



# **An independent investigation into the care and treatment of a mental health service user Mr P in Essex**

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

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## 1 Executive summary

- 1.1 NHS England Midlands & East commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr P. Niche is a consultancy company specialising in patient safety investigations and reviews.
- 1.2 The independent investigation follows the NHS England Serious Incident Framework<sup>1</sup> (March 2015) and Department of Health guidance<sup>2</sup> on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.
- 1.3 The requirement was for an independent investigation to support the Domestic Homicide Review which was commissioned by Uttlesford Community Safety Partnership. The terms of reference for this investigation are given in full in Appendix A.
- 1.4 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.5 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.
- 1.6 Mr P killed Mrs H and Mr F at his mother's address in Essex on 22 July 2015. Mr P was convicted of the murder of the two victims, who were his mother and her friend, and received a life sentence in May 2016.

### **Mental health history**

- 1.7 At time of the first referral to mental health services Mr P was 17 and lived at home with his mother and brother in Stansted.
- 1.8 He was referred to North Essex Partnership University NHS Foundation Trust in February 2010. North Essex Partnership University NHS Foundation Trust (NEP) was dissolved on 31 March 2017 following a merger with South Essex Partnership University NHS Foundation Trust (SEPT) to form Essex Partnership University NHS Foundation Trust (EPUT). In this report 'the Trust' will be used to refer to NEP and its subsequent structures.

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

<sup>2</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

- 1.9 Mr P's first referral to mental health services occurred on 25 January 2010 following a brief referral letter to the Community Mental Health Team (CMHT) from his GP requesting an assessment of his mental health. At this time the CMHT requested further information in order to commence the assessment process.
- 1.10 An additional referral was made by another GP, to add clarification and provide details of what was required. This followed a surgery meeting with Mr P where he had complained that the radio was talking to him and how he had sent a text to his friend threatening to kill him and his family. The GP then visited Mr P at home where it was noted he was suffering persecutory and paranoid beliefs. She noted a door panel missing in the house where Mr P had punched it previously.
- 1.11 A phone call by the CMHT social worker to his mother confirmed that Mr P was in bed but would not go out as he had experienced anxiety provoking experiences when last out of the house, as well as eating alone in his room and cutting off all contact with others. He was described by his mother as having been 'difficult' recently.
- 1.12 At this time Mr P was under the supervision of the Harlow Youth Offending Team (YOT) due to a history of common assault, possession of illegal substances, possession of an offensive weapon and handling stolen goods. His risk assessment considered him a mild to moderate risk of self-harm, a low to moderate risk of violence, and a moderate risk of self-neglect.
- 1.13 The result of the CMHT assessment was that he clearly showed signs of suffering from a mental disorder, and had a history of risk behaviour. It was concluded that he may be detainable under the Mental Health Act 1983 (MHA) but the least restrictive option was taken to treat him at home as he had agreed to engage with services.
- 1.14 The long term plan originating from this assessment was to refer him to the Early Intervention in Psychosis team (EIP).
- 1.15 A full CPA assessment was undertaken by the Crisis Resolution and Home Treatment Team (CRHT) who concluded that Mr P potentially had a drug induced psychosis, paranoid beliefs, thought disorder and passivity phenomena. As a result of the comprehensive assessment it was decided that Mr P would be taken on by the CRHT.
- 1.16 During the period from 21 February 2010 until 18 March 2010 Mr P received frequent interventions from the CRHT/CMHT. Throughout this time he continued to experience symptoms of mental disorder and continued to take illicit substances, mainly cannabis. He was referred to the EIP West team in Harlow on 12 March 2010 and given a working diagnosis of possible drug induced psychosis.
- 1.17 He was discharged from CRHT to the EIP on 18 March 2010. The resulting discharge plan was that the EIP would contact the family within 2-3 weeks once a worker and assessment had been arranged. On 19 April 2010 Mr P's

father contacted the service to enquire why no contact had yet been received from the EIP team, and was advised that a meeting would occur on the 27 April. His father reported that Mr P had become increasingly aggressive towards him and his mother and was still taking illicit substances. It is clear that Mr P's father was unhappy at the level of service but was instructed to contact the crisis team or police should he deteriorate further.

- 1.18 Mr P was visited by a CPN from the EIP and a YOT worker on 27 April. It was noted again that Mr P's father was unhappy with the EIP input and stated that the family had received no support since transfer to the EIP team.
- 1.19 Two weeks later he was assessed by a psychiatrist and CPN from the EIP team. The conclusion was that the CPN would refer Mr P to the 'Employability and Skills Team' and the psychiatrist would consider a reduction in olanzapine<sup>3</sup> in 6-8 weeks if Mr P continued to take medication.
- 1.20 On 17 June the EIP CPN sent a letter to Mr P's father offering a carer's assessment. His father passed this on to his estranged partner Mrs H as he was not the primary carer.
- 1.21 Throughout the period 17 June to 5 November 2010 Mr P was visited on 5 occasions but did not attend a number of appointments or answer planned telephone conversations on 11 occasions.
- 1.22 Mr P was admitted to the Derwent Centre in Harlow on 8 November 2010 under Section 2<sup>4</sup> Mental Health Act 1983 (MHA) from A&E following his arrest the previous day for possession of class A drugs. The reasons given for the detention were that he had a mental and behavioural disorder due to multiple drug use and the use of other psychoactive substances and psychotic disorder.
- 1.23 However following a number of attempts to abscond he was transferred to Shannon House, psychiatric intensive care unit (PICU) where he is noted to have improved. Due to a noticeable reduction in his risks he was transferred to Stort Ward from the PICU.
- 1.24 On 29 November 2010 he was granted home leave to his mother's. On return he was reviewed by the clinical team and discharged from his section. Throughout the period from 2 December 2010 until 5 January 2011 there were a number of contacts from Mr P's father expressing concerns regarding his deteriorating mental health and increased drug use and aggression. This contact included advice from the EIP CPN on what to do in the event of a crisis over the Christmas holiday.
- 1.25 Mr P was again admitted to the Derwent Centre in Harlow on 6 January 2011 under Section 2 MHA, after refusing to engage with EIP.

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<sup>3</sup>Olanzapine is used to treat the symptoms of schizophrenia and mania; preventing high mood swings in bipolar disorder.  
<https://patient.info/medicine/olanzapine-arkolamyl-zalasta-zyprexa>

<sup>4</sup> Section 2 MHA An application for admission for assessment or treatment for up to 28 days.  
<http://www.legislation.gov.uk/ukpga/1983/20/section/2>

- 1.26 He was discharged from this admission on 3 February 2011 and it is noted that on this occasion he still showed signs of poor insight into the relationship between illicit drug use and his mental health.
- 1.27 A home visit occurred on 9 February 2011 following threats of suicide, drug use and aggressive behaviour. This resulted in a risk plan which recognised the various contributory factors in his presentation. He was not admitted but this was included as a contingency should Mr P deteriorate.
- 1.28 Throughout the period from 9 February until 29 October 2011 Mr P had not attended appointments or arranged telephone calls on eight occasions and the EIP team had received several calls from Mr P's father concerned about his deteriorating mental state and drug use. He was visited by the EIP CPN on two occasions and the police had been called on two occasions.
- 1.29 On 29 October 2011 Mr P had been arrested for criminal damage to his mother's house and his father's van. It is noted that his mother now said she was too afraid to have him back at her house.
- 1.30 In December 2011 Mr P was reported to be sleeping in his car on his mother's driveway. He had made threats to kill his father but it is noted the police had not attended at the time of his phone call to report this to the EIP team.
- 1.31 There was no further contact with the EIP team for 25 days. Mr P's father had contacted police on 13 January 2012 on the advice of the CPN and he was detained under Section 136<sup>5</sup> MHA at Braintree Police Station. The EIP CPN concluded at this time that Mr P would benefit from a further assessment by EIP, and outpatients and would benefit from family therapy. He was assessed under the MHA but not deemed detainable. A CPA assessment was undertaken at Chelmsford Magistrates court. It was concluded that the EIP would continue to support, by keeping in touch to monitor, and a 'cold call' would be made every two months.
- 1.32 During the period from 17 January to 17 July 2012 Mr P's father continued to keep in touch with the service. There remained evidence of deteriorating mental health, drug use and aggression. He did not attend appointments on three occasions. On 17 July 2012 a CPA review was undertaken however Mr P did not attend.
- 1.33 On 14 August 2012 EIP received a call from Mr P's father to inform them that he had been seriously assaulted by Mr P the night before and as a result Mr P was arrested and charged with grievous bodily harm.
- 1.34 Mr P's father contacted the EIP service to inform them that Mr P was due in court on 1 February 2013 and was receiving support from a mental health worker in prison. Mr P was subsequently discharged from the EIP case load. A referral to the Trust was made by his GP after his release from prison in April 2015.

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<sup>5</sup> Section 136, police powers to detain for assessment in a public place  
<http://www.legislation.gov.uk/ukpga/1983/20/section/136>

- 1.35 He was assessed by telephone by the Access team after an urgent fax was received from his GP on 23 April 2015.
- 1.36 He told the assessing nurse that he did not require the input of mental health services at that time. It was suggested that he talk to his GP about benefits and this was agreed. It was noted that Mr P denied any mental health concerns and was coherent and well spoken. He did not sound distressed, he did not appear paranoid, and he denied any risk to self or others. He was reported to be willing to discuss his concerns with his GP and was advised to contact the Access service if he had any concerns. A summary of this telephone conversation was faxed to the GP surgery that day.
- 1.37 A letter was sent to Mr P dated 5 May 2015 summarising this conversation and providing contact numbers and the information line. A letter was also sent to his GP confirming the outcome of the conversation, that is that Mr P's case now closed to mental health services, and offering a reassessment if his mental health deteriorates, and this was copied to BR.
- 1.38 The next contact with mental health services was on 23 July 2015 when the Trust was informed that Mr P was in police custody accused of murdering what was then thought to be his parents. A MHA assessment in custody was requested. This was carried out and he was found not to be detainable under the MHA at that time.

