

# HUNDREDFAMILIES CASE REVIEWS AND RELATED NEWS ARTICLES: NORTHEAST ENGLAND

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## 1. Nicholas Rought

In 1994, Nicholas Rought is released from prison after serving a sentence for assault, and is treated by the NHS. While in prison, he has become “mentally unwell”. Since before his sentence, he has used cannabis and other illicit drugs and his psychiatrist and his mother are pretty sure that he is suffering drug-related psychosis due to the illicit drugs. He is treated with chlorpromazine and diagnosed bipolar. The report, casually mentions in a different place that he is still taking fluoxetine, which he started while in prison. Just after his release, he is suffering serious thought distortion and he “threatened to kill [his mother and carer] and believed that he had been talking to God.” There is no other mention of fluoxetine in the entire report, and no consideration of a possible role in his “mental unwellness”. It is not clear when NR stopped taking it, assuming he did. In 1996 NR is sent to prison for inflicting grievous bodily harm, and he is released in 1999. Later his psychiatrist decides that he has schizoaffective disorder unrelated to drug use. For years, NR resists taking neuroleptic (“antipsychotic”) medication and has a number of good years where he works and does fairly well in spite of his mother and the NHS, who are determined to get him, and keep him, on some neuroleptic. They try to get him to take olanzapine, risperidone and aripiprazole, at different times. They also give him multiple prescriptions for diazepam which NR takes willingly, even buying extra on the street, and by 2011 his mother is “concerned he is becoming dependant on diazepam.” Street drugs are a complicating factor in his case, but it is odd to note the NHS disapproval of his street drug use while they are pushing psychoactive drugs at him constantly. By 2013 he has had several short stints on olanzapine, which he does not like. (Among the many side effects of olanzapine frequently reported to the FDA are aggression, agitation, delirium, paranoia, psychotic disorder and schizophrenia. Homicide and homicidal ideation are less common but happen more often on olanzapine than on other drugs (RxISK.org)). On 1 August 2013 “It was recorded in the clinical notes that Mr B was taking his olanzapine intermittently.” By Sept he has stopped the medication altogether. Those who have seen him since August claim he appears to be fine, but on Sept 16 he savagely beats a man to death with a baseball bat, inflicting horrific injuries, with no motive. The news article makes reference to NR receiving mental health services, but there is no mention of medication. The review is highly critical of NRs illegal drug use, and also of his failure to take neuroleptics. They conclude that the fatality was neither predictable nor preventable.

**County Durham dad's murder could not have been prevented, independent report reveals– (Chronicle Live)**

<http://www.chroniclelive.co.uk/news/north-east-news/county-durham-dads-murder-could-11003759>

18:30, 7 Mar 2016

By Keiran Southern

John 'Jonty' Hall, from Houghton-le-Spring, was killed by Nicholas Rought, who was receiving mental health care at the time of the murder

The family of a father-of-two who was beaten to death have welcomed a report which said nothing could have been done to prevent his murder.

John "Jonty" Hall was killed in a savage attack from Nicholas Rought, who was in the care of mental health services at the time.

Rought was jailed for life with a minimum of 19 years for the horrific murder.

His co-accused, Stuart Smith, was found guilty of manslaughter and received a 15-year sentence.

Now, Mr Hall's family have spoken of their relief after an independent report into the NHS's handling of Rought's care concluded the murder could not have been "predicted or prevented".

His daughter Bethany, 26, said: "Everyday since my dad left us has been a struggle. It changes your life and it tore our family apart.

"There will always be stuff that comes up that you have to prepare yourself for. I've had to go through two Christmases without my dad now. It's horrendous.

"It is something we have had to accept and live with.

"After all of the stress caused by waiting for the report and not knowing what it contained, we are happy with its findings."

Rought and Smith subjected Mr Hall to an horrific attack during a drinking game at a house in Shiney Row, Houghton-le-Spring September 2013.

In police interviews after his arrest, Rought appeared to confess, saying he stuck a fork in Mr Hall's face then landed repeated blows with a baseball bat.

Smith said he heard Rought saying: "I've waited 23 years for this and God has had his justice."

After killing Mr Hall in September 2013, Rought and Smith first hid his body in a disused builder's yard.

They then dumped it in a wooded area at West Rainton, County Durham, where it was discovered by a dog walker.

Mr Hall, 46, from Herrington Burn, Houghton-le-Spring, was found to have 20 fractured ribs, liver damage, a cut throat, broken arm, broken thumb and injuries to his torso and genitals.

The report, commissioned by NHS England, investigated Northumberland, Tyne and Wear NHS Foundation Trust's care and treatment of Rought.

## Independent investigation into the care and treatment of Mr B - A report for NHS England, North Region

[http://www.hundredfamilies.org/wp/wp-content/uploads/2016/06/NICHOLAS-ROUGHT-\\_Sep13.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2016/06/NICHOLAS-ROUGHT-_Sep13.pdf)

December 2015

1.1 Background to the independent investigation In September 2013, Mr B, a 45-year-old man, killed Mr X. Mr B was found guilty of murder and sentenced to life imprisonment. At the time of the incident Mr B was in receipt of mental health services provided by Northumberland, Tyne and Wear NHS Foundation Trust. He had been under its care since 1994.

### 4 Executive summary and recommendations

4.1 Overview of care and treatment Mr B first had contact with the trust's adult mental health services shortly after his release from prison in November 1994. This culminated in his first admission to inpatient services the same month.

Mr B was admitted to inpatient services four more times, twice in 2009 and once in 2010 and in 2011. Mr B engaged with mental health services extensively and was under the care of the community team until the index offence in September 2013. Throughout his care in the community Mr B was predominantly managed by the same care coordinator and consultant psychiatrist.

