An independent investigation into the care and treatment of a mental health service user Mr L in Bromley

May 2018

Authors: Tony McGranaghan, Associate Investigator and Nick Moor, Partner, Investigations & Reviews, Niche Health & Social Care Consulting.
First published: **May 2018**

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Niche Health and Social Care Consulting
1, City Approach
Albert Street
Eccles
MANCHESTER
M30 0BG

Telephone: 0161 785 1001
Email: info@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

Contents

1 Executive summary

1.1 NHS England, London, commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user, Mr L. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. [2]

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

The homicide of Mr Parsons

1.5 On the morning of Sunday 2 March 2014, Mr L called the police to inform them that he had killed his neighbour (71 year old Mr Ronald Parsons). Mr L was arrested by police at his flat, and taken to Bromley Custody Suite where he made various admissions to the offence. On 3 March 2014 Mr L was charged with murder and remanded at Bromley Magistrates court.

1.6 We would like to express our condolences to Mr Parsons' family. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr L.

Mental health history

1.7 Prior to the incident of 2 March 2014 Mr L had 11 admissions to mental health services provided by Oxleas NHS Foundation Trust (the Trust).

1.8 In the notes there are references to a single night stay in Green Parks House, an acute psychiatric hospital ran by the Trust, on 19 December 2004, following admission from Accident and Emergency department (A&E) at Princess Royal

[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

University Hospital and he was discharged the following morning. There is no more detail on why he was admitted.

1.9 In early 2006, he had a further overnight night stay at Green Park House following an overdose after an argument with his then girlfriend.

1.10 His third admission followed an assault on his mother, as she refused to buy him some beer. He was assessed and detained under Section 2 of the Mental Health Act (1983) (MHA) on 29 November 2006 on Norman Ward, Green Parks House. Following an assault on another patient on 12 December 2006, he had to be restrained by staff. He also threatened he would rape a female member of staff and kill a staff member every day he was detained. He was transferred to a Psychiatric Intensive Care Unit and detained under Section 3 MHA on 19 December.[3]

1.11 On 12 January 2007 he absconded whilst on escorted garden leave. He was returned by his father and was then transferred to the Tarn, a Psychiatric Intensive Care Unit (PICU) on 15 January 2007.

1.12 He was transferred back to Green Parks House on 9 February 2007. He was assessed by a locum forensic psychiatrist on 7 March, who assessed that he did not need any further input from forensic mental health services at that time. He was discharged on 3 April 2007.

1.13 He attended an outpatient appointment three weeks later, on 23 April 2007, but then disengaged with mental health services, despite repeated attempts to contact him by his Community Psychiatric Nurse (CPN).

1.14 His next contact was via phone to his CPN after another failed visit, on 9 October 2007 and he attended an outpatient appointment and CPA planning meeting in mid-October. He admitted not taking his medication since discharge from hospital on 3 April 2007.

1.15 On 9 November 2007 he had arrived at his parents' house and had attacked his father. He was arrested by the police and taken to Bromley police station where he was charged with assault.

1.16 His condition deteriorated through early November with episodes of hostile and abusive outbursts and some delusional and grandiose thinking.

1.17 On 20 November 2007 a Mental Health Act Assessment was conducted during which Mr L stated that his family were not his real family as they had a different blood type to him. He believed everyone around him was fake and involved in a conspiracy against him. He was admitted to hospital and detained under Section 3 MHA. His mental state improved and he was discharged on 10 January 2008 to temporary accommodation under the care of the Home

[3] *Section 2 MHA relates to an application for admission for assessment for up to 28 days. Section 3 MHA permits the detention of a person for up to six months for treatment, after which point it has to be renewed for a further six months and then subsequently on a yearly basis.* http://www.legislation.gov.uk/ukpga/1983/20/section/2

Treatment Team. He was discharged from the Home Treatment Team on 16 January, as he didn't meet the criteria.

1.18 On 22 January 2008 he was contacted by Bromley Early Intervention Service, and a visit arranged for 28 January 2008. However, when contacted by phone about this visit, Mr L told the service he had moved and a new appointment was arranged for 5 February 2008. This appointment was changed to the 14 February 2008 due to a shortage of staff.

1.19 Between February and May 2008 he was seen on four occasions on home visits and appointments by the Early Intervention Service. He also missed, or was not in for another four appointments and home visits. During this time his family were also in frequent contact with the Early Intervention Service.

1.20 In April Mr L's father reported that Mr L had deteriorated and was expressing violent ideas such as talking about biting the necks out of people, and being able to fight 20 people at once. A further home visit was arranged for 22 April 2008, but Mr L was not in and his door was hanging from its hinges.

1.21 A Mental Health Act assessment was undertaken on 23 April 2008 by Mr L's CPN and a Social Worker acting as Approved Mental Health Professional. Mr L was found to be polite and calm, and had made an attempt to repair his door. He agreed to take his medication, and it was felt that he did not warrant detention under the Mental Health Act at that time.

1.22 However, on 13 May Mr L's father contacted his CPN and informed them that Mr L had further deteriorated. He had been overspending, and became aggressive when his demands were not met. He threatened his mother, and started saying his parents were not his real parents and that he was going to kill them.

1.23 On 14 May 2008 Mr L was apprehended by the police after standing outside his father's business premises shouting and screaming. It is reported he returned the following day and shouted at two women.

1.24 Mr L did not answer his doorbell on a home visit on 15 May 2008. He attended his Care Programme Approach review on 16 May and a recommendation for detention under Section 3 of the Mental Health Act (1983) was made.

1.25 On 20 May 2008 an assessment under the Mental Health Act was carried out and he was admitted under Section 3 MHA to Norman Ward, Green Parks House. During this admission, he received psychological therapy to address his drug and alcohol use. On 2 July 2008 his care was transferred to Banbury House (a closed rehabilitation unit provide by Oxleas NHS Foundation Trust).

1.26 During his admission to Banbury House he received psychological therapy which included helping him to understand the negative impact that alcohol and illicit substances had on his mental state. The bizarre ideas expressed by Mr L were in keeping with the diagnosis of paranoid schizophrenia and his

medication was changed from olanzapine[4] to aripiprazole[5], which was gradually increased to 30 mg daily, the maximum dose. He disagreed with the diagnosis of paranoid schizophrenia and stated he only took his medication to expedite his discharge. He minimised the role that illicit substances and alcohol played in his admission but demonstrated a willingness to stop cannabis, though not alcohol. Mr L believed that he would be able to sustain controlled alcohol consumption without any negative impact on his mental state.

1.27 By the end of 2008 there was a notable improvement in his mental state, successful periods of Section 17 leave[6] and evidence of regular drug and alcohol screening on return from leave.

1.28 On 22 December 2008 it was agreed by Consultant Psychiatrist that Mr L would spend three to four weeks at home with input from his care coordinator and attend Banbury House for weekly ward rounds. On 20 January 2009 Mr L was discharged into temporary supported accommodation managed by The English Churches Housing association. His discharge plan included regular meetings with his care coordinator every fortnight; he would meet with the social inclusion worker to assess suitability for employment and attend regular housing appointments. He agreed to regular urine drug screening, breathalyser tests and to confirm registration with a GP.

1.29 On 17 March 2009 given Mr L's progress in the community it was agreed that the Assertive Outreach Team (AOT) would see him on a three weekly basis and on 7 September 2009 his care was fully transferred to the AOT.

1.30 From January 2009 until June 2009 Mr L's parents expressed concerns regarding Mr L's deterioration in mental state. He had stopped taking his medication and was drinking alcohol on a regular basis. He started to lose weight and was not paying attention to his personal appearance and was requesting a full discharge from mental health services. He had disengaged with contacts, defaulted on his rent and by September 2009 there were complaints from other residents about noise disturbance from Mr L.

1.31 However, an urgent review from AOT concluded that Mr L was not presenting as acutely unwell and did not meet the criteria for detention under the Mental Health Act.

1.32 On 7 October 2009 he was arrested for an assault with a knife on a woman not known to him. Mr L is reported to have approached an elderly woman in the street whilst under the influence of alcohol with the intention of robbing her. It is recorded that he was carrying a small kitchen knife. As the lady resisted the knife caught her shoulder causing a laceration. He ran from the scene of the offence and was pursued by a passer-by whom Mr L then punched in the face.

---

4 Olanzapine is an antipsychotic medicine used for easing the symptoms of schizophrenia and mania; preventing high mood swings in bipolar disorder. https://patient.info/medicine/olanzapine-arkolamyl-zalasta-zyprexa

5 Aripiprazole is an antipsychotic medication used to relieve the symptoms of schizophrenia. https://patient.info/medicine/aripiprazole-abilify

6 Section 17 of the Mental Health Act (1983) permits Responsible Clinicians (RC's) to grant leave to detained patients. This leave must be written down with clear instructions as to the nature and purpose of the leave and for how long.

The passer by then informed police. Mr L was assessed by the Forensic Medical Examiner (FME) who found he was not exhibiting signs of mental illness and was fit to be interviewed. He was charged with intent to cause Grievous Bodily Harm and Actual Bodily Harm and remanded to HMP High Down.

1.33 On the 24 March 2010, Mr L was convicted of wounding, and common assault[7] for an offence that took place on 07 October 2009.

1.34 He spent 11 months on remand, and the conviction for these offences resulted in a community order for two years, with a supervision and 'residence requirement' and 'mental health requirement' for the two years. This meant that he had to stay in a particular environment, and had to receive mental health care and treatment.

1.35 He was released on 6 September 2010 to supported accommodation at Sandford Road, and was again under the care of the AOT on his release. He was to stay on probation until October 2012.

1.36 On 14 March 2011 it was reported to AOT that Mr L had been seeing his probation worker weekly and that it was the probation officers opinion that his risk of reoffending was downgraded to medium. Appointments with the probation officer were then downgraded to fortnightly, then monthly.

1.37 During late 2010 and through 2011 Mr L was in contact with his CPN and also a specialist registrar. A period of compliance and engagement followed which again deteriorated following sustained periods of alcohol use. In the first two weeks of October 2011 Mr L's alcohol consumption increased and he did not attend his voluntary work. On 15 December 2011 Mr L returned to Sandford Road intoxicated and became verbally abusive when staff refused to provide Zopiclone due to his intoxication.

1.38 On 26 December 2011 he stabbed or jabbed a fellow resident of the supported accommodation twice in the side with a kitchen knife, whilst in the kitchen. No injury was sustained due to the other residents wearing thick clothing.

1.39 Mr L reported later that he had heard voices telling him to do this. He had been feeling panicky and paranoid over previous weeks, believing people were conspiring against him, and looking at him in a threatening way. He had stopped his medication in the beginning of December, as his voices had told him he was well and did not need it anymore. He also reported that he had

---

[7] *Common Assault, contrary to section 39 Criminal Justice Act 1988*

An offence of Common Assault is committed when a person either assaults another person or commits a battery.

An assault is committed when a person intentionally or recklessly causes another to apprehend the immediate infliction of unlawful force.

A battery is committed when a person intentionally and recklessly applies unlawful force to another.

It is a summary offence, which carries a maximum penalty of six months' imprisonment and/or a fine not exceeding the statutory maximum. However, if the requirements of section 40 of the Criminal Justice Act 1988 are met, then Common Assault can be included as a count on an indictment. Refer to Summary offences and the Crown Court (Criminal Justice Act 1988 sections 40 and 41; Crime and Disorder Act 1998 section 51 and Sch.3 para.6, elsewhere in this guidance).

been drinking increasing amounts of alcohol, up to five cans a day, five days a week.

1.40 He was disarmed, arrested by the police, and charged with affray. The Forensic Medical Examiner (FME) requested further mental health assessment. He was readmitted to Green Parks House on 26 December 2011 as an informal patient.

1.41 Throughout this time Mr L refused to acknowledge the severity of his drinking. Mr L later reported he had tried to stab the fellow resident because voices had told him to do so. Because of this incident, he was unable to return to his supported accommodation, and Mr L was discharged from Green Parks House to Woodham House, a 24 hour staffed care home, on 1 February 2012.

1.42 At an outpatient appointment in February 2012, he minimised the extent of his drinking when asked.

1.43 On 11 May the Woodham House staff requested a mental health assessment as they thought that Mr L's mental state was deteriorating. He had paranoid ideas and suicidal thoughts. When assessed he reported that he had been drinking for three days averaging four pints a day and that he was stressed about his forthcoming court appearance on 13 June 2012 for the incident on 26 December the previous year. The charges for this offence were dropped at the court hearing.

1.44 Shortly after, he went on holiday with his parents, but became fearful and paranoid. He was readmitted to Betts Ward, Green Parks House on 18 May 2012 with low mood and suicidal ideation.

1.45 He was discharged on 31 May 2012, but readmitted to the same ward three days later on 2 June 2012. On this occasion he was presenting with auditory hallucinations. He was discharged on 28 June 2012.

1.46 Mr L was admitted informally to Norman Ward, Green Parks House on 4 July 2012, with delusions of reference and hearing voices making derogatory comments about him. He admitted he had been drinking consistently since his discharge six days before, and had smoked cannabis with friends. He was discharged to Woodham House on 28 August, with follow up from his Care Coordinator (CCO) and the Assertive Community Team (ACT).

1.47 On 7 December 2012 he was admitted to Norman Ward with an exacerbation of psychotic symptoms following heavy drinking. He presented with auditory command hallucinations, paranoid delusions, and some suicidal ideation. He settled well and complied with his medication. He was discharged on 28 December 2012.

1.48 He received extensive support from mental health services to prepare him to live independently. He was referred by Bromley Homeseekers (a choice-Based Lettings scheme in partnership with Housing Associations operating within the borough) for accommodation to Town & Country Housing a Housing

Association/ Registered Social Landlord. [8] An application was completed by his then care coordinator. He received the keys to a flat provided by Town & Country Housing, on 11 March 2013, and moved in on 17 April 2013. It was at this point that Mr L first became a neighbour of Mr Parsons, who had lived in the building for many years.

1.49 The referral to Town & Country Housing identified that Mr L's care plan would involve at least three times weekly contact with the Assertive Outreach team.

1.50 On 8 May Mr L's care coordinator (CCO) changed. He was introduced to his new CCO, with the plan to see them fortnightly. Over coming months he was seen at home by his CCO and the associate specialist from the ACT. He was supported to claim benefits, and joined in with some group activities.

1.51 The associate specialist from the AOT saw him on 13 June 2013 and noted 'partial remission of psychotic symptoms, related to good medication concordance and controlled intake of alcohol. Good functional recovery demonstrated'.

1.52 In October 2013 there was another change of CCO and a community nurse became his new care coordinator with a plan that they would see him fortnightly. Mr L was seen by the CCO for face to face contact on four occasions between 25 October 2013 and his admission on 2 December 2013.

1.53 It was reported by Mr L's CCO at interview that before the home visit by the CCO and AOT Specialist Registrar to Mr L at his flat on 2 November 2013, they had met Mr Parsons and another neighbour outside the flat. Mr Parsons and the neighbour reported to the CCO and Specialist Registrar how concerned they had been by Mr L playing loud music in to the early hours and Mr Parsons was noted to have appeared frightened of Mr L. The CCO states that he reassured Mr Parsons that Mr L would be getting some help. This is not recorded in the clinical record.

1.54 On 11 November 2013 Mr L was seen at home by his CCO and was noted to present as stable, and compliant with medication. However, on 15 November 2013 Mr L's father reported to his CCO that Mr L's behaviour was strange, erratic and he was not making sense when he spoke. He said that Mr L had been drinking heavily.

1.55 On 20 November 2013 an Environmental Health Technical Officer (EHTO) received a complaint from a neighbour of Mr L's, stating that Mr L was playing music late at night on a regular basis. This had been going on for a few weeks and had got worse since 11 November 2013. The neighbour had phoned London Borough of Bromley (LBB) out of hour's line the night before and had been advised to ring the daytime number on 20 November. The EHTO advised the neighbour to keep a log of the noise nuisance.

[8] *The new general name for not-for-profit housing providers approved and regulated by Government through the Homes & Communities Agency. The vast majority of Registered Social Landlords are also known as Housing associations. Registered Social Landlords can provide additional support for tenants over and above simply renting accommodation.*

1.56 He was seen by his CCO on 26 November 2013 at which time Mr L was described as ‘presented as stable in mental state, although he appeared slightly ‘hyper’.

1.57 The neighbour rang the ‘out of hours’ line at 3:00 am on 27 November 2013 to report Mr L playing loud music and preventing them from sleeping. They were told that nothing could be done until the noise log had been completed.

1.58 In the afternoon of 27 November 2013 another neighbour rang LBB customer contact centre, who put them through to the Social Services Team. They were advised that Mr L wasn’t on the records and advised to contact the mental health team. The customer service advisor who received this call also emailed the LBB Public Health Group (which Environmental Health are part of) to inform them of the contact and concerns about Mr L.

1.59 The neighbour also contacted Town & Country Housing to express their concerns about the noise and anti-social behaviour that Mr L had been displaying, and how threatening they felt he was. The Town & Country Neighbourhood Housing Manager contacted Mr L’s AOT keyworker.