## Recommendations

### Recommendation 1

The Trust should provide evidence that their revised domestic abuse and safeguarding training is being delivered, by reporting on and monitoring training and safeguarding supervision figures against targets.

### Recommendation 2

The Trust should ensure that appropriate communication links are maintained and monitored with Multi Agency Risk Assessment Teams (MARAT)

### Recommendation 3

The Trust should implement structures to monitor adherence to policy guidance with regard to transfers of care, transition from services and inclusion of the service user and carers in the process.



#### **Recommendation 4**

Trust CPA and discharge policies should provide clear guidance on how liaison with prison services mental health teams will occur at entry and exit, to maintain continuity of care.

#### **Recommendation 5**

Commissioners of prison health services in the East, North Midlands and the South must ensure that robust procedures are in place to maintain continuity of mental healthcare in prison, on reception and on inter-prison transfer when a prisoner has received secondary mental health care in the community.

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## 2 Approach to the investigation

- 2.1 The independent investigation follows the NHS England Serious Incident Framework (March 2015) and Department of Health guidance<sup>6</sup> on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. This investigation was commissioned as a joint independent investigation in partnership with the Domestic Homicide Review commissioned by Uttlesford Community Safety Partnership. The full terms of reference for this investigation are given in full in Appendix A.
- 2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 2.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.
- 2.4 The investigation was carried out by Carol Rooney, Head of Investigations, Niche, with expert advice provided by Dr John McKenna, consultant forensic psychiatrist. The investigation team will be referred to in the first person plural in the report.
- 2.5 The report was peer reviewed by Nick Moor, Partner, Niche.
- 2.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance<sup>7</sup>.
- 2.7 We have used information from
- Prison SystemOne records
  - North Essex Partnership University NHS Foundation Trust (NEP) clinical records
  - The IMRs written by Probation, Police and NEP for the DHR
- 2.8 We accessed the following Trust policies:
- West Specialist Therapy, Early Intervention & Assertive Recovery Team Operational Policy, version 1

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<sup>6</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

<sup>7</sup> National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

- Guidance for service users who disengage with mental health services (including non-compliance with treatment) Policy, version 4
- Discharge Policy, version 5
- Safeguarding Adults Policy, version 7
- Risk Assessment Procedure, version 4
- Mandatory Supervision Policy, version 6
- Clinical professional practice supervision policy, version 4
- NEP Process for Adult released from prison
- EPUT carers assessment 'Crystal' reports from April 2017 to July 2017
- Domestic abuse training slides and training vignettes
- Clinical risk assessment training slides
- EIP waiting list numbers from December to February 2017
- NEP Friends and Family Test results and trends to May 2017
- Serious incident panel meeting notes March 2017
- EPUT care plan audit report March 2017
- Sample supervision form

2.9 As part of our investigation we interviewed:

- Clinical Specialist, Safeguarding Adults (NEP)

2.10 The draft report was shared with stakeholders for comment. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content. The report was then submitted to the DHR review panel.

### **Contact with families and perpetrator**

2.11 We met Mr P's father, who gave us his perspective on Mr P's care and treatment. Mr P's father was aware that Mr P was resistive and reluctant to engage with services, but would have hoped for a more assertive approach to Mr P. He questioned whether the care plans from EIP were adequately detailed. He was also concerned that there seemed to him to be a variety of skills experience and abilities in the EIP practitioners, with some seeming confident and able to engage with Mr P, while others were not, in his view. Some factual inaccuracies were corrected after Mr P's father had read the report and given his comments.

- 2.12 Mr P did not wish to take part in the investigation. He did not give consent to access his records, and Caldicott Guardian agreement was provided.
- 2.13 The families of Mrs H and Mr F were not approached as had been agreed through the DHR author, who had been in contact.

### **Structure of the report**

- 2.14 Section 3 describes Mr P's personal history. Section 4 sets out the details of the care and treatment provided to Mr P.
- 2.15 Section 5 examines the issues arising from the care and treatment provided to Mr P and includes comment and analysis.
- 2.16 Section 6 provides a review of the Trust's IMR.
- 2.17 Section 7 sets out our overall analysis and findings.

## 3 Background

### Personal history

- 3.1 Mr P was born in Harlow by normal birth and achieved all developmental milestones. He lived in Stansted all his life. He has described his childhood as 'alright' but said he hated school. He left school aged 16 with a B in graphics and E grades in all other subjects. His parents were not married, and they separated when he was 16.
- 3.2 He apparently had many friends at school, but had withdrawn from them at the time of referral to secondary services because he said they "go against his thoughts".
- 3.3 Mr P had not started any formal employment, but did some piece work for his father, who had an electrical business. He was briefly employed as trainee milkman in 2012.
- 3.4 Mr P described using cannabis<sup>8</sup> and other illegal substances since age 11. The Trust IMR and clinical notes refer to abuse of methedrone<sup>9</sup> and mephedrone,<sup>10</sup> although it is unclear whether he was using both drugs, or whether this is a misattribution.
- 3.5 At time of the first referral to mental health services he was 17 and lived at home with his mother and brother in Stansted.
- 3.6 There is no information about his personal relationships.

### Contact with criminal justice system

- 3.7 In January 2010 Mr P was under the supervision of the Harlow Youth Offending Team (YOT) with a history of offending behaviour of common assault in 2007 during a fight with another pupil, possession and use of controlled substances, handling stolen goods and possession of an offensive weapon.
- 3.8 A six month supervision order was made in October 2011 for two counts of criminal damage against his parents' property.
- 3.9 He was convicted of criminal damage after damaging his mother's back door in January 2012 and fined £200.

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<sup>8</sup> Cannabis is classed as a sedating and hallucinogenic drug which may cause feelings of anxiety, suspicion, panic and paranoia. ([www.talktofrank.com](http://www.talktofrank.com))

<sup>9</sup> Methedrone is a stimulant drug that gives off feelings of euphoria, used mainly for recreational use. It is closely related in structure to 4-methoxymethamphetamine PMMA, a drug reported to have been involved in several fatalities. It is possible that methedrone has a similar risk of acute toxicity. <http://www.urbandictionary.com/define.php?term=methedrone>

<sup>10</sup> Mephedrone, (sometimes called 'meow meow') is a powerful stimulant and is part of a group of drugs that are closely related to the amphetamines, like speed and ecstasy. ([www.talktofrank.com](http://www.talktofrank.com))

- 3.10 Mr P was sentenced to a five year prison term for Grievous Bodily Harm, for an assault on his father in August 2012, in which he inflicted a fractured cheekbone and eye socket. He served two and a half years of this sentence and was released in April 2015.
- 3.11 The Trust became aware of his release from prison through a referral letter from his GP in April 2015.

## 4 Care and treatment of Mr P

- 4.1 Mr P was referred to secondary mental health services at North Essex Partnership University NHS Trust (NEP) in January 2010. NEP was dissolved on 31 March 2017 following a merger with South Essex Partnership University NHS Foundation Trust (SEPT) to form Essex Partnership University NHS Foundation Trust (EPUT).

### First referral

- 4.2 Mr P was referred to the Harlow community mental health team (CMHT) on 25 January 2010 by his GP, requesting an assessment of his mental health. The team asked for further information in order to initiate the assessment.
- 4.3 Further information was provided by another GP, who stated that when she saw Mr P on 18 February 2010 he thought the radio was talking to him and had sent a text to a friend (S) threatening to kill him and his family. This GP then visited Mr P on 18 February 2010. Mr P was reported to be very thought disordered, believing the radio changed channels due to his thoughts and had paranoid beliefs. The GP advised the CMHT that Mr P seemed calm and not suspicious of her and had no history of violence towards professionals. However he had been violent in the past to others and his bedroom door had a panel missing where he had recently punched it.
- 4.4 The GP requested advice on medication and a full assessment of history and risk to be carried out by the mental health team. The CMHT and Crisis Resolution and Home Treatment (CRHT) team then had discussions about the availability of a suitably qualified doctor who could prescribe appropriate medication and carry out a Mental Health Act (MHA 1983) assessment.
- 4.5 His parents were present for the assessment on 19 February 2010 and said he had gradually changed over the past year, withdrawing from his previous social life. Mr P had become convinced that one friend (S) had implanted ADHD into his brain. He believed his brother could access his thoughts and they were then broadcast on the radio.
- 4.6 His mother Mrs H told the CRHT that she had taken him shopping in Harlow recently and he 'froze'. He was convinced everyone was looking at him and became desperate to get back in the car, on the way home he banged his head on the window repeatedly and cried with distress. Following this, Mr P had been verbally aggressive all day, threatening to kill everyone in Harlow for looking at him, and had threatened to kill a friend (S). Mrs H said she did not feel threatened herself, and Mr P had no previous history of violence or

aggression to her, but had recently punched a hole in his bedroom door. Mrs H also described how it was around this time that Mr P was “*getting nasty*”.

