# 1 Executive summary

1.1 On the night of 12-13 February 2017, P1 killed V1 at V1's flat. In her summing up remarks, the judge described this as a 'violent and brutal' killing.

1.2 On 21 March 2017, P1 was detained under Section 136 of the Mental Health Act 1983, amended in 2007 (MHA), he was admitted to an acute hospital, and transferred to the local psychiatric intensive care unit (PICU). Mental healthcare professionals had been attempting to find him for some weeks, following his disengagement with services, known non-compliance with medication and escalating concerns being expressed by his mother, housing staff and a local charity.

1.3 On 22 March 2017, V1's body was found – it was determined in court that he had probably died on the night of 12-13 February 2017. On 30 March 2017, P1 was identified by the police as primary suspect in relation to the death of V1.

1.4 P1's parents divorced when he was eight his mother later remarried. He has two brothers and a sister. He left school with 5-6 GCSEs, and successfully completed various short courses. He successfully completed the first year of an engineering apprenticeship but did not continue the second year due to being mentally unwell. He later successfully completed the first year of an animal welfare course at college but again did not attend for the second year being mentally unwell. He had several unskilled jobs and worked for his stepfather who owned a construction company. P1 has not been in employment since 2004

1.5 His mother, F1, noticed him becoming mentally unwell when he was 17 years of age; she was aware that he had been taking illegal drugs (cannabis, and later heroin and crack cocaine) and alcohol. He was recorded as commencing illicit drug use at the age of 12 years but his mother was not aware that he had started these habits so early.

1.6 P1 first received specialist mental health services[1] in February 2000 when he was admitted informally to The Old Manor Hospital for six weeks. He was then 17 years old and was described as actively psychotic. Between then and the incident in 2017, key events are as follows:

| Date | Event |
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| 2001 | Several admissions under the MHA |

[1] P1 received specialist mental health services initially from Hampshire Partnership NHS Foundation Trust, until it became Southern Health NHS Foundation Trust on 1 April 2011. Both organisations are referred to as 'the Trust' in this report.

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| July 2001 | Involved in fight, later convicted of battery |
| April 2002 | Asked to leave the family home because of his bizarre and aggressive behaviour |
| April – May 2002 | Informal admission to hospital |
| November 2002 | Conviction for public order offence, sentenced to 18 months on probation |
| January 2003 | Admitted to hospital under Section 3 of the MHA, following Section 136 detention by the police |
| February 2004 | Discharged from Section 3 (remained in hospital informally) but detained again the following day; |
| March 2004 | Conviction for drug offence (cannabis) and placed on Probation order |
| March 2005 | Incidents of threatening and aggressive behaviour at the family home and damage to property; leading to arrest, remanded in custody awaiting trial. |
| July 2005 | Transfer from prison to hospital under Section 48/49 MHA; hospital order (Section 5(2) of the Criminal Procedure (Insanity) Act 1964 (CPIA) and Section 41 of the MHA |
| August – November, 2005 | Incidents in hospital include assault on nursing staff |
| November 2005 | Hospital order for damaging property and carrying a bladed weapon |
| April 2006 | Additional hospital order for assault |

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| March 2007 | Conditional discharge from hospital to supported housing, under the care of the assertive outreach team (AOT); remained on Section 41 of the MHA |
| June 2007 | Informal admission to hospital |
| July 2007 | Discharge from hospital (conditional) |
| September 2007 | Informal admission to hospital |
| October 2007 | Formally recalled by the Ministry of Justice (MoJ) |
| September 2008 | Conditional discharge (on appeal to Mental Health Review Tribunal (MHRT) |
| March 2009 | Informal admission to hospital; formal recall at end of month by MoJ |
| June 2009 | Transferred from acute ward to psychiatric intensive care unit (PICU) |
| November 2009 | Transferred from PICU to acute ward |
| October 2010 | Conditional discharge to supported housing |
| December 2011 | Transferred from care of AOT to community mental health team (CMHT) |
| August 2014 | Absolute discharge from hospital order, to CMHT |
| September 2015 | Transferred from CMHT to nurse led clinic |
| January 2016 | Informed by consultant that his discharge from the service would be delayed, to allow for further, but less frequent monitoring. |

