



# INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF MR G

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# **1 EXECUTIVE SUMMARY**

**1.0** On 17 July 2012, Mr G attacked Mr H in what appears to have been an unprovoked and sustained attack. Mr H died of his injuries. Prior to the attack on Mr H, Mr G did not have a history of significant violent behaviour in the past. In fact, there was very little to distinguish him or to highlight him as being unusual or dangerous or, indeed, someone who professionals should keep under supervision so that they knew where he was, both in relation to the harm which he might pose to himself, as well as the harm which he could pose to others.

## **1.1 Care and Treatment (28 September 2011 – 20 October 2011)**

**1.2** Between 28 September 2011 and 20 October 2011, Mr G had received care from Camden and Islington NHS Foundation Trust ('the Trust') in the Laffan Ward at St Pancras Hospital ('the Hospital'). He had been detained in accordance with Section 2 of the Mental Health Act 1983 to allow for the assessment and treatment of his psychotic illness.

**1.3** A Care Plan was developed for Mr G which accorded with NICE Guidelines relating to schizophrenia. Aspects of his Care Plan constituted good practice, including the gathering of a significant amount of information about Mr G's past medical history and the inclusion of his family in the planning of his care.

**1.4** During his stay on the Laffan Ward, Mr G did not exhibit any signs of violence towards himself or others.

**1.5** Further, during the course of interviews conducted by the Independent Investigation Team, a member of the clinical team at the Laffan Ward made the following comment concerning Mr G's presentation:

*[Even] in the acute presentation. He didn't come across as being a behaviourally-disturbed individual. .... you could have, in some ways, a rapport with him, because he presented, in many ways, just as an, in inverted commas, 'normal, everyday person'.*

## **1.6 AWOL (Absent Without Leave) (20 October 2011)**

**1.7** As part of Mr G's care, he was allowed to take periods of escorted leave from the Laffan Ward. Periods of leave from hospital are a recognised and essential part of helping a patient recover from illness. Mr G had previously had several episodes of escorted leave during his stay on the Laffan Ward. These episodes had previously passed without incident.

**1.8** During a period of escorted leave on 20 October 2011, Mr G absconded. There are several accounts of how this occurred, and the accounts differ. It is not clear which version is accurate. A contemporaneous record of what happened was not made or inserted into Mr G's records. Mr G has stated that he absconded when his escort went to the toilet whilst on escorted leave. Accounts in the Discharge Summary, Internal Investigation Report, and Police records differ from this.

- 1.9** Mr G later said that he had absconded because he did not feel that the care which he was receiving was of benefit to him. However, on the day that he absconded, he was told by those caring for him that a recommendation was to be made to apply for an Order under Section 3 of the Mental Health Act 1983 that could have resulted in a longer stay in hospital with a view to him receiving treatment.
- 1.10** It is not acceptable that a contemporaneous record of the circumstances concerning Mr G's absconsion is not contained in Mr G's records and that there is a significant discrepancy between information contained in the Police records relating to the absconsion and the reports given in the Trust's Serious Untoward Incident (SUI) report.
- 1.11** In relation to Mr G's leave, the Independent Investigation Team has noted breaches of the Mental Health Act Code of Practice (2008):
- The outcomes of Mr G's leave were not always recorded.
  - The circumstances of Mr G absconsion whilst on leave were not recorded in his notes.
  - No up-to-date description of the patient was recorded in Mr G's notes following his failure to return from leave.
  - Mr G's absconsion whilst on leave not reviewed or analysed, and no lessons were learnt.
- 1.12** The Independent Investigation Team regards this as significant because patient care has potentially been impacted. In addition, the information which the Trust is required to provide to the Care Quality Commission ('CQC') in the form of data about AWOL incidents was compromised. Further, the Trust's ability to learn from Mr G's departure from the Hospital in order to identify and reduce the risk of going missing was lost until after Mr G had committed a homicide, despite other patients going AWOL and failing to return.
- 1.13 Post AWOL Actions (20 October 2011- 17 July 2012)**
- 1.14** Following Mr G's departure from the Hospital while on escorted leave, the team on the Laffan Ward remained in contact with Mr G's family, who provided the Trust with information as to Mr G's location whilst his Section 2 Order was still valid. They contacted the Police.
- 1.15** The Police were aware that Mr G was the subject of a Section 2 Order, which was due to expire on 25 October 2011. Mr G's family advised the Trust that Mr G was using a different mobile number, and that he was at a specific hostel. This information does not appear to have been passed to the Police, as it is not recorded in the Police records, although the Trust itself tried to call Mr G. It is not clear to the Independent Investigation Team, therefore, why, having taken a decision to contact the Police at a time when they would have had power to return Mr G, the Ward did not appear to pass key information on.
- 1.16** Mr G's Section 2 Order expired on 25 October 2011. This is not to say that Mr

G could not have been detained once more. However, prior to any further detention, a Mental Health Act assessment would have had to have taken place in accordance with the terms of the Mental Health Act 1983, and Mr G would have had to have fitted the criteria for detention in accordance with Section 2 of the Mental Health Act 1983 at the time of assessment.

#### **1.17 Discharge from Care (28 October 2011)**

**1.18** Mr G was discharged on 28 October 2011 in his absence.

**1.19** The Discharge Summary prepared following Mr G's departure from the Laffan Ward was appropriate. However, it lacked depth which could have provided Mr G's future clinicians with additional information, thereby improving continuity of care.

**1.20** It failed to address non-adherence other than superficially. In addition, there was little in the discharge plan about the content of Mr G's psychotic symptoms, in particular the fact that he sought vengeance against people who he believed to have sexually assaulted him. This was a psychotic delusion. The identification of this as a delusion in the Discharge Summary could have alerted clinicians including GPs who he later consulted that this area required further exploration in its respect as a factor which indicates relapse.

#### **1.21 Return to Hospital (Date unknown)**

**1.22** Shortly after his disappearance from the Laffan Ward on an unknown date, Mr G has reported that he returned to the Laffan Ward to collect his belongings, including a passport which had been placed in the Nurse's Office. Mr G recognised some of the staff members responsible for his care. His return to the Hospital is not documented in his notes, and there are no records available relating to Mr G's property to confirm how his passport was returned to him. His return to the Hospital is, however, referred to in the Police records.

**1.23** The Independent Investigation Team wishes to express significant concern about the lack of documentation which is available concerning Mr G's reported attendance at the Hospital to collect his belongings, including his passport. The absence of any records of this attendance from the Trust records was caused by the failure of a number of policies at clinical and administrative level together with failings in individual responsibility. This is a significant concern for the Independent Investigation Team.

#### **1.24 Care in London (21 February 2012 – 5 March 2012)**

**1.25** Mr G's discharge plan was sent to his existing GP in London ('London GP 1'). It was assumed by clinicians at the Laffan Ward that primary services would be likely to come into contact with Mr G, and it was deemed important that those services had access to information relating to Mr G's stay in hospital. Further, it was hoped that London GP 1 would be able to refer Mr G to a Community Mental Health Team ('CMHT') for further treatment.

**1.26** However, following his discharge, Mr G registered with another GP practice in London. Mr G's GP at this practice ('London GP 2') initially did not have access

to his Discharge Summary, but was contacted by the Fixated Threat Assessment Centre ('the FTAC') in London. The purpose of the FTAC is to assess and manage the risks from individuals who harass, stalk or threaten public figures.

- 1.27 The FTAC had become aware of Mr G as a result of having been contacted by the Police.
- 1.28 London GP 2 was advised by the FTAC that Mr G had previously absconded whilst he had been admitted as a formal patient. London GP 2 was also told that Mr G had made attempts to obtain a gun and indeed may have purchased a deactivated gun. A deactivated weapon would not normally be capable of being used as a firearm and is not the subject of the same legal restrictions as an active firearm.
- 1.29 Following a conversation with the Fixated Threat Centre, Mr G's records show that London GP 2, attempted to engage with Mr G, and took the initiative to liaise with London GP 1 in order to find out more about him. London GP 2 was subsequently provided with a copy of the Discharge Summary by London GP 1, but Mr G failed to attend a double appointment which had been booked for him with London GP 2.
- 1.30 The Independent Investigation Team has identified several elements of good practice from both of Mr G's London GPs. They attempted to build a rapport with Mr G, liaised with one another, and shared key information relating to his care. Neither GP was in a position to make an effective referral to psychiatric services because Mr G did not fully engage with them.
- 1.31 During the period in which Mr G remained in London, he came to the attention of the Police. If the Police believe that an individual has a mental illness and is in need of care they can use Section 136 of the Mental Health Act 1983 to take that individual to a place of safety if they are in a public place for assessment of their mental health. A place of safety can be a hospital or a police station. The Police did not exercise their powers under Section 136 in relation to Mr G during any of their contact with him.
- 1.32 **Care in Bournemouth (11 April 2012 – 17 July 2012)**
- 1.33 During June 2012, Mr G presented at a number of primary care providers in the Bournemouth area with persecutory ideas including having had drugs put in his food and having been injected with drugs.
- 1.34 Initially, Mr G registered with Bournemouth GP Practice 1. As a result of his registration with this practice, Mr G's GP records containing information relating to his previous mental health issues were successfully transferred to Bournemouth GP Practice 1 and, in addition, Bournemouth GP Practice 2 through GP2GP. This would have allowed clinicians access to the information contained in the Discharge Summary prepared following Mr G's departure from the Laffan Ward in London together with the information provided by the Police and FTAC that Mr G had attempted to borrow a gun from a gun club and had purchased a deactivated gun some months earlier.

- 1.35** However, Mr G's poor insight and distrust of mental health services meant that he contacted a number of different GPs, which caused difficulties in relation to continuity of care. It is clear from Mr G's records that whenever a GP suggested that there might be a non-physical aspect of his presentation, Mr G would become more reluctant to engage. Mr G failed to return to either the practice or the GP in order to allow an assessment of his mental health to be undertaken and a referral to secondary mental health services made.
- 1.36** In order to secure Mr G's assessment over a period of three months, different GPs in Bournemouth had tried to engage and support Mr G. The GPs dealt with Mr G on a regular basis rather than referring him on in an attempt to build a relationship with him as far as Mr G would allow them. In the absence of a documented history of risk posed by Mr G to himself or, indeed, the risk which he posed to others which would have warranted immediate referral to secondary mental health services, this was an appropriate way in which to manage Mr G at that time.
- 1.37** At the time of the attack on Mr H, Mr G had approached GP Practice 3 as a temporary resident. The records of temporary residents are not transferred through the GP2GP system. Consequently, the referral made by GP Practice 3 to CMHT 1 on 26 June 2012, was made without the benefit of any of Mr G's records.
- 1.38** Whilst confusion surrounded Mr G's use of temporary registrations, different names, and different addresses, the CMHT promptly accepted his referral. This flexibility is an element of good practice.
- 1.39** Whilst the GPs who were in contact with Mr G at this time were concerned about Mr G, and recognised the possibility that his symptoms may have been generated by a 'psychiatric problem', his presentation does not appear to have raised concerns about his capacity to make decisions about his healthcare. If a competent individual declines a referral to secondary mental health services, then the practitioner's duty of care extends to taking whatever steps are possible, within the confines of the individual's wishes, to ensure that the individual has made their decision knowing the consequences of their actions.
- 1.40** Capacity may be affected by chronic disorders such as psychosis. However, a mental disorder does not automatically make someone incapable of making health-care decisions nor does it of itself justify compulsory admission under the Mental Health Act. Before any steps can be taken by law, an assessment must be carried out.
- 1.41** There is no evidence contained in Mr G's GP records that suggests that Mr G lacked capacity at this time. CMHT 1 and GPs from Bournemouth GP Practice 3 did discuss whether assessment in accordance with the Mental Health Act 1983 was indicated on 16 July 2012. This was discounted because Mr G appeared '*too well*'. However, the comments made by clinicians at the Laffan Ward are relevant in this regard.
- 1.42** Based on the evidence contained within Mr G's records, whilst further assessment of Mr G's presentation was indicated, there is no evidence

contained in Mr G's records that indicates that the statutory test set out in Section 2 of the mental Health Act 1983 for detention would have been satisfied at this time.

**1.43** CMHT 1 made assertive attempts to contact Mr G and seek his engagement. Mr G had been contacted by phone on a number of occasions and had also been sent an appointment letter.

**1.44** As a consequence of the conversation between CMHT 1 and Mr G on 16 July 2012 when Mr G indicated that he did not wish the involvement of CMHT 1, a plan was made to discuss Mr G at an upcoming CMHT meeting. Consequently, his referral was not closed and indeed Mr G's presentation was to be reviewed allowing consideration of issues such as safeguarding, capacity and risk assessment to be discussed and explored. However, the attack on Mr H took place before this meeting could happen.

#### **1.45 Predictable / Preventable**

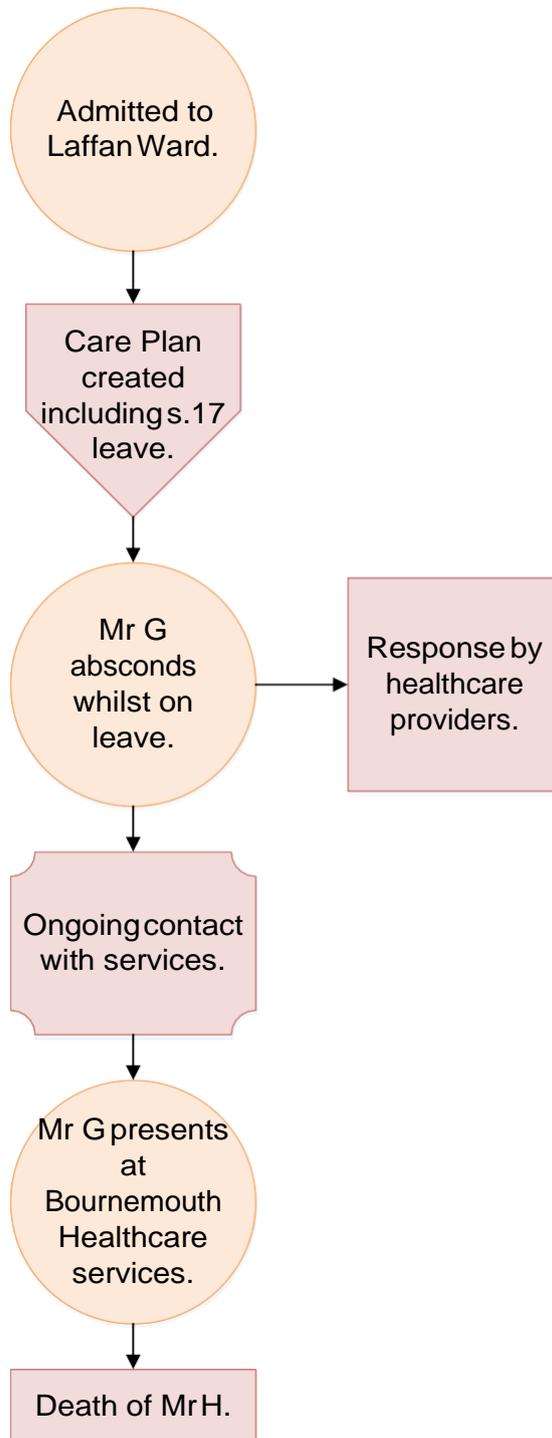
**1.46** The Independent Investigation Team believes that it was not predictable that Mr G would commit a significant act of violence such as the attack which led to Mr H's death prior to 17 July 2012. The Independent Investigation Team believes that it was predictable that Mr G could have become involved in fights, fall out with people, and the disagreement could escalate to the point where he came to the attention of the Police or secondary mental health services. However, the Independent Investigation Team has concluded that the attack on Mr H which led to his death was a significant escalation in violence which was neither predictable nor preventable.

#### **1.47 Internal Investigation**

**1.48** The Internal Investigation was only triggered once the Police alerted the Trust of the death of Mr H. No incident form as required by Trust Policy at the time was completed. This is a matter of concern given that this category of AWOL incident, i.e. the absconsion of a detained patient who did not return, falls into the most serious category of absconsion AWOL incidents.

**1.49** The Internal Investigation did not investigate many key issues, possibly due to a lack of information. The Trust failed to consider or include common themes in mental health homicide highlighted in the Terms of Reference.

**1.50** Crucially, the limited information available to the Internal Investigation led to the conclusion that the problems with record-keeping were isolated incidents of limited significance rather than being a systemic issue. Given the numerous failings with records in this case and the concern which this raised over the ability of the Trust to manage the care given, the Independent Investigation Team would disagree with this conclusion.



## **2 RECOMMENDATIONS**

**2.0** The Independent Investigation Team makes the following recommendations, for the reasons which follow in the main body of the report.

### **2.1 Recommendation One:**

**2.2** The failure to document Mr G's re-attendance at the Laffan Ward when he attended to collect personal possessions, whether in his medical records or, indeed, in the Property Logs (which are an integral part of NHS care at a practical level) is a matter of significant concern. This is because it represented an opportunity to assess his mental health and associated risk. It represents an example of poor practice, which potentially could have had an adverse impact on patient care.

**2.3** For Mr G's attendance to have been absent entirely from the Trust records required the failure of policies at clinical and administrative level together with failings in individual responsibility. This is a significant concern for the Independent Investigation Team.

**2.4** Good record-keeping is a prerequisite to delivering high-quality healthcare. The main purpose of any record is to improve communication and provide continuity of care. However, medical records are also used for other purposes, including the ability to audit and review individual and organisational performance. If the failings in recording information in relation to Mr G's care were replicated across the Trust, this could have a detrimental impact upon the information which was available to the Board when making decisions.

**2.5** The Independent Investigation Team therefore recommends that:

- The Trust reviews its policies and procedures in order to ensure that clinicians and staff are aware of the occurrence of, and can act appropriately upon the return to the hospital of, an individual who had been AWOL. In particular, the Trust shall:
- Review its policies to ensure that all policies which relate to the return of a patient to hospital (including the AWOL policy, safeguarding and property policies) interlink, with a view to highlighting the opportunity that a patient's return to hospital presents to allow services to conduct any necessary clinical reviews of that patient.

### **2.6 Recommendation Two:**

**2.7** Good clinical records are a prerequisite to delivering high-quality, evidence-based, healthcare. This is particularly so where a number of different clinicians are contributing to patient care simultaneously. Unless everyone involved in clinical management has access to the information they require, duplication of work, delays, and mistakes become increasingly likely.

**2.8** All medical records should be validated once completed to ensure that full medical records can be viewed by future clinicians, and other services, such as

the Police. Potentially, this could have had a significant impact on subsequent legal proceedings in this case. For example, expert evidence based on a set of validated records would not have had the benefit of the additional information contained in the 'unvalidated' records, and this potentially could have impacted upon opinions reached in Court proceedings and, indeed, on the ongoing care of Mr G.

