points where the panel did not see entries for long periods of time where there should have been entries. There was evidence of regular contact with his GP as well as good documentation about his medication.

The panel identified from reviewing 2009/3245's clinical notes, that historically the risk assessments and care management plans were of a varied standard. There was an absence of a uniformed approach to risk assessments by consecutive clinicians. In addition, from 2004 onwards there was no mention of past risk or public history in 2009/3245's clinical notes. There appeared to be a failure to record important and significant information such as MAPPA and Section 117. In addition, there appeared to be a focus on a single diagnosis.

Also, with the numerous changes of treating Consultants of 2009/3245, the panel would have expected to see comprehensive transfer summaries and sign posting to the assessment carried out by CP9. These were not in evidence in the clinical notes. There were very few occasions where the history of 2009/3245 was summarised.

(ii) Information Sharing between Interested Parties

Care Coordinator with New Horizons:

It was evident historically that the care and management of Patient 2009/3245 had involved numerous external agencies ranging from the Probation, Police, MAPPA and various Local Authorities but at the time of the index incident, the only external agency that Patient 2009/3245 was involved with was New Horizons (Teesside). They were working in partnership with the care team in providing support, care and management of the risks associated with Patient 2009/3245.

It was therefore crucial when assessing the care provided to Patient 2009/3245 to look at the level and quality of communication between those two organisations and what channels (formal and informal) existed to achieve that. In addition, to investigate what information was shared and whether this affected the care provided.

New Horizons (Teesside) is a charitable organization and as such was established in 1972 to provide supported housing to mental health patients. They are a charitable managing agent for properties through a local housing association providing six month short hold tenancies.

In the Teesside area they worked with Middlesbrough Council and were contractually bound through a service agreement in operation at the time of the index incident to provide accommodation for mental health patients with a view to support integration back into the community.

There was in place at the time of the incident a multi-agency information sharing protocol which governed what could be disclosed to external agencies and what information could be shared with them.

This was necessary to ensure robust governance arrangements with other agencies including charities that would have access to confidential patient information and the security of the same. It also reinforced to non-statutory agencies the significance of the information that they held.

In respect of Patient 2009/3245, New Horizons involvement started with his referral to them through his then Care Coordinator in order to facilitate a move from Park Road North Flats to Clairville Flats, Middlesbrough.

This was raised initially on 13 October 2008 by his Care Coordinator at the Accommodation & Support Mental Health Panel meeting and was documented in the minutes. It confirmed that 2009/3245 was a service user looking to move and who had abused drugs in the past for many years but with no [other] risk issues for years. Present at that meeting was the General Manager for New Horizons (Teesside) as well as 2009/3245's Care Coordinator.

Following on from that meeting, a referral form was generated which was inputted by 2009/3245's Care Coordinator. It suggested that although 2009/3245 had a history of drugs and violence that had occurred "many years ago", in order for the application to be actioned it had to be considered alongside a care plan and risk assessment by New Horizons staff. In 2009/3245's case, a copy letter was attached to the referral form dated 30 July 2008. That letter was from the Care Coordinator to 2009/3245's GP and recorded no concerns with regard to current risks. There was no review of historical risks.

It was the panel's perception that the primary purpose of the completed housing application form was to ensure accommodation was provided to 2009/3245 as opposed to fully briefing the New Horizons staff as to the historical and behaviour risks associated with 2009/3245. If anything, it effectively diluted all the past risks completely and failed to highlight any current risks. 2009/3245's Care Coordinator confirmed in evidence to the panel that the details which she entered onto the form were minimal and insufficient to alert the New Horizons staff to the behavioural risks.

At interview, she said that the information which she gave to New Horizons regarding the risks was "simply not enough". Although the Care Coordinator had done a detailed synopsis dated 25 January 2007 of 2009/3245 past history, this was not provided to the New Horizons staff.

In that respect it seemed to the panel that the communication with the health team and the New Horizons staff was inadequate. New Horizons staff should have been educated as to what they should look out for by way of triggers as to a recurrence. A checklist would have sufficed whereby New Horizons staff were provided with a list of signs and features to look for which could have signalled a relapse or deterioration in 2009/3245's mood. The health team should have highlighted specific circumstances which would invoke the care team's involvement.

Patient 2009/3245 was then interviewed by New Horizons staff in the presence of his Care Coordinator and they carried out an internal risk assessment which correctly identified a past history of violence toward women and the general public. The panel have had sight of the completed interview sheet and the risk assessment. Although the risk assessment document highlights one of the risks associated with 2009/3245, there was a certain degree of minimisation to that risk, viewing it as if it was something in the past and therefore not wholly relevant to the current.

It was evident from interviewing the New Horizons staff that risk assessment training was provided annually to them in-house. They were trained in identifying risk type behaviour but they felt that this had to be considered within an underlying philosophy of normalisation and the promotion of independence. The panel considered that the New Horizons risk assessments carried out during the interview process did not correctly identify what the risk of recurrence was or what the potential triggers were. In addition, given that the Care Coordinator was present during that interview process, the panel were concerned that such information pertaining to 2009/3245's past risks were not shared and provided by his care team Care Coordinator to the New Horizons team.