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| April 2016 | Arrested for allowing premises to be used for Class A drugs; |
| May 2016 | Appointment with NLC, the last NLC appointment he attended |
| May 2016 – February 2017 | Did not attend (DNA) multiple appointments; escalating concerns expressed by housing officer and housing support worker; concerns expressed by staff of the Trinity Centre (homelessness charity in Winchester); concerns expressed by his mother; known not to be collecting all his repeat prescriptions |
| December 2016 and January 2017 | Vulnerable adult forms completed by the police following incidents at his accommodation, communicated to NLC |
| December 2016 | Failed attempt to carry out an MHA assessment |
| December 2016<br><br>January, February 2017 | Communication by NLC with GP: P1 not collecting repeat prescriptions<br><br>Multiple attempts to engage with P1 by NLC and shared care service he did not attend appointments, was not at his flat then they called, did not respond to any attempts to contact him<br><br>Involvement of police who were unable to help |
| 11 February 2017 | Mental State Examination carried out by agency nurse, found no grounds for MHA assessment or for escalation adult mental health services |
| 12/13 February 2017 overnight | P1 killed V1 at V1's flat. |
| 21 March 2017 | P1 detained under Section 136 of MHA, following further attempts to find and assess him – detained on Section 3 of MHA, admitted to acute hospital, transferred to PICU having been brought back by police following an escape attempt. |
| 22 March 2017 | V1's body found |
| 30 March 2017 | P1 identified as the primary suspect in the death of V1 |

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| 6 April 2017 | P1 transferred to independent hospital medium secure unit, returned to the Trust's PICU, then back to the independent hospital in October 2017, where he remains |
| April 2018 | A jury found that P1 had unlawfully killed V1 following a 'trial of the facts' after two attempts to bring him to trial failed on the ground that he was unfit to enter a plea |
| May 2018 | P1 was made subject to a hospital order under Section 53 of CPIA with a restriction order under Section 41 of the MHA. |

1.7 A pattern clearly emerges of mental deterioration followed by hospital admission during which P1's mental health is slowly stabilised, leading to discharge into community settings. Discharge is followed by mental deterioration leading to readmission to hospital leading to discharge into the community. His risk factors were identified early in his life, and are:

- Disengagement from services
- Non-compliance with medication
- Use of illegal substances and alcohol
- Lack of insight into his illness and into the benefits of medication
- Involvement in the local drug subculture

1.8 In combination, these factors contribute to:

- Increasing paranoid ideas
- Hallucinations
- Vulnerability to stress
- Increased aggression, sometimes leading to extreme violence against his family, nursing staff, damage to property.

1.9 Medical staff found it difficult to devise an effective medication regime which P1 would accept – a variety of antipsychotic drugs were used, in different combinations and with different dosages. P1 found the side effects of the most effective drugs impossible to tolerate. Nursing, occupational therapy and medical professionals made every effort to find appropriate and acceptable interventions, with varying degrees of success. The consultant at the time of the investigation (responsible for his care from his admission in May 2017 to an independent hospital medium secure unit until September 2018) informed us that it would take years before P1 could be considered for discharge into the community; and that if he continued to lack insight into his illness and need for medication, he would continue to pose a risk of violence and even further homicide.

1.10 In July 2017, the Trust commissioned Caring Solutions UK Ltd to conduct an internal but independent investigation into the care and treatment of P1. This action complies with NHS England's Serious Incident Framework (2015).

1.11 In accordance with the Terms of Reference (ToR), we analysed and reviewed the facts which surround the services provided to P1 since the time he was first diagnosed with a mental illness. We have examined the events immediately leading up to the homicide and commented on the professional input following the incident and his eventual disposal by the court to detention in secure care.

1.12 We have identified areas of good practice along with care and service delivery problems in the services provided by the Trust. We did not consider that any of these contributed directly to the homicide of February 2017 but we did conclude that these were areas where improvements could be made in order to enhance the care and treatment provided to service users, and improve the working environment for healthcare professionals. We then made a number of recommendations, which are set out below.