- 4.7 An urgent Mental Health Act (MHA) 1983 assessment was carried out by the CRHT psychiatrist, Dr C and CPN 1 (CHRT nurse). The impression noted was that Mr P had shown gradual deterioration over the past year and recent onset of delusions of body abnormalities, control and paranoia along with auditory hallucinations suggestive of an acute schizophrenia-like psychotic disorder. He was particularly concerned about his facial acne, believing that people were staring at him. The long term plan at this stage was to refer Mr P to the Early Intervention in Psychosis team (EIP).
- 4.8 A full CPA assessment was carried out by the CRHT. He presented as believing his friend could change his thoughts, and accused his family of saying things they would not normally say. The previous night he had broken the door to his bedroom in anger after accusing his mother of saying things to him. The result of the assessment was that Mr P was very unwell & exhibiting psychotic symptoms. He was assessed as showing signs of suffering from a mental disorder and had a history of risk behaviour, specifically that he had a possible drug induced psychosis, paranoid ideation, thought disorder and psychotic symptoms.
- 4.9 The Trust ‘risk screening details’ form was completed on 22 February 2010. Under ‘risk of aggression’ it was noted he had been angry and verbally abusive towards his mother, and broken his bedroom door with a vase the night before. His lack of insight related to the use of cannabis and previous convictions were noted. Under ‘self-harm’ he was noted to have punched the floor when angry, and hit his head against the car window several times when his mother was driving. He was deemed to be a low to moderate risk of violence, a low to moderate risk of self-harm and a moderate risk of self-neglect.
- 4.10 Hospital admission was offered, but Mr P preferred to receive home treatment. The initial care plan was to start olanzapine<sup>11</sup> 5mg which would gradually increase to 10mg daily, to stop the chlorpromazine<sup>12</sup> which had been prescribed by his GP, a referral was made to the CRHT who accepted him onto their caseload, and he was advised to stop using cannabis. It is noted that Mr P refused to engage in any urine drug testing.
- 4.11 The long term plan was to refer him to the Harlow Early Intervention in Psychosis (EIP) service once the initial critical period was over. An initial meeting with EIP was planned for 29 March but Mr P did not attend. EIP received a message from Mr P’s father expressing concern that Mr P had not been seen but was due to be seen on 27 April, 42 days after transfer

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<sup>11</sup> Olanzapine tablets contain the active substance Olanzapine, belong to a group of medicines called antipsychotics and is used to treat symptoms of schizophrenia. <https://www.medicines.org.uk/emc/medicine/25031>

<sup>12</sup> Chlorpromazine belongs to a group of medicines called ‘phenothiazines’. It is prescribed for a variety of conditions, including schizophrenia and other similar mental health problems which affect thoughts, feelings and behaviours. <https://patient.info/medicine/chlorpromazine>

to the EIP. There were attempts to contact Mr P both by the CRHT on three occasions during this period and the EIP team on two occasions.

### Early Intervention in Psychosis team

- 4.12 Mr P was referred to the EIP West team in Harlow on 12 March 2010 and given a working diagnosis of possible drug induced psychosis. He was discharged from CHRT to the EIP on 18 March 2010. The resulting discharge plan was that the EIP would contact the family within 2-3 weeks once a worker and assessment had been arranged, that the YOT would continue to work with Mr P and they would liaise with EIP, he would maintain his medication regime and the family and Mr P had all the 'relevant' contact numbers for CRHT and other services.
- 4.13 A joint visit to his home was arranged with the YOT worker in April 2010, and it was planned that there should be a meeting with all those involved in his care.
- 4.14 From the time of this referral until the review at home on 10 May, attempts were made by the EIP to contact Mr P. He did not attend the initial planned meeting and there were concerns from his parents about his mental health.
- 4.15 Mr P was reviewed at home in May 2010 by the EIP junior doctor, in the presence of his parents and EIP care coordinator (CPN2). He was still receiving support from YOT as agreed in his discharge plan and said he found this helpful. Mr P was spending most of his time at home sleeping or playing video games. He denied regular use of illicit substances but admitted taking methedrone a couple of weeks previously. He was described as having 'significant anger issues' and 'loses his cool frequently' manifested in threatening aggression towards his parents, usually over money, and damage to property. He was described as not suicidal or homicidal. He was seen as having reasonable insight and agreed that some structure in his life would be useful. He agreed to be referred to the Trust 'employability' programme. Medication was not changed, and a further medical review was planned in six to eight weeks.
- 4.16 A CPA review was carried out on 3 June 2010, attended by CPN2 and Mr P only. The CPA care plan dated June 2010 had three interventions, monitor mental state, offer support with employment opportunities (particularly in his father's company), monitor his drug abuse and '*discuss support with substance misuse e.g. ADAS*'.<sup>13</sup> Although it is noted that whilst personnel may have been identified there were no specific interventions prescribed, only responsibilities. The only contingencies in place were for his parents to contact services should they require help.
- 4.17 His 'early warning signs' were listed as hearing voices, thinking people can read his mind, thinking his thoughts are controlled and difficulty sleeping. The crisis and contingency plans were to contact the EIP or CRHT, and out of

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<sup>13</sup> West Essex Alcohol and Drug Service. <http://www.adasuk.org/>



hours, the GP or A&E. Risks to be taken into account are noted as '*vulnerability, neglect, and aggression/violence*'. It is noted that on a number of occasions he was assessed by professionals, he was recorded as not displaying any psychotic symptoms however was aggressive and threatening at times. It became apparent that Mr P was adept at masking his symptoms or at least under-reporting them in telephone and face to face assessments, given the contradictory evidence from his parents.

- 4.18 A letter was sent by CPN2 to Mr P's father offering a carer's assessment. Because he was not the primary carer he informed the team that he had handed this over to Mr P's mother, but he was unaware of the outcome of this. There is no reference to whether Mr P's mother was then contacted.
- 4.19 At a home visit in June 2010 tension between Mr P and his father was reported. Mr P was angry and alleged that his father appeared to know that money was being deposited into his bank account, and had searched his room for drugs, and removed some tablets and three knives. Mr P was working for his father's company and said he was not motivated and wanted to stop, and was also angry because his father would not let him drive. His mood was reported to be fine, and no psychotic symptoms were evident.
- 4.20 At a medical review in July 2010 Mr P reported reasonable appetite and sleep, but spending most of his time indoors playing video games and staying in his room. He also disclosed frequent arguments within the family usually over money for illicit substances, or in the context of paranoid beliefs about the actions of his parents, especially his father. Family therapy was suggested but he was reluctant to consider this. There were no delusions or hallucinations detected. He said he was still using cannabis occasionally but minimised the effects of this on his mental state. He was advised to consider family therapy, and the plan was to continue with olanzapine 10mg and monitoring by the EIP. Oversight by YOT ceased in August 2010.
- 4.21 On 3 and 10 August 2010 Mr P was visited at home by EIP CPNs regarding employment and assistance in completing online applications. From this time several attempts were made to engage Mr P in family therapy however he did not attend the appointment. It was noted that Mr P's father had said Mr P was unlikely to attend the meeting or his physical review and wanted to speak to someone to 'sort it out'.
- 4.22 A home visit on 14 October 2010 was carried out by the EIP CPNs where the majority of the meeting was taken up by discussions between Mr P and his father about his lifestyle, and it was noted that Mr P was taking drugs and not concordant with his prescribed medication. It was clear from this meeting that Mr P was no longer willing to attend meetings or take his medication.
- 4.23 On 25 October 2010 Mr P's father attended his appointment after Mr P refused to attend. His father said that he was not taking his medication and suspected him of buying drugs from the internet. He reported his behaviour had been challenging at home and his mother had at one point asked him to leave, but things had settled again. Family therapy was again suggested but Mr P's father said he did not wish to take this up as he did not have faith in the

EIP team. He stated that he knew Mr P was angry with him and was unsure how to relate to him, and asked what to do if he becomes very challenging or aggressive. He was advised to call the police if he was concerned about his safety or the safety of others.

- 4.24 Mr P's father called the EIP on 2 November 2010 to advise that Mr P had "taken a turn for the worse" and was asking to be locked in the house because he was afraid he would kill someone. It was not clear who he might have thoughts of killing, and his father was advised to call the police if there were any concerns about safety. He was informed that a team would arrange to come out to assess Mr P at home.
- 4.25 On 6 November Mr P was arrested for possession of Class A drugs; having been found in a field outside his car under the influence and in possession of drugs. He was deemed unwell and intoxicated through drugs and was bailed by police in order for a MHA assessment to take place.
- 4.26 He returned to his father's address where an argument occurred and Mr P was arrested and taken to Braintree Police station.
- 4.27 From here he was taken to The Lakes mental health unit in Colchester, where he met with the approved mental health professional (AMHP),<sup>14</sup> and two Section 12 approved doctors.<sup>15</sup> The AMHP noted that Mr P appeared not to be aware of where he had been, how he had got to The Lakes, or where he actually was. He was also noted to not know the day month or year, was continually writhing and at times appeared confused, disorientated and frightened.
- 4.28 On 8 November 2010 Mr P was admitted to the Derwent Centre in Harlow (provided by NEP) under Section 2 MHA. He was very resistive initially but settled and accepted olanzapine and his symptoms improved. He was discharged back to the care of the EIP on 2 December 2010. A diagnosis of drug related psychosis was established. After discharge Mr P refused to take medication, saying it would make him "go mad".
- 4.29 Mr P was again admitted to the Derwent Centre in Harlow on 6 January 2011 under Section 2 MHA, after refusing to engage with EIP team members, occasionally closing the door on them. His parents reported that he was agitated and aggressive particularly towards his father, as he was particularly concerned that his father could read his mind. A MHA assessment was carried out by the EIP consultant and Section 2 was agreed. He was very distressed and agitated, and in view of his resistance the police were called to assist with conveying him to hospital. On admission Mr P was very resistive, kicking furniture over and trying to attack staff. He attempted to break a

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<sup>14</sup> The role of approved mental health professional, or AMHP, was created in the 2007 amendment of the Mental Health Act 1983 to replace the role of approved social worker, or ASW. [http://www.mentalhealthlaw.co.uk/Approved\\_Mental\\_Health\\_Professional\\_replaces\\_Approved\\_Social\\_Worker](http://www.mentalhealthlaw.co.uk/Approved_Mental_Health_Professional_replaces_Approved_Social_Worker)

<sup>15</sup> Doctors and clinicians under the Mental Health Act 1983. <https://www.gov.uk/government/publications/mental-health-act-exercise-of-approval-instructions-2013>

window and required restraint and sedation. He denied any substance misuse but tested positive for cocaine three days after admission.