1.60 On 27 November the EHTO spoke to Mr L’s CCO regarding the noise complaint. It was confirmed that Mr L had mental capacity, and that a ‘standard letter’ would be sent out by Environmental Health.[9]

1.61 On the same day another, a different neighbour complained to the Town & Country Housing Neighbourhood Housing Manager that Mr L had been banging and playing loud music in his flat, had ran into the communal area with his top off and screaming and shouting, that the police had been called, and that they felt intimidated by his erratic and at time aggressive behaviour. According to notes provided by Town & Country Housing this information was passed on (‘flagged up the problem’) to Mr L’s keyworker.

1.62 On 28 November 2013 it is noted by his CCO that a ‘neighbour phoned services’ and reported to a member of the AOT that Mr L had been playing his music loudly, shouting at traffic and throwing items from his flat. The neighbour confirmed that they had also spoken to Town & Country Housing.

1.63 The neighbour notes in their log that another neighbour had spoken to a member of staff from the AOT, who said someone would be in touch to take more details and would take further action with regard to Mr L. The records of incidents kept by the neighbours shows that the concerns were not solely related to noise, but also included concerns about Mr L’s erratic behaviours, which resulted in neighbours being frightened of him.

1.64 Mr L’s father called the Oxleas Urgent Advice Line on 1 December 2013 that Mr L had been threatening and violent towards his parents.

[9] *According to LBB, a ‘standard noise one letter’ informs the recipient that a complaint has been received, the type of complaint, and what action will be taken.*

1.65 A ‘standard noise one’ letter was sent by the EHTO to Mr L at his flat on 2 December.

1.66 On 2 December his CCO and a psychiatrist assessed him in his flat when he became verbally aggressive and threatened them with ‘get out before I shoot and cut your throats’. They were unable to properly assess his mental state and left, calling the police via 999. After this a neighbour had called the team and reported that Mr L had left his music playing very loudly and another neighbour was very frightened. They were advised to call the police if concerned and not to approach Mr L.

1.67 Mr L was taken into police custody. He was reported to be very violent and aggressive and had assaulted a female police officer.

1.68 A MHA assessment was completed and Mr L was admitted to Betts Ward, Green Parks House under Section 2 MHA, [10] which was later converted to Section 3 MHA.[11] He presented as challenging argumentative, verbally abusive, and was verbally and physically aggressive to staff and other patients.

1.69 On 6 December at approximately 20:00 he threw hot water over a male patient and shouted threats to kill the patient. The patient sustained burns to his back and neck. Mr L was transferred to the Tarn, which is the Psychiatric Intensive Care Unit (PICU) on 6 December.

1.70 On 12 December 2013 the AOT associate specialist treating Mr L in the community emailed the Tarn consultant psychiatrist CP1, saying his impression was that Mr L was presenting as ‘high’ and ‘dissocial’ and that he was more inclined to see Mr L as having a schizo- affective presentation with dissocial traits exacerbated at time of manic relapse. The associate specialist regarded Mr L as dangerous with the risk of violence being significantly increased if he relapsed. The associate specialist recommended that a forensic referral be considered.

1.71 Mr L was assessed by the forensic consultant psychiatrist CP2 on 20 December 2013. The assessment described Mr L as extremely irritable and negative and was unable to complete the assessment of Mr L at the PICU.

1.72 On 23 December 2013 CP1 described Mr L as manic, talkative and quite threatening but noted that there had been no episodes of physical violence on the ward. Mr L remained very grandiose insisting he could defeat champion heavyweight boxers.

1.73 On 6 January 2014 CP2’s report was received. It concluded that Mr L would benefit from a longer admission to the low secure service, as admission to low secure services would focus on insight orientation work with psychology including illness awareness and a further assessment of personality structure.

---

[10] Section 2 MHA is admission for assessment and treatment for up to 28 days. https://www.legislation.gov.uk/ukpga/1983/20/section/2

[11] Section 3 MHA is admission for treatment for up to six months. https://www.legislation.gov.uk/ukpga/1983/20/section/3

The report recommended a further assessment by the forensic consultant psychiatrist on the low secure challenging behaviour unit.

1.74 In January CP1 felt that Mr L should go on the waiting list for low secure services. If the wait was longer than eight weeks the plan would be to transfer Mr L to an adult acute ward for a phased and gradual return to the community.

1.75 On 15 January 2014 Mr L was assessed by the forensic consultant psychiatrist for low secure services, CP3, with a nurse from low secure services. Mr L walked out of the assessment when the issue of alcohol was raised.

1.76 On 27 January 2014 CP3's report stated that he had found Mr L to be unwell, but he was responding to treatment. He also noted that alcohol played a significant factor in Mr L's risk profile and recommended an admission to the low secure service. An admission to the Memorial Hospital low secure unit was considered.

1.77 On 31 January 2014 Mr L visited the low secure service at Memorial Hospital with the ward occupational therapist.

1.78 On 10 February 2014 the EHTO telephoned the AOT, who confirmed that Mr L's tenancy was still active, and that he could return to the flat. The EHTO informed Mr L's neighbour of this, and also said that due to Data Protection Act he could not disclose any further information.

1.79 On 20 February 2014 CP3 reassessed Mr L at the Memorial Hospital. He communicated to CP1 by email that Mr L had significantly improved, was very reflective and understood what the issues were and that he will be communicating with the Bromley ACT.

1.80 On 26 February 2014, the AOT weekly team meeting discussed Mr L's discharge from the PICU with the CCO, including the suitability of a Community Treatment Order (CTO).

1.81 On 27 February 2014 the CCO and consultant clinical psychologist saw Mr L at Blean Grove the AOT team base at short notice, in the company of his father. The consultant clinical psychologist was only able to meet with Mr L for 30 minutes. The CCO continued to meet with Mr L after the consultant clinical psychologist left the appointment.

1.82 The CCO discussed referral to Bromley Drug and Alcohol services (BDAS) with Mr L who stated that he would prefer 1:1 sessions offered by Alcoholics Anonymous (AA). They discussed the complaints of noise disturbance and the impact this may have had on his neighbours.

1.83 On 28 February a discharge meeting was held at 11.00 am on the PICU and was attended by Mr L and his mother, consultant psychiatrist CP1, specialist registrar SpR 1, CCO and occupational therapy support worker.

1.84 It was agreed that due to the improvement in Mr L's mental state and improved insight, the planned admission to low secure services was no longer necessary. Mr L stated that he never agreed with the diagnosis of schizophrenia but

agreed with the diagnosis of bipolar affective disorder and that he would be abstinent from alcohol.

1.85 At this meeting the CCO raised the issue of noise disturbance and whether neighbours had been affected by his behaviour or understood what had happened when Mr L left his flat and the police were called on 2 December 2013.

1.86 Mr L said that he would apologise to the neighbours but his mother told him he did not need to apologise. There was no discussion about risk assessment regarding the neighbours' concerns.

1.87 Mr L was discharged with two weeks supply of medication and an appointment to see the AOT consultant psychiatrist on 3 March 2014, so they could be introduced and so the consultant psychiatrist could formulate a formal care plan.

1.88 The plan was that Mr L was to spend the first night with his parents at their address and at some point over the weekend return to his own flat. He was provided with a copy of his discharge summary with phone numbers to contact over the weekend if there was a problem.

1.89 Mr L spent his first overnight leave at his parent's house but there were no other formal arrangements for support from mental health services over the weekend.

Relationship with the victim

1.90 Mr Parsons was a 71 year old neighbour, living in the same building as Mr L, but there is no other known relationship between the two men. His family have told us that Ronald Parsons was a quiet and private 71 year old retiree, who wanted nothing more from life than to live out his retirement in peace, in the flat that he had worked all his life to buy. He was dealing with a diagnosis of Parkinson's disease, which was leading to increasing frailty and lack of mobility.

1.91 It was reported by Mr L's CCO at interview that before the home visit by the CCO and AOT Specialist Registrar to Mr L at his flat on 2 November 2013 they had met Mr Parsons and another neighbour outside the flat. Mr Parsons and the neighbour reported to the CCO and Specialist Registrar how concerned they had been by Mr L playing loud music in to the early hours and Mr Parsons was noted to have appeared frightened of Mr L. The CCO states that he reassured Mr Parsons that Mr L would be getting some help. This is not recorded in the clinical record.

Offence

1.92 On the morning of Sunday 2 March 2014, Mr L called 999 to inform them that he had killed his neighbour (71 year old Mr Parsons). Mr L was arrested by police at his flat, and taken to Bromley Custody Suite where he made various admissions to the offence.

1.93 It was reported that when arrested Mr L said 'I'm sorry I did it when I punched my neighbour, I went wild and lost it', and that later in court that Mr L said he had 'done it for Her Majesty the Queen'.

1.94 On 3 March 2014 Mr L was charged with murder at Bromley Magistrates court and remanded into custody, to appear at the Old Bailey on 22 May 2014.

Sentence

1.95 Mr L pleaded guilty to manslaughter due to diminished responsibility on 30 July 2015. He was detained indefinitely under Sections 37 and 41 of the Mental Health Act 1983 (MHA).[12]

Findings

1.96 We have reached a number of conclusions related to care and treatment which contributed to the incident. These are outlined in detail later in this report, but are listed in the following paragraphs.

1.97 Mr L should not have been discharged from the PICU without an adequate and robust care plan. This care plan should have included plans to mitigate any risks Mr L posed to his neighbours or family. It should have been developed in advance of the discharge and by consultation with all agencies involved with Mr L as required by Oxleas 'CPA Discharging from Hospital' policy. None of this happened. Arranging for Mr L to attend an appointment with AOT the following Monday cannot be considered a care plan.

1.98 There is no evidence of victim safety planning. Concerns raised by Town & Country Housing, London Borough of Bromley Environmental Health Technical Officer and his care coordinator (CCO) about his neighbours' fears following the complaints about loud noise were not considered as part of the discharge plan.

1.99 The decision to expedite the discharge interfered with the process of a considered and planned discharge. We heard at interview that not all professionals involved in Mr L's care agreed with the discharge. However, there was no documented evidence that there was any disagreement from the clinical consultants that he should be discharged.

1.100 It is not clear why he was the question of referral to MAPPA was not discussed.

1.101 Mr L should not have been discharged on a Friday, which was acknowledged by the professionals in his clinical team, and by the findings of the internal investigation.

1.102 The decision to discharge Mr L to his own accommodation and not admit him to the Memorial Hospital[13] for a longer period as recommended by the forensic psychiatrist was based on Mr L's rapid progress in the PICU . He had been

---

[12] *Powers of courts to order hospital admission or guardianship under Section 37 of the Mental Health Act and restrict discharge under Section 41 of the Mental Health Act.* http://www.legislation.gov.uk/ukpga/1983/20/section/37

[13] *Memorial Hospital is a low-secure mental health unit based in Greenwich, run by the Trust*

abstinent from alcohol, compliant with medication and had had periods of unescorted leave under the care of his parents without incident, whilst under the care of the PICU.

1.103 Whilst there were some plans in place to commence psychological interventions for his substance use and anger, these interventions should have been commenced and evaluated prior to discharge.

1.104 He did not undergo an assessment by clinical psychology and therefore no psychological formulation of risks was available as a basis for treatment or risk management interventions.

1.105 We have concluded that the root cause for this incident lies within the decision to discharge Mr L directly into the community as opposed to admission to a low secure setting, or through a phased discharge process from an acute ward, without putting in place proper plans to mitigate any risk he may pose, even though services were aware that there had been conflict with neighbours about anti-social behaviour. This decision to discharge Mr L relied on his compliance with abstinence from alcohol and concordance with medication. This was untested other than day leave with his parents.

1.106 We have seen no evidence that his behaviour and progress whilst on leave with his parents was ever assessed or discussed with his parents. This was also the view of the internal investigation. The improvement in risk behaviours was based upon interventions where he had little choice but to comply if he wished to be discharged. The situation was further exacerbated by the decision to discharge him on a Friday without substantial contingency and risk management plans in place, prior to his appointment with his community consultant 2 days later. It has been acknowledged by the professionals in his clinical team that there are less services available in the event of a crisis.

Recommendations

1.107 This independent investigation report recognises that the Trust's own internal investigation made seven recommendations, and the Trust has shown evidence of implementation of these recommendations, and of completed actions in relation to these.

1.108 We have not therefore made any recommendations in the following areas.

1.109 **Internal recommendations:**

- Recommendation 1: Where a person has recent history of substance misuse there should be consideration of its impact with a documented assessment of risk (including risk of violence). A clear plan assessing the risk and relapse should be in place before discharge.

- Recommendation 2: Outcomes of meetings with family and discussions about risk should be documented in RiO.

- Recommendation 3: There should be a clear policy describing the circumstances and leave with family members or carers from the PICU.

- Recommendation 4: If a low secure bed is not available at the time of referral and assessment, there should be a case conference to agree and document a plan of care.

- Recommendation 5: All conclusions of clinical discussions are to be recorded within the primary clinical record, RiO.

- Recommendation 6: If a patient is discharged from acute adult inpatient services over the weekend, the care plan must take into account the support required in the immediate period after discharge.

- Recommendation 7: In the circumstances that discharge to the community is considered from the PICU, such discharge should not take place at the weekend. Furthermore, there must be a formal handover of care from consultant to consultant to manage transition and ensure the availability of a robust care plan with clearly outlined crisis and contingency plans prior to discharge.

1.110 This independent investigation has made three recommendations for the Trust to address in order to further improve learning and practice from this event.

Recommendation 1

The Trust must ensure that where a violent patient has been admitted to its services following concerns by other agencies; or complaints by neighbours about anti-social behaviour and noise and that they have been made aware of:

- The risks are assessed appropriately

- There are care plans developed to address anti-social behaviours towards members of the public (who may have been victims), and these may involve other agencies.

- There is a robust discharge planning process that fully involves these agencies prior to discharge

The Trust should also work in partnership with other key agencies involved (local authority, housing agency, police and CCG) to ensure that there are processes in place to support the routine sharing of information regarding any potential anti-social behaviour of suspected/known service users.

Recommendation 2

NB: This recommendation is made to improve practice in general, and is not specifically related to his care and treatment.

The Trust should ensure that consideration about referral to MAPPA takes place for patients with violent histories and convictions for serious violent offences. Such referrals should consider safeguarding issues and risks of domestic violence for wider family members.

Recommendation 3

NB: This recommendation is made to improve practice in general, and is not specifically related to his care and treatment.

The Trust must assure itself that all practices of seclusion and 'de facto' seclusion on the PICU, including where patients have been segregated from others after rapid tranquilisation, are fully compliant with the requirements of the Mental Health 1983 (amended 2007), the MHA Code of Practice and the MHA Reference Guide.

Notable Practice

1.111 On 27 February 2014 the CCO and consultant clinical psychologist saw Mr L at Blean Grove the AOT team base at short notice. Whilst this could never have been an initial assessment due to the short notice given, it is noted as good practice that the consultant clinical psychologist had made early contact with Mr L even though she was only able to meet with him for 30 minutes.

1.112 The forensic consultant psychiatrists did not downplay the significance of Mr L's previous forensic history and fully considered Mr L's longitudinal risk.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework[14] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[15]

2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

2.3 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

2.4 The investigation was carried out by Tony McGranaghan Associate Investigator for Niche and Nick Moor, Partner for Investigations and Reviews at Niche, with expert peer review provided by Dr Milind Karale.

2.5 The investigation team will be referred to in the first person plural in the report.

2.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.

2.7 We used the following sources of information from Oxleas NHS Foundation Trust:

- Clinical records provided 2006 - 2014 for Mr L
- Tarn Ward (Psychiatric Intensive Care Unit) Operational policy
- Adult Mental Health and Learning Disability Directorate Patient Safety group – Serious Incident Action Plan
- Assessment and Care planning including Care Programme Approach (CPA) policy for all Oxleas service users
- Discharge from Hospital policy

[14] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

[15] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

- Care and Treatment of service users with mental health problems who also use drugs and / or alcohol policy
- Section 117 – The duty to provide aftercare services policy
- Board of Director's Inquiry into the care and treatment of Mr L by Oxleas NHS Foundation Trust
- Section 17 Leave Notification of leave of absence of a detained patient under section of the Mental Health Act 1983 document.
- Neighbours' records of incidents.