1.13 We identified the following areas of good practice:

- We consider the management of this transition [in December 2011, from AOT to Winchester CMHT] to be an example of good practice and recognise that in the contemporary service arrangements attempts are made to replicate this practice.
- The CMHT considers any safeguarding issues when meeting with clients. None were raised or identified at this meeting (Care plan review, 29 September 2014). We considered that this was an example of good practice.
- The processes in place during the earlier years of P1's psychiatric care (i.e. AOT with early detection and the detention in hospital if in crisis) appears to have enabled periods of remission or limited recovery leading to support In the least restrictive environment. We believe the intended outcomes or objectives of this pathway represented good practice.
- Dr 6 requested P1 to attend for a review rather than simply issuing a repeat prescription in December 2016/January 2017, when P1 had not been seen by the surgery and had not requested a repeat prescription in January when it was due. We considered this to be good practice by the GP.
- Communication between P1's support worker and the Winchester CMHT – on 17 March 2017 his support worker at West View[2], who was assisting P1 with housing, telephoned the CMHT with concerns regarding P1s delusional statements. We recognise this as good practice as it resulted in action being taken based on accurate observation – including P1s thoughts of the government taking control of the flat as they had plans to rape children.
- We believe that the procedure of informal admission to hospital in February 2009, with clinical supervisor input represented good practice as it highlighted that the clinical supervisor was directly involved in the treatment and rehabilitation of P1 and was working with other practitioners

[2] Accommodation for homeless people

including the social supervisor and not just checking that P1 was free from symptoms.
- The physical health monitoring clinic [when P1 was prescribed Clozapine] is an area of good practice. A comprehensive assessment was carried out with all relevant investigations and clear communication to the GP.
- Dr 1 reviewing P1 in preparation for his MHRT in August 2014, to support both him and his care coordinator, is an example of good practice.

1.14 We identified care and service delivery problems over the course of P1's care and treatment by the Trust. These were:

- Use of agency staff – particularly to carry out a formal Mental State Examination (MSE)[3] when P1 was causing serious and escalating concern.
- Sometimes inaccurate and superficial recording in RiO – specifically when a CPA review that did not take place was recorded as having happened.
- Over-reliance on self-reporting by P1 and overreliance on information provided by his mother, including misinterpretation and failure to clarify the full meaning of her wording.
- Lack of continuity in consultant cover and overreliance on junior doctors and non-medical mental health professionals.
- Caseloads of staff, including CMHT staff and care coordinators
- Difficulties in accessing the AMHP hub
- Pressures on acute beds
- Disbanding of the AOT service and its replacement with the CMHT – whilst we recognise that the 'shared care' service was intended to compensate for the limitations of the CMHT vis-à-vis the AOT, P1 appears to have been placed on 'shared care' for more time-limited interventions.
- Police call handling and CMHT having inappropriate expectations of what the police could achieve
- Some healthcare professionals (not members of the core team) not informed soon after the incident was discovered, and left in ignorance of the homicide until approached to take part in this investigation.

1.15 We recognise that the resources issue identified in this case reflect the contemporary national picture.

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[3] The Mental State Examination is a structured way of observing and describing a patient's psychological functioning at a given point in time. Observations are recorded under the headings of appearance, attitude, behaviour, mood, and affect, speech, thought processes, thought content, perception, cognition, insight and judgement. Its purpose is to obtain a comprehensive cross-sectional description of the patient's mental state, which, when combined with biographical and historical information, allows the clinician to make an accurate diagnosis and formulation. This information is then the basis for coherent treatment planning. Source: Trzepacz and Baker (1993), p. 202

1.16 We concluded that none of the above problems were directly linked to P1's homicide of V1, but most are areas which might have influenced the course of events in relation to this specific incident. Post-incident practice in relation to staff should comply with Trust policy. We consider that resolution of these care and service delivery problems would overall improve services in the future.