Within two months of Patient 2009/3245 moving in to the Clairville Flat, there were issues relating to his pre occupation with a female support worker at New Horizons. In the contemporaneous minutes of the New Horizons team meeting dated 17 December 2009, it was evident that Patient 2009/3245 seemed to prefer a female support worker than a male. Consequently, a male support worker was allocated to Patient 2009/3245.

Patient 2009/3245's Care Coordinator confirmed in evidence that she was aware of the situation with the female support worker. The panel were concerned that this situation appeared to have been communicated informally to the Care Coordinator by New Horizons and that in turn it was not documented by the Care Coordinator in the clinical notes anywhere. In addition, it did not appear to have been communicated to the treating Consultant at that time - CP15. He confirmed in evidence that he was totally unaware of any problems arising with the female support worker. The panel were concerned that such issues were not raised or repeated at the CPA meetings.

New Horizons staff confirmed that there were weekly team meetings which were the only formal process other than CPA reviews, through which the New Horizons support worker could raise any concerns relating to Patient 2009/3245's behaviour. In attendance were exclusively New Horizons staff; namely his support worker and the Team Leader and occasionally the General Manager. The panel was concerned that neither the Care Coordinator, nor any member of Patient 2009/3245's care team ever attended these team meetings nor received a copy of the minutes from them. Indeed, the care team did not receive any documentation from New Horizons, their minutes or more importantly the visit logs carried out by the support worker at

2009/3245's home. The panel viewed this as a failure on the part of the care team and the New Horizons staff to information share.

The New Horizons staff may have been sufficiently skilled to identify a major risk if 2009/3245 had shown signs or symptoms of a serious deterioration in his mental health, but in the panel's view the New Horizons staff did not appear to have sufficient awareness of 2009/3245's history nor had they access to a set of guidelines as to what subtle signs they should be looking for that might alert them to increasing risks.

However, they were the only ones in a position to observe and pass information on to the care team had the channels of communication and exchange of information been better established. The staff had a significant role as gatherers of intelligence/information, which should in turn have been communicated to the care team. In addition, it was clearly evidenced from the witnesses interviewed from New Horizons that if they did have any concerns their first port of call was to be the Care Coordinator.

It was evident that the New Horizons support worker was in a position to gather information and consequently would have had the greatest insight into Patient 2009/3245 given he was carrying out home visits on a weekly basis. In evidence, the New Horizons male support worker confirmed that he had seen the risk assessment carried out internally before the incident and therefore was aware of 2009/3245's previous history of violence toward women. Indeed, it had been the same support worker who had raised the alarm concerning Patient 2009/3245's preoccupation with the female support worker.

At interview, it was confirmed by the New Horizons support worker that for him the concerns with Patient 2009/3245 were drugs and violence towards women. The panel believed that information should have been flagged up by New Horizons to the care team. They had a basic knowledge about the signs of mental health illness, they had had requisite risk assessment training and they knew or had an awareness (albeit minimal) about the risks of violence towards women.

From January 2009 up until the index offence (11 weeks) it was evident from the weekly New Horizons visit log that Patient 2009/3245 was smoking cannabis and

had a girlfriend. Between 22 January 2009 and the index offence, the support worker communicated with Patient 2009/3245 on sixteen occasions and of those, on nine occasions Patient 2009/3245 mentioned his girlfriend to him.

The panel were concerned that this information was not shared with the care team given that the New Horizons support worker had knowledge of the risks. The information given by Patient 2009/3245 regarding his girlfriend related to buying a valentine card for his girlfriend, referring to her as his soul mate, visiting Monaco together, and obtaining passports to travel to Tunisia. It was also evident that he was spending the weekend with her and staying overnight.

Despite this all being documented in a written log, a copy was not provided to the care team nor did the Care Coordinator ask for a copy and the information was not relayed verbally. The Care Coordinator confirmed in evidence that she had no knowledge that Patient 2009/3245 actually had a girlfriend. She appeared to have satisfied herself that Patient 2009/3245 was not in a relationship by his self-report only.

What was evident from the witnesses interviewed was that the information that Patient 2009/3245 had a girlfriend was not just confined to his support worker. He gave evidence that he had reported the relationship to the New Horizons team Leader because he had concerns. This was corroborated by the New Horizons General Manager who when interviewed gave evidence that the support worker kept bringing it up at New Horizons team meetings that Patient 2009/3245 had a girlfriend and that he was concerned it did not become an obsession.

The panel found it concerning that it was documented that Patient 2009/3245 was in a relationship, that the support worker knew of this as did the General Manager of New Horizons, yet it was not conveyed to the care team.

This was especially concerning because there seemed to have been no formal structures in place for exchanging invaluable intelligence between New Horizons and the care team. In addition, the only means of discussing Patient 2009/3245 was either at a CPA meeting or informally given New Horizons and Parkside shared the same office building. The Care Coordinator when interviewed confirmed that she would see staff from New Horizons routinely every day on an informal basis and she

would use that as an opportunity to discuss Patient 2009/3245. It therefore raised the question as to why she did not know that 2009/3245 had a girlfriend.