In the months leading to Mr B's final inpatient admission in August 2011 Mr B was monitored by his care coordinator and consultant psychiatrist. He was also noted to be deteriorating by his carer (his mother) during this period. The care coordinator made arrangements for Mr B to see the dual diagnosis worker to help him with his drug problem. He declined to engage with this service. Mr B was placed on the CRT 'alert' list.

On 12 August the consultant psychiatrist and care coordinator decided that Mr B should be admitted to hospital under Section 3 of the Mental Health Act. Mr B went absent so the police were informed. He voluntarily presented at hospital two days later and was admitted under Section 3. Whilst on the ward Mr B went absent again and later returned inferring that he had assaulted a man he knew. The inpatient consultant psychiatrist put a risk management plan in place for Mr B in light of this new information.

Mr B was granted periods of leave in September 2011 and was discharged the next month. It was agreed that he would continue to be monitored by his community care coordinator and consultant psychiatrist.

Mr B contacted the care coordinator in November 2011 to tell her that he had been arrested for assault and had been bailed to appear in court the next month.

Mr B was stable in the early months of 2012. It was noted by clinical staff that he was due in court in May 2012 to answer charges of carrying a blade in public. Mr B's carer contacted his care coordinator in May 2012 to advise that she thought her son was over using pain relief medication and that his

behaviour had changed. Mr B's care coordinator subsequently saw Mr B on 2 July (she had been on leave) and identified that Mr B was in the early stages of relapse. She decided that he should be reviewed with the consultant psychiatrist and that her visits should be increased to once a week.

No further concerns were identified and Mr B's risk was identified as low in August. He remained stable until November when he started to use cannabis and his behaviour was noted to have deteriorated. However his carer became unwell and Mr B's behaviour improved.

In May 2013 Mr B's care coordinator noted that he was caring for his youngest child with the support of his carer. Mr B remained stable and it was agreed that his consultant psychiatrist would withdraw from his care.

Mr B's care coordinator contacted social services in July to advise that she had noted some changes in his behaviour. The two discussed Mr B and his social worker deemed Mr B a supportive father and that there were no safeguarding concerns.

Mr B told his care coordinator at their next appointment the same month that he had recently been in a car accident and had been bailed by the police until September. The care coordinator noted that Mr B had been using tramadol and diazepam and started to show signs of irritability and frustration. The care coordinator updated the consultant psychiatrist and left a message with the social worker.

Mr B started to show signs of relapse and was seen by the care coordinator and consultant psychiatrist on 25 July. He displayed early warning signs that indicated his mental health was deteriorating, though did not have pressured speech nor was his mood elated. The consultant psychiatrist assessed Mr B's behaviour as being reasonably well and considered that his risk was contained. They identified that there was a potential risk of violence/aggression to others should Mr B's condition deteriorate though at the time it remained 'minimal'. It was agreed that the care coordinator would continue to monitor Mr B and he would be reviewed again by the consultant psychiatrist. Mr B was placed on enhanced CPA (Care Programme Approach) status.

Mr B's care coordinator was contacted by his child's social worker on 5 August. She advised that Mr B had been arrested on 26 July following an incident at his home which the police attended. Weapons had been removed from the family home.

Mr B's care coordinator spoke to him and his carer on separate occasions in early August. Mr B told her on 12 August that he had been in court the previous day in relation to custody of his youngest child. He reported that he was stable and had not been taking cannabis.

Mr B was last seen by his care coordinator on 11 September. They discussed his needle phobia. Mr B did not report any concerns in relation to his mood, concentration, appetite or energy levels. He did not present evidence of thought disorder, irritability, pressured speech or perception abnormality. Mr B's risk was recorded as 'low' though there remained a risk of violence/harm to others. Mr B said that he was not taking any medication though he had a supply at home if he needed it.

Mr B missed his appointment with his consultant psychiatrist on 12 September. The consultant tried to contact Mr B but received no response.

Mr B's care coordinator was informed on 17 September that he had allegedly been involved in the murder of Mr X.

4.2 Overview of care and treatment and conclusions Mr B engaged extensively with mental health services from 1994 until the index offence in September 2013. As a result of this we focused on Mr B's care in the months preceding his final inpatient admission in 2011 until the index offence in September 2013.

Mr B was predominantly managed by his care coordinator with regular input from the community consultant psychiatrist. Mr B could be difficult to manage. Difficulties included:

- abuse of drugs and alcohol;
- failure to engage;
- threatening and/or intimidating behaviour; and
- non-compliance with treatment.

4.3.1 Findings Based on Mr B's clinical history and his presentation, the most likely diagnosis is bipolar affective disorder. There are no shortcomings in the trust clinicians' approach to Mr B's diagnosis. We have no c4.5 Pathway of care We considered whether Mr B's pathway of care and care planning was appropriate given his diagnosis and presentation.

Mr B's care pathway had to take into account a number of variables including a diagnosis of bipolar affective disorder with dramatic mood swings; Mr B's extensive and persistent use of illicit drugs that had an adverse impact on his mental state; Mr B's repeat offending; Mr B's denial that he had any serious mental illness; and Mr B's non compliance with medication in the community.

It was appropriate to manage Mr B's bipolar affective disorder when severely psychotic with an inpatient admission or MHA detention (as occurred in August 2011). As an inpatient Mr B received antipsychotic medication consistent with NICE treatment guidelines. Mr B was managed in the community with additional community mental health input for the majority of his 19-year period of care, except when he was in prison. In the community, the monitoring of Mr B's mental state and effective communication with his carer was undertaken to a high standard as evidenced by his clinical records.