**2.9** The Independent Investigation Team recommends that the significance of validating records is highlighted in record-keeping policy, and in training.

**2.10 Recommendation Three:**

**2.11** The decision-making process through which Mr G appears to have been granted leave, and the practicalities surrounding how leave would be executed, are undocumented. For example, in one episode, a condition of Mr G's leave was that he had an escort. However, the rationale for this is unclear, as are important components of the leave, such as the frequency and duration of each leave period.

**2.12** The Mental Health Act Code of Practice (2008), at paragraph 21.21, states that any leave authorised, and any conditions which are attached to that leave, should be recorded. This was not done in Mr G's case. This code was superseded in 2015, but the same expectations effectively still apply today.

**2.13** This represents a disappointing omission in record-keeping, as it represents multiple practitioners not correcting the omission, and acting on an incomplete leave prescription.

**2.14** The Independent Investigation Team recommends that the Trust address the prescribing of Section 17 leave in Mental Health Act training.

**2.15** The Trust must ensure that its staff and clinicians comply with the requirements relating to "leave" as set out in section 17 Mental Health Act 1983. The Trust shall provide an assurance that the training afforded to staff will ensure that the Trust complies with all requirements relating to the prescribing of Section 17 leave.

**2.16 Recommendation Four:**

**2.17** Good medical records (whether electronic or handwritten) are essential for the continuity of care of patients. Recommendation two above refers to the need for 'validation' of electronic entries in order to ensure that all information which has been recorded by clinicians is available to assist in the ongoing care and treatment of an individual.

**2.18** In relation to Mr G's leave, the Independent Investigation Team has noted breaches of the Code of Practice as a result of information being omitted from Mr G's medical records despite its clinical relevance:

- The outcome of Mr G's leave was not always recorded;

- The circumstances of Mr G's absconion whilst on leave was not recorded in his notes;
- No up-to-date description of the patient was recorded in Mr G's notes prior to him going on leave; and
- Mr G's absconion whilst on leave was not reviewed or analysed, and no learning could be considered.

**2.19** The Independent Investigation Team regards these omissions as significant for the following reasons:

- Firstly, because patient care has potentially been impacted.
- Secondly, the omission of the circumstances of the leave (where he finally absconded) impacted the Independent Investigation.
- Also, the data which the Trust is required to provide to the CQC in the form of data about AWOL incidents was compromised. This issue was not considered in the Internal Investigation Report.

**2.20** The Independent Investigation Team recognise that the Trust has made considerable improvements to its systems regarding the recording of leave. In order to ensure that the learning from Mr G's care and treatment has become embedded in current practice as a result of the Trust's amended systems and processes regarding leave and absconion, it is recommended that:

**2.21** In order to comply with its obligation to inform the CQC of unauthorised absences relating to patients who are the subject of detention under the terms of the Mental Health Act 1983, the Independent Investigation Team recommends that the Trust undertake an audit to ensure that its internal recording requirements are adhered to in relation to those patients who are the subject of detention under the terms of the Mental Health Act 1983 , in order to ensure that the following information is being recorded in patient's records;

- Outcome of leave is being recorded; and
- Details surrounding any absconsions during leave are recorded; and
- Absconsions are then reviewed from a clinical perspective.

### 3 INTRODUCTION

- 3.0 Mr H was living and working as a waiter at the time of his death. He had recently moved to the United Kingdom from Spain in order to improve his English and employment prospects. Mr H and Mr G shared rented accommodation in Bournemouth between May 2012 and 17 July 2012.
- 3.1 Mr H was fatally stabbed by Mr G on 17 July 2012. Following his death, Mr G decapitated and disembowelled Mr H's body.
- 3.2 The psychiatrists who gave evidence at Mr G's trial were all of the opinion that Mr G suffered from a major mental illness in the form of paranoid schizophrenia at the time of Mr H's death. As part of his illness, Mr G experienced delusional beliefs that he was the subject of persecution from a gang who wished to torture and harm him. Mr G believed that Mr H was connected to that gang.
- 3.3 On 2 December 2013, Mr G entered a plea of guilty to manslaughter by reason of diminished responsibility in relation to the death of Mr H. This plea was accepted. Mr G was sentenced to life imprisonment. The minimum term which the Judge Ordered him to serve was six and a half years. In addition, the Judge made a Direction under Section 45A of the Mental Health Act 1983. The effect of this Direction is that should Mr G's mental health improve within six and a half years, he would serve the remainder of his sentence in prison, rather than being released. Mr G continues to receive high security care in Broadmoor Hospital.
- 3.4 In the period between 27 September 2011 and 17 July 2012, Mr G was in contact with services delivered by the NHS, including mental health services. As a result, NHS England have commissioned an Independent Investigation Team Report in accordance with HSG (94) 27 in order to maximise the learning for the NHS from the tragic death of Mr H. This report sets out the findings of the Independent Investigation Team
- 3.5 In the criminal proceedings which followed the death of Mr H, Mr G was convicted of manslaughter by reason of diminished responsibility.
- 3.6 Although Mr G's guilty plea was successful, the Court was not willing to accept that Mr G could completely absolve himself of responsibility for the death of Mr H. To explain this conclusion, the Court highlighted that Mr G was aware that he had psychiatric issues but actively avoided treatment for his condition. Mr G also continued to live in the same property as Mr H for a significant period of time, despite experiencing untreated delusions that Mr H posed a threat to him.
- 3.7 These factors increased the level of risk which Mr G presented, and the Court was not willing to accept that Mr G was incapable of understanding these risks. Indeed, the Court believed that Mr G had demonstrated attempts to deflect responsibility for his actions after the killing, as well as having insight into the consequences of his attack on Mr H. The Court therefore concluded that:

*'[Whilst] substantially reduced, your responsibility remains significant'.*

- 3.8** A direction was made to admit Mr G to hospital under Section 45A of the Mental Health Act 1983, and to place him under an indefinite restriction in accordance with Section 41 of the same Act. In addition, Mr G was sentenced to life imprisonment with a minimum term of six and a half years.
- 3.9** The effect of this is that Mr G's responsible clinician will need to obtain permission from the Secretary of State for Justice before Mr G can be discharged from hospital. If discharged from hospital, Mr G would be transferred to prison for a term of no less than six and a half years. The Court stated that:
- '[The] public now has the double protection provided by the Mental Health Act and the involvement of the Parole Board. You will be detained for at least six and a half years but will not be released unless the relevant authorities conclude that it is safe to do so'.*
- 3.10** It should be emphasised that the sentence for manslaughter is discretionary in cases which involve a successful plea of diminished responsibility. Where detention is deemed appropriate, it is most commonly the case that admission to hospital will be deemed sufficient in itself, with no additional sentence relating to incarceration
- 3.11** Mr G's decision to consciously avoid treatment after October 2011 was viewed as a significant factor by the Court in finding some degree of insight and, therefore, of culpability.

## 4 VICTIM IMPACT STATEMENT

- 4.0 Mr H was an individual who was much loved and valued by those who knew him. His death has caused ongoing and deeply felt pain and suffering to his family and friends. The Independent Investigation Team appreciates that the traumatic grief which follows a homicide is intense and long-lasting, and affects a wide range of individuals connected with the event. The necessity of dealing with an Independent Investigation Team is an additional source of stress for those bereaved by a homicide.
- 4.1 Whilst this report will focus on the care received by Mr G, it is important to highlight the fact that that Mr H lost his life as a result of Mr G's actions on 17 July 2012.
- 4.2 The Independent Investigation Team contacted Mr H's mother to allow her an opportunity to comment upon the terms of reference in order that her concerns about Mr G's care be taken into account. Mr H's mother provided the Independent Investigation Team with the statement below:

*'When Mr H was born so full of life, his mother fell in love with him, making everything else in her life feel unimportant because he completed her life. In Mr H's first year of life, his father left them and never saw him again. He disappeared from his life. Mr H grew up with his mother, his maternal grandparents and his uncle who acted as a father figure in his life. At ten months old he started walking and that his how started to walk through life, filling all of those that were lucky enough to know him with happiness and peace. His mother worked very hard for him, in order to pay for his studies and Mr H learned to be very responsible and to care for his mother. They were not wealthy, but love substituted everything else and they never needed for anything. As well as mother and son, they were best friends and looked after each other. When he was young Mr H did not stop repeating 'I want to be happy'. He achieved this. His mother could not have been any prouder of him and could not help noticing peoples envy for her having Mr H. A gift from heaven. Her whole life...*

*'He cut Mr H's life short, a boy that only wanted to work, learn, help others, enjoy the life that god had given him and make everybody that new him happy. He had such a beautiful life. He wanted to be a father. He wanted three children, he used to say filled with excitement...*

*Mr H had everything, he was handsome, happy, kind, healthy, responsible, fun, polite and he knew how to enjoy himself without hurting anybody. A lot of virtue in one person, a person who is impossible to replace'.*

- 4.3 Mr H's mother has also stated in relation to what her son told her about Mr G:

*'Mr H lived in a flat, sharing with good people, but also among them was a person who raised his suspicions. He said to me: 'Mom, there's a man who seems strange, but do not worry, I do not think he is a bad person'.*

**4.4** Mr H's mother has also explained her pain following the death of her son. These excerpts have been translated from Spanish:

*'I knew my family was hiding from me the true and tragic death of my son. I learned about it much later, and every time I think of how my son had to suffer at the hands of the author of his death. What was the last thing he saw? Those beautiful eyes seeing such cruelty; the cruelty that claimed his life. How long did the attack take, so brutal, and he felt his life slipping away like water through his fingers? I cannot think, but I cannot get it out of my head, and that's destroying me. Thinking of the agony of my son, now conveyed to me, is killing me slowly.*

*'I knew everything when my big brother, advised by my partner, no longer trying to protect me, decided to tell me. And so I knew how Mr H actually died, and what Mr G did with the body of my son.*

*'British Police travelled to Spain several times to bring me news of their research and sent me Mr H's belongings. I could not look at them, because I would see his clothes, their roles, their memories... but Mr H never came with them. For every piece of clothing I took from his suitcase, my heart died a little more.*

*'What this man did to my son, it's like he has done it to me as well. He murdered my son, and killed me at once; worse, he let me live to suffer the death and subsequent absence of my son.*

*'My son, who still had a nice life ahead of him, with beautiful projects and hopes cut short.*

*'The only consolation I have, if you can define it that way, is knowing that justice will put every person in the place they deserve. And that somehow I could know that the authors of such horrendous events will repay all the damage that has been inflicted on my son, my family, and me especially. But I think there is no possible way to pay for this crime in the course of a lifetime, so horrible and inhuman, that has been committed on my dear son. Anyway, I have no words that can make you see the real damage this has caused me. I do not know if you're a parent but I'm not asking for anything out of revenge, anger or the huge vacuum that fills my being. It is for justice and justice simply, which is all I have left in this life'.*

## **5 INVESTIGATIVE APPROACH**

- 5.0** The aim of the Independent Investigation Team in conducting this Investigation is to improve the delivery of mental healthcare services for individuals such as Mr G who suffer from schizophrenia in Camden, Bournemouth, and more widely and to try to help reduce the risk of a tragedy such as the death of Mr H happening in the future.
- 5.1** The Independent Investigation Team has taken care to minimise the impact of '*Hindsight bias*' in its consideration of the care and treatment of Mr G.
- 5.2** '*Hindsight bias*' is when individuals who know the outcome of an event overestimate its predictability or obviousness, compared to the estimates of individuals who do not know the outcome and who must guess without the benefit of advance knowledge. Hindsight bias can creep into an investigation in a number of ways including the distortion of recollections, or the belief that an event was inevitable or could have been foreseen. Ultimately, hindsight bias matters because it can distort learning from experience. Hindsight bias can be reduced when people stop to think carefully about the causes of the incident. It is also important to consider how other things could have happened in the chain of events. Consequently, the Independent Investigation Team has sought to look at and concentrate upon the facts available to those caring for Mr G at the time key decisions were made, in order to extract the greatest amount of learning for the NHS.
- 5.3** In order to emphasise how care can be delivered differently and possibly to an improved standard, the Independent Investigation Team has attempted to identify the key decisions, including clinical and non-clinical decisions taken, in relation to Mr G's care between 27 September 2011 and 17 July 2012.
- 5.4** Each of these decisions has then been considered in the context of either the applicable Guidelines in place at the time of Mr G's care, or, alternatively in relation to an applicable Trust procedure.
- 5.5** The Independent Investigation Team has sought to align its consideration and analysis of the decision-making process with The Essential Standards of Quality and Safety set by the CQC. Barriers to compliance with Guidance/Policy/CQC Standards such as communication or lack of multi-agency cooperation have been identified where relevant.
- 5.6** The Independent Investigation Team has then sought to identify whether the manner in which the NHS sought to extract the learning from Mr G's care delivered learning at an individual and Trust level for those directly involved in providing care for Mr G, with a view to enhancing the manner in which individuals and the organisations involved provided future care for an individual such as Mr G.
- 5.7** The Terms of Reference of the Investigation, Team Membership, and the methodology used to undertake the investigation can be found at Appendices A - C.

**5.8** The Independent Investigation Team hopes that the families and friends of Mr H and Mr G will find this report helpful in addressing their questions and concerns in relation to the care of Mr G.

## 6 PREDICTABLE / PREVENTABLE

6.0 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether Mr H's death was predictable or preventable. Many Independent Investigations identify failings, missed opportunities or gaps in the care which was provided to an individual. However, this does not mean that a homicide could have been either predicted or prevented. The following tests are commonly applied to determine whether a homicide could have been predicted or prevented.

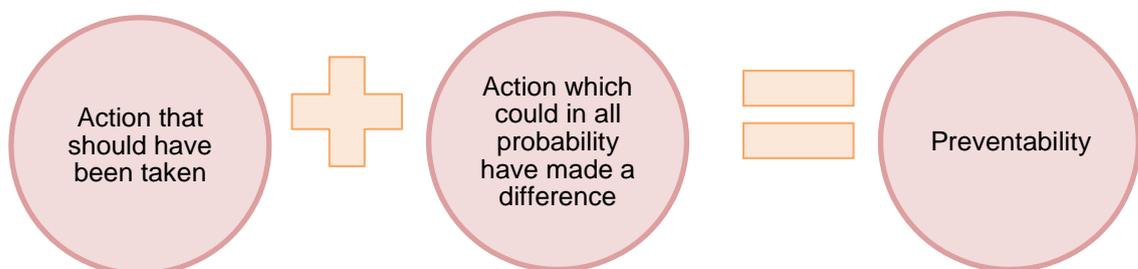
### 6.1 Predictable

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



### 6.3 Preventable

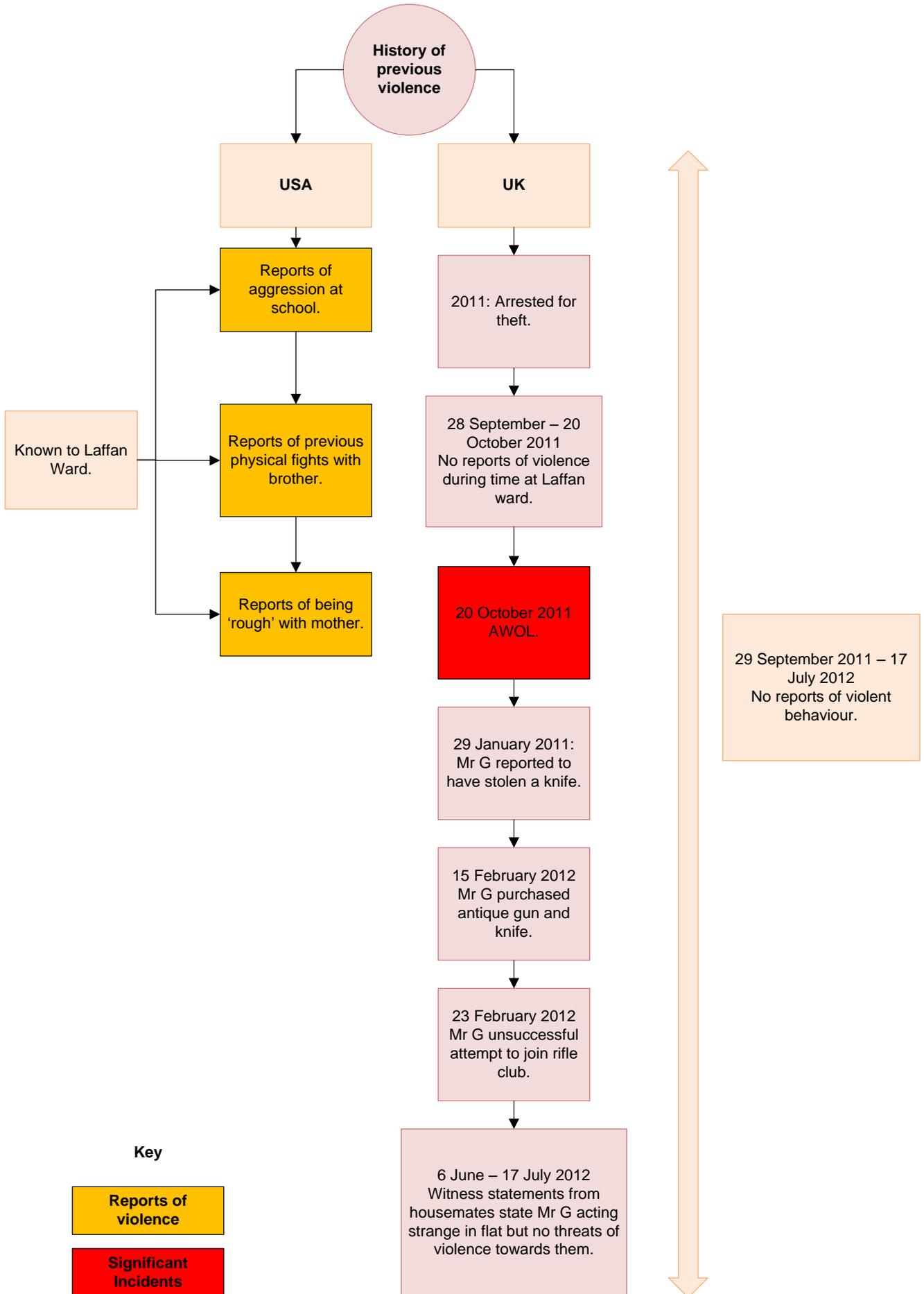
6.4 A Homicide could have been '*Prevented*' if there were actions that healthcare professionals should have taken, which they did not take, that could in all probability have made a difference to the outcome. Simply establishing that there were actions that could have been taken or opportunities which were missed would not provide evidence of preventability, as there are always things that could have been done better.