2.8 As part of our investigation we interviewed and spoke to:

- Consultant Psychiatrist at the PICU – CP1
- Consultant Forensic Psychiatrist at The Bracton Centre – CP2
- Consultant Psychiatrist, Low Secure service – CP3
- Care Coordinator / CPN - CCO 2
- Consultant Psychologist - PS 7
- Ward Manager, the Tarn
- Named Nurse, the Tarn
- Mr L
- The neighbours of Mr L involved in the complaints about noise and anti-social behaviour
- Mr Parsons' nephews
- The then Environmental Health Technical Officer, London Borough of Bromley
- The Regional Operations Manager from Town & Country Housing

2.9 We have adhered to the Salmon and Scott principles to allow individuals the opportunity to respond if there is criticism, or the perception of criticism of their actions.[16]

[16] *The Salmon Process is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1966 Royal Commission on Tribunals of Inquiry. The Salmon Report set out general principles of an adversarial process for conducting an inquiry, similar, in essence, to what may be expected in a court of law. However it was recognised by Lord Justice Scott, during his 1992 inquiry into the sale of arms to Iraq, that it is not practicable or appropriate in all cases to conduct an inquiry with a full adversarial process. Whilst recognising that it is proper that all witnesses must be able to adequately present their evidence, and have access to legal advice if required, it is not necessary to allow a full process of examination and cross- examination by legal counsel in order to achieve fairness in the course of proceedings. In many cases, the financial and logistical implications of such a process would have a significant detrimental impact on the ultimate aim of the inquiry; to reach conclusions on the issue under consideration.*

2.10 The draft report was shared with the Trust prior to completion. This provided opportunity for those that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with the victim's family

2.11 At the commencement of the investigation the victim's family were written to, to inform them of the investigation and its purpose, inviting their contribution. We have subsequently written to them again, met with them and shared the findings of this investigation with them.

2.12 His family have told us that Ronald Parsons was a quiet and private 71 year old retiree, who wanted nothing more from life than to live out his retirement in peace, in the flat that he had worked all his life to buy. He was dealing with a diagnosis of Parkinson's disease, which was leading to increasing frailty and lack of mobility.

Contact with secondary victims

2.13 We have met with neighbours of Mr L who had complained to Town & Country Housing and London Borough of Bromley Public Protection. The neighbours reported that they had expressed concerns about Mr L to Environmental Health, the housing provider and the Trust. The neighbours reported to us that they had made it clear that the concerns were not just about noise, but also about Mr L's unpredictable and challenging behaviour, to the extent that many neighbours were frightened of him.

Contact with the perpetrator's family

2.14 We were informed by NHS England that the perpetrator's family did not wish to participate in this process.

2.15 We attempted to make contact by letter, with no response. Mr L confirmed at our meeting that his parents did not wish to be involved in the the independent investigation.

Contact with the perpetrator

2.16 We wrote to Mr L at the start of the investigation, explained the purpose of the investigation and asked to meet him. Upon initiation of the investigation, we were informed by the Trust that Mr L was currently an inpatient in a secure hospital, and his state of ill health would prevent him engaging with the investigation process.

2.17 However, following further contact, he was sufficiently well enough to be interviewed. We met with Mr L and explained the purpose of the investigation in March 2017 at the secure hospital.

2.18 We met Mr L again in early 2018 to feedback the findings and recommendations of the report.

Structure of the report

2.19 Section 3 describes Mr L's background and history.

2.20 Section 4 sets out the details of the care and treatment provided to Mr L. We have included a full chronology of his care at Appendix B in order to provide the context in which he was known to services in the Trust.

2.21 Section 5 examines the issues arising from the care and treatment provided to Mr L and includes comment and analysis.

2.22 Section 6 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.23 Section 7 sets out our overall analysis and recommendations.

3 Background of Mr L

Childhood and family background

3.1 At the time of the homicide Mr L was 30 years old, and he is the oldest of three children raised by both parents. His father is a financial advisor and his mother a beauty therapist / market researcher. He described himself as a shy child who struggled academically at school and was bullied. He developed a stammer from an early age which has persisted to a lesser degree into adulthood.

Training and employment

3.2 Mr L left school at age 16 with 4 GCSE's and enrolled on a business studies course which he did not complete.

3.3 Mr L started work at age 17. Between the ages of 17 to 23 he had a variety of jobs. At age 17 he gained employment at a printing firm for 2 years and then as a loan administrator in a bank for 15 months. He worked for his uncle in roofing for 2 years followed by a job in his father's financial firm. During this time it was intended that Mr L would wait five months for a permanent position in his father's business but due to a breakdown in his relationship with his father, Mr L left after one month. His last paid employment was in 2007 when he worked for a sales magazine.

Relationships

3.4 Mr L has described himself as heterosexual. His first serious relationship was at the age of 19, which lasted for 17 months before his partner ended the relationship.

3.5 Two months later he entered into a new relationship that lasted for 18 months. This relationship ended when his partner was 2 months pregnant. Their child now lives with his mother (Mr L's ex-partner). Mr L had access to his child in a supervised arrangement facilitated by his parents and his ex-partner. His ex-partner was note to be a strong mother, who would not let Mr L near her family if there were any signs that he was unwell or intoxicated. At the time of the incident Mr L was not known to be in a relationship.

Forensic history

3.6 Mr L has a long-standing history of violent assaults, criminal damage, disruptive and threatening behaviour. This was almost invariably related to alcohol intake, and sometimes resulted in criminal convictions. Trust staff reported that Mr L has a loving and supportive family and they were often unwilling to pursue charges through the Criminal Justice System.

3.7 His first conviction was in December 2003 for drink driving, for which he received a 12 month driving ban and was fined.

3.8 It is noted in the Trust internal investigation report that he was arrested in April 2004 for being drunk and disorderly, and again in November 2006 for

assaulting his mother. It is also noted in the forensic consultant psychiatrist CP2's report of 6 January 2014, that in 2001 Mr L has a conviction for assault. However this is not confirmed elsewhere. The internal investigation states that it had access to Mr L's Police National Computer records and also his Probation records, but the detail is not included.

3.9 In July 2006 he received a police caution for battery.

3.10 The internal investigation report notes that in March 2007 he was arrested for being drunk whilst in charge of a motor vehicle and in November 2007 his father asked him to leave the house and Mr L punched him in the head.

3.11 In April 2008 he contacted the police to inform them that he had strangled a man to death in 2007 but later phoned back to retract his statement.

3.12 In May 2009 he attended Bromley Police station to say he had been the victim of an armed threat but was described by a police officer as smelling strongly of alcohol and the police officer had concerns for his mental health.

3.13 The internal investigation report noted that in August and September of 2009, there were two records of drunkenness outside public houses where Mr L was threatening and abusive to members of the public.

3.14 On the 24 March 2010, Mr L was convicted of wounding and common assault for an offence that took place on 07 October 2009. Mr L is reported to have approached an elderly woman in the street whilst under the influence of alcohol with the intention of robbing her. It is recorded that he was carrying a small kitchen knife which he then used to stab her. He ran from the scene of the offence and was pursued by a passer-by whom Mr L then punched. The passer-by then informed police.

3.15 He spent 11 months on remand, and the conviction for these offences resulted in a community order for two years, with a supervision and 'residence requirement' and 'mental health requirement' for the two years. This meant that he had to stay in a particular environment, and had to receive mental health care and treatment.

3.16 In late September 2011, supported accommodation staff reported to the police that Mr L had not returned as required by his bail conditions. Mr L returned to the accommodation the following day stating that he had spent the night with a woman he had met in a pub.

3.17 On 26 December 2011 he stabbed or jabbed a fellow resident of the supported accommodation in the side with a kitchen knife. No injury was sustained due the other residents wearing thick clothing. Mr L reported later that he had heard voices telling him to do this.

3.18 In November 2013 he was stopped by police and was found to be smelling strongly of cannabis and carrying drug related paraphernalia.

3.19 Mr L's Care Coordinator had contacted police following concerns raised by Mr L's parents that he had threatened to kill them and caused criminal damage to his mother's car.

3.20 When assessed on a home visit by his CCO and associate specialist, he became verbally abusive and aggressive, threatening to shoot and kill them, shouting 'get out before I shoot and cut your throats'. They called the police via 999, who took Mr L to Bromley police station. In this process he assaulted a female police officer who had to be sent home due to her injury. We have not been able to identify if he was charged following this assault. A Mental Health Act assessment was undertaken in Bromley Police Station.

3.21 This resulted in his final admission to Betts Ward, Green Parks House, on 2 December 2013 under Section 2 Mental Health Act.

4 Care and treatment of Mr L

Mental health care up to November 2011

4.1 Mr L previously had eleven admissions to inpatient settings related to his psychotic symptoms, alcohol intake, and violence and self-harm. The first of these admissions was in 2004 where he is described as requiring an overnight admission to a mental health unit, however the circumstances of this are not known.

4.2 In 2006 he attended A&E following an overdose of medication after an argument with his girlfriend. He was admitted overnight and discharged the next day.

4.3 In November 2006 Mr L was admitted to Green Parks House in Bromley under Section 2 of the Mental Health Act 1983 (MHA). This followed his arrest for an assault on his mother when she 'refused to allow him money to buy beer'. Details of his transfer to hospital are not available however he was well known to mental health services at the time. She is noted to have said that Mr L grabbed her by the wrist and attempted to strangle her. She fled to her bathroom from where she phoned the police. He was noted prior to this to have appeared to be psychotic and was known to have assaulted his father and brother and damaged property prior to the admission. The event is described as precipitated by a relationship breakdown, unemployment and misuse of alcohol and cannabis.

4.4 He was placed on Section 3 MHA, and transferred to the Tarn, a Psychiatric Intensive Care Unit (PICU). He improved in the PICU and was discharged in April 2007 although he refused supported accommodation on discharge.

4.5 He attended an outpatient appointment three weeks later, but then disengaged with mental health services, despite repeated attempts by his Community Psychiatric Nurse.

4.6 His next contact was via phone to his CPN after another failed visit, on 9 October 2007 and he attended an outpatient appointment and CPA planning meeting in mid-October. He admitted not taking his medication since discharge from hospital on 3 April 2007.

4.7 He was arrested on 9 November following an assault on his father.

4.8 His condition deteriorated through early November with episodes of hostile and abusive outbursts and some delusional and grandiose thinking.

4.9 On 20 November 2007 a Mental Health Act Assessment was conducted during which Mr L stated that his family were not his real family as they had a different blood type to him. He believed everyone around him was fake and involved in a conspiracy against him. He was admitted to hospital and detained under Section 3 MHA. His mental state improved and he was discharged on 10 January 2008 to temporary accommodation under the care of the Home

Treatment Team. He was discharged from the Home Treatment Team on 16 January, as he didn't meet the criteria for this service.

4.10 On 22 January 2008 he was contacted by Bromley Early Intervention Service, and a visit arranged for 28 January 2008. However, when contacted by phone about this visit, Mr L told the service he had moved and a new appointment was arranged for 5 February 2008. This appointment was changed to the 14 February 2008 due to a shortage of staff.

4.11 Between February and May 2008 he was seen on four occasions on home visits and appointments by the Early Intervention service. He also missed, or was not in for another four appointments and home visits. During this time his family were also in frequent contact with the Early Intervention service.

4.12 In April Mr L's father reported that Mr L had deteriorated and was expressing violent ideas such as talking about biting the necks out of people, and being able to fight 20 people at once. A further home visit was arranged for 22 April 2008, but Mr L was not in and his door was hanging from its hinges.

4.13 A Mental Health Act assessment was undertaken on 23 April 2008 by Mr L's Community Psychiatric Nurse (CPN) and a Social Worker acting as Approved Mental Health Professional. Mr L was found to be polite and calm, and had made an attempt to repair his door. He agreed to take his medication, and it was felt that he did not warrant detention under the Mental Health Act at that time.

4.14 However, on 13 May Mr L's father contacted his CPN and informed them that Mr L had further deteriorated. He had been overspending, and became aggressive when his demands were not met. He threatened his mother, and started saying his parents were not his real parents and that he was going to kill them.

4.15 On 14 May 2008 Mr L was apprehended by the police after standing outside his father's business premises shouting and screaming. It is reported he returned the following day and shouted at two women.

4.16 Mr L did not answer his doorbell on a home visit on 15 May 2008. He attended his Care Programme Approach review on 16 May and a recommendation for detention under Section 3 of the Mental Health Act (1983) was made.

4.17 On 20 May 2008 an assessment under the Mental Health Act was carried out and he was admitted under Section 3 MHA to Norman Ward, Green Parks House. During this admission, he received psychological therapy to address his drug and alcohol use. On 2 July 2008 his care was transferred to Banbury House (a closed rehabilitation unit).

4.18 During his admission to Banbury House he received psychological therapy which included helping him to understand the negative impact that alcohol and illicit substances had on his mental state. The bizarre ideas expressed by Mr L were in keeping with the diagnosis of paranoid schizophrenia and his medication was changed from olanzapine to aripiprazole, which was gradually

increased to 30 mg daily, the maximum dose. He disagreed with the diagnosis of paranoid schizophrenia and stated he only took his medication to expedite his discharge. He minimised the role that illicit substances and alcohol played in his admission but demonstrated a willingness to stop cannabis, though not alcohol. Mr L believed that he would be able to sustain controlled alcohol consumption without any negative impact on his mental state.

4.19 By the end of 2008 there was a notable improvement in his mental state, successful periods of Section 17 leave[17] and evidence of regular drug and alcohol screening on return from leave.

4.20 On 22 December 2008 it was agreed by Consultant Psychiatrist that Mr L would spend three to four weeks at home with input from his care coordinator and attend Banbury House for weekly ward rounds. On 20 January 2009 Mr L was discharged into temporary supported accommodation managed by The English Churches Housing association. His discharge plan included regular meetings with his care coordinator every fortnight; he would meet with the social inclusion worker to assess suitability for employment and attend regular housing appointments. He agreed to regular urine drug screening, breathalyser tests and to confirm registration with a GP.

4.21 On 17 March 2009 given Mr L's progress in the community it was agreed that the Assertive Outreach Team (AOT) would see him on a three weekly basis and on 7 September 2009 his care was fully transferred to the AOT.

4.22 From January 2009 until June 2009 Mr L's parents expressed concerns regarding Mr L's deterioration in mental state. He had stopped taking his medication and was drinking alcohol on a regular basis. He started to lose weight and was not paying attention to his personal appearance and was requesting a full discharge from mental health services. He had disengaged with contacts, defaulted on his rent and by September 2009 there were complaints from other residents about noise disturbance from Mr L.

4.23 However, an urgent review from AOT concluded that Mr L was not presenting as acutely unwell and did not meet the criteria for detention under the Mental Health Act.

4.24 He was transferred to the care of the Assertive Community Treatment Team (ACT) in September 2009 because of his repeated disengagement with services and non-compliance with medication.

4.25 On 7 October 2009 he was arrested for assault on a woman in the street after he had threatened her with a knife with the intention of robbing her by stealing her handbag. She had resisted and the small kitchen knife he was holding caught her shoulder and caused a laceration. A male member of the public had intervened and Mr L had punched him in the face. He was assessed by the Forensic Medical Examiner (FME) who found he was not exhibiting signs of mental illness and was fit to be interviewed. Following conviction he received a

[17] *Section 17 of the Mental Health Act (1983) permits Responsible Clinicians (RC's) to grant leave to detained patients. This leave must be written down with clear instructions as to the nature and purpose of the leave and for how long.*

supervision order for two years. On 6 September 2010, after 11 months on remand, he was released to supported accommodation at Sandford Road, and was again under the care of the AOT on his release. He was to stay on probation until October 2012. A period of compliance and engagement followed which again deteriorated following sustained periods of alcohol use.

Mental health care from December 2011

4.26 Whilst in the kitchen at his supported accommodation he had stabbed or jabbed a fellow resident twice in the side with a knife, although the resident sustained no injury. He was disarmed and arrested by the police, and the FME requested further assessment. He was readmitted to Green Parks House on 26 December 2011 as an informal admission.

4.27 Throughout this time Mr L refused to acknowledge the severity of his drinking. Mr L later reported he had tried to stab the fellow resident because voices had told him to do so. Because of this incident, he was unable to return to his supported accommodation, and Mr L was discharged from Green Parks House to Woodham House, a 24 hour staffed care home, on 1 February 2012.

4.28 At an outpatient appointment in February 2012, he minimised the extent of his drinking when asked.

4.29 On 11 May the Woodham House staff requested a mental health assessment as they thought that Mr L's mental state was deteriorating. He had paranoid ideas and suicidal thoughts. When assessed he reported that he had been drinking for three days averaging four pints a day and that he was stressed about his forthcoming court appearance on 13 June 2012 for the incident on 26 December the previous year. The charges for this offence were dropped at the court hearing.

4.30 Shortly after, he went on holiday with his parents, but became fearful and paranoid. He was readmitted to Betts Ward, Green Parks House on 18 May with low mood and suicidal ideation and was discharged on 31 May 2012,

4.31 Mr L was readmitted to the same ward three days later on 2 June 2012. He was accompanied by his Care Coordinator, (CCO 1) for admission as he was hearing voices. He complained of feeling persecuted by others, that the movement of his hands was being controlled and of auditory hallucinations. He was discharged on 28 June 2012.

4.32 Mr L was admitted informally to Norman Ward, Green Parks House on 4 July 2012. He presented with delusions of reference and hearing voices making derogatory comments about him. He also admitted to drinking at least four cans of beer a day, and had been drinking consistently since his discharge six days before, and admitted smoking cannabis with friends. He was discharged back to Woodham House, with follow up from his CCO and the ACT.

4.33 On 7 December 2012 he was admitted to Norman Ward with an exacerbation of psychotic symptoms which had worsened following a single bout of heavy drinking. He presented with auditory command hallucinations, paranoid

delusions, ideas of reference from the TV and some suicidal ideation. He settled well and complied with his medication. He was discharged on 28 December 2012.