What was evident from the Care Coordinator's evidence was that she had liaised with New Horizons regarding Patient 2009/3245's relationships in the past. She knew he had had a relationship with another service user and that she had dealt with it by contacting New Horizons and asking them to make sure she did not attend 2009/3245's flat again.

The New Horizons support worker carried out a further risk assessment with a support plan on 23 March 2009 which suggested there were no current risks at all with Patient 2009/3245.

The support worker also attended Patient 2009/3245's CPA meeting on 29 January 2009 having visited Patient 2009/324 at his flat first thing. In the morning they chatted and discussed his girlfriend as well as other matters. At the CPA meeting in the afternoon there was no mention of Patient 2009/3245 having a girlfriend despite social factors being discussed and 2009/3245 highlighting that he was having problems with his sexual health by way of erectile dysfunction. There was recorded no "cross sectional risks" at this time. It appeared to the panel that the professional staff failed to pick up on the cue relating to 2009/3245's erectile dysfunction and the possible congruence with a relationship.

Ironically, at the time that 2009/3245 committed the index incident, his New Horizons support worker was operating under the belief that he was doing well and progressing towards independence so much so that he recommended that visits should be reduced to once a fortnight. Indeed, the minutes from the February 2009 New Horizons team meeting recorded 2009/3245 as making friends, responding to support and that he may well benefit from a reduction in his support hours for at least a trial period to see how he copes.

In summary, it seemed to the panel that the information passing from the care team to New Horizons was extremely brief and did not fully particularise the full historical risks and behaviour problems associated with 2009/3245. The key failures on the part of the Care Coordinator were in diluting the risks, not informing New Horizons

staff of what to look for by way of signs of relapse or significant information which once identified should have been passed from them to the Care Coordinator.

Although in theory it was team management, in practice it was more that the Care Coordinator and the New Horizons team were working in isolation. It was clear from the evidence that the New Horizons staff and the Care Coordinator did regularly talk about the clients that they shared. This may have given rise to a sense that information was not being missed. However, in reality, in this instance crucial information was not being passed on.

It was evident from the witness evidence of the New Horizons staff that they knew 2009/3245 had a past history of violence to women, but they saw it as a past risk many years ago and no bearing to the present. Furthermore, despite knowing of that risk and that 2009/3245 had a girlfriend which was getting serious they failed to identify that as significant information or to make any connection with 2009/3245 behavioural risks.

Indeed, they held the view that such a development was in keeping with their philosophy of normalisation. Not only was there a lack of verbal communication between the care team and New Horizons staff, but written information was not shared either. So the New Horizons weekly logs, minutes of New Horizons weekly meetings, were not made available to nor asked for by the care team. In addition, there was an absence of formal structures to exchange information.

Had that information been given to the Care Coordinator, then she would have been aware of 2009/3245 relationship and realised the risks associated with that.

Care Coordinator to Consultant Psychiatrist:

Leading up to the index incident, Patient 2009/3245's care team consisted of the Care Coordinator and CP15. Given both were treating Patient 2009/3245 there should have been in operation information sharing between them both to ensure the standard of care delivered to 2009/3245 was reasonable. Indeed, NWW and the Team Led Clinics actively encouraged working together rather than the Consultants working in isolation.

The panel heard evidence from CP15 that given the time pressure of clinical appointments of 20 minute slots for seeing patients, it would not be unusual for the Consultant to rely on team members to fill in any gaps as to patient knowledge. He stated that involvement, rapport and links with the team were crucial rather than him having to read through the full set of notes.

However, when questioned at interview, 2009/3245's Care Coordinator confirmed that she failed to alert CP15 as to the risks of 2009/3245 becoming violent with women as she thought CP15 would have read the clinical notes as it was his responsibility to do so. In turn, CP15 sought to rely on the fact that it would be the Care Coordinator who would provide information regarding the patient to him.

In 2009/3245's case CP15 suggested at interview that he had no information from the Care Coordinator regarding 2009/3245. He described himself as being hampered in delivering the care without that information, and given he had not read the clinical notes because of a lack of time, he had no knowledge of 2009/3245's forensic history.

CP15 in his opinion had limited capacity, did not access the clinical notes and did not have sufficient information about the risks. This undoubtedly had an indirect impact on the level of care C15 could give.

It appeared that historically, other treating Consultants who provided care also either failed to read the clinical notes or accessed only the most up to date ones, (CP14 and CP13). Thus, knowledge of 2009/3245's MAPPA history or his admission to Ashworth hospital was completely lost.

Some Consultants complained that the clinical records of 2009/3245 were simply too vast to read. The panel heard evidence from CP14 that had he read the clinical notes he would have placed 2009/3245 on CPA instead of Standard Care.

It seemed to the panel that not only was there a lack of communication between the Care Coordinator and CP15 at the time of the incident but historically there was a lack of communication between the Consultants that had treated 2009/3245. This

was evident in the absence of any transfer summary when 2009/3245 was transferred to a new treating Consultant.