## 6.5 Predictable

The Independent Investigation Team believes that it was not predictable prior to 17 July 2012 that Mr G would commit a significant act of violence such as the attack on Mr H which led to Mr H's death.

- 6.6** The medical evidence submitted to the Court during the course of Mr G's trial suggested that, at the time he was responsible for the death of Mr H, he was suffering from paranoid schizophrenia and/or a schizoaffective disorder, both of which constitute a serious mental illness.
- 6.7** The belief that people who suffer from schizophrenia are dangerous is as common and widespread as it is misconceived. The media often depicts mentally ill individuals as violent and out of control which encourages stigmatisation. However, the statistical reality is that most people who suffer from schizophrenia are no more prone to violence than other members of the population. Indeed, there is evidence to suggest that people who suffer from schizophrenia tend to be socially withdrawn and would rather not engage with others and may be more likely to be a victim of crime. Indeed, a number of factors would have led to Mr G having been considered a vulnerable adult following his departure from the Laffan Ward. These include the fact that he was mentally ill, he was single, and was socially excluded. The cumulative effect of these risks was that Mr G was vulnerable to exploitation.
- 6.8** The Independent Investigation Team recognises that if people have a history of violent actions then they are more likely to commit violent acts in the future. Further, the Independent Investigation Team recognises that individuals who have a history of violent behaviour are generally at a greater risk of future violent behaviour, whether they are mentally ill or not. In most cases, the violence exhibited by an individual is likely to mirror the way in which they had been violent before. In many cases, the violence committed by an individual predicts the nature and level of their future acts of violence. A table setting out Mr G's previous acts of known violence and actions which could lead to a violent act is set out below:



- 6.9** Mr G is described by members of his family in his medical records as having '*anger management issues*' and that he could be verbally aggressive and sensitive. His mother told staff on Laffan Ward that Mr G had pushed her and had '*been rough*'. She also stated that he had been in physical fights with his brother. Mr G was also reported as being aggressive at school. It is not clear from the records whether these actions were related to Mr G's illness or whether they were, in fact, a feature of his personality and, therefore, were not directly connected with his mental health issues. However, there is nothing in these reported issues which would mirror Mr G's actions towards Mr H.
- 6.10** The Independent Investigation Team has reviewed Mr G's notes whilst on Laffan Ward at a time that he was known to be ill. There were no reports of any violent acts being committed or threatened by him. Indeed, staff confirmed at interview that Mr G had limited interaction with staff and other patients and that when he did, he did so in a polite and friendly manner. In addition, the Independent Investigation Team has reviewed Police records outlining Mr G's contact with the Metropolitan and Dorset Police Services during the period between 27 September 2009 and 17 July 2012. There are no reports of any violent actions by Mr G during this period. At the time of Mr H's death, Mr G was not taking medication, he was disengaged from services, and was experiencing delusions. The previous violence which he had exhibited was comparatively minor, and not necessarily unusual. In fact, there was very little to distinguish him, or to highlight him as being unusual, or dangerous, or indeed someone who professionals should closely supervise so that they knew where he was in order to ensure that his needs were met.
- 6.11** In addition, the Independent Investigation Team has had access to the witness statements of Mr G's flatmates in the period between 6 June 2012 and 17 July 2012. They all confirm that whilst Mr G was noted to be acting strangely (which unsettled and intimidated them) he did not make any threats of violence towards them. In his witness statement, the victim's step father confirmed that, whilst Mr H complained about Mr G acting strangely, Mr H had stated that Mr G had not acted in a violent way towards him.
- 6.12** In many respects, the greatest degree of predictability in relation to Mr G is in relation to the progression of his psychotic illness. With time, Mr G's presentation is likely to have become increasingly chaotic as he failed to receive care. As a result, he would have become more and more difficult to treat. The risks inherent in untreated illness include a risk of violence, but also of the illness itself becoming more ingrained and potentially resistant to future efforts to treat it. It is, to a degree, predictable that Mr G would relapse, and, to a lesser degree, predictable that the relapse would be similar to the pattern of previous relapses. However, once again it is important to note that the majority of people suffering from schizophrenia are not violent, even when unwell.
- 6.13** Having considered all of the reported incidents of violence committed by Mr G and the fact that even when he was known to be unwell his level of violence did not appear to increase, the Independent Investigation Team believes that it was predictable that Mr G could become involved in fights, fall out with people and the disagreement could escalate to the point where he came to the

attention of services. However, the Independent Investigation Team has concluded that the attack on Mr H which led to his death was a significant escalation in violence which, based on Mr G's previous actions and history, was not predictable.

#### **6.14 Preventable**

The Independent Investigation Team's view is that the homicide of Mr H could not have been prevented.

- 6.15** The homicide of Mr H could not be prevented, because it was not predictable that Mr G would commit a homicide given the pattern of the behaviour which he had exhibited in the past. In addition, the Independent Investigation Team takes the view that it would be difficult to say that Mr H's death was predictable, because the number of people who would go on to commit a homicide from the clinical picture which he exhibited is very small. As a result, the Independent Investigation Team believes that mental health services could not have taken actions to prevent the fatal attack upon Mr H.
- 6.16** In addition, Mr H had not been threatened by Mr G at the time of his death, and there does not appear to be any indication that Mr G discussed his concerns about Mr H being part of a gang with anyone in Bournemouth or, indeed, London. Mr G appears to have discussed his flatmates with GPs in Bournemouth. However, this is recorded in his notes as being a threat to Mr G in that he believed that his food was being poisoned by his unnamed flatmates. The GPs recognised that this statement may have been incorrect. Mr G's GPs in Bournemouth made appropriate referrals to secondary mental health services given the pattern of behaviour exhibited by Mr G prior to the homicide of Mr H.
- 6.17** In the Police interviews following the homicide, Mr G's flatmates with whom he shared the flat in which the homicide occurred stated that there were no threats of violence made by Mr G in the lead up to the homicide. This further demonstrates the unpredictable nature of the homicide, and therefore further adds to the reasoning that the homicide could not be prevented.
- 6.18** Mr G came to the attention of the Police in the period between 20 October 2011 and the homicide of Mr H on 17 July 2012. These include the following:
- Mr G's attendance at Heathrow Airport and Marylebone Station.
  - Mr G's application to join a rifle club.
- 6.19** In mid-February 2012, Mr G was found by Police sleeping on chairs in Terminal 5 departures at Heathrow Airport. Two days later, British Transport Police 'stop-checked' Mr G at Marylebone Station. In addition, Mr G made attempts to join a rifle club and the club were informed that should he attempt to obtain a firearms licence, '*it would not be a straightforward process*'.
- 6.20** Around the times of these interactions, the Police liaised with Chelsea and

Westminster Mental Health Services, to which Mr G was known. The Police also requested that Mr G's details were sent to the Chelsea and Westminster Homeless Unit. It is known that even when unwell, Mr G could present himself as being well. It is possible that Mr G could have presented to a lay person, or even a trained professional as relatively well and not requiring intervention from services.

- 6.21** It is not possible to know how Mr G presented at these interactions with the Police.

## **7 PROFILE OF MR G**

- 7.0** During the period between his absconson from St Pancras Hospital until the death of Mr H, Mr G was an itinerant individual suffering from a serious mental illness. He was a difficult individual for health care providers to treat due to the fact that he moved around, approached a number of primary care providers and was evasive when giving information to health professionals. It could be said that Mr G '*brokered*' health care providers seemingly looking for one who would provide him with the treatment that he, when lacking insight into his condition, believed that he required.
- 7.1** During his interactions with health care providers in this period, other than the content of Mr G's delusions, there was no hint that he would commit the act of killing Mr H or any other individual. His presentation was one of someone requiring treatment for a mental illness, not one of a homicidal person.
- 7.2** It is clear that this would create difficulty for those searching for him following his absconson. Those who were looking for Mr G would be looking for someone withdrawn, quiet and evasive, rather than an aggressive, homicidal man. Due to this Mr G would have been unlikely to provoke a response from those he came into contact with, such as the Police, during this period.

## 8 INITIAL INVOLVEMENT WITH SECONDARY MENTAL HEALTH SERVICES

- 8.0 Mr G went to the Royal London Hospital Accident and Emergency Department on the afternoon of 27 September 2011.
- 8.1 He reported being attacked and drugged at King's Cross Station by individuals whom he knew. He reported that he had been injected in his genitals and that his attackers had attempted to rape him. Mr G explained that he was intending to search for the individuals concerned.
- 8.2 Mr G was initially sectioned in accordance with the terms of Section 5 (2) of the Mental Health Act 1983 on 28 September 2011 at the Royal London Hospital.
- 8.3 The papers relating to Mr G's detention in accordance with Section 5(2) state:
- 'Patient presented to A&E stating he had been drugged and raped in Kings Cross station, this appears to be delusional. He is expressing persecutory and paranoid beliefs regarding the women who drugged him and is at risk of trying to find these 'women' and will not disclose his plans.... there is risk of harm to others..... There is potential risk to others and further assessment and treatment would be beneficial'.*
- 8.4 A Section 5(2) Order is known as the 'Doctor's holding power'. It is used to stop an individual leaving a hospital where they are an informal or voluntary patient. A Section 5(2) Order can be used both in a mental health hospital and a general hospital.

### Comment Box One

An individual can be held for up to 72 hours under Section 5(2). This is not renewable. In practice, the individual who is the subject of concern must be assessed as quickly as possible by an Approved Mental Health Professional (AMHP) and doctors for possible admission under the Mental Health Act. In Mr G's case this happened in a timely manner and with an appropriate disposal.

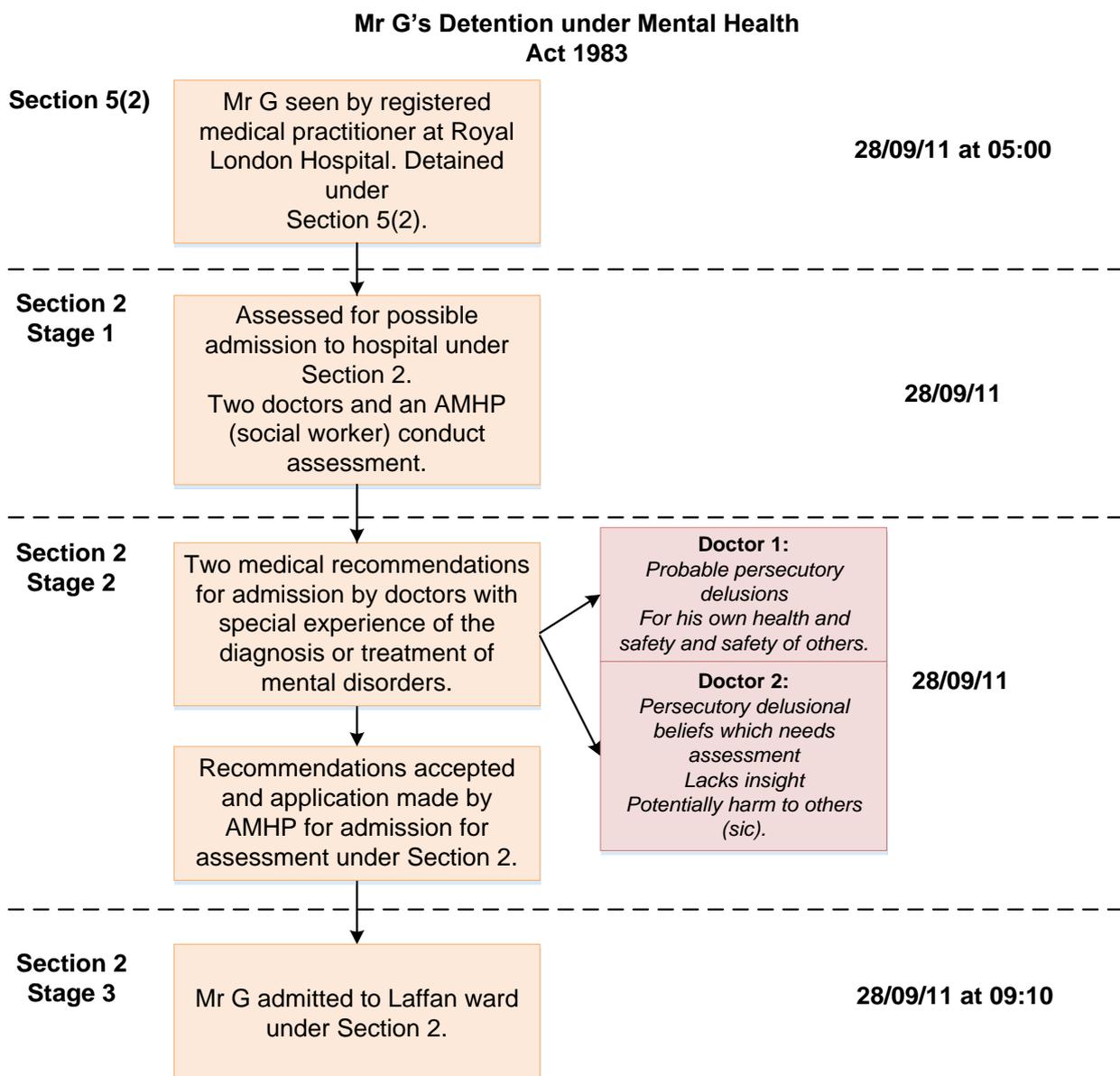
Clinicians must be aware that in restricting an individual's freedom of action, the least restrictive option that will meet the need should be used. However, at this time, Mr G was presenting in a manner which suggested that he posed a risk to himself and others.

The Independent Investigation Team believes that the use of Section 5(2) in these circumstances was appropriate to allow further assessment and care to be given.

As a result, the Independent Investigation Team has not identified any further learning as a result of the decision to use Section 5(2) of the MHA at this stage.

## 9 MR G'S ADMISSION TO ST PANCRAS HOSPITAL

- 9.0 A decision was taken to transfer Mr G to the Huntley Centre, St Pancras Hospital at around 9.10 am on 28 September 2011. This decision was based upon the fact that the Royal London Hospital was out of the area in which Mr G was registered.
- 9.1 Mr G was then reviewed and was detained under Section 2 of the Mental Health Act 1983.
- 9.2 The following diagram shows Mr G's sectioning process on 28 September 2011.



- 9.3** One of the doctors who made the Section 2 recommendation relating to Mr G determined that the detention was necessary:
- i. In the interests of the patient's own health.
  - ii. In the interests of the patient's own safety.
  - iii. With a view to the protection of other persons.
- 9.4** The doctor also noted that:
- 'He does not think he has a mental illness or that he needs any treatment for the same. He is refusing to come into the Hospital informally. We think he needs to come into the Hospital for his own health and safety and also with a view to protect others. He had told the SHO on call that he will be looking for those 'women' in the next few days'.*
- 9.5** The second doctor who assessed Mr G for the purposes of the Section 2 Order determined that the detention was only necessary:
- i. In the interests of the patient's own health.
  - ii. With a view to the protection of other persons.
- 9.6** The second doctor also stated:
- 'He is floridly psychotic with persecutory delusional beliefs which need further assessment in hospital. He denies any drug and alcohol history. He lacks insight and refuses voluntary admission. He has expressed some wish to confront those who injected him therefore may potentially harm to others (sic)'.*
- 9.7** The nature of Mr G's psychosis was therefore deemed to have impacted upon his insight, which was a factor in the decision to admit him under Section 2. While detained at the Hospital, Mr G's lack of insight was subsequently linked to his attitude to treatment, wherein he was not compliant with medication. Mr G was given his medication via injections as a result.
- 9.8** Detention under Section 2 lasts for 28 days, although there is a right of appeal. In Mr G's case, his Section 2 Order was due to expire on 25 October 2011.
- 9.9** Mr G absconded from the Ward during a period of escorted leave, resulting in him becoming classified as AWOL. This is discussed in chapter 15.
- 9.10** Mr G Appealed the Section 2 Order which was made. The Tribunal in respect of his Appeal was held on the 24 October 2011, four days after Mr G had left the Laffan Ward. The Hearing went ahead in his absence and the Section 2 Order was upheld. This indicates that the Tribunal were satisfied that Mr G had met the statutory criteria for detention on the 28 September 2011 when the Section 2 Order was made. This also indicates that the criteria for detention were still met at the time of the AWOL incident.

- 9.11** The effect of this was that Mr G could have been detained until 25 October 2011. After this point, were it felt to be needed, a further Order under the Mental Health Act would have been necessary to detain Mr G if Mr G refused further assessment and treatment in a hospital environment.

### **Comment Box Two**

Section 2 is specifically designed for people who are considered to be in need of an assessment for a mental disorder, and that due to their presentation and possible risks that this needs to take place in a hospital setting. Section 2 provides the legal framework for this assessment to take place. Clinicians can then determine whether the person has a mental disorder and the possible Care Plan and treatment options which are available for them.

Mr G's presentation at this time did suggest the need for assessment to determine whether he was suffering from a mental disorder.

Clinicians must be aware that in restricting an individual's freedom of action, the least restrictive suitable option should be used.

Given that Mr G was at this stage refusing to come into hospital informally and in light of his presentation, the use of Section 2 of the MHA was appropriate and proportionate.

As a result, the Independent Investigation Team has not identified any further learning as a result of the decision to use Section 2 of the MHA at this stage.

## 10 CONTINUING DETENTION UNDER MENTAL HEALTH ACT

- 10.0** Mr G's detention under Section 2 was due to expire on the 25 October 2011, as it can only last for 28 days.
- 10.1** On the morning of 20 October 2011, Mr G and his Responsible Clinician, Consultant 1, met to discuss his ongoing care and treatment. Mr G was advised that Consultant 1 felt he required more care, and that on that basis, Consultant 1 intended to make a medical recommendation for further detention in accordance with Section 3 of the MHA.
- 10.2** If an individual is to be sectioned under Section 3, the Mental Health Act requires that following examination by two doctors, the doctors must confirm that:
- a. *'the individual is suffering from a 'mental disorder of a nature or degree' that makes it appropriate for them to receive medical treatment in hospital; and*
  - b. *'appropriate' medical treatment is available; and*
  - c. *it is necessary to detain the individual for his own health or safety, or for the protection of others, that the individual should receive such treatment and it cannot be provided unless the individual is detained under this Section'.*
- 10.3** If a Section 3 Order is made, a period of up to 6 months detention for treatment can be Ordered subject to appeal. This is renewable for further periods of six months if necessary.
- 10.4** A Section 3 recommendation was completed by Consultant 1 before Mr G had left the Hospital. In making this recommendation, Consultant 1 confirmed that Mr G was:
- a. *'suffering from mental disorder of a degree which makes it appropriate for the patient to receive medical treatment in a hospital' and*
  - b. *that the Section 3 order was necessary*
    - i. *For the patient's own health*
    - ii. *For the patient's own safety'*
- 10.5** On this occasion, it appears that Consultant 1 did not believe that the Section 3 was necessary for the protection of others and because there was no indication to include it in his opinion. This is different to the recommendation for his Section 2 detention when he arrived on the Laffan Ward. His rationale for the detention was as follows:
- 'He (sic Mr G) has virtually no insight, currently. He wishes to leave hospital and stop his medication and return to work. If he were to leave he will disengage to an unknown address and is vulnerable to deterioration in health and exploitation'.*
- 10.6** Only the initial recommendation by Consultant 1 has been recorded and retained in Mr G's records, because Mr G absconded before the process could be completed. There was consequently no second medical assessment (and

recommendation) and therefore no AMHP application.