4.34 He received extensive support from mental health services to prepare him to live independently. He was referred by Bromley Homeseekers (a choice-Based Lettings scheme in partnership with Housing Associations operating within the borough) for accommodation to Town & Country Housing a Housing Association/ Registered Social Landlord. [18] An application was completed by his then care coordinator. He received the keys to a flat provided by Town & Country Housing, on 11 March 2013, and moved in on 17 April 2013. The referral to Town & Country Housing identified that Mr L's care plan would involve at least three times weekly contact with the Assertive Outreach team, and initially daily evening visits from Community Options flexible support team.

4.35 He received the keys to his flat on 11 March 2013, and moved in on 17 April 2013. This was the accommodation to which he was discharged to prior to the homicide against his neighbour.

4.36 On 8 May 2013 Mr L's CCO delivered four weeks of medication, quetiapine[19] and sodium valproate.[20] This was the last meeting with this CCO as they were leaving the team. At this meeting Mr L and his mother were also introduced to his new CCO and support worker.

4.37 In the following months Mr L was supported by both to obtain benefits. The plan was that he was to see them fortnightly. He attended the Assertive Outreach football group and saw his child at weekends under the supervision of his parents. Over coming months he was also seen at home by his CCO and the associate specialist. He continued to improve and was supported to claim benefits, and joined in with some group activities.

4.38 The associate specialist from the AOT saw him on 13 June. Mr L reported to the associate specialist that he felt that quetiapine was having a positive effect and that he was only drinking two to three bottles of beer two to three times a week. The AOT Associate Specialist (AS 5) noted 'partial remission of psychotic symptoms, related to good medication concordance and controlled intake of alcohol. Good functional recovery demonstrated'.

4.39 On 19 August 2013 Mr L telephoned AS 5 regarding concerns he had about his medication. He reported having woken up in the middle of the night unable to breathe. Mr L also said that he had contacted his GP and was awaiting the

---

[18] The new general name for not-for-profit housing providers approved and regulated by Government through the Homes & Communities Agency. The vast majority of Registered Social Landlords are also known as Housing associations. Registered Social Landlords can provide additional support for tenants over and above simply renting accommodation.

[19] Quetiapine is used for the treatment of schizophrenia; mania, either alone or with mood stabilisers; depression in bipolar disorder. https://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/42-drugs-used-in-psychoses-and-related-disorders/421-antipsychotic-drugs/second-generation-antipsychotic-drugs/quetiapine

[20] Semisodium valproate is prescribed as a mood stabiliser in bipolar disorder. http://patient.info/medicine/semisodium-valproate-for-bipolar-disorder-depakote .

results of an ECG.[21] Mr L told AS 5 that he did not wish to stop the quetiapine as it was helping his mood. It was agreed that the quetiapine dosage would be reduced to 500 mg and the ECG results would be followed up.

4.40 In October 2013 there was another change of CCO and a community nurse became his new care coordinator with a plan that they would see him fortnightly. Mr L was seen by the CCO for face to face contact on four occasions between 25 October 2013 and his admission on 2 December 2013.

4.41 On 11 November 2013 Mr L was seen at home by his CCO and was noted to present as stable, and compliant with medication. However, on 15 November 2013 Mr L's father reported to his CCO that Mr L's behaviour was strange, erratic and he was not making sense when he spoke. He said that Mr L had been drinking heavily.

4.42 On 20 November 2013 an Environmental Health Technical Officer (EHTO) received a complaint from a neighbour of Mr L's, stating that Mr L was playing music late at night on a regular basis. This had been going on for a few weeks and had got worse since 11 November 2013. The complainant had phoned London Borough of Bromley (LBB) out of hour's line the night before and had been advised to ring the daytime number on 20 November. The EHTO advised the neighbour to keep a log of the noise nuisance.

4.43 He was seen by his CCO on 26 November 2013 at which time Mr L was described as 'presented as stable in mental state, although he appeared slightly 'hyper''.

4.44 The neighbour rang the 'out of hours' line at 3:00 am on 27 November 2013 to report Mr L playing loud music and preventing them from sleeping. They were told that nothing could be done until the noise log had been completed.

4.45 In the afternoon of 27 November 2013 another neighbour rang LBB customer contact centre, who put them through to the Social Services Team. They were advised that Mr L wasn't on the records and advised to contact the mental health team. The customer service advisor who received this call also emailed the LBB Public Health Group (which Environmental Health are part of) to inform them of the contact and concerns about Mr L.

4.46 The neighbour also contacted Town & Country Housing to express their concerns about the noise and anti-social behaviour that Mr L had been displaying, and how threatening they felt he was. The Town & Country housing manager contacted Mr L's AOT keyworker.

4.47 On the same day (27 November 2013), another different neighbour complained to the Town & Country Housing Neighbourhood Housing Manager that Mr L had been banging and playing loud music in his flat, had ran into the communal area with his top off and screaming and shouting, that the police had been called, and that they felt intimidated by his erratic and at time aggressive

[21] *An electrocardiogram (ECG) is a simple test that can be used to check the heart's rhythm and electrical activity. http://www.nhs.uk/Conditions/electrocardiogram/Pages/Introduction.aspx*

behaviour. According to notes provided by Town & Country Housing this information was passed on ('flagged up the problem') to Mr L's keyworker. The Neighbourhood Housing Manager asked the neighbour to keep a log of incidents and noise.

4.48 On 27 November the EHTO spoke to Mr L's CCO regarding the noise complaint. It was confirmed that Mr L had mental capacity, and that a 'standard noise one letter' would be sent out.[22]

4.49 On 28 November 2013 it is noted by his CCO that a 'neighbour phoned services' and reported to a member of the CMHT that Mr L had been playing his music loudly, shouting at traffic and throwing items from his flat. The neighbour confirmed that they had also spoken to Town & Country Housing.

4.50 The neighbour noted in their log that another neighbour had spoken to a member of staff from the AOT, who said someone would be in touch to take more details and would take further action with regard to Mr L.

4.51 Mr L's father called the Oxleas Urgent Advice Line on 1 December 2013 that Mr L had been threatening and violent towards them.

4.52 A 'standard noise one' letter was sent by the EHTO to Mr L at his flat on 2 December.

4.53 On 2 December 2013 his CCO and a doctor assessed him in his flat when he became verbally aggressive and threatened them with 'get out before I shoot and cut your throats'. They were unable to properly assess his mental state and left, calling the police via 999. After this a neighbour had called the team and reported that Mr L had left his music playing very loudly and a neighbour was very frightened. They were advised to call the police if concerned and not to approach Mr L.

4.54 At interview his CCO told us that prior to the home visit on the 2 December they had met the neighbour and M Parsons outside Mr L's flat. The neighbour reported that Mr L was playing loud music late into the night and Mr Parsons appeared frightened. The CCO told us that he had reassured Mr Parsons that Mr L was going to get help.

4.55 A MHA assessment was completed and Mr L was admitted to Betts Ward, Green Parks House under Section 2 MHA, which was later converted to Section 3 MHA. He presented as challenging argumentative, verbally abusive, and was verbally and physically aggressive to staff and other patients.

4.56 Mr L was taken into police custody. He was reported to be very violent and aggressive and had assaulted a female police officer.

4.57 A MHA assessment was completed and Mr L was admitted to Betts Ward, Green Parks House under Section 2 MHA. He presented as challenging argumentative, verbally abusive, and was verbally and physically aggressive to

[22] *According to LBB, a 'standard noise one letter' informs the recipient that a complaint has been received, the type of complaint, and what action will be taken.*

staff and other patients. He was initially described as psychotic, and had a diagnosis of schizophrenia, which was later changed to bipolar disorder before he was discharged from this admission.

4.58 On 6 December at approximately 20:00 Mr L threw hot water over a male patient and shouted threats to kill the patient. The patient sustained scalding to his back and neck. Mr L later stated to the forensic psychiatrist for low secure services, CP3, in an assessment on 27 January 2014 that the other patient had been refusing to let him play pool. He had woken up that evening and made himself a hot lemon drink. Mr L reported that he was walking down the hallway and encountered the individual who was acting aggressively. On turning round to see if the person was 'going to ignore' him he then had an 'involuntary reflex' of the hand resulting in the hot drink splashing over the person's back and neck. Mr L was transferred to the PICU on 6 December.

4.59 On 12 December 2013 the AOT associate specialist treating Mr L in the community sent an email to the PICU consultant psychiatrist. This email included his impression that Mr L was presenting as 'high' and 'dissocial' and that he was more inclined to see Mr L as having a schizo- affective presentation with dissocial traits which are exacerbated at time of manic relapse. The associate specialist regarded Mr L as dangerous with the risk of violence being significantly increased if he relapsed. The associate specialist recommended that a forensic referral be considered.

4.60 Because of his extensive history of repeated admissions precipitated by violence and the pattern of disengagement and non-concordance, and involvement with the police when in the community, CP1 requested a forensic opinion on Mr L from the forensic consultant psychiatrist from the Bracton centre, CP2. This was undertaken on 20 December 2013, and a report on this was provided on 6 January 2014. The assessment described Mr L as extremely irritable and negative and the assessment was unable to be completed at the PICU. CP2 concluded that Mr L required a protracted admission but acknowledged that he may improve on the PICU.

4.61 On 23 December 2013 the PICU consultant psychiatrist described Mr L as manic, talkative and quite threatening but noted that there had been no episodes of physical violence on the ward. Mr L remained very grandiose insisting that he could defeat champion heavyweight boxers. The PICU consultant psychiatrist sent an email to the forensic consultant psychiatrist thanking her for her report. In this email that was copied on to the community psychiatrist medication was discussed as there were concerns that Mr L would not comply with olanzapine as he disliked the side effect of weight gain. The PICU consultant wanted to achieve symptom control as soon as possible and it was suggested that there were two available options. These were either to augment quetiapine with sodium valproate or to try lithium. The forensic consultant replied by email the same day stating that the preferred option would be to augment the quetiapine with sodium valproate.

4.62 On 6 January the forensic consultant psychiatrist's report was received and it concluded that Mr L would benefit from a longer admission to the low secure service. The report recommended an assessment by the forensic consultant

psychiatrist on the low secure challenging behaviour unit. An admission to low secure services would focus on insight orientation work with psychology including illness awareness and a further assessment of personality structure.

4.63 Following receipt of the first forensic consultant psychiatrists report on 9 January the AOT associate specialist psychiatrist emailed CP1 stating that whilst he wouldn't go as far as diagnosing a personality disorder, Mr L had underlying traits of narcissistic and anti-social personality disorder which were exacerbated through alcohol use or relapse. He also stated that a protracted admission to low secure services would not be certain to affect overall the prognosis.

4.64 In response to the email CP1 emailed the consultant psychiatrist in the ACT, the associate specialist and the forensic psychiatrist (CP3) stating that a protracted admission to PICU was contraindicated and may be challenged by the commissioners. He also stated that anger management and psychological work may not be possible in the community and alcohol was also a problem.

4.65 CP1 felt that Mr L should go on the waiting list for low secure services and if the wait was longer than eight weeks then consideration of a pathway through acute services for a phased and gradual return to the community would be examined.

4.66 On 13 January 2014 there were email exchanges between the psychiatrists involved in Mr L's care confirming that Mr L would be assessed by the consultant for secure services. In the email the AOT associate specialist states that the anger management, support with substance misuse and further work about relapse prevention could be managed in the community but a low secure assessment confirming this would be helpful.

4.67 On 15 January 2014 Mr L was assessed by the consultant psychiatrist for low secure services in the presence of a nurse from low secure services. Mr L walked out of the assessment when the issue of alcohol was raised.

4.68 On 21 January at the ward round on the PICU, the team agreed that the best option was transfer to low security and, it was noted that Mr L and his family agreed.

4.69 On 27 January 2014 the forensic consultant psychiatrist CP3 reported that he had found Mr L to be unwell, but he was responding to treatment. He also noted that alcohol played a significant factor in Mr L's risk profile and recommended an admission to the low secure service. An admission to the Memorial Hospital low secure unit was recommended.

4.70 On 31 January 2014 Mr L visited the service at Memorial with the ward occupational therapist.

4.71 On the 3 February 2014 the Town & Country Housing Neighbourhood Housing Manager closed the case concerning the reported noise nuisance and anti-social behaviour complaint made by his neighbours, because there had been no further complaints (Mr L had been admitted during this period).

4.72 The plan following the ward round on 10 February 2014 was to ‘chase’ the bed at Memorial Hospital.

4.73 At the ward round on 18 February 2014 the plan was agreed that Mr L would remain on Section 3 MHA, continue with hourly observations, and he would be seen again by the forensic psychiatrist CP3.

4.74 At interview with the independent investigator CP3 described how he was approached by CP1, Mr L’s psychiatrist at the PICU, stating that Mr L had made a notable improvement in compliance with copious amounts of leave and a positive response to a mood stabilising medication and maybe the low secure service should reconsider their recommendations.

4.75 CP3 describes how he was insistent that he had an interview with Mr L at this time as whilst he acknowledged the improvement, he had a responsibility in risk assessment and therefore would need to see the patient. On 20 February 2014 the consultant forensic psychiatrist for low secure services reassessed Mr L at Memorial Hospital. CP3 reported that he communicated his concerns that there was a great deal of follow up required and communicated this verbally to Mr L’s AOT psychiatrist and by email to CP1, his psychiatrist at the PICU . Unfortunately, this email cannot be traced since the transition of a new electronic records system.

4.76 On 26 February 2014, the AOT weekly team meeting discussed Mr L’s discharge from the PICU with the CCO, including the suitability of a Community Treatment Order (CTO). It was agreed that Mr L would be transferred to the rehabilitation team in the AOT and that he would benefit from having the same care coordinator. As the AOT associate specialist had now left the team it was agreed that the AOT consultant psychiatrist, CP 4, would be his psychiatrist once discharged from the PICU.

4.77 On 27 February 2014 the CCO and consultant clinical psychologist saw Mr L at Blean Grove, the AOT team base, with his father present. Whilst this could never have been an initial assessment due to the short notice given, it is noted as good practice that the consultant clinical psychologist had made early contact with Mr L even though she was only able to meet with him for 30 minutes, and there was no clinical outcome from this meeting. The CCO continued to meet with Mr L after the consultant clinical psychologist left the appointment.

4.78 The CCO discussed referral to Bromley Drug and Alcohol services (BDAS) with Mr L who stated that he would prefer 1:1 sessions offered by Alcoholics Anonymous (AA). They discussed the complaints of noise disturbance due to him playing loud music prior to his admission to hospital and the impact that this may have had on his neighbours. Mr L said he would write a letter of apology to the neighbours.

4.79 On 28 February a discharge meeting was held at 11.00 am on the PICU and was attended by Mr L and his mother, consultant psychiatrist, specialist registrar, CCO and occupational therapist support worker.

4.80 It was agreed at this meeting that due to the improvement in Mr L's mental state and improved insight, the planned admission to low secure services was no longer necessary. Mr L stated that he never agreed with the diagnosis of schizophrenia but agreed with the diagnosis of bipolar affective disorder and that he would be abstinent from alcohol. We have also heard since that some clinicians disagreed with this plan but were either overruled or not heard.

4.81 The CCO raised the issue of noise disturbance and whether neighbours had been affected by his behaviour or understood what had happened when Mr L left his flat and the police were called on 2 December 2013.

4.82 Mr L said that he would apologise to the neighbours but his mother told him he did not need to apologise. Mr L agreed and said he wanted to put his past behind him.

4.83 Mr L was discharged on 28 February 2014 with two weeks supply of medication and an appointment to see the AOT consultant psychiatrist, CP 4, on 3 March 2014. The purpose of this appointment was so the consultant psychiatrist could introduce himself to Mr L with a view to formulate a formal care plan.

5 Arising issues, comment and analysis

5.1 We have reviewed Mr L's care from his first admission to adult mental health services up to the homicide of Mr Parsons. We have focussed in detail on the period from 2012 up to his arrest on 3 March 2014. We address each element of the terms of reference in separate sections, supporting our analysis with evidence as appropriate. Where concerns have been addressed by the internal review recommendations we have noted these and expanded on these where relevant.

Care Planning and Risk

5.2 There is little doubt that Mr L presented a number of challenges to clinicians in his presentation and lack of compliance with interventions and management. He had a history of repeated admissions usually precipitated by alcohol use or non-compliance with medication and treatment, and often violence.

5.3 There are episodes of his care, both in the community and whilst on the PICU, which have limited documentation. For example, there are no records of discussion with his parents about his behaviour and mental state during his escorted leave with his parents whilst on the PICU, and little documentation concerning contact with his CCO.

5.4 When Mr L was referred to Town & Country Housing his application form was completed by his CCO. This identified that he was 'ready to move on from supported housing'. The application form requires identification of both previous address details and also disclosure of previous convictions.

5.5 Under previous addresses the form states that Mr L was living at Sandford Rd from December 2008 until 31 January 2012. In fact during that time he had spent 11 months in prison between October 2009 and September 2010.