- 4.30 Mr P began to settle after olanzapine was resumed, and it was felt his mental state improvement was also related to not using illicit substances. It was noted that Mr P had some insight into the fact that substance misuse seemed to make his symptoms worse, but he was ambivalent about ceasing his use of substances.
- 4.31 He withdrew an appeal to the Mental Health Review Tribunal and was discharged from Section 2, then discharged from hospital on 3 February 2011. The care plan was to continue with olanzapine 10mg, to see his EIP worker to promote engagement and monitor, and agree to random drug testing.
- 4.32 A review by the EIP consultant psychiatrist and EIP care coordinator was carried out on 22 February 2011. A letter to his GP noted that Mr P was not exhibiting any symptoms of thought disorder, he did however voice his belief that people could know his thoughts; but this was linked to his self-consciousness about his facial acne, as a persecutory delusion of reference, rather than to thought broadcasting. He was using cannabis at the weekends, and occasionally drinking alcohol to excess, when it appeared cannabis was not available.
- 4.33 At this review Mr P reported he felt generally well, although he was sleeping during the day and was up at night. His mother reported irritability at times, and he reported feeling that he was too thin. Mr P described his mood as low, it was noted he was '*objectively euthymic*' and had no suicidal ideas. There is no reference to risk of harm to others.
- 4.34 The plan described was to see the EIP care coordinator weekly, see his GP for treatment for acne, and continue on olanzapine 10mg, with a review by the EIP consultant psychiatrist in four weeks.
- 4.35 Mr P was seen by the EIP consultant psychiatrist on 3 March 2011, with his EIP care coordinator and his mother. He was noted to have a disrupted sleep pattern, and was self-conscious about his facial acne. He reported that he still believed that people knew his thoughts, but this was seen as linked to his self-consciousness about his appearance rather than evidence of formal thought disorder. It was advised in a letter to his GP that he would continue on olanzapine 10mg, see his care coordinator weekly, and that the GP should see him for treatment for his acne.
- 4.36 This was not successful, and from the period February to September 2011 Mr P had not attended appointments or arranged telephone calls on eight occasions. The EIP team had received several phone calls from Mr P's father expressing concern about his deteriorating mental state and drug use.
- 4.37 Police were called to the house on the weekend of 19 September 2011, after an argument between Mr P and his mother. He was alleged to have been verbally abusive, she threatened to ask him to leave, and he had cut himself superficially on his hand. The police spoke to him with both parents present

and explained they would arrest him if he was aggressive to his mother. There was not felt to be a need for a MHA assessment. EIP staff spoke to his mother later that day and she said she felt his aggression was linked to cannabis and although he was “*coming out with bizarre things*” she did not feel he was a risk to her or anyone else at that time.

- 4.38 Mr P’s father called EIP later in September 2011 saying Mr P had been arguing with his mother, and was currently sleeping in his car as she had asked him to leave. He was concerned that Mr P may become aggressive again if he was asked to come into hospital but said he did not feel Mr P was a risk to anyone at that time. It was discussed with the EIP Team Leader and the agreement was to monitor the situation, and Mr P’s father was given the numbers of the emergency team and advised to call the police if there were concerns about safety.
- 4.39 Mr P was offered appointments with the EIP consultant psychiatrist in April, July, September and November 2011, which he did not attend.
- 4.40 Mr P’s father called the Trust crisis line on 29 October 2011, voicing concerns about Mr P’s mental state. He was advised that he could take Mr P to A&E if he was concerned about his mental state, or call the police if he had concerns about safety. Mr P’s father was noted to be unhappy with this level of support.
- 4.41 His mother called the EIP on 31 October 2011 to say that Mr P had been arrested the previous day. He had smashed the back door and window of his mother’s house, and thrown a concrete garden ornament at his father’s van, smashing a door and window. He continued to shout abuse in the street. Mr P’s mother said she was afraid to have him home and he would now be homeless.
- 4.42 On 31 October 2011, a telephone call was taken by EIP from a custody officer at Braintree Station; Mr P had been seen by the duty doctor and deemed fit to charge, so was to be transferred to Magistrate’s Court. He was to be assessed by Chelmsford Criminal Justice Team at Court. At Court he was noted to be guarded but not deemed detainable under the MHA. He said he did not want to engage with the EIP because he was not mentally ill, but had “*drug abuse problems*”.
- 4.43 Mr P was later convicted of two counts of criminal damage, dealt with by a six month supervision order with probation. His father took him to Court, he was no longer living with his mother but temporarily with his father until emergency accommodation could be sourced.
- 4.44 Mr P and his father were seen by the EIP care coordinator at his father’s address on 7 November 2011, with the aim of trying to offer support and continue to look for ways that the EIP could help him. Mr P expressed anxiety about speaking to doctors, because he did not want to be brought to hospital again. He was hesitant but agreed to continue to try to find housing for himself, and if not successful agreed to accept some support from EIP. Both Mr P and his father said he was as well and calm. The plan was that the EIP care coordinator would make contact in another month.

- 4.45 A call to EIP was received from Mr P's father on 13 December 2011, saying Mr P had been sleeping in the car in the driveway after his mother had thrown him out, he was continually smoking cannabis and had been violent and threatening to both his parents. He refused to take medication, or any help from his parents, and had threatened to kill himself and all his family. As Mr P had refused to see the EIP team his father was advised to call the police. The police attended and Mr P was placed on Section 136<sup>16</sup> MHA and later that day a MHA 1983 assessment was carried out at Braintree Police Station involving an AMHP and two Section 12 doctors. He denied feeling suicidal and regretted sending threatening texts. He initially stated he had been drug free for a year then admitted having used cannabis five days earlier, and he also denied thoughts of harming others until he was confronted with the EIP records. He reported "a lack of motherly love" and a fluctuating relationship with his father.
- 4.46 On 19 December 2011 Mr P's father called the EIP to say that they had an argument yesterday over money, and Mr P tried to assault him. He was able to get away and told Mr P to go, who then went to sit in the car in his mother's driveway. His father went to see him that morning and Mr P threw a chisel at his van, and threatened to kill him or get someone to kill him. He had contacted the police and they were expected to make contact with him. His father said he thought Mr P was now dealing in cannabis, and he was also adamant he did not want to be involved with mental health services. This information was shared with Mr P's probation worker who said they could not share any information without his consent. Mr P's continued refusal to engage with EIP services was discussed with his father, who was noted to say he did not think there had been any change in his mental state.
- 4.47 His father called again on 30 January 2012 and spoke to the EIP care coordinator. He said that Mr P had been arrested at the weekend for smashing a window at his mother's house, he was in court that day but was released with a fine. He had apparently been seen by the Criminal Justice Team who had not found him to be in need of a formal MHA assessment. Mr P reluctantly agreed to talk to the social worker by phone, and agreed to meet the following day. His father called the following day to say Mr P was refusing to attend the planned meeting.
- 4.48 A CPA review was carried out on 17 January 2012 with Mr P at Chelmsford Magistrates Court by the EIP care coordinator, following a referral by the Magistrates. It confirmed that Mr P was not engaging with the EIP service and due to constant arguments he was had moved out of his mother's address and was currently living with his father. He had been assessed on the 13 January 2012 but was not deemed in need of formal assessment.
- 4.49 The EIP care coordinator concluded that support would continue to be offered to Mr P and a cold call would be made every two months to the address he

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<sup>16</sup> Section 136: powers of police to detain mentally disordered persons found in public places.  
<http://www.legislation.gov.uk/ukpga/1983/20/section/136>

was living at. She and the EIP team would continue to liaise with his father to monitor Mr P's mental health and it was confirmed that Mrs H had all the relevant contact details if needed. She set the date of the next CPA review for six months' time, on 17 July 2012, unless one was required earlier.

- 4.50 On 30 January 2012 Mr P was again assessed in Chelmsford Magistrates Court by the Criminal Justice Team after appearing in court charged with criminal damage to his mother's back door over the weekend. It was noted that he was not prescribed any medication, was open to EIP but not actively engaging and did not appear to be suffering from a mental illness at this time. He was convicted of criminal damage and fined £200.
- 4.51 His risk assessment was updated to add violence and aggression. His father called the EIP later that day to say he was staying with him at the moment; he continued to express concerns about Mr P's mental state, as he was reported to say his acne was caused by magic and would not clear up until he was given money. Mr P was seen at his father's home on 7 February 2012, and Mr P was noted to look physically unwell, have a flare up of his acne, was very guarded and focused on whether his parents would leave him money when they die.
- 4.52 At a further home visit on 14 February his father said he had called the police the previous day as Mr P had thrown a glass of water at his head because he would not give him money. He also alleged that Mr P said he would rape and kill his grandmother which Mr P denied. Mr P did not attend a medical review planned for 6 March 2012.
- 4.53 On the 12 March 2012 an entry refers to a MARAC<sup>17</sup> meeting, making reference to a risk to Mr P's mother on 28 January.
- 4.54 Mr P's father made contact with EIP on 20 March 2012 to say that Mr P was not using illicit drugs but was still showing psychotic symptoms, acting in a paranoid way and being hostile for no reason. Mr P's father wanted to know more about his diagnosis and what the EIP could do for him. It was agreed that the EIP care coordinator would make contact to allow his father to discuss his concerns further, and meanwhile try to convince Mr P to accept support from the EIP.
- 4.55 Throughout the period until July 2012 Mr P's father kept in contact with EIP. There remained evidence of deteriorating mental health, drug use and aggression. Mr P did not attend appointments on three occasions.

## Discharge from EIP

- 4.56 As planned a CPA review was carried out by the EIP care coordinator and Mr P's father on 17 July 2012. Mr P did not attend. Mr P had been seen on three occasions in the last six months as he did not wish to engage with EIP. It was noted that he currently appeared stable and was working as a trainee

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<sup>17</sup> Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. <http://www.reducingtherisk.org.uk/cms/content/marac>

milkman and this seemed to have improved his self-esteem and mood. His father said he did not appear to be psychotic and had not abused drugs for months to his knowledge. It was agreed that Mr P would remain on the EIP caseload but until he was willing to engage he would not be offered an appointment or visited. He was sent a letter advising him that his care coordinator would be changing due to maternity leave.