**Comment Box Three**

A Section 3 Order allows detention for treatment for an initial period of up to six months which can be extended if needed. His treating doctor was clear that Mr G would benefit from treatment provided under a Section 3 order. However, the process could not be completed because Mr G absconded.

## 11 LAFFAN WARD ST PANCRAS HOSPITAL

11.0 At the time of Mr G's care, the Laffan Ward was an acute assessment ward based in St Pancras Hospital. St Pancras Hospital served several transport hubs including train stations such as King's Cross, Euston and Charing Cross together with some coach stations. The Laffan Ward has 16 beds. The most common reasons for admission were personality disorders, comorbid substance misuse, acute psychosis, alcohol misuse and suicidality. As an acute assessment unit, the Ward would be expected to admit patients frequently, stabilise them rapidly, and move them on quickly.

11.1 Due to significant pressures upon the volume of patients seeking care, a new model of care was formulated for the Ward. A research paper summarising their findings in relation to this new model of care was published on or around 1 September 2012. The authors of the research paper included Consultant 1 and Ward Manager 1.

11.2 The outcome measures for the study were stated to be:

- Duration of stay.
- Need for readmission.
- Patient satisfaction.
- Frequency of conflict behaviour.

11.3 The results and conclusions were stated to be as follows:

*'A total of 485 admissions over the year long study period. The median stay to discharge from the assessment ward was 6 days, whereas in those transferred it was 19 days. Readmission within 28 days following discharge from the assessment ward was 13.9%, whereas those discharged from other wards was 9.2% (P=0.1). Patient satisfaction was no lower, for all domains, than for other wards in the trust. Frequency of conflict behaviour was equal to previous studies, but self harm was significantly less common.'*

11.4 The research paper sought to demonstrate that by focussing on the 'point of entry' to inpatient services, some admission times could be reduced without an increase in 28-day readmission rates or conflict behaviours. The review covered all admissions between 8 October 2009 and 7 October 2010. The results were largely favourable and the model of care was adopted and prevailed during Mr G's admission. Most models of care are not subjected to scrutiny in this manner, and so an element of best practice has been adopted. During the course of the Independent Investigation, staff involved in working on the Ward at the time of Mr G's care made reference to some of the challenges which are an inevitable part of a change process. However, it is clear that staff exhibited a high level of commitment to the changes, notwithstanding the difficulties and conflicts which arise from time to time.

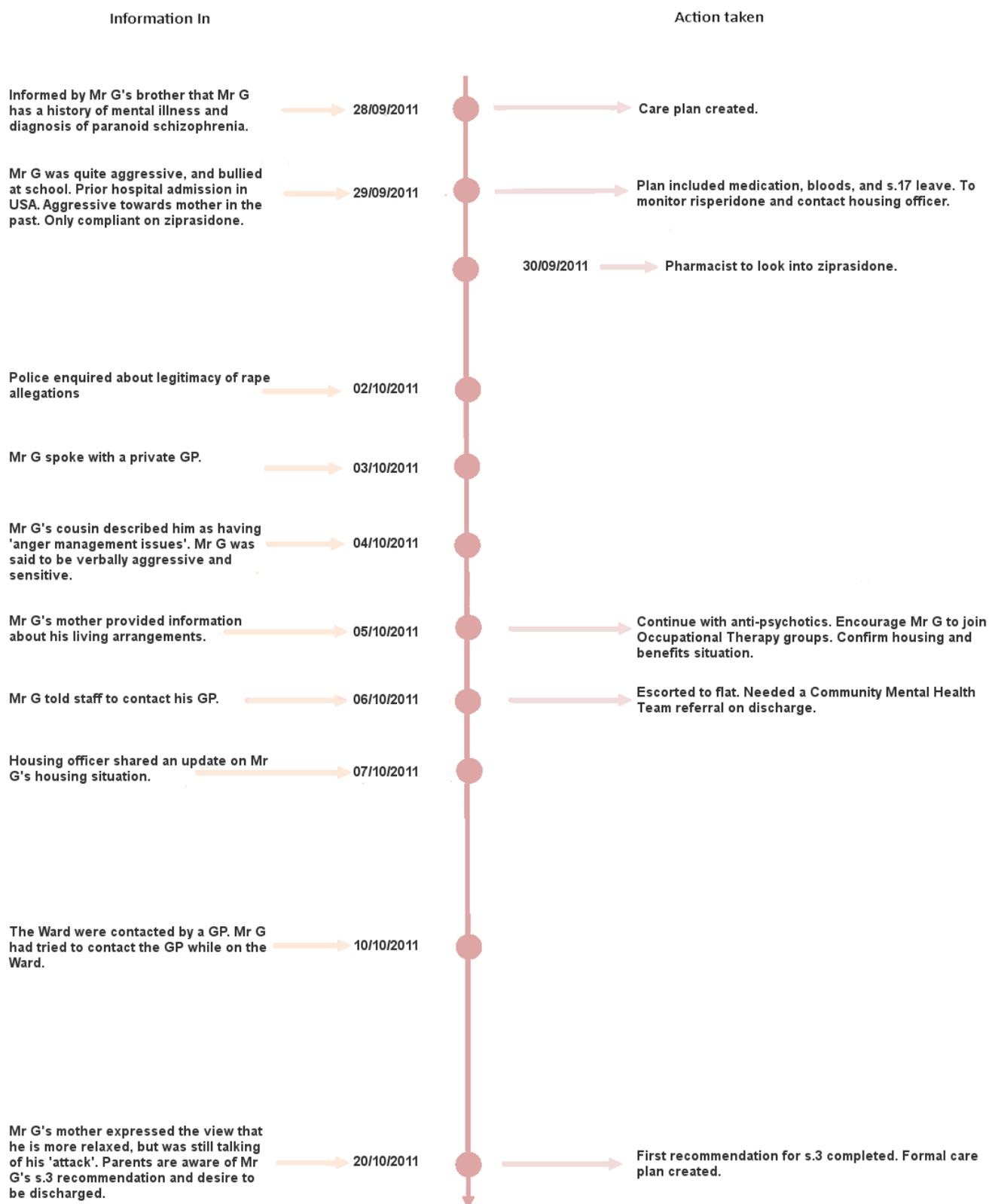
#### **Comment Box Four**

It is clear that at the time of Mr G's care, significant changes were being made to the working practices in the Laffan Ward. This would have imposed new challenges upon resources and staff members. However, the Independent Investigation Team could not find any evidence that suggested that any of these challenges had a negative impact upon Mr G's care. Staff displayed a high level of commitment notwithstanding the difficulties and conflict which arise as part of the change process.

Most new models of care are not subjected to as significant a level of scrutiny as occurred in relation to the changes made to the Laffan Ward. The level of scrutiny imposed is an element of best practice.

## **12 CARE PROVIDED TO MR G**

- 12.0** Mr G was admitted to the Laffan Ward on 28 September 2011. Within two hours of arrival, he was reviewed by Senior House Officer 1 on a ward round. This is an example of good practice.
- 12.1** Mr G had not previously been admitted to an NHS hospital in respect of mental illness. He had received care in the United States where he had lived for some time and where his parents were based.
- 12.2** The team on the Laffan Ward quickly established contact with members of his family who were able to provide background information about Mr G and the mental health issues which he had experienced in the past. This information included details about how Mr G interacted with others and also included a description of incidents where his actions could have been considered violent.
- 12.3** Members of Mr G's family were included in ward rounds and efforts were made to liaise with a number of the GPs, some of which were '*private*' GPs in an attempt to gain a greater understanding of Mr G's presentation.
- 12.4** The information which was gathered is summarised in the following table.



### **Comment Box Five**

The team in the Laffan Ward made good efforts to obtain information about Mr G. Given his connection with the USA, this would have proved challenging.

There is evidence that the Ward staff contacted GPs and included family members in ward rounds.

These are elements of good practice.

One piece of information which has come to light following the criminal proceedings resulting from Mr H's death, is that Mr G was convicted of battery in the USA. This information was obtained by the Police.

Given that the offence of battery fits within the pattern of other, less serious aggressive behaviour exhibited by Mr G, the Independent Investigation Team does not believe that a failing to elicit this piece of information during the time when Mr G was in the Laffan Ward impacted upon the direction which Mr G's care would have taken, nor would its inclusion have warranted re-consideration or re-evaluation of his care.

## 13 CARE PLAN

13.0 Upon admission to the Laffan Ward, a Care Plan was formulated for Mr G. The Care Plan was changed as additional information was received.

13.1 The Care Plan which was formulated for Mr G is set out on the following page.

13.2 The Independent Investigation Team has reviewed the Care Plans produced for Mr G. The Independent Investigation Team takes the view that the Care Plan is reasonable for a patient such as Mr G who presented in crisis but without any static risk factors, including no history of significant violence, and none of substance misuse. At this point in Mr G's care, his presentation would not have distinguished him from a number of patients who experienced delusions.

13.3 When Mr G was initially admitted to the Laffan Ward, he was noted to have persecutory delusions. He believed, as a result of his illness, that he had been attacked and injected by a gang of individuals who had subsequently raped him. He was able to name the individuals who he regarded as being his persecutors. He maintained this persecutory belief throughout his admission to Laffan Ward.

13.4 Throughout the course of Mr G's admission to hospital Mr G had continued to maintain that he had been attacked and raped in King's Cross Station. His records state that he '*demonstrated no insight into the unusual nature of his account*'. He approached a number of members of staff in this regard in addition to the Police and a private GP.

13.5 It is clear from Mr G's medical records that this issue was explored on a number of occasions with Mr G. For example, in Mr G's discharge summary dated 10 November 2011 it was stated:

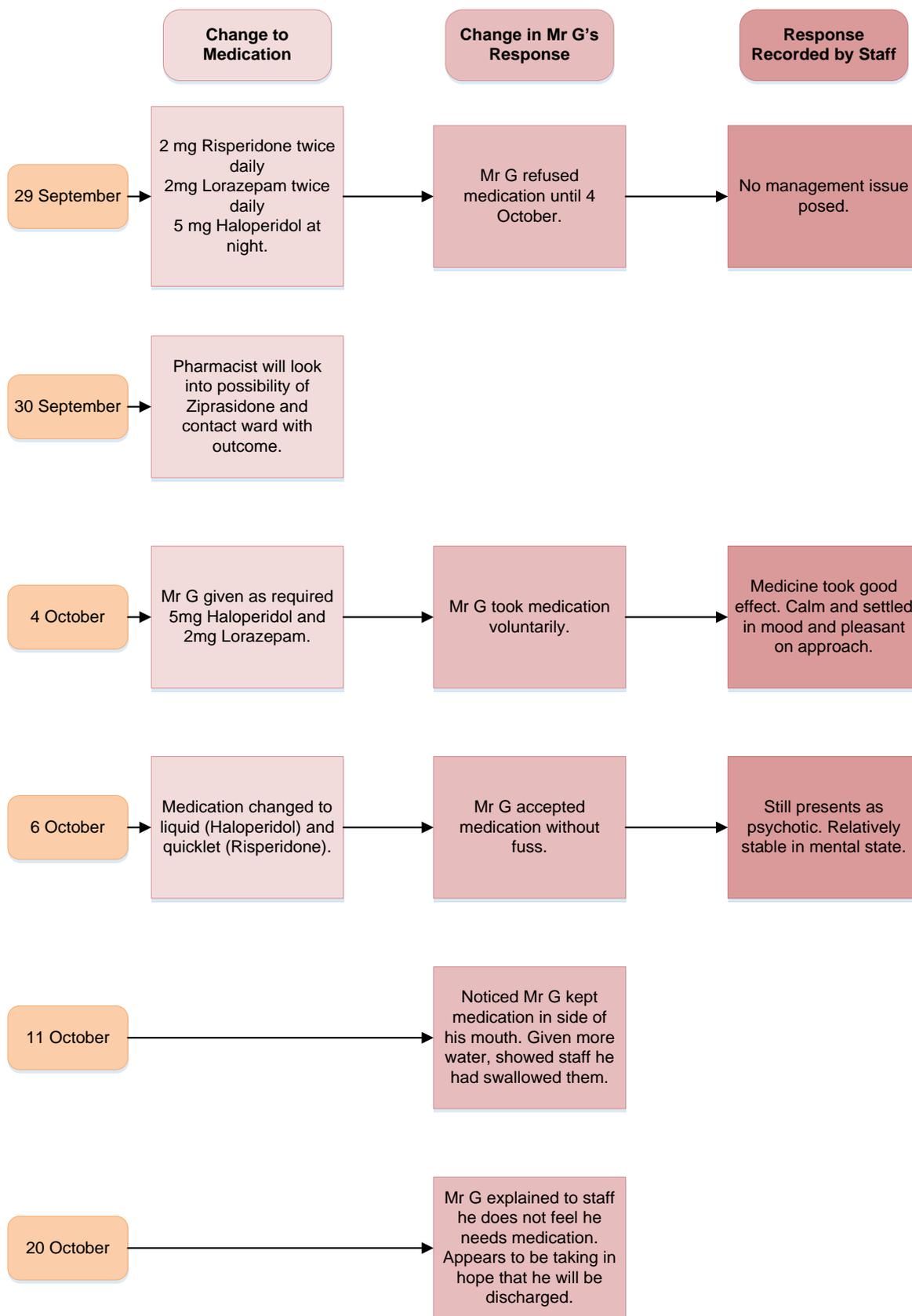
*"Mr G was reviewed during the Consultant ward round by ..... on 20th October 2011. When asked about the circumstances of his admission, Mr G explained that it was a mistake, that he had in fact been attacked. He gave an account of this 'attack', with similar details to previous accounts, although he appeared to have little insight in that he could appreciated (sic) that the series of events does sound 'strange'. However he quite clearly believes his experience to be based in external reality and does not want to remain in hospital any longer. He maintained that he was only taking medication as his solicitor had told that this would expedite discharge from the ward, and that he would not continue to take it if discharged. He continues to deny any previous contact with psychiatric services."*

13.6 It is clear from the interviews which the Independent Investigation Team conducted with members of Mr G's clinical team that work had commenced with Mr G to explore and understand his delusional ideas in an attempt to work with him and engage therapeutically with him.

13.7 The history which was revealed to the team at the Laffan Ward by his mother included a reference to '*longsating (sic longstanding) paranoia therefore he does not tell anyone where he lives and will flee from persecutors*'. This

information was available to those responsible for making the decision to recommend a Section 3 detention.

- 13.8** If the Care Plan had progressed as it had been intended and Mr G's detention under Section 3 had been secured, then Mr G would have moved from an Acute Assessment Ward with a high turnover of patients to a slightly quieter ward. The focus of his care would then have been on trying to understand his beliefs in more detail in order to help him to recognise them and what can be done about them to aid recovery.



	Event	Diagnosis	Plan
28.09.11	Initial admission.	Psychotic illness.	Full clerking, physical examination. Invite brother to ward.
29.09.11	Ward round with Consultant 1 and Mr G's brother.		2mg twice daily Risperidone 2mg Lorazepam twice daily 5mg Haloperidol at night. S17 for escorted leave.
	Phone conversation with Mr G's mother.	Relapse of psychotic illness.	Monitor extrapyramidal symptoms on Risperidone. Refer Mr G to housing officer.
4.10.11	Ward round in Mr G's absence, but in the presence of his cousin.	Mental state noted to be deteriorating.	Mr G to be reviewed in ward round the following day.
5.10.11	Phone conversation with Mr G's mother.		Mr G encouraged to join Occupational Therapy groups. Confirm accommodation status with brother. Refer to benefits adviser and housing officer.
	Ward round.		Continued with oral antipsychotic, use intra-muscular injection if refusing.
20.10.11			First recommendation for s.3 complete. Continue to monitor mental state. No changes to medication. Still need to control housing status.

- 13.9** As part of Mr G's Care Plan, his medication was reviewed at several points. These are summarised in the diagram below.
- 13.10** As part of Mr G's Care Plan, it was agreed that Mr G would be permitted to go on escorted leave from the Hospital.
- 13.11** Section 17 leave is an important part of the care and recovery process for mental health patients and is a key constituent of current clinical practice and Care Planning.

#### **Comment Box Six**

The clinical staff in the Laffan Unit recognised that more therapeutic work had to be done with Mr G even though he was managed in a busy and highly pressured service. They identified the need for more care in a slightly different environment where social factors could be addressed and where Mr G's psychological understanding could be developed.

In addition, the clinical team kept Mr G's medication under review and suggested changes to that medication. They had also started to explore options for working with Mr G's family.

This constitutes elements of good practice and is in line with guidance contained in NICE Clinical Guideline 82 – 'Schizophrenia'.

## **14 MENTAL HEALTH ACT SECTION 17 LEAVE OF ABSENCE**

- 14.0** The longer an individual spends in hospital without contact with the outside world, the harder it is for them to recover. This applies to any medical condition. When a patient becomes the subject of the terms of the Mental Health Act, control of basic elements of their day-to-day life can be lost. The type of activity that can be lost include freedom to come and go and in some circumstances the right to refuse medication. Attempts are always made to maintain as much freedom as possible and as rehabilitation progresses to allow increasing freedom and choice. This is necessary to attain and sustain recovery.
- 14.1** Section 17 leave is used to grant short periods of leave from hospital in the build up to discharge to allow patients an opportunity to rebuild life skills and regain control of their life. It would not be considered good practice for clinicians to admit an individual with an acute mental health condition that involves significant self-neglect, for example, and then keep them detained in hospital until their point of discharge. Section 17 leave is used for patients who are detained under Section 2 and 3 of the MHA in the same manner.
- 14.2** Section 17(1) of the Mental Health Act allows a patient's Responsible Clinician to grant leave with any conditions that may be necessary '*in the interests of the patient or for the protection of other persons*'.
- 14.3** The key question in relation to the granting of Section 17 leave is: '*What is the appropriate thing to do for the individual?*' Determining what is appropriate for each individual patient under their care is a regular challenge for mental health practitioners.
- 14.4** The process by which Mr G was initially considered for leave by the clinical team in the Laffan Ward is not clear as the Section 17 leave forms were missing. It is therefore unclear how information from Mr G's family was included in the decision-making process surrounding his leave. Mr G's medical records contain references to discussions which Mr G's mother had on 29 September 2011 that suggested that she was concerned about the risk of her son fleeing for example.
- 14.5** During the course of the interviews, the Independent Investigation Team was advised that upon admission each patient who was admitted would be seen by a Responsible Clinician at the earliest opportunity. Following this review, within the ward round and in conjunction with the Multidisciplinary Team ('MDT'), a decision would be made about whether Section 17 leave would be granted or not, and if so under what conditions. As a result, information from trainee doctors and other MDT members would be included in the decision-making process as would discussions which the Consultant himself had with the patient.
- 14.6** The Independent Investigation Team was advised that the issues which would be discussed when considering whether leave was appropriate would include whether the patient was unwell or vulnerable. It would also include consideration of issues which the patient himself was worried about. In addition, each leave period would necessitate an assessment by a qualified nurse.