On questioning, CP14 confirmed not to have provided any transfer summary when 2009/3245 moved to treating Consultant CP 15. In turn, CP14 had no expectation of receiving any transfer summary when 2009/3245 was transferred to him. Again, resulting in Consultant Psychiatrists working in isolation.

There appeared to have been no verbal discussion between CP14 and CP15 either when 2009/3245 was transferred to CP15's care. Consequently, information was lost when 2009/3245 care changed hands. It seemed to the panel having heard evidence from both CP14 and CP15, that it was simply not routine for Consultants to access the previous medical notes of a new patient nor to sign post the notes for the benefit of subsequent treating Consultant Psychiatrists.

Multi Agency Public Protection Arrangement (MAPPA)

This will be dealt with substantially in chapter 8 at pages 111-116. However, the panel would identify here the lack of communication evident at the final MAPPA meeting on 13 September 2004 where 2009/3245's status changed and he was reclassified as medium risk rather than high risk and deregistered. There were no Health or Social Care representation at the MAPPA meeting in September; the decision was made by the Police and Probation service representatives.

INTERFACE BETWEEN MENTAL HEALTH SERVICES & OTHER AGENCIES

The inquiry has considered the inter-agency interface and its relevance to the care and treatment of Patient 2009/ 3245. Correlations to specific issues reflecting inter-agency issues have been made throughout this report and for the sake of brevity have not been repeated in detail in this chapter. This section therefore, has sought to summarise the inter-agency context and to examine in further detail the area of Multi agency Public Protection that was of particular relevance in the case of 2009/3245.

The Trust managed a challenging interface working across seven Local Authorities. An example of such challenges was reflected in the difficulties of trying to agree a definitive policy in relation to Section 117 of the Mental Health Act 1983 with all social care partners. This has already been covered in chapter 6 at pages 57-63 of this report.

At the time of the index offence, the key Social Services agency was that of Middlesbrough council. In relation to the Middlesbrough area, documentary evidence was received by the panel that demonstrated an integrated approach had been adopted between Health (the Trust) and Social Services. A formal partnership agreement was in place that applied to all aspects of inter-agency working between the two agencies. Social care staff worked to the operational policies of the Trust. This was also explicit not only in the Partnership agreement but referenced in policies and guidance, for example the CPA policy. In relation to Human Resource policies staff related to the policies of their employing organisation. So, a Social Worker followed Middlesbrough Council grievance policy whereas a CPN would follow the Trusts.

The partnership agreement provided the framework for integration, a joint management structure with Health and Social Care staff having a single management structure, with professional support structures. Clear accountabilities through team and service managers to senior management were in place. Evidence from witnesses demonstrated a clear understanding of those arrangements.

Information was received, that highlighted to the panel further working arrangements between the Trust, Social Services and other agencies. For example there was evidence of Police and Probation being participative in operational working relating to the Mental Health Act 1983. As appropriate, these agencies were also included in relevant policies as key partners.

There appeared to be a clear strategic commitment to work in partnership across agencies from those senior staff interviewed. A clear commitment from the Trust was evidenced by a representative of Middlesbrough Council being appointed as a partner Governor on Tees, Esk and Wear Valleys Council of Governors.

In considering the inter-agency interface, in the case of 2009/3245, the investigatory panel felt it necessary to particularly focus on MAPPA.

Sections 67 and 68 of the Criminal Justice and Court Services Act 2000¹ formally created MAPPA. It placed a statutory responsibility on Police, Probation and Prison Services to establish arrangements for the assessment and management of sexual and violent offenders in the community. These arrangements were consolidated by the Criminal Justice Act 2003², which made the Police, Probation and Prison Services “responsible authorities” and gave other agencies, including Health and Social Services, a “duty to co-operate”. MAPPA agencies had a statutory duty to identify high-risk offenders, carry out risk assessments and ensure that offenders were managed appropriately in the community

In the case of 2009/3245, it was evident from the historical documentation reviewed that he was nominated by a health professional within the Redcar & Cleveland community mental health team for consideration as a potentially dangerous person due to his aggressive behaviour, especially towards females he formed a relationship with. At that time (2000), he had not been convicted of any violent offences, however there were impending prosecutions for threats to kill, common assault, battery and affray. A public protection conference was held on the 16

¹ Criminal Justice and Court Services Act 2000.
www.legislation.gov.uk/ukpga/2000/43/contents

² Criminal Justice Act 2003.
www.legislation.gov.uk/ukpga/2003/44/contents

October 2000 and concluded 2009/3245 should be placed on the Teesside Probation and Cleveland Police Dangerous Person Register at that time.

There then followed a review meeting on 24 January 2001 to consider whether this status should remain in addition to agreeing a level of risk and revising the inter-agency strategy plan to manage that risk. It was concluded his name should remain on the register. The records of the meeting did not specify the next review date and recorded "to be arranged at a later stage". The panel was unclear as to what further occurred within the MAPPA framework prior to March 2002.

On the 20 March, 2002 2009/3245 received a custodial prison sentence for 45 months. It was felt appropriate to remove him from the Dangerous Offenders Register on the basis of a full risk assessment being carried out prior to release from prison.