5.6 Under the section on previous convictions, when asked if the applicant has 'been convicted of any criminal offence' this is noted 'yes'. However, when providing more details the form states 'GBH, Not Guilty 2010' and Common Assault 2010'. In fact he pleaded guilty to common assault and wounding in 2010.

5.7 It is concerning that such serious offences were not recorded properly, which could have led the housing association to down play any perceived risk themselves, taking reassurance from the regular input from the Assertive Community Team and Community Options Flexible Support team.

5.8 However, this support was not maintained for long, and by September 2013 the CCO was visiting fortnightly. There is no evidence that Town & Country Housing were informed of the changes to mental health services input.

5.9 Lengthy discussions took place at the final CPA/ discharge meeting at the PICU on 28 February 2014 about the reasons behind the decision to discharge him back into the community. The details of these meetings were not entered on to the electronic records system until after the offence, in a retrospective entry by

CCO 2 dated 7 March 2014, but related to the CPA / Discharge Planning meeting on 28 February 2014. This meeting was attended by his Responsible Clinician (RC) (henceforth CP1), SpR 4, Mr L's Care Coordinator (CCO 2), Mr L and his mother, and the Occupational Therapist from the PICU.

5.10 In the email exchange in January between the associate specialist in the Assertive Outreach Team and CP1, the associate specialist stated that Mr L would benefit from anger management, support with alcohol including motivational interviewing and relapse prevention work, and stated that this was possible in the community but would require a forensic opinion. CP1 held the view that such work was less viable in the community. In any event, this was not properly planned before his discharge. It was noted that Mr L was concerned about losing his tenancy if he was admitted to a low secure unit.

5.11 Mr L's limited care plan on discharge on 28 February contained only general information. This was a brief discharge plan, although this was not the formal care plan for the community. This included removing him from his Section 3 MHA, discharging him to spend the first night at his parents, and then to his flat, relying on his engagement in alcohol and anger management related interventions (with no evidence that these had commenced whilst an inpatient), and his assurance of compliance with medication when discharged. There was no specific detail of these interventions, as the care plan was due to be agreed with Mr L's AOT psychiatrist CP 4 three days following discharge. This discharge plan also contained details of the number to phone in the event of a crisis and Mr L's intention to abstain from alcohol and drugs, as well as the planned meeting with the AOT the following week. There were no further treatment or management plans identified.

5.12 We noted that that the full care plan was not completed on discharge, despite what was known of Mr L's history of non-engagement / noncompliance. CP1 explained to the investigation team that the decision to rely on the AOT to complete the task was because they had a detailed knowledge of Mr L from which to formulate a comprehensive care and risk management plan. This is in direct contravention of Trust CPA and Discharge Planning Policy and also Section 117 MHA aftercare planning.

5.13 Trust CPA policy[23] states that a service user can expect 'A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs & risks' and 'Comprehensive formal written care plan: including risk and safety/contingency/crisis plan and in line with national best practice guidance'.

5.14 We found no evidence that any contingency plans had been agreed prior to discharge. According to the Trust CPA policy the care plan should have been commenced two weeks prior to discharge, coordinated by his Named Nurse, and agreed by all relevant stakeholders.

5.15 We also could not find evidence of consideration of aftercare needs under Section 117 MHA.

[23] *'Assessment and Care Planning including Care Programme Approach (CPA) for all Oxleas Service users', Version 8.2*

5.16 Trust Section 117 policy states that:

‘Section 117 patients should be part of the Care Programme Approach, as the CPA is the framework for all services, both health and social care. Prior to discharge from hospital, all patients will have received a core assessment including an assessment of their needs provided by Social Care funded services under the Care Act.

The need for after care for patients under s117 should be assessed as part of the CPA process and considered at CPA care planning meetings in the same way as the care needs of any other patient. Key differences are:

- Both health and social care staff must be part of the pre-discharge meeting (and all subsequent reviews).
- The CPA should be specifically described as a CPA/s117 pre discharge meeting.
- The CPA care plan should indicate that s117 applies.
- The core assessment should make clear which needs relate to mental disorder and which are not.
- The care plan should make clear which services are planned to meet mental disorder and which are based on other needs.
- Any care plan and package, including residential care, should be drawn up with an awareness of s117 rights and responsibilities.
- This includes explaining the rights under the section to the service user and their family or carer.’

5.17 The referral to Town & Country Housing completed in February 2013 does state that Mr L’s fees are paid for by social services. It does not state that this is a statutory obligation under Section 117.

5.18 Mr L was discharged without any form of robust care plan to support him over the weekend. Both Town & Country Housing and the Environmental Health Officer had requested they be informed of the discharge. They were not. There was no underpinning risk assessment upon which to base a plan on, as expected by the Clinical Risk Management policy and the CPA policy. Whilst risks were acknowledged, the interventions relied on an assumption that Mr L would require no intervention over the weekend and that he would comply with psychological and substance abuse interventions and that these issues would not require ongoing management whilst he received these interventions.

5.19 Mr L had a long and extensive history of offences, many of which were violent, including convictions for common assault and wounding, and the police involvement leading up to his admission on 2 December 2013. We find it unusual that there was no consideration of placing him under Multi-Agency

Public Protection Arrangements (MAPPA).[24] We would expect there to have been discussion within the care team and possible involvement with the police about a possible referral for MAPPA. We do not know if Mr L would have been identified as suitable and this would have led to any arrangements, but at least it would have been considered. Referral to MAPPA may also have been helpful with regard to any issues of safeguarding and his parents being at risk of domestic violence.

The decision to discharge Mr L at a weekend

5.20 Because Mr L's presentation had recently improved, and continued admission in the PICU was no longer felt to be appropriate, a decision was taken to discharge Mr L back to his unsupervised accommodation (his flat) in the community. This was despite the previously documented problems with anti-social and violent behaviour, excessive alcohol intake, threatening behaviour and criminal damage towards his parents, and notably, complaints from his neighbours about noise prior to this admission.

5.21 The rationale for this decision is recorded in a retrospective entry dated 7 March 2014, relating to a CPA /Discharge meeting held on 28 February 2014. It is recorded by his CCO that CP1 stated at this meeting that following discussions with CP3 it was agreed, considering his improvement, that Mr L's planned admission to low secure services was no longer required. CP1 informed us that this was a verbal agreement which had not been noted at the time. CP1 later informed the investigation team that he would not make the same decision now.

5.22 We would expect that the process would have followed expected protocols outlined in the Trust policy for CPA and Section 117, in that the discharge planning should have been commenced two weeks prior to discharge, and included reference to any management interventions for known risks and specified any contingencies for enhanced interventions.

5.23 CP1 reported to us how Mr L had been very motivated and needed to be congratulated on how hard he had worked on his recovery, recognising what he needed to avoid to remain well, and that he had conducted himself so well that he was now considered well enough for discharge directly into the community.

5.24 CP1 also discussed the revised diagnosis of bipolar disorder and noted that Mr L had confirmed he had never agreed with the diagnosis of schizophrenia but accepted that he had a bipolar affective disorder.

5.25 Expert forensic mental health advice had been sought and provided by two separate forensic consultant psychiatrists, CP2 and CP3. Both forensic consultant psychiatrists believed that Mr L would benefit from a longer admission in low secure services where he could start to address some of the issues that had led to his frequent relapsing and admissions. However, CP3 had later assessed Mr L on 20 February and found that there were indications that his condition had improved. However, we were told by CP3 that he

[24] *Multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders.*

communicated his concerns that if Mr L were to be discharged into the community, there would need to be a robust care plan in place.

5.26 Due to Mr L's apparent rapid progress, with periods of unescorted leave from the PICU and abstinence from alcohol during this admission, it was decided to push forward with discharge. He had been granted leave of up to five hours a day. It is acknowledged above that CP3 accepted the reports of improvement from CP1 as measures of reduced risk and was convinced by CP1's opinion on Mr L's ability to remain abstinent in the community. Specifically, there appears to be an acceptance by CP3 that the plans to commence treatment for alcohol use and anger management following discharge were sufficient to manage his risk to others in the community, and therefore admission to low secure services was no longer required.

5.27 However, we have not seen evidence that Mr L's parents were asked about Mr L's behaviour and mental state during his leave. Nor is there any evidence that his parents reported any issues during his leave. We have since heard from Mr L's neighbours that on one occasion (11 February 2014) Mr L was seen leaving his flat with some bin bags, accompanied by a woman. We have seen no evidence that the mental health services were aware he had visited his flat.

5.28 CP1 reported at interview that there was a need to balance Mr L's improved mental health condition and therefore increasingly inappropriate and lengthy stay on a PICU, with the need for him to receive longer term support for his underlying condition. He drew our attention to Mr L's increasing periods of unescorted leave and continued abstinence from alcohol.

5.29 Whilst it appears that the decision to discharge Mr L to the community was based on improved presentation, the risk factors that led to his admission were not revisited to any great extent other than that he would commence treatment interventions for these after he had been discharged. There were concerns raised by his CCO regarding the victim's fear of Mr L but there is no record of any intervention which acknowledged this, nor of the specific issue of complaints made by neighbours about his noise. On interview, CP1 said he was not aware of these concerns. And yet there was extensive communication between the EHTO, Town & Country Housing manager and the AOT keyworker and Mr L's CCO regarding these issues.

5.30 CP3 told us that he had insisted on seeing Mr L on 20 February to assure himself of the improvement, and noted a positive response and a degree of insight in Mr L. He had also requested that there was follow up for Mr L from psychology and drug services.

5.31 The ward Occupational Therapist has documented how Mr L had managed interactions with other patients which would previously have possibly triggered an aggressive response, and similarly when a close family friend died.

5.32 Although this does demonstrate some aspects of how Mr L's behaviour had changed, whilst Mr L was on the PICU there is little evidence of formal review of his nursing interventions except leave and compliance with medication. It is not known from either recorded notes or interviews with key staff how changes in

risk were recorded or indeed measured. The CPA and Clinical Risk Management policies state that regular review of interventions is a prerequisite of expected practice.

5.33 The change of plan from the advice given by the forensic psychiatrists appears to have been formed on the basis of Mr L having had absences from the ward, which had been without incident. There had also been compliance with medication. The leave was primarily under the supervision of his parents. We consider that these were not accurate measures of reduced risk, specifically in relation to the reasons that he was admitted in the first instance.

5.34 There is evidence in the records to suggest that Mr L remained intimidating in many of his interactions with others and he appears to have played some part in expediting his discharge back to his flat by making promises and demanding leave.

5.35 It is apparent from his final ward round and CPA discharge meeting that there were discussions regarding the implementation of a Community Treatment Order (CTO).[25] However it appears that there was a decision made by CP1 (Mr L's Responsible Clinician/ RC) and SpR 4 that, due to his recorded improvement he would be discharged from his Section 3 MHA because of his current ongoing compliance, and therefore a CTO was no longer necessary.

5.36 It is not clear how concerns by the team members were acknowledged and acted upon, despite retrospective entries confirming that concerns were raised. We now know that both Mr L and his parents said in his trial that they had been concerned about his discharge and that Mr L was not ready. We have not seen any evidence that they raised any concerns prior to his discharge. As Mr L's parents have declined to make contact we have not been able to pursue this further, we note however that his mother was present at the discharge meeting on 28 February 2014, and his father had attended the pre-discharge meeting with the psychologist.

5.37 Mr L was discharged without the relapse prevention and offending behaviour work recommended by CP3. We note that CP1 was of the view that anger management and psychological work may not be possible in the community. References have been made to Mr L's improvement and insight into his alcohol problems, however the investigation team is of the view that it is unlikely that Mr L would have gained insight into his alcohol issues without any relapse prevention work, considering the long history of alcohol use with significant psychosocial disruption and associated criminal behaviour. Mr L was discharged on a Friday against the usual practice of the unit. We therefore hold the view that the decision to expedite the discharge interfered with the process of a considered and planned discharge.

[25] *17A Community treatment order under the MHA. The responsible clinician may by order in writing discharge a detained patient from hospital subject to his being liable to recall in accordance with section 17E MHA. https://www.legislation.gov.uk/ukpga/1983/20/section/17A*

Clinical decision making and risk assessments

5.38 The Trust has a clear policy on Clinical Risk Management. Within this it states that 'The identification of risk and its subsequent management are a central component of mental healthcare and of the Care Programme Approach'.

5.39 It quotes directly from Department of Health guidance on best practice, saying **'Safety is at the centre of all good healthcare. This is particularly important in mental health as it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk**'.[26]

5.40 It then goes on to say 'Risk assessment is not an exact science, an individual's circumstances may change rapidly and the factors which constitute a risk may vary between individuals. For clinicians, our aim is not necessarily to predict actual outcomes but simply to assess and manage risk in a consistent and reliable way' (Cooper and Navneet, 2004).[27]

5.41 The policy states that clinical risk management is 'The actions taken, on the basis of a risk assessment, that are designed to prevent or limit undesirable outcomes. Key risk management activities are treatment (e.g. psychological care, medication), supervision (e.g. help with planning daily activities, setting restrictions on alcohol use or contact with unhelpful others, and so on), monitoring (i.e. identifying and looking out for early warning signs of an increase in risk, which would trigger treatment or supervision actions), and, if relevant, victim safety planning (e.g. helping a victim of domestic violence to make herself safe in the future and know better what to do in the event of a perceived threat)'.

5.42 The policy contains much in the way of guidance and best practice. For example it states 'If a service user is detained under the Mental Health Act (1983), it is the responsibility of the Responsible Clinician to ensure that a clinical risk assessment and clinical risk management plan is made before the decision is taken to discharge the person or grant leave'.

5.43 The Trust Care Programme Approach policy discusses what should happen where there is a past history of violence. It states 'Exploration of the service users past experience of violence and abuse will need to be undertaken in all mental health assessments. Questions should be asked by suitably trained staff at assessment about the experience of physical, sexual or emotional abuse at any time in a service user's life. The response, with brief details, should be recorded in the core assessment. If the specific question is not asked, the reason(s) for not doing so should be recorded'. In this case there is no record that the specific issue of violence and risk to his neighbours was explored with Mr L.

---

[26] *Department of Health, Best Practice in Managing Risk, 2007, page 5*

[27] *Cooper, J. and Navneet, K. (2004) Assessing Suicide Risk, Chapter 2 in: New Approaches to Preventing Suicide: A Manual for Practitioners, Duffy, D. and Ryan, T. (eds.). Jessica Kingsley: London.*

5.44 In this case there is little evidence that Mr L's risks were adequately explored, discussed and planned for prior to his discharge in line with the Trust's policies. The risk assessments contained details that were repeatedly recorded in ward round and CPA reviews. There is no evidence of how these risk assessments were updated, although examples are noted when risk behaviours occurred. Examples included no acknowledgement of interpersonal aggression and intimidation whilst on the ward and his assertion at interview that he took drugs whilst on the PICU, which casts doubt on the level (unrecorded) of drug screening. During our interview Mr L stated that he remembered smoking 'one joint' whilst at the PICU. There appear to be other issues which were not explored, such as Mr L's motivation to comply and change. There are several examples where Mr L appeared to dictate interventions, such as refusing to attend for alcohol work at the Bromley Drug and Alcohol Service (BDAS) saying he preferred one to one work with Alcoholics Anonymous.

5.45 His risk assessment, noted in his discharge plan (28 February 2014), did not specify which interventions were to address his risks other than the alcohol and anger related interventions, which had not commenced prior to discharge. In any event, these would rely on Mr L's compliance despite multiple examples of disengagement and non-compliance. There was no formulation in place which would help distinguish which factors were to be addressed, and how these were to be reviewed.

5.46 The review information available is often repetitive, not related to specific components of risk, and specifically not designed in a way that would record changes or developments in risk factors.

5.47 Mr L's named nurse was unable to confirm that reviews on care plans had occurred and what the outcome of these were. The Trust 'CPA and Clinical Risk Management Policy' and the 'Trust Guide to the Assessment and Management of Risk' both provide instruction that review of interventions is an integral part of care planning and risk assessment processes, specifically 'care plans should routinely include arrangements for setting out, measuring and reviewing specific outcomes'.

5.48 The history of Mr L's presenting risks was acknowledged in the records prior to and during his admission from 2 December 2013. In a report prepared for a Mental Health Tribunal on 23 January 2014 by his CCO, it is reported that a neighbour had phoned services, and that Mr L was causing disturbance, through making a lot of noise at night playing music loudly and shouting at traffic. This report goes on to say that the noise was causing a significant disturbance to the neighbours, one of which was a night worker who could not get to sleep and the other was an elderly gentleman who was very frightened.

5.49 There is also a record of concern noted about the potential risks to his neighbour. This was raised by his CCO in the retrospective entry written on 7 March 2014, related to the discharge meeting on 28 February 2014. In this, it is noted that Mr L offered to apologise to the victim Mr Parsons, but that his mother had said that he did not need to apologise to anyone. It is noted Mr L had said that he did not wish to discuss the matter in detail and just wanted to move on. CP1 stated that he was not aware of these concerns

5.50 The decision to meet with the AOT psychiatrist, CP 4, on the Monday following discharge rested on the premise that CP 4 and Mr L would formulate and finalise his care plan. This does not meet the requirement of the CPA discharge policy, the PICU operational policy or the Clinical Risk Management policy. In these it is stipulated that a comprehensive care plan is required to be in place. Mr L was discharged without an agreed care plan. The reason for this, it seems, was based on the perception that the AOT had more experience of providing care management to Mr L, and that they would be better able to formulate his care and risk management plans.