**14.7** Mr G was granted leave in accordance with Section 17 of the Mental Health Act 1983 on the following occasions:

<b>Date of Leave</b>	<b>Type of Leave</b>	<b>Result</b>
<b>6 October 2011</b>	Escorted off Ward for fresh air.	No problems reported.
<b>9 October 2011</b>	Escorted leave to garden.	No problems reported.
<b>10 October 2011</b>	Escorted leave to and church.	No problems reported.
<b>11 October 2011</b>		Did not use leave.
<b>12 October 2011</b>	Escorted to see advocacy worker on ground floor of Huntley Centre, within hospital building.	
<b>14 October 2011</b>	Escorted leave.	Went well.
<b>16 October 2011</b>	Escorted leave with brother and staff.	No problems reported.
<b>17 October 2011</b>		Did not use leave.
<b>18 October 2011 (am)</b>		Did not use leave.
<b>18 October 2011 (pm)</b>	Escorted leave to shop.	'walking with slow movement'.
<b>20 October 2011</b>	Escorted leave.	Absconded whilst on leave.

**14.8 Leave On 20 October 2011**

**14.9** On 19 October 2011, Mr G was visited in hospital by his solicitor. It is stated in

his records that Mr G lacked insight into his condition and that he had advised staff that he was only compliant with medication in order to be discharged from hospital.

- 14.10** On 20 October 2011, during the course of a morning ward round, Mr G stated that he was eager to leave hospital. He stated that he did not want to take medication, that he was not unwell and that he did not want to be in hospital. However, he was advised that the clinical team felt that he would benefit from further time in hospital and that they would be seeking an order which would prolong his stay in hospital. It was also noted that in relation to risk, Mr G was *'vulnerable to exploitation and deterioration of mental state – no insight, non compliance, non engagement'*.
- 14.11** While on the Ward, the response to Mr G's lack of insight was to provide him with medication via injections, and to progressively trial periods of supervised leave. The Independent Investigation Team did not have access to a copy of Mr G's Section 17 leave form. This notwithstanding, it can be noted that the preceding entry provides a clear description of Mr G's mental state and attitude towards medication. Earlier entries also note that Mr G had previously been granted leave at times when his mental state had become more settled in order to support him in addressing accommodation issues and to attend therapy groups off the Ward. These leave periods had not been problematic.
- 14.12** Later that afternoon, whilst on escorted leave, Mr G stated that he absconded from his escort and did not return to the Hospital until a later date in order to collect his belongings including his passport. The nurse who escorted Mr G on leave stated that they were in Camden High Street and Mr G increased his speed to the extent that the nurse could no longer keep up.
- 14.13** It is not clear whether any of the following potential changes in Mr G's circumstances were explored to understand whether they could have been considered to be a potential risk to Mr G or indeed others on 20 October 2011, as there is no documentation relating to the consideration of his leave on this occasion.
- 14.14** Whilst the Trust's internal report states that each leave was risk managed, there is nothing in Mr G's notes to suggest whether any of the following issues were considered as being a change which could potentially have impacted upon leave for Mr G on that day:
- The impending Hearing relating to his detention in accordance with Section 2 of the Mental Health Act.
  - Notification that clinicians were preparing to recommend applying for a Section 3 Order.
  - The conversation with his solicitor which is documented in Mr G's records.
  - His stated desire to leave hospital and cease taking medication.
- 14.15** These features indicate that Mr G may potentially have lacked insight into his difficulties causing him to undervalue the care which he was receiving, which in itself was a risk to his ongoing care. In addition, Mr G's mother had previously

recorded her concern that Mr G 'will flee from persecutors'.

**14.16** However, it should also be remembered that had Mr G's detention been sought in accordance with Section 3 of the MHA, it is likely that Section 17 leave would have been granted to him and would have been undertaken in a similar manner to that operated by the Laffan Ward.

**14.17** It should also be remembered that the lack of insight which Mr G had could have affected him at any stage of his care and could have impacted upon any decision to grant leave at any point. Importantly, until the point at which he absconded, Mr G had been compliant during episodes of leave. Whilst it has not been recorded in the notes, he was said to have acted calmly in response to being told that a Section 3 Order was to be recommended in relation to his care going forward. These factors would have had a positive impact upon the decision to grant leave on 20 October 2011.

### **Comment Box Seven**

Leave is an important part of the recovery process. If leave is not included in the Care Plan, clinicians would not be acting within current practice guidelines. The issue is whether on balance, leave was appropriate for the individual at that time.

There is insufficient detail contained within the notes to allow the Independent Investigation Team an opportunity to fully understand the process through which the Clinical Team reached the view that it was appropriate to allow leave to proceed on 20 October 2011. However, this may be a feature of the poor record-keeping which is a significant issue in this case rather than a failure to recognise any real changes in Mr G's circumstances which would have led to leave being inappropriate for him to have leave on that day.

The Independent Investigation Team would recommend learning in relation to more effective record-keeping for staff. Whilst the Independent Investigation Team accepts that an uneventful leave would not necessarily be documented good practice would include recording any change in circumstances and any review of leave conditions.

This did not occur in Mr G's care.

## 15 ABSENT WITHOUT LEAVE

- 15.0** Where a patient who has been granted leave fails to return to hospital upon its completion, or where they fail to return if recalled from such leave where that leave has been revoked, they become '*Absent Without Leave*' (AWOL), under the MHA. This then entitles the staff of the relevant hospital, a Police officer or anyone else authorised by the managers of the Hospital, to take the patient into detention under Section 18 MHA and return them to the Hospital.
- 15.1** Patients being AWOL is a very common experience across the country. Patients go AWOL for a variety of reasons. They may feel that they have little to do, dislike hospital, the food, it may be noisy, etc. However, there will also be reasons which may be specific to the individual and so prior to each leave, consideration must be given to conducting an assessment in order to assess whether leave was appropriate, for that patient, that day. In these circumstances, it would be accepted practice to only record the reasons why leave was not facilitated by nursing staff.
- 15.2** Since 1 April 2010, providers have been required to notify the CQC of any inpatients who are absent without leave, which is defined by certain parameters.
- 15.3** For the first three years following this requirement for data collection, Trusts had to inform the CQC of all patients who were absent without leave. Absences without leave were also monitored by the Mental Health Minimum Dataset ('MHMDS'). The CQC recognised that the requirements for notification were putting an additional burden on general wards, which were already required to complete this information for the MHMDS. As a result, in 2011 the NHS worked with the Department of Health to change the regulation and reduce the scope of when providers had to notify the CQC of inpatients absent without leave. This therefore resulted in a change in the data reported.
- 15.4** There are four different reports of how Mr G absconded during a Mental Health Act Section 17 leave of absence on 20 October 2011. The report contained in the discharge summary states that Mr G was on leave with a nurse and that he '*ran off whilst they were in a local shop*'. The incident occurred during a period of escorted leave, and the support worker who was escorting Mr G was no longer working for the Trust at the time of the Independent Investigation.
- 15.5** The second report is contained in the Internal Investigation report compiled by the Trust and states that the nurse '*reported he accompanied Mr G to Camden High Street. Mr G quickened the pace and continued along the street and refused requests by staff member to return to the ward*'.
- 15.6** The third report is that within the Police records which states that Mr G and his escort went to a shop but were unable to find what Mr G wanted. The report goes on to state that Mr G told the nurse that he wanted to go and see his friend and walked away from the nurse who was unable to stop him.

- 15.7** The fourth report is that which Mr G gave to the Independent Investigation Team. He stated that whilst on leave, he and his escort were in a café when his escort went to the toilet. At this point Mr G decided to leave.
- 15.8** Mr G advised the Independent Investigation Team that he left because he felt that those responsible for his care had not been listening to him. In particular, they were not listening to his complaints about his physical health, not that he had absconded in order to offend or stop his medication.
- 15.9** Mr G was offered a number of one-to-one sessions, in which he either raised no concerns, or was sufficiently lacking in insight to make it difficult for him to use these sessions. Indeed, Mr G was offered a session on 3 October 2011, which he declined. There is also evidence that, with encouragement, Mr G would attend supervised sessions with a technical instructor or occupational therapist, such as on 5, 11, 18, and 20 October 2011. A retrospective entry on 31 October 2011 also contains good review of Mr G's mental state and level of insight. There is therefore good evidence of several attempts to engage Mr G using different strategies and personnel. The staff at the Ward therefore understood Mr G's lack of insight, which suggests that it is possible that a situation existed in which those involved in Mr G's care were in fact listening to him, but that he was either not aware of this or did not recognise those attempts.
- 15.10** When he went AWOL, Mr G left his mobile phone, passport and other possessions at the Hospital.
- 15.11** The Mental Health Act Code (2008) provides guidance to registered medical practitioners, approved clinicians, managers and staff of hospitals, and approved mental health professionals. While the Mental Health Act does not impose a legal duty to comply with the Code, the people to whom the Code is addressed must have regard to the Code. The reasons for any departure should be recorded. Departures from the Code could give rise to legal challenge, and a Court, in reviewing any departure from the Code, will scrutinise the reasons for the departure to ensure that there is sufficiently convincing justification in the circumstances. This version of the Code has now been superseded.
- 15.12** Paragraph 21.22 of the Code of Practice states:
- 'The outcome of leave – whether or not it went well, particular problems encountered, concerns raised or benefits achieved – should also be recorded in patients' notes to inform future decision-making'.*
- 15.13** The Code of Practice states that:
- 'In case they fail to return from leave, an up-to-date description of the patient should be available in their notes'.*
- 15.14** The circumstances of Mr G's departure from his escort are unclear because no account or details of the incident are included in his clinical records, nor was an incident form completed as a result of the incident. The Independent Investigation Team regards this as a major omission.

**15.15** Paragraph 22.21 states:

*'All instances of absence without leave should be recorded in the individual patient's notes'.*

**15.16** The Code goes on to state at Paragraph 22.20 that:

*'Incidents in which patients go AWOL or abscond should be reviewed and analysed so that lessons for the future can be learned, including lessons about ways of identifying patients most at risk of going missing'.*

**15.17** The Independent Investigation Team looked extensively at Mr G's care record, and was unable to locate any progress note of the AWOL incident. The Section 17 leave record was also missing. There was no indication from the case record that escorted leave had been granted at the clinical team meeting which had occurred the previous day. Though absconding while on leave is not uncommon, the lack of records relating to the incident is indicative of poor practice, and prevented the Independent Investigation Team from discerning the rationale behind the decision to grant Mr G escorted leave under Section 17.

**15.18** When the Independent Investigation Team met with Mr G, he said that he had returned to the Laffan Ward to collect his belongings from the Nurse's Office a 'few days' after absconsion. This accords with information contained in the Police records. Although the timescales are unclear, had Mr G returned to the Laffan Ward within 5 days of his departure, he would still have been subject to his Section 2 Order. However, the Police records suggest that he returned shortly after his Section had expired. If this is correct, the Hospital would not have had a legal right to detain Mr G without a further mental health assessment having been performed.

## **16 THE RESPONSE TO MR G'S ABSCONSION AND THE STEPS WHICH WERE TAKEN TO PROMOTE RE-ENGAGEMENT**

- 16.0** There was limited documentation available to the Independent Investigation Team from which to understand the response which the Trust took to the decision taken by Mr G to abscond from hospital. The Independent Investigation Team had access to the Police records relating to Mr G's departure from the Hospital.
- 16.1** The Independent Investigation Team understands from Police records that Mr G's departure from the Hospital took place at approximately 5.30 pm on 20 October 2011. Police records state that he had been out with a nurse on a 30-minute period of escorted leave. Mr G had stated that he had wanted to go to the shops. Mr G and his nurse went into the shop but were unable to find what Mr G was looking for. Mr G then said that he wanted to go and see his friend and walked away from the nurse who was unable to stop him. This account differs from the account of the event given by the Trust in its Internal Report and that given by Mr G himself.
- 16.2** The table below sets out the action which the Trust took following Mr G's departure from the Hospital.

Date	Activity	Response	Action required by Policy
20 October 2011	Mr G absconded.	Health care assistant added contact numbers for Mr G's brother to the clinical notes.  Police were contacted.	Police contacted. However, details not recorded in notes and relevant forms Incident form not completed.  No risk assessment completed.
21 October 2011	Mr G's mother telephoned the Ward to see if there was any news about Mr G. His mother said he usually goes to Kingston Hotel in King's Cross with friends or goes to internet cafes.  Police attended the Ward to get more information about Mr G.	Mr G's passport was found during Police search of the Ward and placed in the safe in the nurses' office. This is recorded in Mr G's medical records.	
22 October 2011	Mr G's mother telephoned the Ward to say that Mr G had contacted her from 'Greens ways hostel' on a new telephone number which she gave the Hospital.	Staff phoned Mr G's number but he did not pick up this call.  Police not contacted with new information or Mr G's new telephone number.	
23 October 2011	Entry states 'Mr G remains AWOL no contact from Police'.	No action taken.	

<p><b>23 October 2011</b></p>	<p>Mr G's mother contacted hospital to say that Mr G had an appointment at Marylebone Job centre the following day and asked if someone could attend from the Hospital. She was told that Police were aware of the situation and everything was being done to bring him back.</p>	<p>No action taken.  Police not contacted with new information.</p>	
<p><b>24 October 2011</b></p>	<p>Mr G's mother phoned the Ward and was asked about places Mr G was likely to go.</p> <p>Information included:</p> <ul style="list-style-type: none"> <li>• 24-hour internet cafes.</li> <li>• Hostels in King's Cross area.</li> <li>• Marylebone job centre.</li> <li>• Keystone House Hostel in King's Cross.</li> </ul>	<p>Staff contacted the hostel who had not seen Mr G. Staff left Keystone House Hostel the number of the Ward with a message to contact them should Mr G contact them.</p> <p>However, information not passed to other bodies including GP and Police.</p>	
<p><b>25 October 2011</b></p>	<p>Mr G's mother rang asking to speak to Senior House Officer 1 without success.</p>		
<p><b>26 October 2011</b></p>	<p>Mr G's mother rang hospital and staff rang Mr G's brother and left a message for him to contact the Laffan Ward.</p>		

27 October 2011	Two unsuccessful attempts to call Mr G or his brother.		
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- 16.3** The Hospital acted appropriately in advising the Police that Mr G had absconded. This is an element of good practice which accords with Trust Policy and the Code of Practice.
- 16.4** However, following this, the approach which was adopted by the Trust became largely passive. When information was passed to them by Mr G's mother, it does not appear to have been shared with the Police.
- 16.5** The Police were told the circumstances of Mr G's disappearance and that;
- [He] was under section until 25 October 2011 and has been diagnosed with paranoid schizophrenia'.*
- 16.6** No further details which might have helped the Police find Mr G have been recorded in the Police records, and it is not clear what information the Laffan Ward provided the Police in order to assist them. Whenever the Police are asked for help in returning a patient, they must be informed of the time limit for taking them into custody. In telling the Police that Mr G's Section 2 Order lapsed on 25 October 2011, the Laffan Ward were acting in accordance with good practice.
- 16.7** However, on 22 October 2011, Mr G's mother advised the Laffan Ward of her son's whereabouts. This is recorded in his medical notes. The Ward telephoned Mr G's mobile, he did not pick up. Mr G's mother then contacted the Laffan Ward on 23 October 2011, to advise them that her son would be at Marlborough Job Centre (sic) the next day in order to fulfil an appointment. The contact made by Mr G's mother and Mr G's appointment would have been within the period when Mr G's Section 2 Order was still valid. Mr G's mother also provided the Ward with an updated mobile telephone number for Mr G. Neither piece of information appears to have been transmitted to the Police. It is unclear why the Laffan Ward did not transmit this information (which did not impinge upon Mr G's right to confidentiality) to the Police.
- 16.8** The Police will usually respond in two situations to requests from psychiatric units. If a person is AWOL, they will bring them back if there is a legal power which empowers them to do so. The second situation is where someone is acutely disturbed and is causing nuisance or risk or trouble in a public place and who appears to be mentally unwell. Nothing else would usually be within the Police's remit to follow up and it is doubtful if the Police would have powers in any event to do so.

**16.9** The Code is relevant to this situation, it states at Paragraph 22.13:

*'The Police should be asked to assist in returning a patient to hospital only if necessary. If the patient's location is known, the role of the Police should, wherever possible, be only to assist a suitably qualified and experienced mental health professional in returning the patient to hospital.'*

**16.10** The circumstances of Mr G's departure from the Ward are unclear as no entry has been made explaining what happened and the nature of the contact between the Ward and the Police. It is also clear that the Police took Mr G's disappearance seriously, and visited the Ward to find out more about Mr G. Indeed, they searched Mr G's room and found his British passport.

**16.11** However, what is not clear is why the Ward subsequently failed to provide the Police with information which could help them find Mr G within his period of detention under Section 2 of the Mental Health Act, and use their powers to return him to the Ward. This may be a feature of poor record-keeping. It may be that after a discussion with the Police, it was decided that Mr G should not be brought back to the Ward by the Police due to the level of risk which he was perceived to present with or indeed after his Section 2 Order had expired. However, this risk assessment or the rationale behind such actions is not documented. In addition, it does not accord with assurances given to Mr G's mother which are recorded in Mr G's notes that:

*'She wanted to know if it's possible for staff to visit this job centre. She was informed that the Police are aware of Mr G's absence from the ward and that everything is being done to bring him back.'*

### **Comment Box Eight**

The Independent Investigation Team is concerned that so much of the decision process undertaken by the Laffan Ward in relation to Mr G's possible return to the Hospital is unclear and poorly documented.

In particular, it is not clear to the Independent Investigation Team why having taken a decision to contact the Police at a time when they would have had power to return Mr G, the Ward failed to pass key information on.