Mr B's care coordinator and consultant psychiatrist knew him well. Mr B trusted them which meant reliable risk assessments were made of his evolving risk and his clinical management was appropriately adjusted when necessary. There is no evidence to suggest that their treatment of Mr B was inappropriate, misjudged or wrong.

Repeated attempts were made by those involved in Mr B's community care to persuade him to take antipsychotic medication. This was consistent with NICE guidance. The clinical team discussed whether to compel him to take medication. This would have required compulsory powers under the MHA. There

is evidence that this option was discussed prior to Mr B's hospital discharge; however the decision was made not to pursue this.

The majority of experienced consultant psychiatrists would probably have reached the same conclusion not to pursue a supervision order. This would largely have been because of Mr B's clinical circumstances, guidance in the MHA code of practice and research evidence of the effectiveness of community treatment orders in preventing relapse and readmission.

4.5.1 Findings Mr B's care plan was completed in line with trust policy and guidance.

The care pathways followed by clinicians caring for Mr B were appropriate throughout his care.

4.6 Forensic services and MAPPAs The clinicians caring for Mr B were aware he had a forensic history and offences included convictions for criminal assault and GBH. There is evidence in the notes that Mr B and his family shared information relating to his offences with clinical staff.

If Mr B's minor offence history is considered alone, there would be no indication for the need to seek a forensic psychiatric opinion. However the team could have sought a forensic opinion prior to Mr B's conviction in 1996 for GBH or after his release in October 1999. If such advice had been sought then expert guidance on the issue of a MAPPA referral would have been forthcoming. There is no written evidence to indicate that Mr B's consultant was told about any assault offences committed after his release in 1999 by criminal justice services. It is surprising that the probation service supervising Mr B in 2008 and 2009 did not discuss seeking a forensic opinion with the trust. In March 2010 the clinical notes reference the option of referring Mr B to the complex case panel/forensics and psychotherapy however there isn't a record of a decision or further consideration of a referral.

There is no evidence of a MAPPA referral being considered after Mr B was released from prison in 1994. Mr B's treating team gave priority to managing his complex bipolar disorder and his consultant did not think that this condition was the primary contributing factor behind the assaults. This was not unreasonable and we have no criticism of this.

4.6.1 Finding The failure of the team to refer Mr B to forensic services may have been a missed opportunity to explore alternative approaches in his care and management.

The trust has now introduced advice clinics where clinicians can seek advice and guidance from specialist forensic staff as required. Therefore we have not made a recommendation.

4.7 Drug and substance misuse It is clearly documented throughout Mr B's clinical notes that he abused illicit drugs. His drug use typically coincided with periods in which his mental health deteriorated. Mr B was offered a referral to drug and substance misuse services on more than one occasion, however he either declined or did not attend appointments.

Mr B's consistent denial that he had a drug misuse problem meant that there was little chance of a referral ever being successful.

There is evidence that at least from 2011 onwards the trust had a dual diagnosis service. Though Mr B declined to engage with the service his treatment team could have sought advice from the team in relation to treatment strategies which may have been helpful for his management.

4.7.1 Finding Mr B's treatment team may have benefited from advice from the dual diagnosis service about treatment strategies for him. However Mr B declined to be assessed by the dual diagnosis service.

4.7.2 Recommendation Community teams should seek specialist advice as required in relation to treatment strategies when managing patients with a history of drug and/or alcohol abuse who do not engage with the service.

4.8 Engagement with other agencies A number of agencies were involved in Mr B's care and management including the trust, his GP, probation services and social services.

4.8.1 Finding The level of engagement between agencies involved in Mr B's care was adequate however the trust would have benefitted from some agencies (e.g. criminal justice services) sharing information on a more proactive basis.

4.8.2 Recommendation The clinicians should ensure they comply with the information sharing requirements of the trust Care coordination policy.

4.9 Predictability and preventability In reaching a conclusion about predictability and preventability we set out below the standards against which we have assessed Mr B's care.

We consider that the homicide would have been predictable if there was evidence from Mr B's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

We consider that the homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

We have considered the circumstances, information and means available to the community team about Mr B at the time of the incident in September 2013 and conclude that the team could not have predicted the incident nor was it in a position to have prevented it.

4.9.1 Findings

**We found that the incident in September 2013 could not have been predicted.**

**We found that the death of Mr X could not have been prevented...**

Mr B also had a forensic history that included custodial sentences for criminal assault in 1994 and GBH [grievous bodily harm] in 1996. In 2008 Mr B was charged with carrying an offensive weapon and faced

theft charges in 2009. Further incidents occurred after this, the most recent of which was in August 2013 when the police were called to Mr B's house. The police removed weapons from Mr B's house.

The volume of information in relation to Mr B's care is extensive therefore in the interest of brevity we have focused on the months preceding his last inpatient admission in July 2011, until the index offence in September 2013. When Mr B was not an inpatient he was cared for in the community under CPA. Mr B's primary diagnosis most often reached by clinicians throughout his care was bipolar affective disorder.

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#### Mr B chronology 1994-2010

1994 At the age of 25 Mr B was charged with Section 18 Wounding with Intent. He had used a broken bottle to cut a man's throat. The injury was not life threatening. He was remanded in prison in July 1994 where he became mentally unwell. He was seen by a psychiatrist who assessed him as having amphetamine-induced psychosis which was treated with chlorpromazine. Mr B was released on bail in November of the same year.

In November 1994 Mr B was seen at home by consultant psychiatrist 4. He presented with hypomania thought to be the result of taking illicit drugs. Consultant psychiatrist 4 made arrangements for Mr B to be informally admitted to hospital 3. Upon admission Mr B admitted to a history of taking illicit drugs and abusing alcohol on a regular basis from the age of 14. He was observed to be expressing delusional thoughts and pressured speech during his admission. Mr B was transferred to a locked ward and placed on Section 2 of the Mental Health Act (MHA) but was later granted periods of overnight leave. Mr B was discharged on 20 December with a diagnosis of drug-induced psychosis.