- 4.57 Mr P's father phoned on 14 August 2012 and advised that Mr P had been enjoying his job and not taken drugs for a few months, he had appeared settled and not displayed any mental health problems. However he said the previous night Mr P had attacked him, knocked him out and stamped on him until neighbours called the police. Mr P was arrested and was remanded into prison.
- 4.58 After a period in prison on remand, on 22 January 2013 it was noted by the EIP that Mr P was in a prison outside of Essex awaiting trial later in 2013. A CPA plan was completed by the EIP service and Mr P was discharged from the EIP service. It would appear that he was also discharged from CPA at this time, although this is not explicitly stated. It was also noted that the EIP agreed to keep in touch with Mr P's father despite him being discharged from their service.
- 4.59 On 24 January 2013 EIP contacted a mental health nurse at HMYOI Glen Parva<sup>18</sup> and were informed that Mr P was seen by the prison psychiatrist and had been prescribed aripiprazole 10mg<sup>19</sup> as he had been displaying psychotic symptoms. As a result he had been deemed unfit to plead. It is noted that Mr P had preferred to stay in the general population and not the healthcare centre. A verbal handover of his history was provided to Glen Parva mental health inreach and the record of this exchange notes that clinical information was provided.
- 4.60 On 14 May 2013 a letter was sent to Mr P and his GP confirming that Mr P had been discharged from EIP into the care of mental health inreach at HMP Bedford, and advising '*the inreach team would make appropriate referrals on Mr P's release*'. At this point he was no longer on CPA.

## Prison healthcare

- 4.61 Mr P was accepted at reception at HMP Bedford on 13 August 2012, and admitted to healthcare because there were no normal prison cell locations available. He told the nurse at reception screening that he had no mental health history and had never been admitted to a mental health hospital. At that time primary and secondary mental healthcare in HMP Bedford was provided by South Essex Partnership University NHS Foundation (SEPT).

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<sup>18</sup> HMYOI Glen Parva is a young offenders unit in Leicestershire

<sup>19</sup> Aripiprazole is prescribed for mood disorders, or to relieve the symptoms of schizophrenia.  
<https://patient.info/medicine/aripiprazole-abilify>

- 4.62 His care coordinator from EIP made contact with the prison health care team on 7 September 2012 and informed them that Mr P was under the care of the EIP, had been on CPA and had two admissions to hospital. He was seen for a screening assessment by the mental health inreach team on 12 September.
- 4.63 Mr P showed no evidence of thought disorder and he politely declined to be under the care of another mental health team, but agreed to a further review. It was decided he would remain on normal location, and the inreach team would report back to the EIP and maintain contact. He was reviewed again by the HMP Bedford mental health inreach team on 18 September, he reported no symptoms of mental disorder and reports from wing officers indicated that there were no management issues. He was transferred to HMYOI Glen Parva on 21 September 2012. A transfer letter was sent to HMYOI Glen Parva in September 2012 from HMP Bedford (inreach at HMP Bedford stating he was under the care of mental health inreach, and had been under the care of EIP in Harlow, Essex.
- 4.64 At HMYOI Glen Parva he was assessed by a mental health triage nurse at reception and found to be settled with no concerns. The summary of mental health care that had been provided to them by the EIP was faxed by HMP Bedford healthcare team on 25 September. At that time primary and mental healthcare in HMYOI Glen Parva was provided by Northamptonshire Healthcare NHS Foundation Trust.
- 4.65 He was assessed by the mental health inreach team on 26 September 2012. It was noted that during the interview his eye contact was sporadic, and his speech was appropriate in form and content. He did not appear to be responding to unseen stimuli, and denied any current psychotic experiences and stated that he had never been mentally ill. He appeared to have no insight into his previous psychotic episodes and felt that the involvement of mental health services was an overreaction resulting from the concerns of his parents. He appeared guarded and suspicious. Mr P was noted to say that his current offence of assaulting his father was because his father is "an idiot". He does not appear to have any remorse for his actions and stated that it wasn't a serious assault and he didn't understand why he had been remanded into custody. On further questioning it transpired that his father has been left with a fractured cheek bone and fractured eye socket. When it was put to him that these were serious injuries he smiled and looked away.
- 4.66 The initial assessment of risk was 'increase in levels of aggression/violence when becoming mentally unwell. At such times believes people can read his mind by looking into his eyes. Currently denying any psychotic symptoms but eye contact poor which may indicate his suspicion that people can read his thoughts. Lack of insight into mental illness.'
- 4.67 It was agreed that an inreach care plan would be in place to 'monitor his mental health: develop a therapeutic relationship; monitor mental health with particular reference to a belief that people can read his thoughts by looking into his eyes; be aware of raised levels of suspicion and being guarded; in the event of onset of psychotic symptoms assess for need of treatment with antipsychotic medication and liaise with the CPA Coordinator at EIP'.



- 4.68 He was seen for assessment regularly by the mental health inreach team, and continued to maintain there were no problems. On 19 October 2012 he was seen by a mental health nurse and noted to be 'restless with his leg moving all the time and a little guarded in presentation'. He maintained reasonable eye contact, engaged well and did not appear to be responding to unseen stimuli said that he has been fine no concerns on the unit denied any problems with any of the prisoners. He denied any concerns with his mental health any unusual experiences or paranoia. He said he did not feel that he has any mental illness and that he was fine when he was sectioned and it was to do with his father. He was not happy with his father and blamed him for being in prison and for his admissions in hospital. He said that he does not want to be sectioned again and that he had a bad experience when he was on the ward
- 4.69 It was explained to him that at the present there was no need for him to go to hospital, however if things changed with his mental health he may be referred to the psychiatrist. He agreed to have visits from the mental health team for ongoing monitoring.
- 4.70 By 25 October 2012 Mr P had moved back to HMP Bedford, and he was seen by a mental health nurse, who had attempted to see Mr P for assessment on return to the establishment from HMYOI Glen Parva. The inreach team at HMYOI Glen Parva was phoned for a verbal handover, and it was noted no overt psychotic symptoms were observed there and there were no indicated risks of self-harm, no issues of vulnerability and no deterioration of mood. Mr P continued to respond with "*I was absolutely fine, there is nothing wrong with me*". This presentation was noted to be similar to when he was last in similar to when he was at HMP Bedford. He was transferred back to HMYOI Glen Parva on 31 October 2012 after a court appearance.
- 4.71 On 1 November 2012 he was seen by the mental health inreach team at HMYOI Glen Parva again, appearing a little anxious in presentation where his leg was moving throughout. Mr P told the mental health nurse he had been fine, and the judge has requested a psychiatric report before sentencing. He did not appear to be responding to unseen stimuli and had no concerns. He said he would like to see the inreach team weekly at present.
- 4.72 On 14 November 2012 concerns were expressed by an officer that Mr P had been talking to his TV and appeared suspicious, and also said he did not like sharing a cell and may harm his cell mate if he gets angry. He was moved to a single cell and appeared to gradually become more suspicious and emotionally incongruous. On 25 November prison wing staff reported that Mr P was acting strangely, in that he had asked if the unit staff have changed his clock and was laughing inappropriately. A message was sent to mental health in reach to see him. He was seen by the inreach team nurse on 26 November 2012, he appeared guarded, with minimal eye contact looking around the room mainly saying that he liked the chairs. During the conversation he was noted to be a little restless and moving his leg throughout, and an appointment was made to see a psychiatrist.
- 4.73 On 5 December 2012 he presented as bright in presentation but was restless, he said that this was due to him being in the cell and that wanted to go out on

association so that he can have a walk. He also stated that he thought that people were coming into his cell changing his clock and gave a 'rational reason' for why he thought this.

- 4.74 On 6 December 2012 he was assessed by a psychiatrist on request by the inreach team, no psychotic symptoms were elicited and it was decided to maintain contact by the inreach team to monitor his mental state. A diagnosis of possible drug induced psychosis was made, and there were concerns that he may have a learning disability. Mental health inreach staff maintained contact, seeing him on 19 and 20 December.
- 4.75 On 27 December 2012 he was seen by a psychiatrist with an inreach mental health nurse. He was reported to be deteriorating since his video appearance in Court, laughing to himself, seeing figures in 'sudoku', asking officers to give him other prisoners' supplies. He had no insight into his behaviour, and there was some history of irritable mood. Mr P denied hallucinations, did not appear deluded or thought disordered. He was reported to be inappropriately elated and jocular in a classroom. Mr P reluctantly agreed to a trial of aripiprazole 5 mg. The plan was also to carry out an ECG and test his bloods for sugars and lipids.
- 4.76 He appeared less agitated in January 2013 and aripiprazole was increased to 10mg. Support from the mental health inreach team continued until his transfer out of HMYOI Glen Parva on 4 February 2013.
- 4.77 In the process of attending court Mr P was transferred to HMP Bedford on 3 February 2013, and a verbal handover is noted from Glen Parva healthcare staff. The inreach mental health team again maintained support, although it is unclear when the aripiprazole was discontinued. His care coordinator at the EIP in Harlow was contacted for more background information.
- 4.78 He was transferred to HMP Blundeston in July 2013, and HMP Rochester in November 2013. In these two prisons his only contact with healthcare was for acne treatment, and no concerns about his mental health were noted.
- 4.79 He was then transferred to HMP Ford in March 2014 and was referred to a primary care mental health nurse by a practice nurse who expressed concerns about his vulnerability. Primary mental health care is provided by Sussex Partnership NHS Foundation Trust at HMP Ford, and there is no provision for secondary mental healthcare.
- 4.80 He did not attend the first appointment offered on 3 April 2014. He was seen for assessment by a primary care mental health nurse on 14 April 2014.
- 4.81 He did not present with any psychotic symptoms or concerns about intellectual ability although he was noted to be evasive when asked about friends. It was planned to see him again for further assessment, and after a second assessment on 13 May 2014 he was noted not to be in need of any mental health intervention and was discharged from the *primary care* case list as there was no indication of any psychotic thoughts or beliefs, and he denied any unusual thoughts, hallucinations or paranoia.