2009/3245 was scheduled to be released from Lindholme Prison on the 29 January 2004. Prior to this, on the 14 January 2004, a multi risk management meeting was held to decide on the level of risk once he was released back into the community. He was assessed as being "high risk: potentially dangerous" and his name was placed on the Cleveland Police and National Probation Service Teesside's high risk register. A risk management strategy was agreed.

The panel considered the forward planning and inter-agency work relating to MAPPA meeting prior to his release to have been good practice

Following release from prison as planned on the 29 January 2004, a review meeting took place on the 1 April 2004. This re-assessed the level of risk and concluded the high risk status should remain unchanged

The next review took place on the 23 June 2004. There was no Health or Social Services in attendance. The agreed risk management strategy indicated the need to invite Social Services to the next review meeting and to follow up the Health position. The high-risk status remained unchanged.

The final multi agency risk management meeting took place on the 13 September 2004. It was concluded that there had been positive progress and the risk factors

had reduced at that time. It was concluded he should be removed from the register of high-risk offenders. He was classed as medium risk having the potential to cause harm, but was unlikely to do so unless there was a change in his circumstances. Attendance at the meeting was limited to Probation, Police and Housing support. It appeared there was no direct Health or Social Services involvement in either the meeting or the decision. He was discharged to a single agency management on the basis of the Custody Diversion Team being contacted to confirm outpatient attendance. No further MAPPA meetings were planned.

The investigation could find little evidence to confirm the level of information that was shared with Health following the MAPPA meeting that led to his deregistration. There was reference in the case records, on the 22 September 2004, to a discussion between Health and Probation that indicated he had been de-registered from high-risk status. After that time, 2009/3245 had no further involvement with MAPPA.

The historical information associated with the MAPPA process was significant in supporting assessment and formulation of risk issues in the future for 2009/3245's care provision. At the point of discharge from the MAPPA process in September 2004, CP13 indicated he was not aware of this occurring. There did not appear to be evidence of a comprehensive transfer of information following the decision to remove his high-risk status.

The evidence from reviewing the case records demonstrated the lack of consistency in information transfer / communication of 2009/3245's MAPPA history, between practitioners, throughout his subsequent treatment in Health and Social Services. The panel heard evidence that some of the senior medical staff, at the time of providing Consultant care to 2009/3245, were not aware he had previously been subject to MAPPA registration as a high risk individual. Neither were they aware of the reasons for this due to his aggressive behaviour towards women with whom he formed relationships.

Whilst the issues relating to MAPPA were a number of years earlier than the index offence, the panel considered evidence relating to current arrangements in the context of learning lessons. In this respect, there was contradictory evidence presented.

The panel were informed a review of MAPPA had taken place since the time of the index offence in light of wider guidance being published. Arrangements were described as being more robust and there was a higher commitment to attend strategy board meetings by Health and social care representatives. The panel saw evidence of a memorandum defining the duty to co-operate had been developed and this included guidance on MAPPA procedures. The panel were informed intensive training / briefing had taken place to address these issues.

The panel were advised that additional resources had been allocated and a full time co-ordinator was in place to support MAPPA / MARAC. They were to provide a link to all MAPPA boards and when individual case meetings were organised they were to liaise with clinicians to ensure attendance as well as offering support in accompanying clinicians to case meetings.

In exceptional circumstances, if a clinician was unable to attend they would receive a briefing and represent the Trust. The panel were informed that attendance to case meetings in 2011/12 had been 100%, although this was not validated by the panel. The panel were also informed the referral threshold for MAPPA had now become more flexible and staff were more vigilant and likely to refer if they had concerns. The number of informal enquiries for advice and discussion increasing also evidenced this.

The panel however heard contradictory evidence from a number of senior medical staff that indicated a limited awareness of MAPPA procedures and some views were held that there was inadequate guidance available for staff of when individuals should be referred. No staff member interviewed indicated they had received training to assist their understanding of MAPPA and how this operated locally.

The panel heard that some concerns had been raised by a senior social care manager, that some staff, particularly CPNs, did not always raise concerns at an early enough stage that may require a MAPPA referral. This was felt to be due to some staff, particularly in the Psychosis Service, dealing with highly complex clients with a high level of risk and as a result had developed a high reporting threshold.

The development of a memorandum defining the duty to co-operate responsibilities, together with the associated guidance was seen as good practice. There appeared

however to be a lack of consensus regarding how embedded knowledge and awareness of MAPPA arrangements were within Adult Mental Health Services.

The panel considered, based on the evidence, further work was required in this area to address concerns in practice.

EXECUTIVE SUMMARY

Having regard to the terms of reference, the panel approached the investigation by primarily focusing on the standard and level of care which was provided by the mental health team, particularly the treating clinicians (the Care Coordinator and CP15) to Patient 2009/3245 at the time of the index offence. That was then considered in the context of the accumulation of organisational changes that had and were taking place in the Trust, driven by local and national influences, leading up to and when the serious untoward incident occurred.

The panel recognised the importance of contextualising the care and investigated how outside external factors shaped or impacted on the standard provided to Patient 2009/3245. However, the panel have viewed this as secondary to their assessment of the level of care which was provided direct by the mental health team to Patient 2009/3245.