1995 Mr B was seen by consultant psychiatrist 4 on 16 January. Mr B attributed his previous violent behaviour to being high on ecstasy and alcohol. He said that between the age of 20 and 22 he had been dealing and using illicit drugs. He said that he was physically abused by individuals who believed he had stolen money from them. Mr B did not report this to the police.

There is a gap in the chronology until 2001. It is known that Mr B was in prison in 1996 having been sentenced to six years for GBH. A CPA review took place at this time. It is also known that Mr B was released 14 months early from prison in October 1999.

2001 In the early months of 2011 [*this appears to be a typo, they mean 2001*], Mr B's mental health fluctuated. In early January there were concerns about his behaviour and mood which had appeared both 'high' and 'low' over the Christmas period. He admitted to, his GP, on 10 January that he was regularly taking cannabis in addition to the fluoxetine he had been prescribed in prison. Mr B was reluctant to see a psychiatrist or CPN because he was concerned he would be detained under the MHA again.

Ms C contacted Mr B's GP on 15 January to advise that Mr B's condition had deteriorated. Mr B had threatened to kill her and believed that he had been talking to God. This information was shared with consultant psychiatrist 1 who agreed to see Mr B urgently at an outpatient clinic on 18 January.

Mr B presented at the clinic with an episode of acute psychosis that may have been drug induced (Mr B denied drug use beyond cannabis however his mother suspected otherwise). Consultant psychiatrist 1 could not rule out an underlying severe mental illness such as bipolar affective disorder or schizophrenia. Mr B declined to be informally admitted to hospital and was ambivalent towards taking antipsychotic medication. Ms C did not want her son to be detained under the MHA. It was agreed with consultant psychiatrist 1 that Ms C would trial managing Mr B at home with the potential to escalate his care if necessary.

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Mr B continued to display bizarre behaviour throughout January and February though was noted by consultant psychiatrist 1 to be calmer and less agitated. Towards the end of February and during March a significant improvement was noted though **Mr B was not taking his antipsychotic medication**. Mr B had reduced his level of isolation and his sleep and energy levels had improved. His consumption of alcohol and cannabis was variable during this period. Consultant psychiatrist 1 recorded in the notes that Mr B's symptoms had improved since reducing his illicit drug use and that the episode experienced may have been drug induced.

Mr B was accompanied by his father, Mr A, to an outpatient appointment on 9 March. During this appointment Mr A said that his son had taken a number of ecstasy tablets (over Christmas) a short time before the onset of any symptoms.

Mr B failed to attend appointments with consultant psychiatrist 1 in April and June. Mr B's mother, Ms C reported that Mr B was not displaying psychotic symptoms but appeared mildly depressed and had been drinking heavily. Mr B was not taking any medication prescribed by consultant psychiatrist 1. Consultant psychiatrist 1 reviewed the position with Mr B's mother who reported that he was well, showing no affective or psychotic symptoms. She was unsure whether he was taking illicit drugs but had no evidence to suggest that he was. **Mr B had returned to work and had not taken any antipsychotic medication for three months**. Consultant psychiatrist 1 agreed with Ms C that he would review Mr B in three months (an appointment was made for 17 September), but Ms C should make contact earlier if Mr B started to deteriorate.

Mr B attended the 17 September [2001] appointment. Consultant psychiatrist 1 observed him to be well and stable. Mr B acknowledged his heavy drug use prior to the onset of the symptoms he experienced at the beginning of the year. This reinforced consultant psychiatrist 1 diagnosis of drug-induced psychosis. **[note however that he had also been taking fluoxetine, the drug he had been given in prison where, the report notes, he "became unwell".]**

2002 Ms C spoke to consultant psychiatrist 1 in early January. She outlined that Mr B had relapsed over the Christmas period. His thoughts were mixed and his conversation had developed religious overtones.

Ms C was unsure whether Mr B had been taking illicit drugs. She had been giving Mr B diazepam that he had left from a previous prescription.

Consultant psychiatrist 1 saw Mr B with Ms C on 4 March [2002]. Mr B reported that he was well and confirmed that he was smoking cannabis. Mr B did not show any psychotic symptoms during the appointment. Consultant psychiatrist 1 wrote in the notes that he believed Mr B had experienced a minor relapse but it was unclear whether Mr B was taking illicit drugs at the time. Consultant psychiatrist 1 prescribed a one-week course of diazepam for Mr B to take as required for his insomnia or agitation. It was planned that Mr B would be reviewed in four months.

Mr B was seen for an urgent appointment on 24 June before the planned review took place. Ms C reported that Mr B had deteriorated over the previous week; he had

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started talking about Jesus, believed he had special powers and was physically overactive. His cannabis use had increased and Ms C suspected he was taking other illicit drugs. Mr B admitted to consultant psychiatrist 1 that he was smoking cannabis but denied other drug use. Mr B appeared irritable during the appointment. Consultant psychiatrist 1 believed Mr B was experiencing an episode of hypomania. He agreed that Mr B could be managed at home (he was living with Ms C) unless the circumstances deteriorated. Mr B agreed to start taking olanzapine at night and diazepam as required.

Consultant psychiatrist 1 referred Mr B to CPN 1 on 26 June. Consultant psychiatrist 1 indicated to CPN 1 that CPN input would be helpful for Mr B in relation to managing his episode of illness and providing support to Ms C. An appointment was arranged for 9 August.