- 4.82 On 1 December 2014 Mr P was transferred to HMP Lewes and at reception screening previous drug and mental health problems were noted, but Mr P said these were all resolved.
- 4.83 Mr P was transferred to HMP Rochester on 12 December 2014. Mental health inreach at HMP Rochester is provided by Oxleas NHS Foundation Trust. He was referred to the mental health inreach triage team for assessment. He did not attend the first appointment offered by a mental health practitioner.
- 4.84 A phone call from his father on 18 February 2015 to healthcare giving details of his past mental healthcare was noted. His father said he seemed “very psychotic” when he had visited and spoken to him. He was seen for assessment on 21 February 2015. His ‘earliest date of release’ was noted as 10 April 2015. Mr P denied any problems with his mental health, he stated he had not seen a psychiatrist or taken medication for a year and did not need anything from services.
- 4.85 His past mental health history was accessed from healthcare notes, and it was noted he was due out of prison in two months’ time. It was decided he would be discussed within the multidisciplinary team and reviewed in two weeks’ time. There are no records of any further reviews or assessments, until his pre-discharge health screening appointment on 8 April 2015.
- 4.86 He was released from HMP Rochester on 10 April 2015. The healthcare notes record that he expressed no concerns at the pre-discharge screening appointment and was registered with a GP. Mr P confirmed he was fit and well for release and declined to sign a consent letter for records to be sent to his GP. His family collected him from HMP Rochester and arranged temporary accommodation.

### Referral after prison

- 4.87 The Mental Health Access and Assessment Service at the Derwent Centre received an urgent faxed letter from Mr P’s GP on 23 April 2015. A review was requested for Mr P, who was said to have been released from prison on 10 April 2015 after spending two years and seven months in prison serving a sentence for GBH. It was noted that he was ‘*under a psychiatrist in prison*’ and had been under the care of a consultant psychiatrist from the EIP at the Trust for some years for ‘*paranoid psychosis*’. Mr P had presented to the GP with not sleeping well, and the request was for ‘*assessment and review with follow up given his significant history of psychosis with criminal record*’. A CPN attempted to make contact with Mr P on 3 May 2015 and left a message for him to contact the team. Three further telephone attempts were made, and he was eventually spoken to by another CPN on 4 May 2015. Mr P told this CPN that he was not hearing voices and denied suicidal or paranoid thoughts. He said he was not sleeping well and had planned to discuss this with his GP, and he confirmed that the main reason for contacting the Access team was about benefits.
- 4.88 Mr P requested that the Access team send a copy of his past assessments and a letter to the benefits agency to ensure he could continue to get benefits.

He confirmed that he did not require the input of mental health services at that time. It was suggested that he talk to his GP about benefits and this was agreed. It was noted that Mr P denied any mental health concerns and was coherent and well spoken. He did not sound distressed, he did not appear paranoid, and he denied any risk to self or others. He was reported to be willing to discuss his concerns with his GP and was advised to contact the Access service if he had any concerns. A summary of this telephone conversation was faxed to the GP surgery that day.

- 4.89 A letter was sent to Mr P dated 5 May 2015 summarising this conversation and providing contact numbers and the information line. A letter was also sent to his GP confirming the outcome of the conversation, that is that Mr P's case now closed to mental health services, and offering a reassessment if his mental health deteriorates, and this was copied to BR.
- 4.90 The next contact with mental health services was on 23 July 2015 when the Trust was informed that Mr P was in police custody accused of murdering what was then thought to be his parents. A MHA assessment in custody was requested. This was carried out and he was found not to be detainable under the MHA.

## 5 Arising issues, comment and analysis

- 5.1 Mr P had a number of identified risks exacerbated by his illicit drug use. These were his violence and aggression, psychotic phenomena, compliance and concordance with medication.
- 5.2 He presented frequent challenges for his family due to his explosive aggression, paranoid ideation and ongoing disputes with his parents related to requests for money for drugs and general dissatisfaction with the relationship he had with his parents.
- 5.3 We have reviewed Mr P's care using the headings of the terms of reference.

### The quality of NHS contributions to Mr P's care and treatment

- 5.4 We agree with the findings of the Trust IMR that the CMHT and CRHT reacted quickly and appropriately to the initial referrals made by the two GPs. To consider the least restrictive option was also appropriate at this time.
- 5.5 The initial input from CRHT was intensive, supportive, and included daily monitoring of his mental health and risk. This input included a high standard of communication between the relevant agencies in his care.
- 5.6 However from the point of transfer to the EIP team the frequency of contact and intervention deteriorated somewhat. There was a period of 42 days between the point of referral and the initial assessment. It is acknowledged that Mr P was not always compliant with meetings and phone calls. It is noted that there were periods of up to 25 days with no contact from EIP did appear to cause some distress to his parents when seeking support.
- 5.7 We agree with the IMR conclusion that no failures in care occurred over this period. However the effect of the decrease in the frequency and context of support does not appear to have been acknowledged. The level of input decreased dramatically when the case was transferred to the EIP team.
- 5.8 The role of the EIP was explained to the family and whilst general instructions were outlined in care and risk management plans the primary support mechanism for the family relied on them contacting the police or mental health services should a crisis occur.
- 5.9 A significant factor in Mr P's care and treatment relates to the fact that at no time did the mental health services identify Mr P's behaviour as domestic violence. This issue is being addressed as part of the action plan from the Trust IMR. It is not known however the influence this may have had on his management and treatment but would have facilitated expert advice.

- 5.10 Mr P had a working diagnosis of drug induced psychosis (DIP), noted on 2 December 2010 as ICD10<sup>20</sup>: F19.9 'mental and behavioural disorders due to multiple/psychoactive drug use: unspecified mental disorder'. A diagnosis was recorded on 31 January 2011 as ICD10: F19.5 'mental and behavioural disorders due to multiple/psychoactive drug use: psychotic disorder'.
- 5.11 DIP is known to be a problematic diagnosis, and it has been argued that it should be used rarely if at all.<sup>21</sup> The diagnostic requirements of DIP require establishing a temporal relationship between intoxication/abstinence and the presence/absence of symptoms. There is no evidence that this was formally considered or set out in the records. An opportunity to 'test out' this diagnosis could have been to use the opportunity presented by an admission to enforce a drug-free assessment (i.e. no illicit or prescribed drugs). There is no evidence that this opportunity was taken or considered in either of his two admissions. In fact, he was medicated very quickly or immediately.
- 5.12 If DIP was the preferred diagnosis, the implication of that diagnosis is that he would have got better with no medication. Using medication immediately is potentially very helpful where a clinician is confident that the person has a psychotic disorder, but may be unhelpful if the opportunity is not taken to observe the presentation when not under the influence of illicit drugs.
- 5.13 Another way of weighing up DIP is to consider the counter-evidence for a psychotic disorder like schizophrenia, and see how the evidence for DIP and for schizophrenia compares. There appears to us to be quite good evidence compatible with a potential diagnosis of schizophrenia (the below were recorded before the 2012 GBH incident):

- **Time course:**

In Jan 2010, social withdrawal over one year was noted (said to be 6-12 months when then seen), and in March 2010 his mother said he had become more abusive over the previous 18 months, with "*difficulties functioning around people*".

- **Bizarre and florid symptoms:**

In Jan 2010, he believed a friend had inserted ADHD into his brain, that his brother could access his thoughts, and that his thoughts were broadcast on the radio. Before admission in Jan 2011, he was "*particularly concerned that his father could read his mind*". In Feb 2010, he believed his brain had been literally turned upside down.

He was described as persecuted, accusing his parents of many things, 'not quite rational', 'saying strange things', too paranoid to enter a Court building (20 Apr 2010), said his jeans were 'wonky' (24 Jun 2010), confused speech and illogical or childlike reasoning, watched his face

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<sup>20</sup> International Classification of Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines [http://www.who.int/substance\\_abuse/terminology/ICD10ClinicalDiagnosis.pdf](http://www.who.int/substance_abuse/terminology/ICD10ClinicalDiagnosis.pdf)

<sup>21</sup> Poole, R. and Brabbins, C. (1996). Drug induced psychosis. *Br. J. Psychiatry*, 168, 135–138

changing in the mirror, people can read his mind linked to invisible spots on his lips, saying odd things, people can read his mind through his eyes, saying his brain was not working properly, bizarre behaviour and speech, believed his father had become invisible, referred to a link between magic and acne, and believed that father should immediately give him a vast sum of money.

- **Deterioration in functioning:**

Lacking motivation, low self-esteem (Mar 2010), social isolation, friendlessness, increasing (or at least not decreasing) reliance on parents, and significant self-neglect and physical deterioration (7 Feb 2012).

- 5.14 Several of these symptoms can be regarded as 'first rank symptoms'<sup>22</sup> of schizophrenia. Several also fall into the category of 'threat/control override' symptoms, i.e. feeling threatened while at the same time being controlled by others. These types of symptoms have been linked to violence. Associated anger has also been linked to violence, and he was certainly angry. His delusions specifically incorporated other people (friend, brother, father), and this can also be associated with specific risk.
- 5.15 We believe it would have been appropriate to consider the possibility that this was a person at higher than average risk of developing schizophrenia (male in the late adolescent period, who used cannabis and other illicit drugs), and who may have deteriorated over a period of a year even by the time he first presented and was therefore potentially at particular risk of a poor outcome (i.e., young man, insidious onset, long duration of untreated psychosis).
- 5.16 From this we consider that that if a diagnosis of DIP was made, then the differential diagnosis should have included schizophrenia; and that it should have continued to include schizophrenia all the way along the timeline.

## **Referral and discharge procedures from prison health into external NHS services**

- 5.17 At the beginning of Mr P's remand and sentence there is evidence of continued communication and information sharing between the community mental health services and prison inreach mental health teams.
- 5.18 Mr P was discharged by the EIP team in 2013 as he was considered to be under the care of the prison inreach services. It is not confirmed if he was still under CPA at this time, although we have inferred that he was no longer on CPA. It is noted that the prison inreach services were expected to recommence contact with community mental health services on his release from services. The implied expectation that he would be referred back to mental health services on release was unrealistic, as it would not be possible to ensure continuity of mental health service care unless the structures of CPA were used.