#### **16.12 Mr G's Return to The Hospital to Collect His Possessions**

**16.13** Mr G has stated that he returned to the Hospital, to collect his possessions on an unknown date. Mr G recalls that he was seen by a nurse and possibly a doctor who had been involved in his care. His re-attendance at the Hospital is also referred to in the Police records. The Police records suggest that Mr G returned to the Hospital after his Section 2 Order had expired but shortly after his departure from the Laffan Ward.

**16.14** Mr G described an amicable exchange between himself and staff members on this occasion. He was given his possessions and was wished luck for the future. When Mr G was asked by the Independent Investigation Team if he would have been happy to return to the Hospital for care and/or treatment when he returned for his belongings, Mr G stated that he would have been prepared to stay had this option been offered.

**16.15** The Code of Practice states that:

*'It is good practice when a detained... patient returns after a substantial period of absence without leave always to re-examine the patient to establish whether they still meet the criteria for detention'*

**16.16** Mr G's re-attendance at the Hospital to collect his belongings is entirely undocumented. Consequently, it is unclear what happened on this occasion or indeed whether Mr G presented at the Ward or indeed Hospital reception. However, it does appear that Mr G was given his belongings, although this too is unclear, as the Trust were unable to provide entries in the Trust Property Log relating to Mr G's belongings including his passport. Mr G's passport is referred to in his medical records as having been placed in a drawer in the Nurse's Office for safe keeping following advice from the Police given after Mr G went AWOL.

**16.17** The scarcity of evidence in relation to Mr G's return to the Ward means that it remains unclear where he presented and which staff had interactions with him. Although Mr G said he returned to the Ward, there is little certainty about the circumstances of the apparent return. Staff members were unable to recall Mr G returning to the Ward.

- 16.18** It does appear that when Mr G re-attended the Hospital, his Section 2 Order would have lapsed. As a result, the Hospital staff would not have been able to readmit him under his Section 2 Order. However, consideration could have been given to his presentation and whether or not a new period of detention was justified under the Mental Health Act.
- 16.19** However, this does not mean that all that should have been done on this occasion was to hand over his belongings. Nor does it explain the complete lack of documentation relating to this attendance. As a minimum, the Independent Investigation Team would expect in these circumstances, if a patient returned to a ward, that a nurse and the doctor on-call should have discussed the action to be taken. This discussion should have been documented.
- 16.20** In addition, it would have been desirable for Mr G to have been seen and a mental state assessment and a risk assessment conducted. This would have allowed the clinical team to reach a proper conclusion as to whether there were grounds to seek Mr G's detention once more. If it was a junior doctor who was present on the Ward at this time and they felt that they were too inexperienced to make the decision, then a more senior doctor on call should have been contacted.
- 16.21** The failure to document what happened on this occasion is potentially a significant failing and one which had the possibility to impact upon Mr G's future care. For example, this event is not referred to in Mr G's discharge summary and in addition, when the Hospital were contacted by GPs later that year for information about Mr G's presentation following his departure from the Ward could not have been accurately given.

## 17 DISCHARGE PLANNING AND PROCESS

- 17.0** Mr G was formally discharged from the Laffan Ward on 28 October 2011.
- 17.1** A Discharge Summary was completed on the 10 November 2011, within two weeks. This delay is not unusual, nor is it unusual for it to take longer than two weeks to produce a Discharge Summary due to the administrative delays caused by dictation, audio-typing, checking, making revisions, and signing-off.
- 17.2** Mr G was discharged following his departure from the Hospital when he went AWOL. He was discharged at a point in his Care Plan when he would not have been discharged had he not left the Hospital on 20 October 2011. In fact, those caring for Mr G had made an application to detain him for treatment which it had not been possible to implement. Consequently, the discharge planning process faced the difficulty that the Care Plan which had been developed could not be implemented properly and, as a result, the clinical team was not in a position to fully assess Mr G.
- 17.3** Given Mr G's individual circumstances, the Independent Investigation Team takes the view that, to be successful, the Discharge Summary would have to make the circumstances of Mr G's discharge very clear. It would need to detail that Mr G was a person who had been in hospital, that he did not complete his course of treatment, and that he had been subjected to an assessment that identified that there was a need for ongoing treatment. A brief letter notifying of Mr G's discharge was sent to Mr G's GP, and this does summarise the necessary information.
- 17.4** The formal Discharge Summary is lengthy, spanning several pages. It has a comprehensive overview of Mr G's history and presentation at the time he left the Ward. It makes it clear that Mr G was poorly engaged, and he was not concordant because he lacked insight.
- 17.5** In the section entitled '*Main Risks*' it states that '*On admission, Mr G denied any thoughts of harm to himself or others*'. It does, however, note his thoughts of perpetrators of the '*attack*' and that he is vulnerable, since he has little insight and is likely to disengage from services.
- 17.6** The Discharge Summary contains some information about future care for Mr G. It advises:

*'Should Mr G re-present to mental health services, the above issues will need to be explored.'*

*'We were planning on referring him to the CMHT on discharge and should he appear amenable to this I (sic) the future, please could the GP arrange this.'*

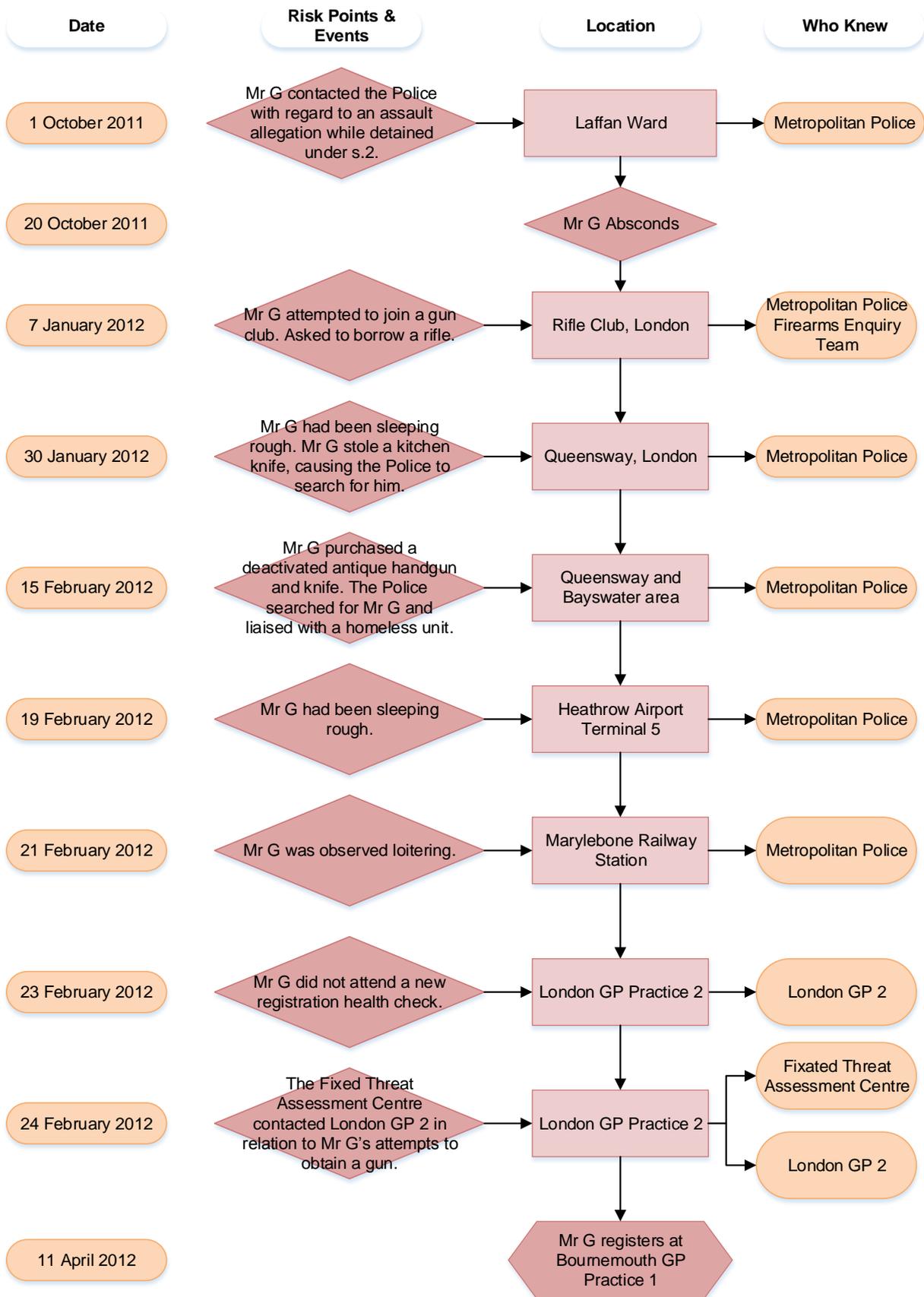
- 17.7** However, it does lack depth which could have provided Mr G's future clinicians with information thereby improving continuity of care. Mr G was not an individual who was experiencing a first episode psychosis when he attended the Laffan Ward. His problem was a recurrent one. It was also known that he was non-adherent with treatment. However, the discharge plan fails to address non-adherence other than superficially.
- 17.8** The issues with Mr G's non-adherence were described in his progress notes. Mr G's belief that he was not ill underpinned his belief that he did not need treatment. During his admission, this was being addressed by efforts to engage him therapeutically, alongside a recommendation to use depot medication under the Sections 2 and 3 of the Mental Health Act 1983.
- 17.9** In addition, there is little in the discharge plan about the content of Mr G's psychotic symptoms, in particular the fact that he seeks vengeance against people who he believes to have sexually assaulted him. This is a psychotic delusion which could have alerted a GP who he later consulted that this area required further exploration. It could also have been useful for the Police to have when they were in contact with Mr G in Heathrow Airport and when he attempted to purchase a gun.
- 17.10** Further, if it was the case that Mr G returned to the Ward after he went AWOL, this information should have been contained in the Discharge Summary. This is especially the case if any assessment was undertaken or if he was deemed well enough to be allowed to leave.

## **18 POLICE CONTACT WITH MR G**

- 18.0** On 1 October 2011, Police had attended the Laffan Ward because Mr G had contacted them to report an allegation of sexual assault against him which had occurred on 27 September 2011 at King's Cross Station. Mr G was able to name his alleged assailants and gave the Police a detailed account of the incident. Mr G also disclosed that similar attacks had been made on him by these individuals in the past.
- 18.1** Staff at the Laffan Ward told the Police that Mr G was the subject of a Section 2 'Mental Health Assessment'. The Police records state:
- 'He was seen by a Senior House Officer 1 (sic), a mental health professional whom has stated VIW1 is suffering from harmless delusions. There is a note of the report from V1W1 brother whom states that VIW1 has a history of mental psychotic illness and has always refused medication'.*
- 18.2** The incident was closed by the Police given the absence of supporting evidence and knowledge of Mr G's history of delusions.
- 18.3** Following Mr G being reported as having gone AWOL on 20 October 2011, the Police were in contact with Laffan Ward, as detailed in Section 14 above.
- 18.4** There are a number of instances where the Police had contact with Mr G at the end of 2011 and the beginning of 2012.
- 18.5** Firstly, on 7 January 2012, it appears that the Firearms Enquiry Team received an e-mail from a rifle club. This enquiry related to Mr G, who had attended the club on two consecutive nights. On the second night, Mr G had asked whether he would be able to borrow a rifle if he joined them. Mr G was told that he would not be able to borrow a gun. The club drew the matter to the Police's attention. The police responded on or around 21 February 2012.
- 18.6** On 30 January 2012 the Police were alerted to the fact that Mr G had stolen a kitchen knife, and was sleeping rough in the vicinity of the North Westminster and Queensway areas. A photograph of Mr G was disseminated, and the Queensway area was searched for him without success.
- 18.7** On 15 February 2012, the Police learned that Mr G had purchased a deactivated antique handgun and a knife.
- 18.8** A deactivated weapon is any firearm that has been converted so that it can no longer discharge any shot, bullet, or any other missile. Deactivation is intended to be permanent, and cannot be reactivated without specialist tools or skills.
- 18.9** Any weapon (including prohibited one, such as a machine gun) can be deactivated, and will no longer deemed a firearm under the Firearms Act.
- 18.10** Deactivated weapons may be possessed without a firearm or shotgun certificate, and may be displayed without the need for a locked gun cabinet.
- 18.11** Mr G's mental health history was recognised at this time, and unsuccessful

attempts were once again made to locate him. A mental health liaison update from 16 February 2012 noted that plans were made to send the information to the local homeless unit so that they might attempt to refer Mr G to a homelessness outreach mental health team if contact was successfully established. It is unclear whether this information was passed on or not due to the limited documentation available to the Independent Investigation Team on this point.

- 18.12** On 19 February 2012, Police officers on patrol approached a man who was sleeping rough at Terminal 5 of Heathrow Airport. This man was Mr G, who was subsequently ejected from the airport.
- 18.13** On 21 February 2012, Mr G was stop-checked at Marylebone Railway Station. Mr G had been loitering and behaving strangely and without any evident purpose. No action was taken by the police, and Mr G was moved on.
- 18.14** There are occasions when the Police may act to detain someone, but this may happen only if they believe that individual is suffering from a mental illness and is in need of immediate treatment or care. Their powers for such occasions are set out in Section 136 of the Mental Health Act.
- 18.15** If a Police officer finds any person in a public place who they believe is mentally ill and in need of immediate care or control, the officer is allowed to remove them from the public place to a '*Place of Safety*', either for their own protection or for the protection of others, so that their immediate needs can be properly assessed. There is nothing in the Police records to indicate that Mr G's presentation on any of the occasions when he came into contact with the Police could fulfil the criteria for detention outlined in Section 136 of the Mental Health Act.
- 18.16** The Police records indicate that Mr G remained within the London area following his departure from the Laffan Ward until at least mid-January 2012. It appears that Mr G may have stayed at three hostels in the NW1 area at around this time. He may also have stayed at a hostel in Queensway W2. Mr G first made contact with GP services in Bournemouth during April 2012.
- 18.17** Below is a diagram of reported movements of Mr G following his departure from Laffan Ward: Some reports cannot be confirmed or it remains unclear whether Mr G actually attended the places listed, as these were locations he was possibly going to visit. It appears that whilst Mr G was in contact with the Police, they did not have any remit to intervene.



### **Comment Box Nine**

There are a number of instances where the Police had contact with Mr G at the end of 2011 and the beginning of 2012. These included a time when Mr G was sleeping rough at Heathrow Airport and when Mr G attempted to join a rifle club.

Mr G was unable to purchase or borrow a weapon which was the subject of restrictions under the Firearms Act 1968. He was, however, able to purchase a deactivated weapon.

It appears that whilst Mr G was in contact with the Police they did not have any remit to intervene because he was not, in the opinion of the Police officers, an individual who was suffering from a mental disorder and was in immediate need of care or control which warranted him being taken to a place of safety.

## 19 GP CARE IN LONDON

- 19.0** Mr G was discharged from care at the Laffan Ward earlier than anticipated as a result of his decision to abscond. The formal date of discharge was 28 October 2011, whereupon he was discharged to the care of GP services. Mr G's whereabouts were unknown at this time. By this stage, his formal detention under the Mental Health Act 1983 had also ended.
- 19.1** The intended discharge plan adopted by the Trust had been to refer Mr G to CMHT services. However, this proved to be impracticable due to Mr G's whereabouts being unknown and also given the fact that Mr G did not have a permanent address. London GP 1 (Mr G's GP at the time he was admitted to hospital) was therefore asked to make a referral to his local CMHT should Mr G get in contact.
- 19.2** As a result, it was assumed that primary services would be likely to come into contact with Mr G, and therefore it was deemed important that they had access to information relating to his treatment in hospital, in order that they could continue with the proposed Care Plan. By sharing the discharge summary with Mr G's GP, it was hoped that those responsible for his care would be able to implement the Care Plan which had been proposed. This is a reasonable course of action for the hospital to have taken, and is in keeping with standard practice.
- 19.3** Following his discharge, Mr G did not see London GP 1, but instead approached London GP 2 to register with this practice on 21 February 2012.
- 19.4** On 24 February 2012, it is recorded in Mr G's GP records that London GP 2 was contacted by the Fixated Threat Assessment Centre ('the FTAC'), and was informed that Mr G had previously gone AWOL whilst under a Section 2 Order.
- 19.5** The FTAC is responsible for dealing nationally with the stalking or harassment of public figures by lone individuals. The FTAC receives referrals of people who have engaged in threatening or harassing communications towards politicians or the Royal Family. Around half are assessed as being of low risk after initial enquiries. The remainder are investigated by FTAC staff. They may then be referred to local health services for further assessment. In some cases, they may be detained by police under the Section 136 powers of the Mental Health Act 1983 prior to referral.
- 19.6** The FTAC is a specially commissioned service. In addition to officers drawn from the Metropolitan Police, it includes psychiatric professionals as core members, and is funded jointly by the Department of Health and the Home Office.
- 19.7** The note of this consultation states:
- 'Patient went AWOL on a section 3 from St Pancreas Hospital MH unit in October. Recently came to police attention as sleeping rough at Heathrow Airport, then went to one possibly two gun clubs asking if he could borrow a gun in the last 1-2 weeks. Their service works with MH and police services.'*

*Address above is thought to be his brothers. Not seen here, but will look out for patient from now on'.*

- 19.8** On 2 March 2012, Mr G failed to attend an appointment with London GP 2.
- 19.9** London GP 2 therefore telephoned Mr G later that day to obtain further information. Mr G's notes state:
- 'He says no PMH of mental health. Need to talk to previous GP. Called patient 12.19h wants an appointment to talk about incident where stabbed with syringe, also feels he may have had drink spiked. Asking about referral to a poisons centre. Explained not possible but happy to see him here Monday 11 am. Called GP again 1507 will fax Dx summary. PMH fixed delusion about being injected with substances. Was on risperidone 2mg b.d. psych SHO..... Called GP ....staff confirmed he was registered there Dr at lunch will call later'.*
- 19.10** The Independent Investigation Team believes that this was a reasonable response to Mr G's presentation. London GP 2 was acting with limited information. Referring Mr G to psychiatric services may have had a limited chance of success without first engaging with him to explain the potential benefits which such a referral could provide. Further, London GP 2 had reason to believe that Mr G's physical condition may need to be reviewed based on the details of his complaint. Consequently, it was appropriate to invite Mr G to the surgery in order to be assessed.
- 19.11** London GP 2 also contacted London GP 1 later on 2 March 2012 to discuss Mr G's presentation. London GP 2 received confirmation that Mr G was in fact still registered with London GP 1 during this call.
- 19.12** It should be noted that when a patient registers with a new practice, there is often a delay whilst their records are transferred to the new practice. London GP 2 sought to alleviate this issue by contacting London GP 1 directly. This conduct display elements of good practice by London GP 2.
- 19.13** The Laffan Ward discharge summary was then faxed from London GP 1 to London GP 2 later that day. This level of responsiveness is an element of good practice.
- 19.14** Subsequently, on 5 March 2012, Mr G failed to attend an appointment with London GP 2, and ultimately did not return to London GP Practice 1 or 2.
- 19.15** Following Mr G's failure to attend the appointment on 5 March 2012, notes from his Discharge Summary were copied into his records. The Independent Investigation Team was unable to find any evidence which suggested that Mr G came to the attention of a GP in the London area again in the period before the offence.