Consultant psychiatrist 1 reviewed Mr B routinely between July and November. During the appointments in July and August Mr B continued to voice grandiose and bizarre ideas. Ms C told consultant psychiatrist 1 in July that she was giving Mr B olanzapine without his knowledge. In August she told consultant psychiatrist 1 that Mr B had attended a funeral in August during which he drank alcohol and became verbally aggressive. Consultant psychiatrist 1 stopped the olanzapine because Mr B said he was not taking it. He agreed to start taking risperidone. Consultant psychiatrist 1 noted that if Mr B deteriorated further/failed to improve, it might be necessary to consider the compulsory powers of the MHA.

Mr B told consultant psychiatrist 1 at his September appointment that he was feeling "ok" and had started exercising. He said he was still smoking cannabis but denied any other drug use. Ms C told consultant psychiatrist 1 that Mr B was not taking the risperidone. She admitted that she continued to covertly administer olanzapine to Mr B without his knowledge. Consultant psychiatrist 1 told Ms C that Mr B should only receive medication that he was aware of and her actions were not acceptable.

Consultant psychiatrist 1 noted at the October appointment that Mr B had made some progress though still voiced abnormal thoughts and had refused to see CPN 1. Mr B showed further improvement in November. Ms C confirmed to consultant psychiatrist 1 that Mr B had significantly improved and had

stopped smoking cannabis. However it was noted that Mr B had been in a road traffic accident a number of weeks previously having drunk five pints of beer then driven and crashed his car. Mr B was to face charges for this offence.

2003 Consultant psychiatrist 1 saw Mr B on 17 January. He noted that Mr B had significantly reduced his cannabis and alcohol intake since his car accident. Mr B appeared reasonably well and stable though occasionally referenced being able to cure asthma.

Mr B failed to attend his outpatient appointment with consultant psychiatrist 1 on 28 April. Consultant psychiatrist 1 contacted Ms C who said Mr B had been well over the previous three months and had not shown any abnormal or psychotic symptoms.

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He had been taking his medication during the previous five weeks. Ms C was concerned because Mr B had resumed his relationship with a previous girlfriend who she viewed to be a bad influence over her son. Mr B's court case pertaining to the road traffic accident was postponed until July.

Mr B was seen by consultant psychiatrist 1 in October (having failed to attend an appointment in August). He reported that he was well and had not experienced any abnormal thoughts. He displayed insight in relation to his previous psychotic symptoms, attributing these to his ecstasy and cocaine misuse, and excessive use of cannabis. **Mr B was not taking psychotropic medication other than diazepam as required.**

2004 Consultant psychiatrist 1 saw Mr B for review on 16 February. Mr B had deteriorated, expressing beliefs that he could heal people with his "divine gift". Consultant psychiatrist 1 noted that Mr B appeared calm and displayed no pressure of speech and was not aggressive, intimidating or inhibited. Consultant psychiatrist 1 contacted Ms C the next day to discuss Mr B. She outlined that his mental state fluctuated on a daily basis but she was not concerned that he would become violent or aggressive. They agreed to keep the situation under review. Mr B had admitted that he was smoking cannabis however denied using any other drugs. **He was not taking antipsychotic medication and was reluctant to do so.**

Consultant psychiatrist 1 referred Mr B for CPN input. In his referral he outlined that he believed Mr B to have a bipolar affective disorder with a number of psychotic episodes that had occurred in the context of illicit drug use. Consultant psychiatrist 1 noted that he had initially diagnosed drug-induced psychosis, but now considered that Mr B's symptoms could not all be related to drug use. Consultant psychiatrist 1 believed Mr B needed ongoing CPN support. He highlighted previous risk factors in his referral, relating to aggressive and intimidating behaviour that had predominantly been verbal. He noted Mr B's conviction for GBH though added that it was unrelated to Mr B's psychiatric symptoms.

Consultant psychiatrist 1 saw Mr B urgently on 10 May at the request of Ms C. Mr B had returned from a week in London displaying features of hypomania with grandiose thoughts. He had wired his mobile

phone to a lamp, and had become verbally abusive and threatening towards Ms C. Mr B agreed with consultant psychiatrist 1 that he would start taking olanzapine at night. Mr B refused CPN input.

When seen again on 19 July, Mr B was noted to have significantly improved. He no longer held abnormal beliefs and demonstrated insight into his illness. Mr B's olanzapine was reduced (he had been experiencing excessive weight gain which is a side effect).

2005 Consultant psychiatrist 1 noted Mr B to be well and free of psychiatric symptoms in early 2005. He was not taking psychotropic medication, indicated that he had

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stopped smoking cannabis and had reduced his alcohol intake to four cans of lager a week. Mr B was noted to be actively engaged in the family business.

Having failed to attend a review appointment in June, Mr B was next seen by consultant psychiatrist 1 on 12 October. Mr B said that he had not smoked cannabis or used illicit drugs in the previous months. His alcohol consumption continued to be controlled and he had not encountered any further problems with the police. Consultant psychiatrist 1 summarised that Mr B's mental health was good and there continued to be no evidence of psychotic or affective symptoms. Mr B was not taking any psychiatric medication. Consultant psychiatrist 1 believed if Mr B could abstain from illicit substances it was possible he would remain well. However, there remained the possibility of an underlying predisposition to mental illness, such as bipolar affective disorder. Consultant psychiatrist 1 decided to continue to provide occasional outpatient follow-up.

2006-2007 Mr B failed to attend outpatient appointments in April and September. Consultant psychiatrist 1 wrote to GP 1 to outline that Ms C had contacted him with concerns that Mr B had 'gone to ground'. Consultant psychiatrist 1 added that services would continue to try to engage Mr B and asked GP 1 to provide any information that became available.