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<sup>22</sup> First rank symptoms for schizophrenia. Soares-Weiser et al Cochrane Database of Systematic Reviews (2015)

- 5.19 By the time he was discharged from EIP, Mr P had been under services (mostly with EIP) for virtually three years, during which time he had shown social deterioration, psychotic symptoms and aggression, and had twice required detention. He had then committed a very serious assault on his own father. There is no evidence that the possibility that this assault may have been potentially psychosis-driven was considered. Parental assaults of this nature are not that common, compared parent-to-parent assaults or young man-to-young man assaults. The possibility of psychosis-driven intra-familial violence should also have been flagged up as a possibility, and there should have been timely communication with prison mental health services.
- 5.20 He was in fact discharged from the prison inreach list in May 2014 due to the fact that he did not present with psychotic symptoms or further concerns about intellectual ability. However prison mental health services are provided by many different providers across the prison estate, and each service would make their own assessment based on Mr P's presentation as appropriate, unless a CPA process was in place.
- 5.21 On his release from HMP Rochester in April 2015 his pre-discharge notes from a routine health care screening state that Mr P had no concerns. It is noted however, that he declined to sign a letter of consent to release his records to his GP.
- 5.22 The first time the Trust became aware that he had been released was when an urgent referral was received from his GP in April 2015.
- 5.23 We have seen the NEP 'Process for Adult released from prison' and suggest that the pathways described are incorporated into CPA and discharge policies.

## **Compliance with local policies, national guidance and relevant statutory obligations**

### **MAPPA**

- 5.24 It is noted in the Trust IMR that Mr P was sentenced to a period of five years imprisonment and should have been subject to MAPPA conditions, however the Trust was not included in this process. This has been clarified by the Trust as an error within the Trust IMR, as the Trust were involved with the MAPPA process for Essex. A representative from the Criminal Justice Mental Health Team was a core member of MAPPA at Harlow, Chelmsford and Colchester. Thus if Mr P had been referred into the Harlow MAPPA the Trust should have been aware of it and the Trust should have been asked if they had relevant information to share. However the Trust would not necessarily have been notified if he was referred to MAPPA in another county.
- 5.25 Under MAPPA<sup>23</sup> guidance; Mr P would qualify as a 'Category 2 Offender': Violent Offenders and Other Sexual Offenders: violent offenders qualifying for

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<sup>23</sup> MAPPA Guidance 2012 Version 4.1 [Updated December 2016]



MAPPA include those who have committed 'an offence under section 18 of that Act (wounding with intent to cause grievous bodily harm)... [and] have received a sentence of imprisonment for a term of 12 months or more'.

- 5.26 It was noted by the Trust that it would be expected that someone with Mr P's risk profile and offending history would be subject to MAPPA considerations following release, but that the Trust were not involved in any discussions about this. It would be expected that the arrangements for MAPPA processes would be initiated by probation, and as part of the probation risk assessment made prior to release, Mr P was under no licence arrangements to co-operate with mental health services. The probation service IMR has examined this in detail.

### **CPA**

- 5.27 Mr P appears not to have been subject to CPA processes since his discharge from the EIP in 2013, although this is not explicitly stated.
- 5.28 Some of the fundamental principles of CPA are that care should be planned, a named worker will oversee care and treatment, keep in close contact with the person, and liaise with others involved.
- 5.29 The Trust Discharge policy provides clear guidance on the process of discharge from CPA, with the care coordinator's responsibility to ensure a review is held prior to discharge including the updating and recording of the risk assessment and management plan, with detail of who should be involved in the review. The Discharge policy lists the process to be followed in a variety of special circumstances, such as non-engagement, transfer to substance misuse etc. The policy does not give guidance about transfer to prison of a service user in receipt of CPA.
- 5.30 The process of discharge should be planned in coordination with the person and with any other services involved. This did not occur in Mr P's case, and formal liaison should have taken place with mental health inreach services at his initial remand, using the CPA process.

### **EIP service**

- 5.31 NICE Guidance on psychosis and schizophrenia in adults<sup>24</sup> contains clear quality standards. The expectations of service provision are:

*'Early intervention in psychosis services are multidisciplinary community mental health teams that assess and treat people with a first episode of psychosis without delay (within 2 weeks). They aim to provide a full range of pharmacological, psychological, social, occupation and educational interventions for people with psychosis.'*

*Services should also take into account the 'negative' symptoms of psychosis and schizophrenia (such as emotional apathy, lack of drive, poverty of*

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<sup>24</sup> <https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-1-referral-to-early-intervention-in-psychosis-services>

*speech, social withdrawal and self-neglect), and ensure services are accessible for people with these symptoms.'*

- 5.32 We suggest that the EIP service offered to Mr P fell short of these expectations. The waiting times from referral to assessment and treatment are now monitored robustly, and show evidence of improvement by March 2017.

### **The appropriateness and effectiveness of the care plan, including involvement of the service user and the family**

- 5.33 It is of note that at no time during his care and treatment from 2010 to 2103 that Mr P had an intention to abstain from illicit drug use. His family reports differed greatly from Mr P's self-report on his drug use. However it appears that services did not suggest or seek the help and support from specialist substance misuse services.
- 5.34 In his contact with the CMHT, CRHT and EIP Mr P often reported that he was doing well and not using illicit substances. There is ample evidence to the contrary. It would seem that services relied on this self-report of abstinence as a marker of current risk.
- 5.35 There was discussion in EIP about referring him to the substance misuse service (ADAS) but there is no evidence that this occurred. From the various reviews it would be reasonable to assume the link between his illicit drug use and his presenting behaviour and symptoms. This did not appear to be the primary focus of intervention.
- 5.36 It is acknowledged from the records that the staff who dealt with Mr P were aware of his risk factors, of violence, potential suicide, self-neglect and paranoid thinking and illicit drug use.
- 5.37 The care plans and risk management plans recognise these but there is no evidence of specific interventions to ameliorate these problems. There are instructions on which service will be addressing particular risks but no details on how each of the services would address these.
- 5.38 This lack of focus appears to have inhibited the EIP from accurately monitoring Mr P's mental state and drug use, behaviour and presentation. It is also noted that this may have affected EIP capacity to monitor improvement or deterioration.
- 5.39 The care plans relied on the contingency that Mr P's parents would contact services should they require help, however little else in terms of support for the parents was stipulated.
- 5.40 There is no recorded offer of a carers' assessment to Mr P's mother, after his father made it clear he was not the main carer. Mr P's father had originally received the offer but said he was not the primary carer. However there is no evidence that Mr P's mother was offered a carer's assessment.

### **Non-engagement**

- 5.41 On 20 Mar 2012, it was recorded in the IMR that his father was told that “*EIP service works on exhibited symptoms ... as Mr P was not engaging ... it was not possible to undertake a formal diagnosis*”. This in our view should not have been noted in the IMR without comment.
- 5.42 Diagnosis is, or can be, an iterative and longitudinal process, as well as a cross-sectional one. History is always relevant. We question the implication that no diagnosis can (ever) be made because there are no current symptoms and suggest that diagnosis cannot, or at least should not, always be exclusively reliant on ‘exhibited symptoms’ and engagement.
- 5.43 We also consider that given the reasonably posited possibility of missing a psychotic disorder (see 5.10-5.15 above), getting the diagnosis wrong could have serious implications, and this meant that at least attempting to ‘undertake a formal diagnosis’ was more important than usual.
- 5.44 The IMR states that ‘it is important to recognise that mental health practitioners were always making decisions based on the presentation of [Mr P] at the relevant time and the information available to them from [third parties]’. This appears to contradict what EIP told Mr P’s father: his father was told that a decision (about diagnosis) could not be made. This also does not specify whether the decisions that were being made were, in addition to presentation and informants, taking in historical / longitudinal information.

#### **Personal responsibility**

- 5.45 On 18 Mar 2010, [Mr P] was described as finding it ‘difficult to accept responsibility for his drug use or offending behaviour, citing other people as the reason’. On 31 Oct 2011, ‘He was taking little responsibility for his actions, blaming others ...’ and on 13 Jan 2012, ‘he did not appear to assume full responsibility for his actions or incidents’.
- 5.46 The IMR stated (at paragraph 5.5) that ‘*[Mr P] did not acknowledge ... that he was accountable for his own actions*’. This seems to be a repetition of what staff involved at the time recorded, and appears to be an opinion of the IMR authors rather than an objective piece of data. Thus, it should in our view be near the end of an investigation report (i.e. after data has been presented, weighed up and analysed) and not at the beginning.
- 5.47 Mr P was often aggressive and sometimes severely violent interpersonally and to property. It is noted from the various reviews that he often rationalised his behaviour and demonstrated little remorse for his actions. This feature of his personality was said to often impede constructive dialogue or intervention.
- 5.48 This aspect of the case is not given any further analysis. We consider that the IMR should have offered more curiosity about why a man of apparently unremarkable intelligence and early functioning comes to appear as if he does not accept accountability. A potential explanation could be linked to an ongoing, essentially untreated psychotic process that was associated with social deterioration, a paranoid and mistrustful stance to the world, poor judgement, blunting of affect, and a felt need to ‘self-medicate’ to try to rationalise or ameliorate distressing and strange psychotic experiences.

- 5.49 This should include positively eliminating other explanations (e.g. negative symptoms/affective blunting, or active paranoid thinking) or positively supporting the assertion (e.g. formal assessment of personality, or specifying which traits of which personality disorder are said to be present).

### **MHA/detainability**

- 5.50 The IMR states that Mr P was generally not detainable when assessed, at 5.4: *'in the majority of interactions he did not meet the strict criteria for a detention under the [MHA]*. On 31 Oct 2011, the CJLT in Court deemed him not detainable, and that they reached the same conclusion after arrest in Jan 2012.
- 5.51 It is not clear what information the CJLT had taken into account in coming to these decisions. Mr P had had two admissions under Section 2 MHA by 2011. When last discharged, the plan was for him to take medication, to see his worker, and to accept drug testing. It appears that the Section 2 was rescinded on the basis that it was expected by services that these three things should happen and were going to happen. Very clearly, none of these things were in any sense happening at all by the times of these two CJLT assessments.
- 5.52 We consider that it should have been made explicit what information was taken into consideration when making these assessments, whether his history was considered, and what working diagnosis they were working to. In particular we believe it should have been made clear whether a professional with training and responsibility for MHA decisions such as an approved mental health professional was involved in this assessment.