### **Comment Box Ten**

The Independent Investigation Team is of the view that the conduct of the GPs in London was appropriate.

GPs can only assess patients based on the evidence before them. London GP 1 had access to Mr G's records and his Discharge Summary, but did not have an opportunity to engage with Mr G and encourage him to utilise mental health services. Indeed, London GP 1 did not see Mr G after he was discharged.

London GP 2 was acting without prior knowledge of Mr G, and experienced only limited contact with him. London GP 2 noted concerns about Mr G after reviewing his file and considering information provided by from the FTAC and as a result the Police.

When London GP 2 spoke to Mr G by phone on 2 March 2016, attempts were made to establish a rapport and to encourage him to attend a double appointment. This would have furthered efforts to build a rapport and would additionally have provided the opportunity to carry out a more comprehensive and current assessment of Mr G's mental state. Indeed, Mr G's complaint of poisoning would have warranted a physical examination, notwithstanding suspicions that the story was the result of delusions.

The level of liaison between the two GPs is another element of good practice. London GP 2 demonstrated initiative by contacting Mr G's former GP to seek further insight, and London GP 1 responded by faxing Mr G's discharge summary as a matter of urgency. This level of responsiveness is commendable.

London GP 2 also recorded the fact that the FTAC had been in contact and their concerns in Mr G's records. This could have ensured that practitioners who saw Mr G would have this information available to them were they able to subsequently assess Mr G.

Given that Mr G's whereabouts were unknown, it would not have been practical for either London GP to have made a referral to a CMHT at this time.

## **20 MR G'S PRESENTATION IN BOURNEMOUTH**

- 20.0** The accommodation in which Mr G was living in Bournemouth was owned by a private landlord. It had been further sub-let by individual room to members of what was a relatively transient community comprised in the main of foreign students. The flat in Lansdowne Road where Mr H died is in an area which is close to the city centre and college and is therefore popular with students. A significant amount of the property in Lansdowne Road is private rental property.
- 20.1** The landlords themselves are not part of a structure which would be applicable for example in local authority supported accommodation. If for example, a tenant in supported accommodation was behaving in a manner which suggested declining mental health, it is possible that a landlord or manager in this sector would contact social or health services to spark multi agency discussions about an individual's welfare.
- 20.2** This type of accommodation allows individuals to become relatively anonymous. Fellow tenants may not speak English and may have temporary work. They may move accommodation on a relatively regular basis and may not have a proper opportunity to develop relationships with flat mates, neighbours etc.
- 20.3** The Independent Investigation Team has had access to a number of witness statements prepared for the criminal proceedings involving Mr G. These provide some information about Mr G's behaviour in the days leading up to the death of Mr H.
- 20.4** Mr G's tenancy in Lansdowne Road commenced on or around 15 May 2012. He rented a single room in a second floor flat. He paid his rent in cash. On or around 6 June 2012, Mr H and his friends moved into the remaining rooms in the flat. They had come to the United Kingdom from different countries to improve their English and had been in the UK for approximately 2 months.
- 20.5** Problems between the flatmates quickly arose. Mr H and his friends complained to their landlord about a number of aspects of Mr G's behaviour which they did not find to be acceptable. These included the following:
- Difficulties interacting – Mr G was described by his flat mates as '*autistic*'.
  - When invited for a meal with his flatmates, Mr G would sit and stare at his food and not eat, despite encouragement.
  - Mr G would spend a significant amount of time in the bathroom and would run a shower for 10 minutes before getting into it. It was usual for him to spend two hours at a time in the bathroom. This could be in the middle of the night creating a disturbance for his flatmates.
  - Mr G would spend significant periods of time in the kitchen sitting and laughing inappropriately to himself.
  - Mr G would stand in the hall of the flat for several hours at a time in the dark looking lost.
  - He would watch his food burn and not do anything about it.
  - He spent lengthy periods in his local supermarket, but when he was spoken to in the supermarket by his flatmates, he would appear not to

recognise them.

- His personal hygiene was poor in that he would use the pages of a book as toilet paper. The toilet paper would block the toilet causing friction with his flat mates.
- His room became odorous and his flatmates had to open windows to freshen the air in the flat.
- Mr G borrowed Mr H's computer to download information about obtaining false credit cards and espionage.
- He would go out very early and come back very late. He stayed away for two or three days at a time without providing any explanation of where he had been.

**20.6** As a result of his behaviour and his failure to pay his rent, his landlord asked him to leave the flat. He was told he was to leave on 5 July 2012 and the date by which Mr G was supposed to leave the property was 17 July 2012.

**20.7** In the period following the 5 July 2012, his flatmates noticed a deterioration in his behaviour. One spoke of him looking at her '*badly*'. He did not appear to be sleeping and spent much of the night talking to himself. There was an occasion in the middle of the night when he knocked on his flat mate's door and asked him '*where are you from*'. The witness statements reveal that each of the flatmates were unsettled and to varying degrees were frightened by his behaviour.

**20.8** However, Mr G did not threaten or use violence towards any of his flatmates before the attack on Mr H on 17 July 2012. Indeed, all of Mr H's flatmates have confirmed that there was no fight or hostility between Mr G and Mr H. In addition, no one had noticed any weapons or instruments around the flat which belonged to Mr G and which caused them concern. However, when asked to confirm ownership of the knives which were used in the attack against Mr H, none of them were able to identify these implements as having been present in the flat previously.

**20.9** Consequently, it appears that Mr G may have purchased knives, although the timing of this purchase is unclear.

#### **Comment Box Eleven**

During the period in which Mr G was in Bournemouth, there were no reports of acts of aggression or violence by Mr G towards his flatmates, although he was noted to be acting strangely which some of them felt alarmed by.

## **21 GP CARE IN BOURNEMOUTH**

### **21.0 GP2GP ELECTRONIC RECORD SYSTEM**

**21.1** GP2GP allows patients' electronic health records to be transferred directly and quickly between their old and new practices, when they change GPs. This improves patient care by making full and detailed medical records available to practices, for a new patient's first and subsequent consultations. 98% of England's 7,696 GP practices are able to utilise GP2GP.

**21.2** If a patient's existing and previous practice use GP2GP, then their electronic notes can be transferred straight after the patient's registration with their new practice. In comparison, paper medical records can take weeks or months to arrive.

**21.3** GP2GP also means practices can support the Department of Health's objective that patients should have digital records that follow them around the health and social care system.

**21.4** GP2GP is a three-stage process.

1. The first stage is to register the new patient on the clinical system and perform a Personal Demographics Service search, to see if the patient has an entry on the NHS Spine. A successful search and match will allow a request for the patient's electronic health record to be sent to the patient's old practice.
2. The second stage, sending, is automated and usually takes no more than a couple of minutes.
3. Once the record is received, the third stage is to integrate or file the record into the clinical system. This makes it available for use within the practice and also informs the sending practice if they need to print copies of the record or attachments, before they send the Lloyd George envelope to the new practice.

**21.5** However, if a patient registers as a temporary resident with a practice then their health records remain at their existing practice and are not transferred either as a paper record or via GP2GP.

**21.6** The temporary practice must therefore contact the patients' registered GP if they require any information.

### **21.7 Bournemouth GP Practice 1**

**21.8** Mr G formally registered at Bournemouth GP Practice 1 on 11 April 2012.

**21.9** A GP2GP (an electronic record transfer system) record was transferred on the date of Mr G's registration. Mr G attended a single emergency consultation with Bournemouth GP 1 on 13 April 2012.

**21.10** The record of this consultation states:

*‘[Several] weeks ago injured right hand and was seen in London Hospital and feels hand was set wrong and interested in assessment by private dr (sic)(apparently has private health insurance) wearing it hand splint. Mental state unremarkable although seems rather fixated on private referral. Plan nil acute for tonight. Appt booked with normal dr on Monday morning, pt given written details (double apt booked as GP2GP notes suggest careful assessment of mental state may be helpful’.*

**21.11** Bournemouth GP 1 booked Mr G in for a double appointment on 16 April 2012. This is indicative of good practice, as a lengthy appointment would have provided a good opportunity to focus on Mr G’s assessment needs.

**21.12** In addition, it appears that on 13 April 2012, Bournemouth GP 2 made two unsuccessful attempts to telephone Mr G. The records do not indicate what the issues were that Bournemouth GP2 had planned to discuss with Mr G, or whether the attempts were made before or after the emergency consultation. Nonetheless, these attempts are another example of good practice in relation to attempts to engage with Mr G on the part of Mr G’s GPs.

**21.13** Mr G subsequently failed to attend the follow-up appointment on 16 April 2012, and did not make any further appointments at Bournemouth GP Practice 1. He appears to have been de-registered from the practice on 2 May 2012.

**21.14** Consequently, Bournemouth GP 1’s experience with Mr G was restricted to a single face-to-face consultation. At this consultation, London GP 2’s concerns about Mr G’s mental health problems, which were included in the GP2GP notes, were acknowledged, and an attempt was made to explore this issue with Mr G was made. A follow-up appointment was arranged with Mr G, who failed to attend, and then proceeded to register with another practice.

**21.15** The attempts to build a rapport through follow-up appointments were appropriate given the limited knowledge which Bournemouth GP 1 had of Mr G and the passage of time since his in-patient stay. GP 1 clearly identified a need to review Mr G’s mental health. The Independent Investigation Team is satisfied that the Bournemouth GPs 1 did not have sufficient grounds upon which to conclude that Mr G presented a risk to himself or others on 13 April 2012 based upon his presentation at this consultation.

**21.16** As a result, pursuing a compulsory intervention under the Mental Health Act 1983 would not have been appropriate. However, Bournemouth GP1 recognised the need for a more in-depth review which would have allowed consideration of the information in the Discharge Summary dated 28 October 2011 together with the information provided by the Police and FTAC.

**21.17 Bournemouth GP Practice 2**

**21.18** On 9 June 2012, Mr G attended an out of hours appointment, presenting with a complaint that a friend had put drugs in his food.

**21.19** Mr G registered with Bournemouth GP Practice 2 on 11 June 2012, and was seen by Bournemouth GP 3 on the same day. The note of this consultation states:

*'History: seen by OOH on 9.6.12 – says his friend put some drugs in his food – felt unwell Mr G said that he was feeling better, but wanted further treatment for it - vague presentation – told is v reassuring that he is feeling better'.*

**21.20** On 12 June 2012, staff at Bournemouth Practice 2 scanned an opt-out form which Mr G had completed, stating that he wanted his clinical information to be withheld from the Summary Care Records. This indicates that Mr G was concerned about disclosure of information which was contained within his medical records. It should also be noted that Mr G registered with the practice under a different name, which would have added an additional layer of complexity in obtaining his medical records.

**21.21** On 13 June 2012, Mr G's notes show an admin entry which records that Bournemouth GP 4, who worked at Bournemouth GP Practice 2 was now Mr G's registered General Practitioner. Mr G did not contact Bournemouth GP 4 at any point. In addition, Mr G did not attend any appointments at Bournemouth GP Practice 2 after 11 June 2012.

### **21.22 Bournemouth GP Practice 3**

**21.23** On 12 June 2012, the day after he registered with Bournemouth GP Practice 2, Mr G had a telephone consultation with Bournemouth GP 5 at Bournemouth GP Practice 3, and requested a referral to a consultant. The entry relating to this conversation states:

*'History: Telephone encounteringested? (sic) drugs on Saturday from flatmate putting drugs in food. Seen by OOH on Sunday morning. Was very drowsy at the time and noises seemed loud. Somewhat better now? Acid or mushrooms. Says he wants to see a consultantwith a view to investigations and treatment. I don't know how helpful that would be 72 hours after the vent. He says he will investigate further'.*

**21.24** On 14 June 2012, Mr G telephoned Bournemouth GP 6, a different practitioner at Bournemouth GP Practice 3 asking to be referred to a toxicologist. The note of this consultation states:

*'History: tel.....rather unusual story, pt now req to see a toxicologist. Plan best to see him in person and find out a bit more about him and his pmh...offered appointment'.*

**21.25** An appointment was made for Mr G later that afternoon with Bournemouth GP 6. Mr G said that he was sharing a flat with a drug user who had been putting drugs in his food. Mr G explained that he had done some research, and wanted to be referred to an endocrinologist due to a lack of toxicologists. Mr G also asserted that he had no previous history of mental health problems. A record of this consultation states:

*'History: shares a flat with a chap who does drugs,, says he puts them in his*

*food... pt has done some research and seems to want to see an endocrinologist (sic),, [due to lack of toxicologists,,] says he has no other pmh, studies aerospace engineering ?then finance investment import export/ now sales ,, on no medications, does not do any drugs or smoke any drugs ,,says noises are still loud in head feels strange//spacey,, 'I feel things tooo (sic) much' ...pt has been looking on wikepedia, Plan reg bloods,, and ask if they can do common toxicology,, [or is this the start of some other supratentorial problem more likely I feel ring next week re resultI have given the patient my advice but he does nt seem particularly keen to follow it'.*

- 21.26** On 15 June 2012, Bournemouth GP 6 discussed Mr G's presentation with a colleague and decided that a referral should be made to the 'Priority' as 'they deal with drug toxicology and psy (sic) difficulties'.
- 21.27** On 19 June 2012, Bournemouth GP 5 spoke with Mr G regarding his request for an appointment with an endocrinologist. Mr G had been given some forms and agreed to have some tests done due to the possibility that he had been poisoned. It was agreed that further contact would be made by email. The record of this telephone conversation refers to the fact that Mr G was 'feeling a bit better'. Later that day, the GP records set out the results of a number of blood tests. The results indicated that no further clinical action was necessary.
- 21.28** On 20 June 2012, Bournemouth GP 6 received a call from Portsmouth General Hospital. Mr G had provided the hospital with a urine sample and asked for 'toxicology' to be carried out. It had been explained to Mr G that the lab at the hospital was unable to perform the tests he had requested. It was suggested during the conversation that the problem was related to his mental health.
- 21.29** Mr G again contacted Bournemouth GP Practice 3 on 21 June 2012, on this occasion, he submitted an urgent request for a private referral by email. Mr G requested appointments with a non-NHS Community Psychiatrist 1, and a urologist. At this point, Mr G outlined an account of his poisoning which was inconsistent with previous versions, describing an attack in which drugs had been injected into his genitals. It was agreed that Bournemouth GP Practice 3 would email Mr G and request more information when an unsuccessful attempt to contact Mr G by telephone was made later that day.
- 21.30** On 22 June 2012, the Senior Practice Manager spoke to Mr G, who attended Bournemouth GP Practice 3 in person. Mr G was advised that Bournemouth GP 6 was prepared to refer him to non-NHS Community Psychiatrist 1. Mr G was insistent that referral to a urologist was also necessary. The matter was referred back to Bournemouth GP 6 by the Senior Practice Manager.
- 21.31** Later on 22 June 2012, a psychiatric referral was made on a private basis to non-NHS Community Psychiatrist 1 following a conversation between Bournemouth GP 6 and Mr G. The referral letter made it clear that Mr G was a temporary resident and that the referring GP had not had access to Mr G's previous history. The letter highlights possible 'psychiatric problems', describing Mr G as 'slightly unusual', and noting that 'he described noises being loud and his head feeling 'spacey''. Bournemouth GP 6 also placed a note in Mr G's file

emphasising that he may attempt to approach other doctors within the practice. This is an element of good practice, indicating that the GPs took a particular interest in Mr G's behaviour and were aware of the unusual challenges which he presented.

- 21.32** On the evening of 22 June 2012, Mr G attended Bournemouth GP Practice 3 once more, and requested a physical assessment of his genitals. Bournemouth GP 7 assessed Mr G, and could not find any abnormalities. Mr G persisted with his request to see a urologist that night. He was reassured.
- 21.33** On 25 June 2012, Bournemouth GP Practice 3 was contacted by non-NHS Community Psychiatrist 1's secretary. The psychiatrist was not prepared to accept the referral for Mr G made by Bournemouth GP 6. Non-NHS Community Psychiatrist 1 was of the view that Mr G needed support from a comprehensive team operating within the NHS. This is an element of good practice, demonstrating an understanding Mr G's complexity, and the fact that he could not suitably be managed by a lone psychiatrist.
- 21.34** The Practice Manager acted promptly to ensure that Mr G would be assessed quickly, and therefore faxed a copy of Bournemouth GP 6's referral letter and patient summary to a local CMHT ('CMHT 1') later on 25 June 2012 *'with a request on the cover sheet that the patient could be seen 'soon'*. It is not clear whether Bournemouth GP 6 was consulted prior to this action being taken.
- 21.35** On 26 June 2012, CMHT 1 informed the staff at Bournemouth GP Practice 3 that Mr G was using an alias, and that he was also registered with Bournemouth GP Practice 2. Bournemouth GP 5 contacted Mr G. Mr G was advised that his registration status was being clarified. Mr G continued to seek referral to a urologist.
- 21.36** CMHT 1 accepted Mr G's referral despite the ongoing confusion, only for Mr G to subsequently inform Bournemouth GP 5 that he did not want any contact with NHS mental health services, and to request that the appointment be cancelled.
- 21.37** Mr G was not seen again by any of Bournemouth GPs, notably failing to attend a follow-up appointment made with Bournemouth GP 4 at Bournemouth GP Practice 2 on 2 July 2012, by which time the Practice had access to his records. This unattended appointment had been scheduled after Mr G attended at a local Accident and Emergency department, and once again requested to see a urologist.

## Comment Box Twelve

During June 2012, Mr G presented at a number of primary care providers in the Bournemouth area with persecutory ideas including having had drugs put in his food and having been injected with drugs.

During this period, Mr G was in contact with three GP practices in the Bournemouth area which would make it difficult for healthcare providers to deliver appropriate care to him. In addition, during this time Mr G had adopted an alias.

Initially, Mr G registered with Bournemouth GP Practice 1. As a result of his registration with this practice, Mr G's GP records containing information relating to his previous mental health issues were successfully transferred to Bournemouth GP Practice 1 and in addition Bournemouth GP Practice 2 through GP2GP. This would have allowed clinicians access to the information contained in the Discharge Summary prepared following Mr G's departure from the Laffan Ward in London together with the information provided by the Police and Fixated Threat Team that Mr G had attempted to borrow a gun from a gun club and had purchased a deactivated gun.