Consultant psychiatrist 1 saw Mr B on 13 November. Mr B reported that he was well though admitted that he was smoking cannabis. He denied using any other drugs. Mr B did not display any psychotic symptoms. Ms C subsequently contacted consultant psychiatrist 1 to advise that her son had accumulated a significant amount of debt. She described the situation as difficult and stressful. Consultant psychiatrist 1 gained consent from Mr B to provide Ms C with a letter to support her in addressing the debt issues.

It was noted in December that Mr B had gone to Dubai with his father. Ms C wrote to consultant psychiatrist 1 in March 2007 to advise that Mr B remained in Dubai. He was well and she did not have any concerns about him. She wrote that she would arrange a follow-up appointment for Mr B when he returned.

2008 Consultant psychiatrist 1 saw Mr B on 4 August. Mr B described himself as 'excellent' and outlined that he had returned to the UK in December 2007 and had been living with his mother. Mr B appeared calm and denied taking illicit drugs. He showed no evidence of hallucinations though expressed some

grandiose ideas. Consultant psychiatrist 1 believed that these were early indications of a relapse of psychosis/hypomania. Mr B was unwilling to take any medication.

Mr B's family contacted the crisis team on 9 August to report that Mr B had attempted to assault Ms C. The family requested an out-of-area admission bed (Ms C worked at the local mental health hospital). Mr B could not be admitted without assessment therefore it was agreed that he would be seen by the crisis team at the

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A&E at hospital 4. At the appointment Mr B was noted to be intimidating and uncooperative; the assessment was not completed. Mr B was given a two-day supply of lorazepam and zopiclone to reduce agitation and promote sleep. It was agreed that Ms C would arrange an early appointment with consultant psychiatrist 1, but if this was not possible she would contact the crisis team.

Mr B was seen with Ms C by GP 2 on 11 August. They had requested an urgent psychiatric assessment. Mr B's engagement with the crisis team was noted along with the fact the police had been called to the family home following a verbal outburst by Mr B. GP 2 recorded in the notes that Ms C did not feel at risk. GP 2 made an urgent referral to consultant psychiatrist 1. GP 2 was aware that Consultant Psychiatrist 1 was on annual leave until 18 August. Mr B and Ms C opted to wait to see consultant psychiatrist 1 though agreed to contact on call cover if the situation escalated. Mr B agreed to stop drinking alcohol and was prescribed a week's course of lorazepam.

Consultant psychiatrist 1 saw Mr B on 18 August. He was accompanied by Ms C and his brother, Mr D. Mr B denied any problems with his mental health however Ms C and Mr D did not agree with this. They described incidents that had happened when Mr B was intoxicated which would not have occurred if he were well. He had caused damage to the family home, verbally threatened a neighbour, held a knife to his own throat and his speech had become bizarre. Mr B had been arrested and was on bail for carrying an offensive weapon. Ms C and Mr D said that Mr B had been binge drinking for about four months. Ms C had started to administer a previous prescription of olanzapine to Mr B; consultant psychiatrist 1 expressed his concern to Ms C about her giving Mr B medication without his or GP 2's agreement.

It was agreed that Mr B would take aripiprazole at night and would be closely monitored by the crisis team – which would observe him taking his medication. However Mr B's family contacted consultant psychiatrist 1 shortly after to advise that Mr B was refusing to take his medication. The crisis team indicated an unwillingness to accept Mr B due to his potential risk (and that he was outside of its catchment area). As a result consultant psychiatrist 1 decided Mr B warranted detention under Section 3 of the MHA for further assessment. Consultant psychiatrist 1 completed the medical assessment however Mr B left the family home and the police were informed he had gone missing. Consultant psychiatrist 1 asked social worker 1 to monitor the situation daily in relation to locating Mr B.

Social worker 1 wrote to consultant psychiatrist 1 on 2 September to advise that Ms C had confirmed Mr B had not visited his mother because he was fearful of being detained under the MHA. Ms C had been able to see him and reported that he appeared 'level' and she did not observe any signs of mental

illness. Having been advised that the original MHA assessment was now invalid, Ms C said she thought Mr B would be willing to see consultant psychiatrist 1. An appointment was made for 22 September however Mr B failed to attend having double booked an appointment with his GP. Ms C phoned the service to arrange another appointment. She reported that Mr B was “really good” and she didn’t have any concerns.

A new appointment was arranged for 1 October however Mr B cancelled saying that he had a court appearance. Ms C spoke to consultant psychiatrist 1. She said

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there was no evidence of psychiatric illness and Mr B was level headed. He had not been drinking and there was no evidence of drug taking. There hadn’t been any further incidents. Consultant psychiatrist 1 reiterated that Mr B should have CPN involvement.

At this time consultant psychiatrist 1 wrote to the assistant medical director, hospital 1 to explain the family’s position in relation to their wish that Mr B be treated outside of the local catchment area. The assistant medical director replied that it would be difficult to facilitate community services from another locality, and it would be more appropriate for Mr B to be treated within the local catchment. It was agreed however that if Mr B required admission he should not be placed at the hospital where members of his family worked.

Mr B failed to attend an outpatient appointment on 26 October. Consultant psychiatrist 1 spoke to Ms C and Mr B over the phone. Ms C said she had no concerns and Mr B reported that he was well. He was calm, coherent and rational. Consultant Psychiatrist 1 contacted Mr B’s probation officer indicating that it would be helpful to maintain regular contact with Mr B who had been placed on a community probation order.