5.51 As a minimum requirement we would have expected a discharge care plan in place prior to discharge. This should have included specific interventions on managing, supervising and monitoring risks, in particular with regard to his neighbours, as well as information / interventions on protecting potential victims. From the available information we would recommend that this should have included details of his response to alcohol, his propensity for violence in the context of alcohol and non-concordance with medication, his frequent disengagement and compliance with agreed plans and effective contingency plans for the initial period of discharge. It should also have been developed with some discussion at the very least with Town & Country Housing and the LBB Environmental Health Technical Officer who had reported their concerns to the AOT, and had specifically asked to be kept informed.

Effectiveness of the care plan

5.52 Whilst there is evidence from the records that Mr L was aware of his responsibilities in developing and reviewing his care plan the details of the care plan do not appear to address any interventions to examine and treat the components of risk.

5.53 There is no clinical rationale for the ‘leave interventions’ and the actions required are about managing his treatment and risk behaviours whilst an inpatient, e.g. confirming the parameters of leave.

5.54 There was a brief discharge plan, although this was not the formal care plan for the community. This discharge plan contained details of the number to phone in the event of a crisis and Mr L’s intention to abstain from alcohol and drugs, as well as the planned meeting with the AOT the following week. The arrangements for the weekend were contained in a brief plan of action. There were no further treatment or management plans identified.

5.55 It is known that Mr L stayed at his parents’ house as agreed at the discharge meeting on the Friday 28 February, saw his child on Saturday 1 March 2014 and then returned to his flat that evening.

5.56 When interviewed for this investigation Mr L described how he ‘had’ to get to his flat as he wanted to be alone and was ‘not feeling well’, stating that he was depressed and a little paranoid.

5.57 He described how he had been becoming more unwell and that he had been phoning his mother a lot. He reported that due to his phone battery running out

he was unable to contact the emergency number given to him over the weekend. He told us that he had been unwell mentally and needed to speak to his friend and neighbour, G, as he was panicking, but G was not in. He then knocked on the door of the victim's flat and commenced the assault.

5.58 Prior to his discharge there was little effective discussion and preparation for Mr L to respond to his neighbours, even though the complaint was discussed at the pre-discharge meeting and in conversation with his CCO. That his neighbours were concerned, and one was known to be frightened of him does not appear to have been considered.

5.59 We have concluded that it would have been difficult to develop specific interventions for conditions of discharge to the community given that the care plan did not address specific components of risk behaviours and there is little evidence of comprehensive reviews of interventions and their effectiveness.

The involvement of the service user and the family

5.60 From the available records it appears that Mr L's parents were actively involved in discussions with the care team at various reviews in the past and by their attendance were aware of current care and management.

5.61 His parents remained closely involved in his care and attended the pre-discharge meeting. It is also noted that they have received a carer's assessment under CPA guidelines.

5.62 However, we have found no record of discussion with his family about the boundaries expected while on leave from the PICU, or involvement in contingency or crisis management. Feedback from family on the detail of his presentation whilst on leave was not recorded.

5.63 National and local guidance on CPA practice stipulates that family / carer involvement is an essential component of care planning.

5.64 The Trust 'CPA and Clinical Risk Management Policy' states that 'Care Plans must reflect the holistic assessment of the service user and be in line with national policy guidance on best practice' These are to include family and Carer views.

5.65 It was notable from our interview with Mr L that he believed that his parents did not want him 'released' and wanted him to return to Green Parks House.

5.66 We also know that after the trial the family also stated that they believe that Mr L was not ready for discharge, but we have not seen any evidence that this was reported at the discharge planning meeting on 28 February and we have not been able to meet with his parents to confirm their views.

Safeguarding

5.67 We heard from several members of the team that the mother of Mr L's child was an extremely capable and competent mother who wouldn't allow Mr L to visit their child when unwell or intoxicated.

5.68 We have not been able to find any record of due consideration of the safeguarding issues for Mr L's family or his child, nor any details of which interventions were in place to address any potential risks based on previous behaviour. There is no reference to any joint discussions with safeguarding or social services in this regard.

5.69 There is a well-documented history of threats and assaultive behaviour by Mr L towards his parents, although they appear to have remained supportive and involved in his care.

5.70 We have not seen any evidence that demonstrates the vulnerability of Mr L's parents, nor any assessment of the risk Mr L posed to his parents. We were told by the Trust that the police were aware of Mr L's previous threatening behaviour towards his wider family but that his parents were not vulnerable people requiring a safeguarding assessment/referral.

5.71 We would have expected the risks to both his parents and wider family to have been noted and the safeguarding aspects considered and where appropriate discussed with the Trust safeguarding team at the least.

The management of Mr L after throwing hot liquid on another patient

5.72 Early in his last admission to Betts ward, Green Parks House, in December 2013 Mr L committed an assault on another patient.

5.73 Mr L stated that another patient had refused to let him play pool. Mr L woke up on 6 December 2013 and made himself a hot lemon drink. He said he was walking down the hallway and encountered the individual who was acting aggressively. On turning round to see if the person was 'going to ignore' him, he had then had an involuntary reflex of the hand resulting in the hot drink splashing over the person. He did not express remorse about this incident until several weeks before discharge. This 'assault' precipitated a transfer to the PICU.

5.74 It is noted from his clinical records at the time that Mr L was transferred to the PICU three hours after the incident at 11 pm that evening.

5.75 We believe that this rapid transfer to the PICU was an appropriate and timely response to a very challenging and threatening individual with a history of assaultive behaviour.

5.76 The following day (7 Dec 2013) a care plan to manage his aggressive behaviour was developed. It is recorded in the notes at this time that Mr L was placed in 'seclusion', despite the investigation team being made aware by CP1 during interview that seclusion facilities do not exist at the PICU. He is also noted to have been on constant observation at the time with a 3:1 staff to patient ratio of observation during the initial period which eventually decreased to 1:1. We were told by CP1 at interview that when a patient becomes aggressive, the staff members de-escalate the situation by moving the patient to his room. If needed, rapid tranquilisation is then used to calm the patient. There is always one staff member with the patient when he is moved to his

room, and the staff member may persuade the patient not to leave the room if he is agitated. We were told that they do not keep patients in a room for more than 50 minutes at a time but can bring the patient back to the room again after a brief period.

5.77 It was conveyed to us that this process was de-escalation and not seclusion, and that if a patient requires seclusion, the patient is transferred to the Trust's forensic services.

5.78 We have specific concerns about this as this is 'de facto' seclusion. This practice is in breach of the Mental Health Act Code of Practice.[28] We have made a specific recommendation about this.

5.79 We have no concerns about the care planning for Mr L immediately following this incident.

5.80 The other patient sustained superficial burns that were treated with Jelonet[29] dressings on the ward. The patient was supported to report the incident to the police.

5.81 We have also been provided with evidence that the Trust has a clear policy for the Prevention and Management of Violence & Aggression (PMVA).

5.82 The Trust audited incidents occurring in 2017 to determine if the police were being informed after violent incidents. We have been given the results of this audit involving 148 incidents involving staff and 177 incidents involving other patients. Of 148 incidents involving staff, 79 were reported to the police, and all incidents involving patients were reported to the police. However, the audit doesn't tell us the outcome of this (i.e. were the perpetrators charged). This audit demonstrates the policy is embedded and generally appears part of routine practice, so that violent and aggressive incidents are reported to the police.

5.83 We note that this policy was recently updated (March 2018) to include specific guidance on reporting incidents to the police:

"**12.1 Reporting assaults**

All violent assaults on other patients or staff are reported to the police, and there is discussion about what steps should be taken next in both the public's and the patient's best interests".

Housing and environmental health

5.84 It is noted in a retrospective entry after the homicide, and during their interview with the investigation team, that CCO 2 had raised their concerns about the

[28] *Code of practice: Mental Health Act 198. https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983*
[29] *Jelonet is a paraffin gauze dressing suitable for minor burns and scalds*

fears expressed by the victim to CCO 2 prior to the homicide. CP1 stated that he was not aware of these concerns at the time of discharge.

5.85 There is no evidence in the available records that concerns raised by different parties, including another neighbour, Town and Country Housing manager and Environmental Health, were acted upon or if they were ever considered as part of the decision to recommend discharge, even though Mr L's CCO and keyworker were aware of these concerns and the specific issues of noise complaints and Mr Parsons appearing afraid of Mr L.

5.86 There was no specified risk management plan to address these concerns nor do they seem to have informed any part of the strategy to manage Mr L over the weekend of his discharge.

5.87 We have referred to victim safety earlier, and in this context we have concluded that the known concerns about Mr L's behaviour towards and in the vicinity of neighbours should have formed an integral part of the contingency plans on discharge back to his accommodation.

5.88 We are of the opinion that he should not have been discharged without these issues being considered in his management in the community. It would have been preferable to also have addressed these whilst an in-patient on the PICU.

Compliance with local policies, national guidance and relevant statutory obligations

5.89 Mr L was discharged without a comprehensive care and risk management plan, which indicates that there were omissions in practice by the clinical teams involved. Both the PICU and AOT appear to have been aware that a comprehensive plan of care and risk management were not in place, that Mr L had not commenced psychological therapies for his two primary risks, and that he was being discharged on a Friday with limited weekend support.

5.90 It is known that there are particularly complex discharge planning issues for service users with 'dual diagnosis' (co-morbid mental health and substance misuse problems). Service users with drug or alcohol problems often have an increased risk of overdose, suicide or violence to others upon discharge which requires clear follow-up arrangements to be put in place as part of CPA. It is therefore critically important to ensure that there is a full multidisciplinary care plan in place which takes account of substance use issues.[30] Good discharge planning would involve formulating a comprehensive care plan addressing risk to others, including family and neighbours, risk to self, managing substance misuse and managing compliance with medications.[31]

5.91 With regards to CP3's and the associate specialist's clinical opinions, they concluded that Mr L would benefit from a longer admission to address his

[30] *National Institute for Mental Health in England 'A positive outlook: a good practice toolkit to improve discharge from inpatient mental health care' 2007*

[31] *National Institute for Healthcare Excellence 'Transition between inpatient mental health settings and community or care home settings'. NICE guideline NG53 Published: 30 August 2016* https://www.nice.org.uk/guidance/ng53/resources/transition-between-inpatient-mental-health-settings-and-community-or-care-home-settings-pdf-1837511615941

needs and risks. The rationale for this was based on what appeared to be a significant improvement in his presentation and risk, and the weight attached to these by his RC.

5.92 Although there are frequent notes about Mr L's psychotic presentation, more latterly he was diagnosed with bi-polar affective disorder. For the care and treatment of patients with a bipolar disorder, in addition to pharmacological interventions, NICE guidance emphasises that intensive psychological interventions for up to 6 months should be offered.[32] These interventions may include a family intervention for people living with or in close contact with family. This could have been offered alongside appropriate on-going social and team support as well as interventions to manage and control substance misuse (often a clear disinhibiting factor for acts of violence). Moreover, in line with recovery principles, there should also be active support for structuring daily activities and developing valued leisure occupational or prevocational training.

5.93 From interviews with staff it became apparent that the decision to discharge was based on what appeared to have been successful and uneventful day leaves escorted by his parents, and no indications that Mr L would not comply. However, as we have discussed earlier, there was no discussion with his parents about his behaviour and mental state whilst on leave in an attempt to evaluate the success or otherwise of his leave. These leaves had been escorted and there had been no trial period of overnight leave either at his parents or in his flat. Also the impression gained from the records and interviews is that Mr L was quite forceful in getting what he wanted at times.

5.94 Given the brief introduction to the psychology service without an assessment, the rapid and incomplete discharge planning process and documentation, and lack of a clear plan of care whilst an inpatient, it is concluded that the teams have not practised fully within the guidance contained within local and national policies. Namely:

- 'Assessment and Care Planning including Care Programme Approach (CPA) for all Oxleas Service users'. Version 8.2
- 'Clinical risk assessment and management policy for Mental Health and Learning Disabilities Services'. Version 1.2
- The PICU Operational Policy - undated
- NICE guideline NG53 'Transition between inpatient mental health settings and community or care home settings'.
- NICE Clinical Guideline 185 'Bipolar disorder: assessment and management'.

[32] *National Institute for Healthcare Excellence 'Bipolar disorder: assessment and management'. Clinical guideline 185, Published: 24 September 2014, https://www.nice.org.uk/guidance/cg185/resources/bipolar-disorder-assessment-and-management-pdf-35109814379461*

6 Internal investigation and action plan

6.1 The terms of reference require that we:

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.

6.2 The report is described as a 'Grade 2 comprehensive investigation', as would be expected in the NHS England Serious Incident Framework. The families of Mr L and Mr Parsons were invited to participate, through police liaison. Both families indicated through the police that they did not wish to be involved. It was noted that it was made clear by the Trust that lines of communication would remain open.

6.3 We met with the family of Mr Parsons and they told us that they did meet with the Trust after the investigation was completed and some of the findings were shared with them. However, they were concerned that they were only provided with an edited version of the findings, and were never provided with a copy of the investigation report.

6.4 The internal investigation was commissioned on 2 March 2014 and completed on 19 August 2014.

6.5 The internal investigation team comprised:

- Director of Nursing and Governance
- Medical Director
- Non-executive Director
- Trust Governor
- Head of Patient Safety

6.6 We concur with the internal investigation report findings and recommendations.

6.7 The internal investigation report acknowledges that the quality of the assessments and subsequent care plans undertaken on the PICU were neither adequate nor accurate and did not include appropriate care planning. An appropriate recommendation is made in relation to this, specifically regarding people with a history of substance misuse.

6.8 The internal investigation report appropriately noted the issue of the need for recording of reviews of care, and including family involvement.

6.9 The internal investigation report has identified the need to have an appropriate plan for leave which should reflect need and therapeutic rationale, and also

identified that the PICU Operational policy requires updating on this to include leave with family.

6.10 The internal investigation report identifies some of the issues with the decision making about discharge into the community, accurate recording in clinical notes, and clear handover of care plans.

6.11 Despite this, we believe that the internal investigation contains a significant omission. It was well known that Mr L's neighbours had complained about him and his behaviour, and Mr Parsons in particular was afraid of him. The neighbours had been so concerned they had raised these concerns with Environmental Health and Town & Country Housing and his keyworker and Care Coordinator in the AOT. Yet these factors were never considered in the discharge planning arrangements, nor were these agencies involved in the planning. This was identified in the internal investigation, but did not lead to any recommendation.

6.12 In addition, there are some aspects of the internal investigation that are of minor concern.

6.13 Firstly we have identified that there are 11 admissions between 2004 and 2014, whilst the internal investigation does not mention one overnight admission for self-harm on 2006 and two admissions in June and July 2012.

6.14 Whilst this may not have affected the overall findings of the report, it is of concern that Mr L's rapid cycle of an admission every month for two to three weeks over the summer of 2012 was not noted.

6.15 One other area of concern that is not noted is that on several occasions there are different records and interpretations of historical events. For example, the assault on the 60 year old lady has descriptions of her sustaining an injury to her arm or shoulder, of the knife being caught in her scarf with no injury, and of her being stabbed. Similarly the knife used in the assault on his fellow resident is variously described as both a kitchen knife and a butter knife, and Mr L is said to have stabbed his fellow resident, and elsewhere, jabbed him in the side. Following the incident with the hot lemon drink the fellow patient was described as having both significant burns and minor burns.

6.16 This leaves the reader with a blurred perspective on the actual historical harms that Mr L has perpetrated, and could have led to the downplaying of risk in any future assessment.

6.17 That the forensic psychiatric assessments did not downplay these incidents and injuries is to their credit. However we believe that the historical risks and violent behaviour were downplayed by his treating team on the PICU, leading to a belief that his rapid improvement through February whilst an inpatient taking only escorted day leave, and not tested overnight, would be sustained when living independently in the community.

6.18 The Trust's internal investigation made seven recommendations, which the independent investigation team agree with. We have expanded on them where appropriate.

- **Recommendation 1**: Where a person has recent history of substance misuse there should be consideration of its impact with a documented assessment of risk (including risk of violence). A clear plan assessing the risk and relapse should be in place before discharge.

- **Recommendation 2**: Outcomes of meetings with family and discussions about risk should be documented in RiO.[33]

- **Recommendation 3**: There should be a clear policy describing the circumstances and leave with family members or carers from the PICU.

- **Recommendation 4**: If a low secure bed is not available at the time of referral and assessment, there should be a case conference to agree and document a plan of care.

- **Recommendation 5**: All conclusions of clinical discussions are to be recorded within the primary clinical record, RiO.

- **Recommendation 6**: If a patient is discharged from acute adult inpatient services over the weekend, the care plan must take into account the support required in the immediate period after discharge.