Usually individuals who contact a GP are '*help seeking*' and cooperative. However, knowing you have a mental illness and being referred onto specialist mental health care require a level of awareness that Mr G did not appear to have had at this time.

Mr G's poor insight and distrust of mental health services meant that he contacted a number of different GPs which caused difficulties in relation to continuity of care. It is also clear from Mr G's records that whenever a GP suggested that there might be a non-physical aspect of his presentation, Mr G would become more reluctant to engage. Mr G failed to return to either practice to allow an assessment of his mental health to be undertaken and a referral to secondary mental health services made.

The attack on Mr H did not involve the use of a gun. However, given Mr G's risk profile which was identified by the Laffan Ward, the attempt to possess a gun whether activated or not would require assessment in order to have determined its clinical significance. In the opinion of the Independent Investigation Team, being diagnosed with a mental disorder is insufficient to disqualify an individual from owning a deactivated gun since most forms of mental illness are not related to an increased risk of violence. However, Mr G did need to be questioned about what he planned to have done with the gun some months earlier as this information may have been of clinical significance.

In order to secure Mr G's assessment over a period of three months, different GPs tried to engage and support Mr G. The GPs dealt with Mr G on a regular basis rather than referring him on in an attempt to build a relationship with him as far as Mr G would allow them. In the absence of a documented history of risk posed by Mr G to himself or, indeed, the risk which he posed to others which would have warranted immediate referral to secondary mental health services, this was an appropriate way in which to manage Mr G at that time.

An individual may be detained under the provisions of the Mental Health Act 1983 if they have or are thought to have:

1. A mental illness which needs assessment or treatment;
2. Which is sufficiently serious that it is necessary for:
  - a. The individual's health or safety, or;
  - b. For the protection of other people.
3. The individual needs to be in hospital to have the assessment or treatment; and,
4. The individual is unable or unwilling to agree to admission.

Based on the evidence contained within Mr G's records, whilst further assessment of Mr G's presentation was indicated, there is no evidence contained in Mr G's records that indicates that the statutory test set out in section 2 of the mental Health Act 1983 for detention was satisfied at this time.

GPs attempted to engage with Mr G by establishing rapport, but it is clear that they had concerns about his mental health. However, Mr G was not willing to engage with mental health services, although an appropriate referral was made, and he had agreed to be seen. As a result, this made it more difficult to attempt to help Mr G receive treatment for consideration of use of the Mental Health Act 1983.

If an individual refuses treatment, their subsequent clinical management depends upon whether they have capacity. During the course of interviews conducted by the Independent Investigation Team, a member of the clinical team at the Laffan Ward made the following comment concerning Mr G's presentation:

*'even in the acute presentation. He didn't come across as being a behaviourally-disturbed individual. .... you could have, in some ways, a rapport with him, because he presented, in many ways, just as an, in inverted commas, 'normal, everyday person'.*

Whilst the GPs who were in contact with Mr G at this time were concerned about Mr G, and recognised the possibility that his symptoms may have been generated by a *'psychiatric problem'*, his presentation does not appear to have raised concerns about his capacity to make decisions about his healthcare.

In England, adults are presumed to have capacity. It is only by overcoming this presumption by proving that: (i) the individual has an impairment of, a disturbance in the functioning of the mind or brain; and (ii) is unable to understand the relevant information, retain it, weigh it, and communicate their resultant decision that the diagnosis of incapacity can be made.

If a competent individual declines a referral to secondary mental health services, then the practitioner's duty of care extends to taking whatever steps are possible, within the confines of the individual's wishes, to ensure that the individual has made their decision knowing the consequences of their actions.

The individual would need to be assessed as to whether they are competent to refuse mental health care. Capacity may be affected by chronic disorders such as psychosis. However, a mental disorder does not automatically make someone incapable of making health-care decisions nor does it of itself justify compulsory admission under the Mental Health Act.

## 22 CMHT CARE IN BOURNEMOUTH

- 22.0** Mr G was referred to CMHT 1 on 26 June 2012 by Bournemouth GP Practice 3. He was referred under a different name to that which he had provided to Bournemouth GP Practice 3, though CMHT 1 became aware that he was using an alias by referring to RiO (An electronic case record used by mental health services). Mr G provided the address of the flat which he shared with Mr H to GP Practice 3.
- 22.1** The purpose of a CMHT is to offer assessment, treatment and care at home for people with mental health problems. The service provided by CMHTs focuses on individuals who are over 18 and have a significant mental disorder and includes individuals with:
- Schizophrenia and other psychotic disorders.
  - Affective disorders such as bipolar disorder and moderate / severe or complicated depressive disorders.
- 22.2** Referrals are made via letter, telephone, electronically or fax, directly to the CMHT by the GP or any other health or social care professional.
- 22.3** CMHT Worker 1 and CMHT Worker 2 identified that Mr G's registered GP was practicing at Bournemouth GP Practice 2, and not the practice which made the referral. This alerted them to the fact that Mr G was simultaneously registered at two practices. CMHT 1 decided to accept Mr G's referral despite the description of the situation as '[a bit] *confusing*'. This is an element of good practice, as CMHT 1 could feasibly have attempted to absolve themselves of responsibility for Mr G by finding him to fall outside of their remit, but instead chose to try and engage him.
- 22.4** On the same day, CMHT Worker 2 phoned Bournemouth GP 5, and forwarded the information that Mr G was registered with two practices and was using an alias.
- 22.5** Mr G did not attend an appointment on 12 July 2012. A plan was therefore made to contact Mr G by phone and attempt to make another appointment.
- 22.6** On 13 July 2012, administrative staff spoke to Mr G regarding his missed appointment. Mr G said that he did not know he had an appointment with CMHT 1, nor did he believe he needed their help. Mr G stated that the appointment must have been made by mistake, and therefore declined the offer of a further appointment. Such behaviour is consistent with Mr G's record of avoiding mental health services up until that point. This information was passed on to the treatment team by the administrative staff.
- 22.7** CMHT Worker 3 made further attempts to contact Mr G by phone, succeeding on 16 July 2012. Mr G explained that he did not wish to be involved with CMHT 1, and '*declined any home visits as soon as soon as I told him that I was a CMHN. He refused to confirm his address and hurriedly hung up*'.

- 22.8** As a consequence of this conversation, CMHT Worker 3 made a plan to inform Mr G's GP that he had refused to be involved with CMHT 1, '*and to call for an MHA assessment if worried about his mental health state*'. Further, CMHT Worker 3 planned to discuss Mr G at an upcoming CMHT meeting, which indicates that his presentation would have been reviewed allowing consideration of issues such as safeguards to be discussed and applied.
- 22.9** CMHT 1 established contact with Mr G, and he clearly declined their involvement. As has been mentioned, if a competent individual declines a referral to secondary mental health services, then the practitioner's duty of care extends to taking whatever steps are possible within the confines of the individual's wishes, to ensure that the individual has made their decision knowing the consequences of their actions.
- 22.10** There is clear evidence in Mr G's records that CMHT1 attempted to establish a rapport with Mr G in order to try and build a '*relationship*' which would allow an assessment to take place. However, Mr G was not prepared to engage with CMHT 1.
- 22.11** CMHT 1 and Bournemouth GP 5 clearly discussed the use of the Mental Health Act which was not felt appropriate because Mr G did not appear '*unwell enough*' and the risk of violence based upon Mr G's presentation and risk profile at that time.

*'Discussion with Bournemouth GP 5, he has had contact with Mr G who has told Bournemouth GP 5 that he wants nothing to do with NHS services and that he changed his name by deed poll [...]. Bournemouth GP 5 advised that he has nil evidence of this. Bournemouth GP 5 has also told Mr G that he is registered with Bournemouth GP Practice 2 and must attend their surgery and not register with various surgeries. Bournemouth GP 5 advised that although Mr G was somewhat odd he did not think that he was a risk of violence and was definitely not unwell enough to warrant a MHA assessment.*

*'PLAN*

*'Although Mr G has now said that he does not want NHS involvement I have advised that we will keep the OPA open in order for Mr G to be assessed as it may be he changes his mind'.*

- 22.12** Given Mr G's presentation prior to the death of Mr H, there was limited action within the Mental Health Act Framework which the CMHT could have taken to assess Mr G in view of his apparent capacity and presentation at the time.
- 22.13** On 17 July 2012, CMHT 1 was informed that Mr G was in police custody. Mr G was detained under Section 2 of the Mental Health Act 1983 on 18 July 2012.
- 22.14** The Independent Investigation Team recognises that the staff at the CMHT demonstrated good communication both within the team, and with Mr G's GPs. Further, CMHT 1 demonstrated strong awareness of the difficulties which Mr G presented, but attempted to persevere with him.

### **Comment Box Thirteen**

The CMHT in Bournemouth made significant efforts to engage with Mr G despite his reluctance to be involved with secondary mental health services.

As a consequence of a conversation between CMHT 1 and Mr G on 16 July 2012 when Mr G indicated that he did not wish the involvement of CMHT 1, a plan was made to discuss Mr G at an upcoming CMHT meeting. Consequently, his referral was not closed and indeed Mr G's presentation was to be reviewed allowing consideration of issues such as safeguarding, capacity and risk assessment to be discussed and explored.

They were able to work flexibly to ensure that, despite a number of uncertainties including his name, his address, and the GP which he was registered with, he was afforded an opportunity to access care promptly.

These are elements of good practice.

## **23 REACTION TO INCIDENT BY HEALTHCARE PROVIDERS**

**23.0** As part of its Terms of Reference, the Independent Investigation Team is required to:

- Review the Internal Investigation Report (SUI 2011/21879) and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that has been made in implementing the action plan.

**23.1** An Internal Investigation (SUI 2011/21879) was performed by Camden and Islington NHS Foundation Trust. The Internal Investigation was initiated on 19 November 2012 and was approved by the Trust on 23 January 2013. The Internal Investigation was triggered when the Trust were contacted by the Police following the death of Mr H. Until this point, there is no record of an investigation at any level into Mr G's departure from the Hospital. Indeed, neither the Internal Investigation nor the Independent Investigation Team was shown a contemporaneous incident form in respect of Mr G's absence from the Laffan Ward.

**23.2** It is clear that at the time of Mr G's departure from the Laffan Ward, systems to collect data regarding AWOL incidents from the Hospital were not in place. The Trust has now extensively revised its processes and these deficiencies have been addressed. The following improvements have been made:

- Revised Section 17 leave form.
- Revised AWOL policy.
- Datix entry to be completed following AWOL incident.
- Routine review for AWOL incidents longer than a few weeks.
- Developing a discharge checklist (in progress).
- Regular updates by Police on missing persons.

**23.3** However, it is clear that, had Mr H's death not occurred, Mr G's disappearance from the Hospital would not have been the subject of an investigation at any level by the Trust. This is of itself disappointing. The most serious type of AWOL situation is where a detained patient goes AWOL and does not return. This situation merits investigation and detailed scrutiny.

**23.4** The terms of reference for the Internal Investigation were:

- To review the treatment and care provided to Mr G.
- To investigate the circumstances of the incident.
- To produce a report making recommendations to prevent a similar incident happening and/or to improve standards and practice.

**23.5** The Internal Investigation made use of Root Cause Analysis techniques in its analysis of Mr G's care. Root Cause Analysis is a useful tool extensively used throughout the NHS to establish how and why incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients and those with whom they come into contact. When used effectively, Root Cause Analysis is a powerful investigative tool. In this case

aspects of Mr G's presentation have clearly been subjected to Root Cause Analysis.

- 23.6** It is thirteen years since the events giving rise to the Ritchie Inquiry into the care of Christopher Clunis who killed Jonathan Zito, a musician, in an unprovoked attack at a London Underground station on 17 December 1992. His care was described as a '*catalogue of failure and missed opportunity*'. During that time, significant changes have been made to the legal framework governing mental health and there have also been changes in the manner in which services are delivered. However, analysis of independent mental health homicide reports since the Ritchie Inquiry into Mr Clunis' care show that the issues highlighted in that Report remain a persistent and common feature in the findings of Independent Homicide Investigation Teams from around the country.
- 23.7** Following the Ritchie Inquiry, the NHS introduced processes to support patient care mainly around the Care Programme Approach. Subsequently, the Francis Inquiry encouraged NHS organisations to think not only about processes but to include individual judgement in order to develop a culture which is based around care when those processes are being applied.
- 23.8** It would be difficult to argue that the Internal Investigation performed by the Trust did not comply with its Terms of Reference. However, other key areas which in fact are commonly occurring themes in homicide reports and indeed were aspects of the Ritchie Report have not been included in the Terms of Reference. It might be that these areas were not highlighted because it was felt that no lessons could be learned, but learning can arise from both good and bad practice and in order to maximise the possibility of learning from a mental health homicide, these areas could be included when Internal Investigation Terms of Reference are being considered.
- 23.9** These areas include:
- Inter-agency communication.
  - Missing information.
  - Failure to keep proper records.
  - Failure to plan care properly.
  - Failure to do adequate risk assessments.
- 23.10** The Internal Investigation spoke to a range of people, including Ward staff, Consultant 1, one of Mr G's GPs and Mr G's brother. This is an element of good practice. The only person absent from this list, who perhaps could have been spoken to was SHO 1, the junior doctor who had significant contact with Mr G.
- 23.11** Further, the Internal Investigation contacted a member of Mr G's family by telephone. The Internal Investigation did not, however, speak to members of the victim's family.
- 23.12** The Internal Investigation concluded that Mr G was treated appropriately on Laffan Ward. It recommended:
1. Reviewing application of the trust's AWOL procedure to ensure incident

forms and clinical notes are written up following AWOL incidents.

2. Developing an AWOL policy checklist.
3. Ensuring relevant documents, including Section 17 forms, are included in patient's notes on discharge.

**23.13** These recommendations have largely been implemented by the Trust.

**23.14** The Internal Investigation largely accepted the information it was told at face value and did not conduct further inquiry. Consequently, some important aspects of the incident including the circumstances under which Mr G may have returned to the Hospital to collect his property were not included in the Internal Investigation. The Independent Investigation Team had the benefit of access to Police files relating to this case. The Internal Investigation did not have the benefit of this information which was of significant value to Independent Investigation Team. Crucially, the limited information available to the Internal Investigation led to the conclusion that the problems with record-keeping were isolated incidents of limited significance rather than a systemic issue. Given the numerous failings with records in this case and the concern which this raises over the ability of the Trust to manage the care given, the Independent Investigation Team would disagree with this conclusion.

#### **Comment Box Fourteen**

The Internal Investigation was only triggered once the Police alerted the Trust of the death of Mr H. No incident form as required by Trust Policy at the time was completed. This is a matter of concern given that this category of AWOL incident, i.e. the AWOL of a detained patient who did not return falls into the most serious category of AWOL incidents.

The Internal Investigation Team did not contact the victim's family during the course of its consideration of Mr G's care, but did speak to the perpetrator's family.

The Internal Investigation did not investigate a number of issues, possibly due to a lack of information. The Trust failed to consider or include common themes in mental health homicide highlighted in the Terms of Reference.

Crucially, the limited information available to the Internal Investigation led to the conclusion that the problems with record-keeping were isolated incidents of limited significance rather than being a systemic issue. Given the numerous failings with records in this case and the concern which this raises over the ability of the Trust to manage the care given, the Independent Investigation Team would disagree with this conclusion.

## **24 MEDICAL RECORDS**

- 24.0** During the course of the Independent Investigation, copies of Mr G's records were obtained from the Trust.
- 24.1** At the time of Mr G's care, the Trust used the RiO Electronic patient record system which is an electronic system used by many community and mental health trusts across the south of England.
- 24.2** The notes which were supplied were in two versions. Notes were either validated or unvalidated. Unvalidated records contained more information about Mr G, particularly in relation to the periods of leave which were granted. They also included crucial clinical information obtained and discussed during Mr G's first ward round after admission. The validated notes were therefore an incomplete set of notes.
- 24.3** Validated notes were explained to be notes that have been approved by the author, which involved ticking a box on the system at the time they created the note. They can be downloaded directly. Unvalidated notes were explained to be notes where the box to validate them has not been ticked by the author, for example if the author is intending to come back to the note to add more information. Unvalidated notes cannot be downloaded directly and have to be '*copied and pasted*' into another software package in order to download them. It is possible to view the history for each entry made in RiO.
- 24.4** All records are supposed to be validated, therefore marking them as complete and ensuring they cannot be edited.
- 24.5** During the course of the Independent Investigation, the Independent Investigation Team was given access to information provided by the Police. The Independent Investigation Team was concerned to note that when the Police were supplied with a copy of Mr G's notes on 7 September 2012, they were supplied with a validated set of records and therefore a full clinical record for Mr G was not made available to the Police.

## **25 INTERNAL INVESTIGATION BY DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST**

- 25.0** Following the death of Mr H, Dorset Healthcare University NHS Foundation Trust and Poole Teaching PCT gathered together a chronology of events which was then shared with South West Strategic Health Authority who had the responsibility for overseeing the conduct of Mental Health Homicide Investigations at that time.
- 25.1** It was agreed that the PCT would initially report the circumstances surrounding Mr H's death on the Strategic Executive Information System (STEIS) in line with the National Patient Safety Agency National Framework relating to the Reporting and Learning from Serious Incidents. It was anticipated that the Strategic Health Authority would arrange for the case to be reallocated to the relevant London Mental Health Provider which was Camden and Islington Foundation Trust. This transfer subsequently took place and the case was transferred. The chronology was subsequently shared with Camden and Islington Foundation Trust and the Independent Investigation Team.
- 25.2** Whilst Dorset Healthcare University NHS Foundation Trust prepared a chronology setting out the contact which Mr G had with services, that chronology did not contain an analysis of those contacts. Given that Mr G was not seen by services in Dorset following his move to the area from London, potentially, there could have been issues regarding access to services for example, which in turn could have provided learning for other service users. The Independent Investigation Team did not identify any such issues during the course of its Investigation.

### **Comment Box Fifteen**

It is a relatively common practice not to undertake an Internal Investigation when a patient has not been seen by a Trust. However, where an individual has travelled to an area and is seen by multiple GPs but has not engaged with secondary mental health services and then goes on to commit a homicide that in itself may be a cause for an Internal Investigation. Such an investigation would allow a Trust to be confident that there were no barriers present within its pathways towards encouraging engagement with secondary services.

Consequently, the Independent Investigation Team believes that there are circumstances where an individual such as Mr G who fails to receive treatment and goes on to commit a homicide would warrant review to determine if lessons can be learned.