## **6 Internal investigation (IMR)**

- 6.1 The internal IMR was written by an independent domestic abuse specialist, and quality assurance was provided by the Trust Head of Safeguarding.
- 6.2 The internal report correctly identifies that Mr P should have been transferred from CRHT to EIP when his condition stabilised. It does not however acknowledge that when this transition occurred, he was not entirely stabilised, still required frequent input and that there was a dramatic reduction in frequency of contact following transfer.
- 6.3 The internal investigation makes three recommendations related to the recognition of and management of domestic violence for clinical/Trust staff. It also recognises that the absence of the Trust from the MARAC table may not have impacted on this case. Nevertheless the IMR provides guidance on how the Trust may address this issue in the future. This is to be commended.
- 6.4 In its analysis, the Trust IMR recognises the difficulties experienced by Mr P as well as the challenges to the services given his continued use of drugs and compliance. The report also recognises that reduction in level of input by EIP. It is of note that it does not make any reference to the quality of service provided by EIP in its recommendations, which we have highlighted.

- 6.5 We have however identified a number of issues related to practice which could have enhanced Mr P and his family's experience. There is no recommendation within the internal investigation related to some of the issues raised in our investigation: namely, diagnosis, care planning and review practices, the involvement of specialist drug and alcohol services and the frequency and quality of the EIP contact with the family and Mr P.
- 6.6 With regard to the depth of the Trusts' internal review of care, the IMR stated that because [Mr P's] relationship with Trust ceased after imprisonment in 2012, no staff involved prior to August 2012 were interviewed *'as any treatment or otherwise would not necessarily have been relevant to his mental health three years later'*.
- 6.7 It is not clear whether this time frame was agreed by the Trust in commissioning the IMR, or whether this was a decision by the authors. Decisions made, and not made, will have consequences later on. Diagnosis, and differential diagnosis, is one of those decisions. This conclusion meant that the IMR did not make any inquiries about what diagnosis was made or considered by those involved at time, and why.
- 6.8 We also question the decision not to interview any staff from before his sentencing in 2013. If staff involved had considered, or should reasonably have considered, that someone might be suffering from a psychotic disorder (or a drug problem, or a personality disorder), then in our view it stands to reason that that could be relevant to that person's mental health in the future, and to how people in the future might and should think about and respond to the person.
- 6.9 Further there is no investigation into the response to the GP's urgent referral in April 2015, stating *'this was a telephone call only and the recorded contents were in accordance with the Trust guidance the practitioner has not been interviewed regarding his contact with [Mr P]'*. We suggest this was a missed opportunity to review this issue with the GP, and to critically analyse what information the practitioner used to determine the outcome of their assessment.
- 6.10 The IMR does not review why it took ten days to respond to a GP referral marked 'urgent'. This, if accurate, cannot reflect good practice. At the very least, if a referral is to be downgraded from 'urgent' we consider that there should have been a call to the GP to clarify this.
- 6.11 It is not made clear what information was taken into account in deciding that no further action was required.
- 6.12 The GP made some cogent clinical points in his referral in April 2015. Mr P was known to have a history of psychosis and significant violence, he had been treated for psychosis by the Trust (for not much less than three years), he had been treated by a psychiatrist in prison since then, and he was not taking medication. This raises several questions which the IMR does not analyse, and it may be that this was an appropriate response, but both the

data used and the underlying reasoning should have been examined. For instance:

- Did the receiving clinician review the records and/ or discuss the case with anyone?
- Was it known or recognised that schizophrenia was a possible diagnosis, and if so why not?
- Was it known or recognised that a history of psychosis-driven violence was a possibility, and if not why not?
- Why simply rely on denials of symptoms in someone who is known to have previously unreliably denied symptoms on multiple occasions? We consider that it is questionable to describe someone as lacking insight on the one hand (i.e. by definition, as consistently providing inaccurate or unreliable self-report), and then at a later date regard that same person's self-report as simply so accurate and reliable that it robustly supports a decision not to take any further action.
- What is the (decision-making) relevance of Mr P no longer being a patient of the Trust? Decisions must be based on things like assessed need and risks, and whether a case is open or closed at a given point in time is a minor (and essentially administrative) point, which is not necessarily relevant.

6.13 It seems true that the GP was indeed not raising concerns about Mr P's mental state at that point. But he was saying that he was concerned about him for some reason, and that reason presumably related to the clinical material the referral did mention: violence, treatment for psychosis, treatment in prison, and medication non-compliance. It was reasonable for the GP to have expected a response. Given his history we believe it would have been reasonable to look for other sources of information, if Mr P did not want to be seen. One option would be to speak to others involved; his mother, his father, or his probation officer. We believe that ten days would have been long enough to have attempted that.

6.14 We were surprised that the IMR authors did not review prison health contacts. His symptoms in prison, in our view, completely undermine the IMR's decision that earlier treatment events can have no bearing on future treatment. His history as noted in prison health records shows this evidence of mental disorder:

- By early 2013, EIP were advised that he showed psychotic symptoms, that he was unfit to plead, and that he had been prescribed aripiprazole from Dec 2012.
- By then, Mr P had referred to people reading his thoughts by looking into his eyes, talking to his TV and appearing suspicious. There were concerns he may have a learning disability, and he had presented as elated and out of touch with reality.

- In March 2014, he appeared slow to respond and lacking comprehension, and it was queried if he had a learning disability.
- 6.15 In any event, some of the above was apparently reported to, or at least known by EIP, and should therefore have been in Mr P's records.
- 6.16 In concluding that there was no cause for further action, the IMR relies firstly on a point that is in our view irrelevant ('no longer a service user of the Trust'), secondly on a point that is of minor relevance (the GP's multiple concerns did not include his current mental state), and thirdly on a point that it was appropriate to unquestioningly rely on Mr P's report that he was asymptomatic as a basis for doing nothing further.
- 6.17 The Trust serious incident panel now scrutinises the quality of all IMR reports, starting from March 2017.

## 7 Overall findings

### Predictability and preventability

- 7.1 Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'.<sup>25</sup> An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.<sup>26</sup>
- 7.2 In the case of Mr P, and in relation specifically to the predictability of the homicides carried out by him, it is concluded that his actions were not predictable by mental health services at the time of the offences.
- 7.3 He had been released from prison in the context of being mentally well, not using illicit substances and not expressing any paranoid thinking. He had not required the input of prison mental health inreach services for almost a year before his release; and his only contact with services following release was to facilitate access to benefits.
- 7.4 Following the offence he was deemed mentally well and thought not to be suffering any mental disorder.
- 7.5 Prevention<sup>27</sup> means to 'stop or hinder something from happening, especially by advance planning or action' and implies 'anticipatory counteraction'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

<sup>25</sup> <http://dictionary.reference.com/browse/predictability>

<sup>26</sup> Munro E, Runggay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000)176: 116-120

<sup>27</sup> <http://www.thefreedictionary.com/prevent>

- 7.6 When previously in the care of community mental health services, workers had a good knowledge of his risk factors. There are many examples of incidents relating to his illicit drug use, his psychotic phenomena and his violent and aggressive behaviour. We have noted above (paragraph 5.37) that while Mr P was under the care of EIP his risks were appropriately assessed, but there is no evidence of specific interventions to ameliorate these problems. There are instructions on which service will be addressing particular risks, but no details on how each of the services would address these. The last risk assessment carried out by the EIP however relates to contact in July 2012, when he was noted by family to be very settled, and had stated work. The assault on his father occurred shortly after this in August 2012, for which he was remanded into custody.
- 7.7 None of the specific mental health issues which could suggest an increased likelihood of violent behaviour from Mr P were present at the time of the offences. He had been seen by his GP after release in April 2015, who made an urgent referral for an assessment by mental health services, but did not raise any concerns about his mental state. While, as we have noted, it was reasonable for the GP to have expected a response before 5 May, there is no indication either from the GP's consultation or the mental health service's telephone assessment that Mr P was experiencing symptoms of relapse, which have previously indicated an increase in risk.
- 7.8 We have concluded that it would not have been possible for mental health services to predict or prevent Mr P's actions on the day of the homicides.
- 7.9 We have however found a number of areas where best practice and policy were not adhered to. The Trust (NEP) no longer exists in its previous form, and service provision has been redesigned. Where we have had evidence of improvement we have not made recommendations, in the areas of domestic violence and risk assessment training, management of waiting times in the psychosis service, and the oversight of quality of IMRs.
- 7.10 We have made four recommendations for the new Trust (EPUT) and one for the commissioners of prison healthcare.

## Recommendations

### Recommendation 1

The Trust should provide evidence that their revised domestic abuse and safeguarding training is being delivered, by reporting on and monitoring training and safeguarding supervision figures against targets.

### Recommendation 2



The Trust should ensure that appropriate communication links are maintained and monitored with Multi Agency Risk Assessment Teams (MARAT).

**Recommendation 3**

The Trust should implement structures to monitor adherence to policy guidance with regard to transfers of care, transition from services and inclusion of the service user and carers in the process.

**Recommendation 4**

Trust CPA and discharge policies should provide clear guidance on how liaison with prison services mental health teams will occur at entry and exit, to maintain continuity of care.

**Recommendation 5**

Commissioners of prison health services in the East, North Midlands and the South must ensure that robust procedures are in place to maintain continuity of mental healthcare in prison, on reception and on inter-prison transfer when a prisoner has received secondary mental health care in the community.

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## Appendix A – Terms of reference

### Core terms of reference

- Oversee and quality assure all NHS contributions to the care and treatment of the service user
- To examine the referral arrangements and discharge procedures of the prison health services into the wider NHS services
- Review and assess compliance with local policies, national guidance and relevant statutory obligations
- Examine the effectiveness of the service user care plan, including the involvement of the service user and the family
- Review the appropriateness of the treatment of the service user in light of any identified health needs
- To work alongside the DHR Panel and DHR Chair to liaise with affected families
- To provide a written report to NHS England that includes measurable and sustainable recommendations

### Specific terms of reference

1. The requirement is for a joint Independent Investigation in partnership with the Domestic Homicide Review to be undertaken in respect of the Trust Internal Management Review (IMR) Report and quality reviewing all health organisations contribution.