- **Recommendation 7**: In the circumstances that discharge to the community is considered from the PICU, such discharge should not take place at the weekend. Furthermore, there must be a formal handover of care from consultant to consultant to manage transition and ensure the availability of a robust care plan with clearly outlined crisis and contingency plans prior to discharge.

6.19 The internal investigation does not appear to have considered any aspects of safeguarding with regards to Mr L's parents or his child. We believe this is an omission and suggest that future incidents involving significant violence to others should include consideration of safeguarding issues and practice as core terms of reference.

6.20 We also note that although the internal investigation notes that on 2 December 2013 a standard 'noise one letter' was sent to Mr L from the Environmental Health Technical Officer there does not appear to have been any further exploration of this.

6.21 Both the AOT Housing Support Worker and his CCO were aware of the concerns around Mr L disturbing his neighbours with noise and anti-social behaviour, and we would expect that some mention of relationships with his neighbours and management of noise should have at least been considered in

[33] *RiO is the electronic clinical record used by Oxleas.*

any discharge planning and risk management arrangements, given Mr L's history.

6.22 The internal investigation states that there was no root cause to this incident. We disagree with this finding for these reasons:

- It was known by Mr L's CCO, specialist registrar from the AOT and his keyworker that Mr L had been playing very loud music late at night, sufficient for his neighbours to complain to Environmental Health and the Housing Association, and that Mr Parsons had made them aware he was frightened of Mr L. Mr L's CCO did try to explore his attitude to his neighbours on several occasions but this was not followed up by other members of the care team. The noise complaints were discussed at the discharge planning meeting but in no great depth, other than to agree that Mr L need not apologise. The EHTO had specifically raised their concerns with the AOT, and had asked to be kept informed of any plans to discharge. They were not. It could therefore have been foreseen that there was potential for conflict with his neighbours, and that there should have been wider involvement of both the London Borough of Bromley Environmental Health team and Town & Country Housing when planning his discharge as this may have led to a more comprehensive care plan to support Mr L and mitigate the risks to his neighbours.

- Expert advice was obtained from forensic psychiatrists who recommended interventions related to Mr L's future care and treatment and included a recommendation to transfer Mr L to conditions of low security for longer term interventions, in line with NICE guidelines for people with severe mental illness and violence. The decision to discharge Mr L back to his flat relied on the positive impression given from a series of interventions which required Mr L's adherence if he were to be discharged into the community or continue with his leave routine. And whilst the additional risk factors of alcohol, aggression and non-concordance with medication were recognised, they were not acted upon prior to discharge, and relied upon Mr L's compliance.

- The process of discharge, specifically the decision to discharge, appears to have been hurried, and whilst risk factors appear to have been known; suggested future interventions for his anger in response to psychosocial stressors, and his alcohol intake were not due to commence until after discharge, with only a brief contact with his psychologist and no initial work whilst at the PICU. This is also reflected in the final point below.

- Mr L was discharged on a Friday. Feedback during interviews would suggest this is not a practice the clinicians involved in Mr L's care and treatment would agree with. There was a consensus from all of the staff that there was a diminished community service at the weekend and that people may have an increased need for intervention in the early stages of discharge into the community. Mr L was given an emergency number to call but no other contingency plans seem to have been put in place. Mr L was discharged without an agreed plan of care, with the intention of agreeing this at the appointment with his new psychiatrist whom he had yet to meet.

6.23 In patient safety terms, the root cause of an incident is the earliest point at which service intervention, or a change in service delivery, could have prevented the incident. We have concluded that the root cause for this incident lies in the decision to move away from the longer term low secure pathway envisaged by the forensic psychiatrists, and to discharge Mr L back to his flat based solely on his behaviour in relation to a number of interventions which he was aware he was required to adhere to. It appears that although these factors were not present prior to his discharge, the important longitudinal factors of violence, anti-social behaviour, alcohol and substance use, and medication concordance were not prioritised for intervention, despite recommendations from forensic mental health professionals that Mr L would benefit from longer term interventions related to these.

The Trust's internal action plan

6.24 We have received reassurance from the Trust that there were seven elements to the Trust's internal action plan which reflect the internal investigation. We have been provided with an up-to-date action plan for the recommendations which are identified as having all been addressed.

6.25 **Recommendation 1:** Where a person has a recent history of substance misuse there should be a consideration of its impact with a documented assessment of risk (including risk of violence). A clear plan addressing the risk and relapse should be agreed and in place prior to discharge.

6.26 We believe that the new PICU operational policy addresses this concern.

6.27 **Recommendation 2:** Outcomes of meetings with family and discussion about risk should be documented in RiO.

6.28 The PICU operational policy now includes this.

6.29 **Recommendation 3:** If a low secure bed is not available at the time of referral and assessment there should be a case conference to agree and document a plan of care.

6.30 We were informed by CP1 that 'bed pressure' was not a consideration in this case despite it being suggested by CCO 2 in her interview. We welcome this recommendation and understand that it is now embedded in the PICU operational policy.

6.31 **Recommendation 4:** All conclusions of clinical discussions are to be recorded within the primary clinical record, RiO.

6.32 We view this as an essential component of clinical practice and we have made reference to record keeping and clinical decision making. We welcome this recommendation and understand that it is now embedded in Trust practice.

6.33 **Recommendation 5:** If a patient is discharged from acute adult mental health inpatient services over the weekend the care plan must take into account the support required in the immediate period after discharge.

6.34 We agree with this assertion but are aware that as far as possible it will no longer occur in the PICU, except in extenuating circumstances as stated in the PICU operational policy. We were told that it has not occurred since.

6.35 **Recommendation 6:** In the circumstance that discharge to the community is considered from the PICU such discharge should not take place at the weekend. Furthermore, there must be a formal hand over of care from consultant to consultant to manage transition and ensure the availability of a robust care plan with clearly outlined crisis and contingency plans prior to discharge.

6.36 We agree that the practice of discharging at weekends is stopped as per the PICU operational policy. We believe that the policy contains adequate advice on this issue however adherence to this practice will need to be monitored.

6.37 The adult mental health and learning disability patient safety group are the authors of a 'Serious Incident Action Plan'. The two primary outcomes of the action plan are the development of a new operational policy for the PICU and an away day for PICU staff from which feedback was to be used to contribute to the policy.

6.38 We have received assurance in the form of the new PICU operational policy (May 2015) from the Trust. The policy now addresses the Care pathways, Referrals, PICU pre admission screening and Criteria for admission including a definition of which behaviours result in admission and exclusion.

6.39 The new policy describes the admission process including what should happen within the first 72 hours. Significantly, in relation to the internal review report and our investigation, there is a definitive statement about discharge planning.

6.40 **Recommendation 7:** Patients will never be discharged from the PICU to the community unless there are exceptional circumstances such as discharge by tribunal[34] or nearest relative.[35] If this is the case a comprehensive discharge plan will be implemented which will include information on how to access support. All information and plans will be shared with the patient's carers.

6.41 With regard to our conclusions that Mr L should not have been discharged on a Friday it is noted that the PICU operational policy now includes a statement that no discharges will happen on a Friday even in the above exceptional circumstances. However, transfers to the referring ward or alternative inpatient placements can happen on any day of the week.

6.42 In reference to the transfer process it is noted that the PICU will now include planning as part of the process and sets out a number of criteria for transfer as well as an acknowledgement that there are two groups of patients who may

---

[34] Patients have the right to apply to a First Tier Tribunal to review their detention under the MHA. The FTT has the power to discharge the patient. https://www.legislation.gov.uk/ukpga/1983/20/part/V

[35] The patients' nearest relative (NR) can apply for the MHA section to be rescinded Under s23(2) the NR has the power to 'order' discharge from s2 or s3 or CTO; however, this right is qualified by the provisions of s25. The NR must give the hospital managers 72 hours' notice of his intention to discharge the patient. He can use a form or write a letter. https://www.legislation.gov.uk/ukpga/1983/20/section/23.

potentially ‘block ‘ a PICU bed. These are described as those requiring increased security and those who require a longer period of low security.

6.43 There is a section of the new policy which addresses the forensic (to and from) referral pathway. This also includes the criteria for referral and assessment and the MDT review of referrals, record management and time limits for action and outcome. We note however that there may be an erroneous entry in this policy section (referrals from forensic services) as it states that a case conference should be held if there is a delay in waiting for a low or medium secure bed. We believe this should be in the referrals to forensic services section of the policy document. The ‘referral to’ section includes a timescale of two weeks between assessment and outcome. There are flow chart diagrams available related to the referral pathway and transfer procedures.

6.44 The policy does include a section on risk assessment and management but this is not cross referenced to the Risk Management policy. However, it does include ‘consideration’ to safeguarding adults, child protection, victim considerations, substance misuse and other vulnerabilities. It is noted that the appendices include a referral form which clearly stipulates that all information must make reference to the information in the risk assessment.

6.45 With regard to leave it is now the policy that no leave should occur where there is not a staff escort, including leave with family / carers. For leave to occur it is now expected that a nursing review of the last 24 hours occurs before each leave can be granted. We welcome this inclusion as it directly related to our conclusions that these processes were inadequate at the time of the incident. We concur with this being included but would suggest that there needs to be a statement which stipulates that leave forms part of therapeutic interventions and as such should have an expected outcome, clear rationale for leave and contingency plans.

6.46 It is of note that the new policy does not include specific guidance on seclusion practices or de-escalation techniques.

6.47 However, all of the actions identified are process actions, which rely on policies being rewritten, and matters being brought to people’s attention either through discussion or email to bring about change. Only one action has a specific outcome focussed action, and that is for a 6 month Audit of RiO notes by the Ward Manager of all direct discharges to the community to provide assurance that discharges from the PICU are not taking place at weekends.

6.48 Whilst changes to process are required to address gaps in practice, recommendations and action plans should describe the outcome required and the evidence of a change in practice that should be seen.

7 Overall analysis and recommendations

7.1 We have reached a number of conclusions related to care and treatment which contributed to the incident. We have indicated in Section 6 where we have agreed with the findings and recommendations of the internal investigation report, and have not repeated them.

7.2 Mr L should not have been discharged from the PICU without an adequate and robust care plan. This care plan should have included plans to mitigate any risks Mr L posed to his neighbours or family. It should have been developed in advance of the discharge and by consultation with all agencies involved with Mr L, including Town & Country Housing and London Borough of Bromley Environmental Health, as required by Oxleas 'CPA Discharging from Hospital' policy. This did not happen. Although he was provided with a short 'discharge plan' at discharge which outlined numbers to call in an emergency and arrangements for his appointment with AOT on the following Monday, this cannot be considered a care plan.

7.3 There is no evidence of victim safety planning. Concerns raised by Town & Country Housing, London Borough of Bromley Environmental Health Technical Officer and his CCO about his neighbours' fears following the complaints about loud noise were not considered as part of the discharge plan.

7.4 The decision to expedite the discharge interfered with the process of a considered and planned discharge. We heard at interview that not all professionals involved in Mr L's care agreed with the discharge.

7.5 Mr L should not have been discharged on a Friday, which was acknowledged by the professionals in his clinical team.

7.6 The decision to discharge Mr L to his own accommodation and not admit him to Memorial Hospital for a longer period as recommended by the forensic psychiatrist was based on Mr L's rapid progress in the PICU. He had been abstinent from alcohol, compliant with medication and had had periods of unescorted leave under the care of his parents without incident, whilst under the care of the PICU.

7.7 Whilst there were some plans in place to commence psychological interventions for his substance use and anger, these interventions should have been commenced and evaluated prior to discharge.

7.8 He did not undergo an assessment by clinical psychology and therefore no psychological formulation of risks was available as a basis for treatment or risk management interventions.

7.9 It is not clear why there was no discussion about a possible referral to MAPPA.

7.10 We have concluded that the root cause for this incident lies within the decision to discharge Mr L directly into the community as opposed to admission to a low secure setting, or through a phased discharge process from an acute ward, without putting in place proper plans to mitigate any risk he may pose, even

though services were aware that there had been conflict with neighbours. This decision to discharge Mr L relied on his abstinence from alcohol and concordance with medication. This was untested other than day leave with his parents.

7.11 We have seen no evidence that his behaviour and progress whilst on leave with his parents was ever assessed or discussed with his parents. This was also the view of the internal investigation. The improvement in risk behaviours was based upon interventions where he had little choice but to comply if he wished to be discharged. The situation was further exacerbated by the decision to discharge him on a Friday without substantial contingency and risk management plans in place, prior to his appointment with his community consultant 2 days later. It has been acknowledged by the professionals in his clinical team that there are less services available at weekends in the event of a crisis.

Predictability and preventability

7.12 Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'.[36] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. [37]

7.13 Prevention[38] means to 'stop or hinder something from happening, especially by advance planning or action' and implies 'anticipatory counteraction'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

7.14 We do not concur with the findings of the internal investigation which concluded that although there were lessons to be learned the incident on 2 March 2014 could not have been predicted or prevented.

7.15 We agree that it was not predictable that Mr L would kill Mr Parsons. However, whilst it may not have been predictable that Mr L would attack and kill Mr Parsons on that occasion, it was predictable that at some point in the future he would likely be involved with a violent assault given his forensic history. Mr L was highly likely to become aggressive and violent in a short period should he engage in drinking alcohol or start to omit his medication and / or encounter stressful situations.

7.16 We accept that the decision to discharge Mr L was based on a noted and significant improvement in his mental state and behaviour over a short period of time. He had had periods of escorted day leave, was concordant with his medication and had abstained from alcohol. Even though his behaviour and

[36] *http://dictionary.reference.com/browse/predictability*
[37] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*
[38] *http://www.thefreedictionary.com/prevent*

mental state whilst on leave was not properly assessed, there had been no indication over that month that he would deteriorate so rapidly once discharged.

7.17 We accept also that this improvement occurred when he was waiting for a low secure bed whilst a patient on a PICU, and that due to his progress, the PICU was increasingly the incorrect place to treat him.

7.18 Nonetheless, there were other professional views that maintained that Mr L should have followed a care pathway through a longer term low secure placement to ensure that his illness and behaviour had stabilised.

7.19 Even if it was agreed by all to discharge Mr L, there should have been a robust and proper care plan in place to support him, as required by Trust policy and best practice guidance. This care plan should have involved the housing association and LBB Environmental Health, and fully considered and mitigated any risks to his neighbours arising from their complaints about his anti-social behaviour and noise. These concerns were known by the care team.

7.20 Because this proper discharge care planning did not happen we believe that the death or Mr Parsons was preventable.

Contributory factors analysis

7.21 Below is the analysis of events using a root cause analysis and contributory factors structure. The problem statement is:

‘Mr L was discharged back to his flat in the community without adequate risk management, treatment and contingency plans in place. Subsequent to this he committed a homicide on a neighbour two days after discharge’.

Contributory Factors	Analysis
Patient Factors	Long standing history of involvement with mental health services characterised by non-concordance with medication, sporadic engagement with services, violence, threatening and anti-social behaviour and excessive alcohol intake. Mr L has a history of offending behaviour, including assault with a weapon. History of unprovoked assaults as well as intimidating and aggressive behaviour whilst on the ward.
Individual Factors	No formal reviews of nursing interventions recorded. Dissent on decision to discharge not reflected in records or discharge interventions. Recommendations from forensic psychiatrists not adhered to and rationale for discharge based on other improvements with limited evidence of sustained change. Professionals did not fully adhere to local or national guidance on discharge and treatment.

Contributory Factors	Analysis
Task Factors	Deemed not suitable for discharge five weeks prior to discharge, and recommended for Section 3. No comprehensive psychological assessment completed. Discharge plans stipulated addressing risk needs following discharge. Risk Assessment inadequately addressed known risks / reasons for admission. Mr L discharged without agreed care plan. Process of discharge appeared hurried, ill prepared and did not include formal discussion.
Communication Factors	Risks and plans not adequately explored with Environmental Health and Town & Country Housing. Issues raised about communication between forensic psychiatrist and psychiatrist at the PICU. It does not appear that the AOT were kept 'in the loop'/AOT not fully included / communicated in planning of discharge process. Dissent to decision to discharge not formally communicated.
Team factors	Dissent to decision to discharge by team members (CCO and named nurse) not included as part of discharge plan. The 'hurried' nature of the discharge decision did not include all relevant stakeholders. Limited inclusion of clinical stakeholders in decision to and process of discharge. No involvement of wider stakeholders (police, Town & Country Housing and Environmental Health) in discharge planning. Disagreement about level of readiness and understanding of 'coerced' compliance not acknowledged in discharge plan.
Education and Training factors	Lack of awareness and application of local guidance and policy.
Equipment and resources	Unavailability of a low secure bed leading to prolonged stay on PICU.
Working conditions Factors	Given the forensic psychiatrist's assessment, Mr L was not in the correct environment to undertake a comprehensive review of needs and develop treatment interventions to address his risks.
Organisational and Strategic Factors	Insufficient consideration given to the interpretation of CPA, Risk Assessment and discharge policies and practice guidelines.