The panel considered the current position as well as historically given Patient 2009/3245 had contact with Mental Health Services from the age of 7.

The recommendations that follow reflect the approach of focusing on the care rather than organisational changes. The panel have ranked the recommendations in order of weight to be attached to them, starting with the most important.

The panel were aware that they had the ability to look at events with the benefit of hindsight and also the time to scrutinise in full, all the available records relating to Patient 2009/3245.

The panel were also conscious of the fact that unlike the majority of other inquiries, in 2009/3245's case, there was no suggestion of any recurrence of any mental illness prior to him committing the index offence. Indeed, at the time of his trial, there was no evidence offered to suggest otherwise and consequently, he was sentenced to a period of imprisonment rather than given a hospital order.

Understanding the factors that led to the index offence were also limited by Patient 2009/3245's amnesia of what took place when the offence was committed. In the panel's view, it was not predictable that he would behave in the way he did at the time that the index offence took place. However, given his previous history, the panel believed there should have been far greater awareness by the care team of how a new and close interpersonal relationship might affect Patient 2009/3245.

(1) The inquiry view the quality and scope of care and treatment provided to Patient 2009/3245 had been affected by the mental health care team's ability to carry out their work, given the demands of their case loads, their management responsibilities and supervisory roles.

In evidence, the Care Coordinator for Patient 2009/3245 at the time of the index offence confirmed to the panel that she had a personal case load of approximately 80 clients, management supervision for 20 staff as well as management duties. The panel were concerned at the extent of the responsibilities being carried solely by the Care Coordinator and her ability to comply with Trust's policies and procedures in place relating to the provision of care to Patient 2009/3245.

Given the extent of her work load, not surprisingly, the Care Coordinator's perception of her role appeared to the panel to be self-limiting. She saw her role as focusing on social issues rather than the holistic needs inclusive of clinical issues. This narrow approach was mirrored by CP15 who viewed his main role as reviewing and suggesting changes to prescribed medication. Whilst these dual roles might have worked in a complementary way, in the case of Patient 2009/3245, there was evidence of a complete lack of coordination in the care team and an absence of a team based approach.

Consequently, the panel have prioritised in the first recommendation, the need for the Trust to look at monitoring work load pressures taking into account individual practitioner's caseloads in order to prevent staff becoming overstretched, overloaded and ineffectual in their role which in turn impacts on the level of care and treatment provided.

Managing and monitoring caseloads needs to be viewed collectively as a team as well as individually. Given that the nature and number of the caseload will dictate

the role this needs to be part of the monitoring process. This will promote higher standards of care, best practice as well as providing support to staff allowing proactive management, supervision and support of their case loads.

(2) One of the issues which was very apparent to the panel was the lack of continuity in care given the number of Consultants that treated Patient 2009/3245. Part of this was due to organisational changes within the Trust and in part due to Patient 2009/3245 relocating.

Between 1985 – 2009, (24 years) there were consecutively 15 Consultants responsible for Patient 2009/3245's care. This inevitably had to have an impact on the level of care delivered to Patient 2009/3245. It seemed to the panel that over those 24 years there was little if any communication between Consultants by way of handover, and no expectation by Consultants that there should be any.

Over time, the clinical notes of Patient 2009/3245 became voluminous and consequently, not easily accessible. Indeed, at interview some Consultants confirmed they had not read Patient 2009/3245's notes, whilst others had simply read the most recent entries. With the implementation of PARIS, some Consultants relied upon what had been imported on to PARIS and did not peruse the paper file, despite the fact that no detailed risk information in respect of 2009/3245 had been moved over during the migration process.

There appeared to have been very little consistency between treating clinicians as to what information should be communicated between them upon the transferral of Patient 2009/3245's care. Hence, the panel's second recommendation.

The absence of a comprehensive standardised transfer summary in Patient 2009/3245's circumstances had to affect the standard of care and treatment that was given to 2009/3245. By 2009, 2009/3245's MAPPA history, Section 117 status and forensic history appeared to be lost, consequently treating clinicians had to a large extent become unaware or complacent to his historical risks. There was no sign posting of any relevant past documents for the benefit of subsequent treating clinicians nor any comprehensive review of his history since the report carried out by CP9 in 1996.

Furthermore, it appeared to the panel that with only modest information being communicated on transfer that in reality the Care Coordinator and/or the Consultant Psychiatrist were actually working almost in isolation, particularly, when it came to coordination and delivery of the care plan to Patient 2009/3245.

It therefore seemed to the panel that to improve on the continuity of care and to facilitate the transfer of key patient information between Consultants that there ought to be a template which as a minimum common standard should cover historical risks as well as diagnosis, treatment plan, medication and in selected cases Section 117 details, MAPPA and the patient's forensic history. This should be readily accessible on PARIS.

(3) The only external agency involved in Patient 2009/3245's care at the time of the serious untoward incident was the accommodation provider - New Horizons (Teesside). Through witness evidence and review of their documentation, it became apparent that there appeared to be very little collaboration between New Horizons and Patient 2009/3245's care team. Key facts were simply not shared between the two.