2009 Mr B was seen by consultant psychiatrist 1 on 7 January. Mr B reported he was “ok”. Mr B had not been taking his prescribed medication. He agreed to CPN involvement. Consultant psychiatrist 1 contacted the rehabilitation recovery team to request the allocation of a CPN. He provided a Sainsbury risk assessment (dated 1 October 2008) and a narrative overview of key longer-term risks relating to other periods of illness. Consultant psychiatrist 1 outlined that these risks increased in relation to aggressive or reckless behaviour when Mr B was non-compliant with medication or disengaging from services. Consultant psychiatrist 1 added that he believed Mr B to be stable at the time and of low risk.

Mr B was seen by the rehabilitation recovery team on 11 February. The team did not identify any rehabilitation needs – Mr B indicated that he could manage on his own and did not require support. The team did not accept Mr B onto its caseload. Consultant psychiatrist 1 planned to refer Mr B to the planned care team for CPN input.

Ms C contacted consultant psychiatrist 1 on 26 February to report that Mr B had deteriorated. Consultant psychiatrist 1 and social worker 1 undertook a home visit. Mr B admitted that he occasionally smoked cannabis, and had been drinking heavily to help him sleep but denied any

problems. The clinicians' impression was that there had been an early relapse of a bipolar disorder and that Mr B required close monitoring given that his behaviour could escalate quickly. Admission was considered however a trial of home treatment was agreed with Ms C, on the basis that this would involve the local team. A short-term prescription for diazepam was given to Mr B and a follow-up appointment was scheduled for 9 March.

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The crisis resolution team (CRT) undertook home visits on 27 and 28 February and 1 March. The diazepam Mr B had been prescribed was noted to have had a positive and calming effect. The CRT contacted consultant psychiatrist 1 on 2 March to advise it felt Mr B could be discharged from the service. The team suggested it undertake a seven-day follow-up visit after Mr B was discharged.

Ms C contacted the CRT on 8 March to say she was concerned about Mr B's behaviour. Consultant psychiatrist 1 became involved and arranged for Mr B to be informally admitted to hospital 4 that day. Mr B said he had not been taking his medication. He reported an elevated mood, increased irritability, and that he was not coping at home and had not slept in the previous 48 hours. It was thought that his deterioration in mood was partly due to his pending court case. Mr B had been scheduled to attend court on 9 March in relation to two offences of jewellery theft. Consultant psychiatrist 1 had previously identified that Mr B was not fit to stand trial and the case had been adjourned.

Mr B was settled during his period of inpatient care and was granted overnight leave. Mr B did not return to the ward on 14 April following a period of leave, and it was agreed he could be discharged. It was agreed at the post discharge CPA meeting on 21 April that consultant psychiatrist 1 would follow up with Mr B.

CPN 2 contacted Mr B to offer an appointment for assessment. Mr B did not respond therefore CPN 2 discharged him from his caseload without being seen on 28 April. Mr B was referred again for CPN input in May. CPN 3 met Mr B on 28 May who agreed to engage with the service.

Consultant psychiatrist 1 saw Mr B on 1 June. His mood was noted to be fairly stable though he was stressed about his impending court case.

Ms C contacted GP 2 on 4 June [2009] to report that Mr B had reverted to his previous behaviour since seeing consultant psychiatrist 1. He was hostile and confrontational – Ms C suspected he was taking drugs. Mr B failed to attend a planned appointment with GP 2 that day. GP 2 asked Ms C to get Mr B to contact him.

Consultant psychiatrist 1 saw Mr B on 8 June. His behaviour had become increasingly erratic and he was informally admitted to ward C. Mr B's urine test was positive for a morphine-based substance.

Mr B attended court on 15 June (a decision supported by consultant psychiatrist 1) and returned to ward C the same day. He was found not guilty in relation to a burglary charge but was to attend court on 10 July in relation to another offence. Throughout June Mr B showed no evidence of psychosis or

elevated mood. He was granted regular leave. Mr B attended court on 10 July. He was found guilty and received a 12 month probation order.

Mr B deteriorated during a period of authorised leave and presented as aggressive. Ms C contacted the ward to voice her concerns in relation to the management of Mr B's leave and the failure to consult her when a leave plan was being developed.

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Consultant psychiatrist 1 reviewed Mr B on 30 July [2009]. He decided that Mr B should return to the acute ward when a bed became available, but be granted ground leave at the discretion of nursing staff. Consultant psychiatrist 1 was considering a referral to MAPP (Multi Agency Public Protection Arrangements). Ms C believed that Mr B should be detained for 28 days without leave. However it was agreed at an MDT (multi-disciplinary team) meeting on 3 August that Mr B could be discharged home after his mother had indicated she was happy for him to be discharged. Mr B was discharged and a seven-day follow-up appointment arranged for him to be seen on the ward. The CRT was informed of the discharge. Mr B failed to attend the seven-day follow-up appointment. Consultant psychiatrist 1 saw him on 17 August. Mr B reported he was well and planning to get back to work. He reported he was taking his olanzapine. In advance of this appointment Ms C had confirmed with consultant psychiatrist 1 that Mr B was well though she was unsure if he was taking his medication.

Mr B contacted care coordinator on 18 August to explain that he could not attend their appointment that day. Another appointment was arranged which Mr B again failed to attend. Care coordinator made a number of attempts to contact Mr B and subsequently contacted consultant psychiatrist 1 and the probation service to discuss his non engagement.

Care coordinator attended Mr B's appointment with consultant psychiatrist 1 on 19 October. Mr B appeared well though [he] indicated he had stopped taking his medication. Mr B confirmed he was amenable to an ongoing dialogue with mental health services and the probation service. Care coordinator made two appointments to see Mr B, neither of which he attended.