1.17 We did not consider that any of the care and service delivery problems could be identified as root causes. However, we did identify the following patient factors as root causes. These factors were:

- Diagnosis of paranoid schizophrenia
- Fell into the category of people with mental health problems who were convicted of a homicide, which make up 11% of homicide convictions[4].
- Use of alcohol and illicit substances, including opiates
- Lack of insight into his condition and resistance to the benefits of medication
- Disengagement with services
- Involvement in the illegal drugs subculture
- History of uncontrolled, extreme aggression and violence.

1.18 We have made the following recommendations, acknowledging that resources issues are part of the wider national picture.

1.19 We reiterate that these recommendations are intended to support the Trust in learning and improving services and practices, the issues did not contribute to the incident and are not causally linked to the unlawful killing of V1.

**Recommendation 1** The Trust should ensure that staff who are not part of the core team (e.g. agency staff, trainees) and are involved with the care and treatment of a person linked to a homicide should be sought out at the earliest opportunity, offered support and be advised that they may be asked to contribute to an investigation. In the case of trainees, this will also include the Trust contacting the Director of Medical Education and the Deanery, in line with their agreed procedures. This to be monitored after every homicide which is reported to the Trust.

**Recommendation 2** The CMHT to focus on how they use the resources they have for their higher risk patients. This is in the context of the Trust-wide dependency and acuity review currently being carried out by the Trust, which is intended to enable the Trust to understand the staffing resources they have and how to best deploy them,

[4] "During 2005-2015, 11% of homicide convictions were in mental health patients, a total of 835 patient homicides over the report period, an average of 76 homicides per year". The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales. October 2017. University of Manchester, p. 5

and to improve the service[5]. This to be subject to peer review six months following the formal acceptance of this report by the Trust and CCG.

**Recommendation 3** When there is clear evidence of a relapse signature, where appropriate, there should be senior medical review of the case utilising supervision of trainees and reflective practice.

**Recommendation 4** At times of high risk e.g. a change of antipsychotic medication consideration should be given to placing the service user on shared care . This to be subject to annual audit.

**Recommendation 5** All decisions to place patients in the practitioner-led clinic (formerly the NLC) should be taken in a multidisciplinary forum with consultant psychiatrist input. Due consideration to the risk history should be given. This to be subject to annual audit.

**Recommendation 6** The Trust reviews the Trust-wide Care Planning Policy and service specific Care Planning Procedures, to ensure that:

- Details of care planning procedures and the Admissions, Discharge and Transfers policy are consistent with each other and implement the same principles.
- There is detailed guidance on technical aspects of CPA processes, such as when to call a CPA review.
- A CPA review is held at key points of a care plan, such as transfer between teams or consultants, changes in medication and decisions to remove a service user from the CPA framework.

This to be completed within six months and reported to the relevant group or committee.

**Recommendation 7** Documentation should be clear and unambiguous. Recording transfer meetings that did not take place is clearly inaccurate. A panel of representative users of the RiO system should meet and comment on the reliability and accuracy of this means of recording key events in care delivery, particularly focussed on the transfer of care. This panel to report within six months.

**Recommendation 8** The Trust to ensure that before any Trust policy is reviewed, consideration of good practice guidance is included within the template reference.

**Recommendation 9** Where appropriate the CMHT sample audit every six months that all transfers are accompanied by a comprehensive description of the service user's health and social care needs and risk assessment, including a recorded clinical formulation to assist the CMHT in the planning of future care.

[5] This review involves the use of NHS Improvement/National Quality Board (2018) " An improvement resource for mental health" and appendices.

**Recommendation 10** The Trust to build on their current work with the Trust Wide Police Liaison Group and to collaborate with the AMHP service, to facilitate:

- An understanding of each other's roles
- Flexibility in approach for complex cases
- A system of escalation within each organisation

In addition, each agency should consider having a link worker within each organisation, to promote mutual understanding and improved joint working

Progress to be reviewed by all stakeholders within six months of formal acceptance of this report by the Trust and CCG.

**Recommendation 11**. When changes to the AMHP Hub are taking place, the Trust to work collaboratively and in partnership with the LA to focus on its capacity and capability to respond to requests for MHA assessments originating from colleagues and fellow practitioners. The Trust to collect, collate, and record any incident data relating to MHA assessment and feedback to the local authority responsible for the AMPH Hub.