Facts like Patient 2009/3245 having started a relationship, staying overnight at victim A's home, the development and seriousness of that relationship all were not brought to the attention of the treating clinicians. Information contained in the New Horizons weekly attendance logs and minutes of their team weekly meeting were not sent to or asked for by the mental health care team responsible for 2009/3245.

Conversely, there seemed to be no advice or guidance from the care team to the New Horizons staff as to what they should be alert to and what information they should percolate upwards to the mental health team.

In addition to the absence of information sharing between the care team and New Horizons staff, it seemed apparent to the panel that (apart from the occasional attendance of the New Horizons support worker at 2009/3245's CPA meeting) there was no formal structure in place to communicate with one another. Instead, communication seemed almost ad hoc by virtue of the fact that New Horizons and Parkside both operated out of the same building.

It is against this backdrop, the panel made the third recommendation to try and improve on the system of information exchange with partnership organisations such as New Horizons. A review of the current information sharing protocol to promote collaborative care coordination between the Trust and partnership organisations.

(4) The next recommendation concerns MAPPA. The panel were aware that the Trust's internal report dated 22 January 2010 made recommendations to review the MAPPA process in order to ensure that sufficient guidance and robust processes were in place. However, it was evident to the panel from the witness evidence that staff overall lacked knowledge and understanding of what the MAPPA procedure was, when to refer to it and when patients may be discharged from it.

In addition, the panel considers that patients subject to the MAPPA process should be readily identified by clear recording of this on PARIS and in the paper file.

Specifically relating to Patient 2009/3245, the panel were concerned by the fact that the meeting held on 13 September 2004 which involved his discharge from the MAPPA register was conducted without any representatives from the mental health care team or Social Services being present or playing a part in the decision making process. Consequently, the inquiry has included in the MAPPA recommendations, the need to ensure the relevant staff attend (or at the very least are involved in discussions about the change of status) during de- registration or re assessment of a patient's risk.

(5) Recommendation 5 refers to the documentation of risk assessment and management. Despite risk assessment being an integral part of the Care Programme Approach, it seemed evident to the panel that the FACE tool simply was not used in respect of Patient 2009/3245. There was no comprehensive approach to risk formulation and risk management planning. Instead, in its place and being used by the treating clinicians at the time of the index offence was a proforma risk assessment which was descriptive and subjective rather than being evidence based and measurable. The use of the proforma unlike the FACE tool had not been subject to the rigours of the Trust's governance approval process. This ties in with the panel's eighth recommendation.

The panel also found historical evidence that the risk documentation relating to Patient 2009/3245 was inconsistently completed and of varied differing formats. This ranged from a comprehensive summary of risk that demonstrated a deep level of understanding of Patient's 2009/3245's behaviour risks to examples that lacked any depth or analysis of past and current risks.

Consequently, the significant forensic and risk history particularly with regard to Patient 2009/3245's violence towards women did not appear to have consistency or continuity of communication through transfer of his care.

As a result, the panel believed that the potential significance of his risk history was not fully considered when decisions were taken to formulate his care. The panel view this as fundamental given the key indicator in determining future risk is past behaviour of the individual. The panel have therefore recommended a review to ensure the significance of risk assessment is understood amongst practitioners and those responsible for delivering care.

(6) During the witness evidence the inquiry was also concerned regarding clinicians' knowledge of Section 117 and how that impacted on the level of care given to Patient 2009/3245 who was of course subject to Section 117 after care from 1985.

In reviewing the historical and contemporary evidence, the panel considered the lack of specific social care involvement in the delivery of Section 117 responsibilities to have been detrimental to a holistic approach in the provision of Patient 2009/3245's aftercare. This led to significant periods of care where Patient 2009/3245 did not have the appropriate Health and Social Services involvement in aftercare planning and provision.

The panel considered that comprehensive clinical guidance needs to be given to staff as to what Section 117 entitlement means and what process it invokes. Similar to MAPPA, patients subject to Section 117 should be readily identifiable though the central register and clearly recorded on PARIS on the patient's page.

The panel also noted that there appeared to be conflicting evidence regarding the current status of the Trust's Section 117 policy by senior health staff and social care

workers. Although many practitioners in the course of giving evidence confirmed a Section 117 policy was in place, the reality appeared to be that there was not.

The need is not only that the policy sets out how Section 117 responsibilities are established but it needs to ensure that it enables clinical staff to be aware of what they should be doing. For example, as in the case of Patient 2009/3245 who had previously been detained under a section which would have entitled him to Section 117 aftercare, but who had been living in the community for many years before the index offence was committed, there undoubtedly is a need for a common working approach with the Local Authorities and the Trust working in partnership endorsing a joint approach.

(7)The panel recognised that the Trust CPA policy complied with the revised Department of Health framework for CPA and set clear standards in relation to expectations of what service users should expect. In the case of Patient 2009/3245, he met the criteria for CPA but these CPA standards were not fully met given he remained on Standard Care. In particular, the evidence did not support a comprehensive multi-disciplinary / multi-agency assessment covering a full range of needs and risks. The panel was satisfied that progress had been made in the Trust since the time of the index offence, but felt it was important to reinforce the need for governance systems to identify noncompliance and rectify any subsequent deficits in both eligibility and compliance.