Recommendations

7.22 We have made three recommendations to improve practice.

Recommendation 1

The Trust must ensure that where a violent patient has been admitted to its services following concerns by other agencies; or complaints by neighbours about anti-social behaviour and noise and that they have been made aware of:

- The risks are assessed appropriately
- There are care plans developed to address anti-social behaviours towards members of the public (who may have been victims), and these may involve other agencies.
- There is a robust discharge planning process that fully involves these agencies prior to discharge

The Trust should also work in partnership with other key agencies involved (local authority, housing agency, police and CCG) to ensure that there are processes in place to support the routine sharing of information regarding any potential anti-social behaviour of suspected/known service users.

Recommendation 2

NB: This recommendation is made to improve practice in general, and is not specifically related to his care and treatment.

The Trust should ensure that consideration about referral to MAPPA takes place for patients with violent histories and convictions for serious violent offences. Such referrals should consider safeguarding issues and risks of domestic violence for wider family members.

Recommendation 3

NB: This recommendation is made to improve practice in general, and is not specifically related to his care and treatment.

The Trust must assure itself that all practices of seclusion and 'de facto' seclusion on the PICU, including where patients have been segregated from others after rapid tranquilisation, are fully compliant with the requirements of the Mental Health 1983 (amended 2007), the MHA Code of Practice and the MHA Reference Guide.

Appendix A – Terms of reference

Purpose of Investigation

To identify whether there were any gaps or deficiencies in the care and treatment that the service user received which could have been predicted or prevented the incident from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring. Specifically,

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the findings if relevant from any additional report such as Domestic Homicide Review (DHR) and the Trusts progress in implementing any recommendations.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.

Specific Terms of Reference for Independent Investigation into the Care and Treatment of Mr L (Ref: 2014/7319) by Oxleas NHS Foundation Trust

- To review and consider if Mr L's care planning and risk assessments prior to admission on the 2nd December 2013 and following discharge 28th February 2014 incorporated the understanding and management of risk to others and risk of relapse following substance misuse.

- To explore the clinical decision making and risk assessments specifically relating to risk to others and substance misuse prior to periods of leave from PICU.

- To explore the various diagnoses and how these impacted on Mr L's care pathways.

- To understand the ongoing management plans relating to risk to others following Mr L's receipt of a 'noise one letter' on the 2nd December 2013.

- To consider the wider safeguarding issues in relation to Mr L's family following several reports of physical violence and threats.

- To understand the decision making around Mr L's suitability for a Community Treatment Order on the 26th February 2014.

- To review and consider the decision making process to discharge Mr L at a weekend following admission to PICU and the Mental Health support structures in place to monitor risk to others and relapse.

Appendix B – Chronology

Date	Information
19 December 2004	Mr L's first admission was when he was admitted at 23:30 from Accident and Emergency at The Princess Royal University Hospital, he was discharged the following morning at 11:00.
Early 2006	Admitted overnight following self-harm attempt after an argument with his girlfriend.
29 November 2006	Mr L was admitted to Green Parks House on Section 2 of the Mental Health Act (1983) following an assault on his mother. He was arrested by the police and taken into custody where a Mental Health Act assessment took place. Mr L's parents reported that his behaviour had become increasingly violent at home, also alleging that he had assaulted his father and brother and caused damage to their property. The clinical team saw these as evidence of a psychotic disorder and he was described as intimidating, threatening and verbally abusive.
12 December 2006	Mr L attacked another patient who was shouting and making threats to kill staff and a week later (19 December) he was assessed under the Mental Health Act and detained under Section 3.
12 January 2007	Mr L absconded from escorted leave and was brought back by his father. He was then transferred to the PICU (Psychiatric Intensive Care Unit) on 15 January 2007. This was his first admission to PICU. He was started on oral Olanzapine (an antipsychotic medication) 20 mg at night. It was documented that he responded well to the structured environment of a PICU and his medication concordance and mental state had improved leading to his discharge back to Green Parks House on 9 February 2007.
7 March 2007	A forensic consultant psychiatrist assessed Mr L following an arrest for being in charge of a motor vehicle with excess alcohol. Followed up by Assertive Community Team due to risk of non-engagement Further follow up from forensic services was not considered necessary. He was discharged on 3 April 2007 on Olanzapine with a follow up outpatient appointment. Following discharge from hospital Mr L did not comply with antipsychotic medication and disengaged from services.
9 November 2007	Mr L was unable to sustain a job and started to isolate himself. His mental state started to deteriorate again. Mr L was arrested for the alleged assault of his father at home. It was also alleged that the previous week Mr L had gone to his father's workplace and threatened one of his father's co-workers.
20 November 2007	Mental Health Act Assessment was conducted during which Mr L stated that his family were not his real family as they had a different blood type to him. He was detained on Section 3 of The Mental Health Act, admitted to hospital and restarted on Olanzapine 10 mg at night. His mental state improved and he was discharged on 10 January 2008 to the care of the EIP (Early Intervention in Psychosis) team.

Date	Information
20 May 2008	Mental Health Act Assessment was convened and he was detained under Section and admitted to hospital. He admitted to using alcohol and cannabis prior to admission and denied that he had been aggressive to his father. The antipsychotic Olanzapine was increased to the maximum dose.
2 July 2008	On 2 July 2008 Mr L was transferred to Banbury House closed rehabilitation unit where he received psychological therapy which included helping him to understand the negative impact that alcohol and illicit substances had on his mental state During the course of his admission to Banbury House his treatment included sessions that focused on insight orientation. He minimised the role that illicit substances and alcohol played in his admission but demonstrated a willingness to stop cannabis, although not alcohol.
20 January 2009	Mr L was discharged into temporary supported accommodation. His discharge plan included that he would attend regular meetings with his care coordinator every fortnight; he would meet with the social inclusion worker to assess suitability for employment and attend regular housing appointments. He agreed to regular urine screening, breathalyser tests and to confirm registration with a GP: On 17 March 2009 given Mr L's progress in the community it was agreed that the Assertive Community Team (ACT) would see him on a three weekly basis.
7 September 2009	Mr L's care was fully transferred to the ACT.
7 October 2009	Clinical team were alerted that Mr L was in police custody following his arrest for an alleged assault on 60-year-old woman not known to Mr L. He had attacked the woman using a small kitchen knife that became caught in her scarf. The Forensic Medical Examiner (FME) who saw him in custody suggested that Mr L did not present with features of mental disorder and was fit to be interviewed and charged. Mr L was remanded in custody at HMP High Down.
July 2010	The mental health team were informed that suitable accommodation had been found prior to his release date of 6 September 2010 and that he would most likely be subject to a probation order post- release from prison.
14 March 2011	It was reported to AOT that Mr L had been seeing his probation worker weekly and that it was the probation officers opinion that Mr L's risk of reoffending was downgraded to medium. Appointments with the probation officer were then downgraded to fortnightly, then monthly.
26 December 2011	Mr L was arrested for jabbing/ stabbing a housemate at Sandford Road in the side with a 4-inch blade knife but did not cause him any injury. Admitted to Green Parks House under Section 3.
1 February 2012	Mr L was discharged from Green Parks House to Woodham House a 24 hour staffed care home as he could not return to his previous accommodation. He agreed to take Clopixol depot 250 mg monthly as well as Promethazine tablets at night to help him sleep.

Date	Information
8 May 2013	Mr L's care coordinator delivered four weeks of medication. This was to be the last appointment with his care coordinator who was leaving the team. Introduced to his new CCO and support worker.
18 May 2012	Whilst on holiday with his parents Mr L described feeling paranoid and fearful of his safety. On return he was admitted to Green Parks House. The frequency of the Clopixol injection was increased to weekly. Mr L was discharged on 31 May 2012 back to his supported accommodation.
2 June 2012	Mr L was readmitted to the same ward three days later on 2 June 2012. He was accompanied by his Care Coordinator, (CCO 1) for admission as he was hearing voices. He complained of feeling persecuted by others, that the movement of his hands was being controlled and of auditory hallucinations. He was discharged on 28 June 2012.
4 July 2012	Mr L was admitted informally to Norman Ward, Green Parks House on 4 July 2012. He presented with delusions of reference and hearing voices making derogatory comments about him. He also admitted to drinking at least four cans of beer a day, and had been drinking consistently since his discharge six days before, and admitted smoking cannabis with friends. He was discharged back to Woodham House, with follow up from his CCO and the ACT.
7 December 2012	Admitted to Norman Ward with an exacerbation of psychotic symptoms which had worsened following a single bout of heavy drinking. He presented with auditory command hallucinations, paranoid delusions, thoughts of reference from the TV and some suicidal ideation. He settled well and complied with his medication. He was discharged on 28 December 2012.
13 June 2013	The associate specialist visited Mr L at home and Mr L stated that he was drinking 2 or 3 times a week and was consuming 2 or 3 bottles of beer each time. Mr L put the improvement in his mental state to Quetiapine. The associate specialist's impression was 'Partial remission of psychotic symptoms, related to good medication concordance and controlled intake of alcohol. Good functional recovery demonstrated'.
19 August 2013	Mr L telephoned the associate specialist with concerns that he may be developing side effects of Quetiapine as he had woken in the night unable to breathe. Mr L had already contacted his GP and was awaiting the results of an ECG. Mr L stated that he did not want to stop taking Quetiapine as it helped with his mood. It was agreed to reduce the dose of Quetiapine (to 500 mg) and follow up the ECG results.
October 2013	His CCO left the team and a community nurse became his new care coordinator with a plan that she would see him fortnightly. It is noted that Mr L was seen by the CCO for face to face contact on 4 occasions between 25 October 2013 and his admission on 2 December 2013.
8 November 2013	Mr L cancelled his appointment with his care coordinator (CCO). He was seen on Monday 11 November when he presented as stable however on Friday 15 November 2013 Mr L's father phoned and reported that Mr L had been drinking heavily.

Date	Information
20 November 2013	The Environmental Health Technical Officer received a complaint from a neighbour of Mr L's who was not the victim, stating that Mr L was playing music late at night on a regular basis. The complainant was provided with log sheets to document their concerns and the officer received these on 22 November 2013. Mr L denied drinking when he was seen by his CCO on 26 November 2013 at which time she described Mr L as presenting as stable in mental state, although he appeared slightly 'hyper'.
28 November 2013	The Environmental Health Technical Officer contacted the neighbour who raised the complaint and also the Town and Country housing manager. The Town and Country manager informed the Environmental Health Technical Officer that he had also received complaints about noise from Mr L's accommodation. He had written to Mr L and would be visiting him on 29 November 2013. The Environmental Health Technical Officer left a telephone message for the housing support worker and spoke to the CCO who informed him that Mr L had capacity.
2 December 2103	Mr L was sent a standard 'noise one letter' from the Environmental Health Technical Officer. The letter did not give the name of the complainant and stated that if the situation did not improve a formal investigation would be conducted. The contact details for housing support worker were provided to the complainant and the case was then closed.
2 December 2013	Mr L was admitted to Betts Ward, Green Parks House again in response to auditory hallucinations and persecutory beliefs, as well as reports of criminal damage to his mother's car. Prior to this admission there had been a protracted period of unsettled behaviour, housing issues and alcohol use.
4 December 2013	Transferred to the PICU following an assault on another patient on Betts ward with a hot drink.
12 December 2013	The AOT associate specialist, AS 5, (who was Mr L's treating psychiatrist whilst in the community until his admission to hospital), sent an email to the PICU consultant psychiatrist copying this to the AOT consultant psychiatrist and the CCO including his impression that Mr L was presenting as 'high' and 'dissocial'. His impression noted that he was 'more inclined to see Mr L as having a schizo-affective presentation with dissocial traits which are exacerbated at time of manic relapse'. The associate specialist regarded Mr L as having a high risk of violence which was significantly increased in the context of relapse.
20 December 2013	Following a request by CP1 to CP2 for a forensic opinion a report on this was provided on 6 January 2014. CP2 concluded that Mr L required a protracted admission but acknowledged that he may improve on the PICU. However, she also stated that 'we all need to use our skills together and make it more stable for this man in the community'. She did not however, feel he needed Medium Secure care and requested an opinion from CP3, for Low secure services.
9 January 2014	The AOT associate specialist psychiatrist (AS5) (following receipt of the forensic psychiatrist's report) emailed The PICU psychiatrist

Date	Information
	(CP1) stating that whilst he wouldn't go as far as diagnosing a personality disorder, Mr L had underlying traits of narcissistic and anti-social personality disorder which were exacerbated through alcohol use or relapse. AS5 also stated that a protracted admission to low secure services would not be certain to affect overall the prognosis. In response to the email CP1 emailed the consultant psychiatrist at AOT, CP4, the associate specialist (AS5) and the forensic psychiatrist (CP3) stating that a protracted admission to PICU was contraindicated and may be challenged by the commissioners. He also stated that anger management and psychological work may not be possible in the community and alcohol was also a problem. CP1 felt that Mr L should go on the waiting list for low secure services and if the wait was longer than eight weeks then consideration of a pathway through acute services would be examined.
21 January 2014	At the ward round on The PICU , the team agreed that the best option was transfer to low security and that Mr L and it was noted that his family agreed.
26 January 2014	A report by his nurse for the Mental Health review tribunal (one month prior to discharge) states that Mr L was still irritable and threatening but was not displaying violence. He was noted to have 'threatened to spill blood' if not allowed to go home at Christmas. Mr L's behaviour towards others was described as irritable, abusive and aggressive and was noted to be intimidating on the ward. He was noted to have screamed and shouted and often had unprovoked altercations with fellow patients. However, he was also noted to be able to interact appropriately.
27 January 2014	CP3 provided details of the requested assessment, including an interview with Mr L on 15 December 2013 (nine days after having Mr L was interviewed by CP2) and concluded that; 'It is my view that [Mr L's] mental state requires further stabilisation. He has a significant history of repeated admissions to hospital precipitated by alcohol misuse, non-compliance with medication, and psychosocial stressors. He has limited insight into his illness and in particular, in relation to his alcohol misuse. It appears that his violent behaviour is a result of psychotically driven beliefs'. CP3 report also stated 'I believe he would benefit from a period of rehabilitation at the Memorial [low secure service] to address these issues. It is hoped that he would engage in psycho education groups, relapse prevention and offending behaviour work. He would also be able to engage in a rehabilitation programme and/ or work roles for us to provide him with a structure following discharge from hospital. It is also noted that Mr L only partially engaged in the assessment, left the room and refused to answer any further questions.
18 February 2014	At the ward round the plan was agreed that Mr L would remain on Section 3 MHA, continue with hourly observations, and he would be seen again by the forensic psychiatrist.

Date	Information
20 February 2014	Mr L was seen by CP3 and a staff nurse from low secure services, who reported in RiO that Mr L had significantly improved, was very reflective, and that the AS 5 understood what the issues were in terms of care and treatment and would be communicating with Bromley AOT regarding his potential discharge.
26 February 2014	The AOT consultant, CP 4, had discussed Mr L's discharge with CCO 2. The possibility of a Community Treatment Order (CTO) was discussed. It was agreed that given his improved insight and compliance, he would be transferred to the rehabilitation stream of the AOT, without a CTO.
28 February 2014	He was discharged following a discharge meeting attended by Mr L and his mother. Also in attendance were consultant psychiatrist CP1, Specialist registrar, occupational therapist, support worker and CCO.
28 February 2014	Mr L and his father attended a meeting with the psychologist PS 7 and was described as an informal meeting and that no formulation was developed.
28 February 2014	The final CPA / discharge meeting took place on the day of discharge and the entries related to this are entered retrospectively on 7 March 2014 by CCO 2, 21 March by CP3, and 7 March 2014 by CP 4, the AOT Consultant Psychiatrist.
28 February 2014	Mr L was discharged from the PICU on 28 February 2014 without an agreed formal care plan, as this was to be discussed and agreed with his new consultant psychiatrist, CP4, on the Monday following his weekend discharge. The arrangements for the weekend were contained in a brief plan of action which included a telephone number for him to contact in the event of a crisis but no further treatment or management plans other than his proposed meeting.
28 February 2014 – 1 March 2014	It is known that Mr L stayed at his parents' house on the Friday 28 February, saw his child on Saturday 1 March 2014 and then returned to his flat that evening.
2 March 2014	Mr L called the police to inform them that he had killed his neighbour (71-year-old). Mr L was arrested by police at his flat, and taken to Bromley Police Station custody suite where he made various admissions to the offence. On 3 March 2014 Mr L was charged with murder and remanded at Bromley Magistrates court.

Appendix D – People interviewed

Role and organisation	Pseudonym
Consultant Psychiatrist at the PICU	CP1
Forensic Consultant Psychiatrist at the Bracton Centre	CP2
Forensic Consultant Psychiatrist Low Secure Service	CP3
Care Coordinator from ACT	CCO
Clinical Psychologist from ACT	PS7
Ward Manager, the PICU	No pseudonym
Named Nurse, the PICU	No pseudonym
Mr L	No pseudonym
The neighbours of Mr L involved in the complaints about noise and anti-social behaviour	No pseudonym
The Environmental Health Technical Officer	No pseudonym
Housing Manager from Town & Country Housing	No pseudonym