(9, 10) Lastly, the panel proposes an action plan to implement the recommendations contained in this report and the monitoring of that progress. In the course of this investigation, it became apparent to the panel that several senior clinical staff had not been aware of the internal report undertaken by the Trust into the care of Patient 2009/3245.

The panel's view is that to learn from other investigations, the Trust should be disseminating the conclusions and recommendations following inquiries into serious untoward incidents to senior clinicians, thus, minimising the possibility of recurrence and ultimately promoting high standards of care and best practice.

RECOMMENDATIONS

1. The panel were encouraged to hear at interview that steps had been taken by the Trust to ensure transparency of multiple concurrent projects following the introduction of an overview project framework. However, the inquiry believes that the effectiveness of practitioners' workloads being monitored is also essential in both supporting and challenging staff to develop best practice and to promote high standards of care. All agencies should be able to demonstrate robust systems of monitoring work load pressures inclusive of individual practitioner caseloads.

2. Patient 2009/3245 was transferred on numerous occasions to different treating Consultants. The Panel considered that continuity of mental health care would have been greatly improved had there been in use a comprehensive standardised transfer summary by the clinical staff treating Patient 2009/3245. The inquiry, therefore recommends the introduction of a transfer summary template which as a minimum common standard should cover key historical issues which is likely to include diagnosis, treatment plan, medication, Section 117 details, MAPPA, forensic history and to clearly signpost relevant past assessments. The transfer summary should be available on the PARIS system and ideally, be readily accessible from the patient's home page.

3. The importance of ensuring clarity and accuracy of recording and dissemination of information is an essential part of inter-agency working. The panel were concerned at the effectiveness of the system of exchange of information between Mental Health Services and the accommodation provider - New Horizons (Teesside). The inquiry therefore recommends a review of the current information sharing protocol with partner organisations in order to achieve collaborative care coordination and to implement a regular systematic audit of compliance annually in this area.

4. (a) The effectiveness of the action taken by the Trust following their internal review relating to MAPPA was not demonstrated to the panel at interview. The inquiry therefore recommends the development of a strategy to increase the understanding and knowledge of practitioners as to the role and processes associated with MAPPA locally, and;

(b) The criteria and MAPPA referral procedures should be clearly understood by all relevant staff. This should form part of any induction training, and;

(c) In addition the inquiry recommends that it should be possible to readily identify patients who have been subject to MAPPA; this should be clearly recorded on PARIS, and;

(d) Where there has been Health and / or Social Services involvement with patients; these organisations must be represented at MAPPA meetings when decisions are made to alter a patient's level of registration or discharge them from MAPPA.

5. Current strategies should be reviewed within inter-agency working (inclusive of non-statutory agencies), to ensure practitioners and those delivering care understand the significance of risk assessment, risk management and the established relationship between historical risk and current risk. The sharing of formal risk assessment information should be considered.

6. (a) The inquiry recommends that the Tees, Esk and Wear Valley NHS Foundation Trust and the Local Authorities that it works in partnership with should review the current policy in relation to Section 117 aftercare and endorse their joint working approach. They should ensure full compliance of their joint responsibilities for those patients subject to Section 117 by demonstrating the effectiveness of their revised governance arrangements, and;

(b) In addition, the panel were concerned during the clinical staff interviews about the lack of staff awareness of Section 117 entitlement and therefore the inquiry recommends comprehensive clinical guidance (which should confirm who should attend any Section 117 aftercare meetings, especially when the patient is unlikely to be given any costed services). Training should also be given to front line clinical staff about what the practical implications are for patients who have been detained under Section 3 and who are subject to Section 117 aftercare, and;

(c) The Trust should also ensure that it is possible to readily identify all those patients subject to Section 117 aftercare through enforcement of central registration and also Section 117 to be clearly recorded on the PARIS system.

7. It was apparent to the inquiry from the evidence of the witnesses that despite the Trusts adherence to Departments of Health's framework for CPA, in the case of Patient 2009/3245, he met the criteria for CPA but these CPA standards were not fully met. The panel therefore, recognise the need for the Trust to systematically audit and robustly monitor compliance with the CPA policy to ensure progress in

line with national priorities and any noncompliance to be clearly identified and rectified.

8. Tees, Esk and Wear Valley NHS Foundation Trust should review their governance systems to ensure they can demonstrate continuous and systematic monitoring of compliance and where necessary corrective action, to the Clinical Risk Policy by practitioners.

9. To review Trust procedures to ensure the dissemination of information to senior clinical staff of the conclusions and recommendations of internal and external reports investigating serious untoward events.

10. The recommendations of this independent review should be endorsed and in addition the panel recommends:-
 - (a) An action plan is developed and shared with key stakeholders both internal and external to implement the recommendations of this report and;
 - (b) The Board of Tees, Esk and Wear Valley NHS Foundation Trust has a regular agenda item to monitor progress on the implementation of the action plan.