2010 Consultant psychiatrist 1 and care coordinator saw Mr B together on 11 January. Consultant psychiatrist 1 recorded no concerns. Mr B appeared mentally well. Mr B continued to fail to engage with care coordinator, saying he would call her if he needed support. Ms C told care coordinator on 19 January that she had concerns about Mr B whose behaviour suggested he had started taking drugs again. Ms C thought he was abusing his prescribed medication. Care coordinator spoke to Mr B over the phone and it was agreed she would visit him on 21 January. Care coordinator contacted the CRT to place Mr B on 'alert', and updated consultant psychiatrist 1 of the situation.

Care coordinator saw Mr B at home on 21 January. He told her he was implanted with poison from dog bites. Ms C outlined to care coordinator that Mr B had been physically and verbally intimidating. Mr B displayed slight pressure of speech and continued to take his antipsychotic medication. Care coordinator referred to the CRT, asking it to contact Ms C that evening and see him the next day.

The CRT was unable to contact Ms C – the phone was either engaged or not answered. Care coordinator spoke to Ms C the next day who asked that there be no contact from two members of the CRT who she had previously had bad experiences

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with. Ms C said that she would manage the situation at home but would contact the CRT if the risk changed. The situation was monitored by care coordinator and probation officer and remained unchanged throughout January and early February. Probation officer was aware Mr B had been actively using cannabis and his mental health was showing early signs of relapse.

Ms C contacted care coordinator on 15 February to ask for help. Care coordinator arranged to visit the next day and brought forward Mr B's planned appointment with consultant psychiatrist 1. During the planned visit care coordinator found Mr B presented with symptoms of further relapse. Care coordinator accompanied Mr B to his appointment with consultant psychiatrist 1 the next day. Mr B was prescribed olanzapine and diazepam.

Care coordinator noted during a home visit on 2 March that Mr B's behaviour had deteriorated further. It was agreed that CRT involvement should be activated to support home treatment in addition to arranging a short supply of diazepam. The CRT visited the next day. The home situation was described as fraught however Ms C indicated that she would prefer to manage Mr B at home. The CRT arranged a further a medical review for 4 March and asked Ms C to contact the team if she needed help. Ms C requested a carer's assessment.

Consultant psychiatrist 3, CRT undertook an assessment on 4 March. His impression was that Mr B was presenting with a manic episode of what appeared to him as bipolar affective disorder or possibly schizoaffective disorder with illicit drug use being a significant factor. Mr B's risk was seen to be low but he required ongoing assessment. A plan was agreed between care coordinator and the CRT. The CRT visited Mr B regularly during which time the team considered a hospital admission.

Consultant psychiatrist 1 reviewed Mr B on 12 March. It was noted that Mr B remained unwell – his behaviour was less irritable though it was known he was continuing to use cannabis. Consultant psychiatrist 1 felt Mr B could be managed at home. His medication was increased. The CRT and care coordinator continued to engage with Mr B throughout March. Mr B was seen by consultant psychiatrist 1 and care coordinator on 23 March. He continued to express grandiose ideas but was not irritable. He declined a hospital admission. Further medication was prescribed and Mr B agreed to continued contact with care coordinator.

Mr B's engagement with care coordinator and consultant psychiatrist 1 was variable in April and he was informally admitted to hospital 4's acute inpatient ward on 24 April. Mr B was an inpatient from 24 April until 19 August. During his admission Mr B's behaviour and presentation fluctuated. Incidents included Mr B presenting as intoxicated, irritable, exhibiting bizarre behaviour and going AWOL.

Mr B's behaviour was described as floridly psychotic on 11 May. Staff noted his behaviour as intimidating and he absconded from the ward the next day. He was subsequently detained by the police under Section 136 of the MHA. The police later contacted the ward to advise they suspected Mr B had broken into a vehicle when he was AWOL on 10 May.

Mr B was granted periods of escorted ground leave from 18 May. The MDT met on 1 June. Plans were made by the team that included encouraging Mr B to contact the relevant drug advisory service in the area. Random drug screening was introduced in parallel with two-hour-a-day unescorted ground leave.

Mr B tested positive for cannabis, benzodiazepines and morphine on 5 June. On 8 June it was decided by inpatient staff that Mr B's section should be converted from Section 2 to a Section 3. Consultant psychiatrist 1 completed the first medical recommendation. However the second opinion doctor asked to assess Mr B concluded he could not support a Section 3 therefore when the Section 2 expired at midnight Mr B became an informal patient. Mr B was reassessed two days later and he was detained under Section 3 of the MHA. Mr B made a formal appeal against his detention the next day.

Between 12 and 30 June Mr B was generally described as settled though concerns remained that he was accessing illicit drugs when on leave. Mr B continued to be generally settled in July and appropriately utilised periods of leave during this period. The MDT decided on 19 August to revoke the Section 3 and he was discharged. It was agreed care coordinator would maintain weekly contact and that consultant psychiatrist 1 would resume his responsibility as the consultant lead in the community.

Mr B attended his seven-day follow-up appointment on 22 August [2010]. Mr B appeared well when seen by his care coordinator in August, September and October though he told her he had been arrested and interviewed regarding the alleged incident on 10 May. Ms C was present during some of these visits. During the September visit Mr B said he had experienced some problems obtaining his medication because of this he had reduced his intake of olanzapine. Care coordinator resolved the issue in relation to his prescription however Mr B continued to reduce his intake on olanzapine without following care coordinator's advice that he consult consultant psychiatrist 1 first. Mr B continued to see care coordinator and consultant psychiatrist 1 until the end of 2010. No concerns were raised during this period with the exception of Mr B refusing to take olanzapine. Additionally he told care coordinator he had accrued some debt in relation to his mobile phone.

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5.2 2011 Mr B was seen by care coordinator 1 in early 2011. Mr B told her that one of his children had needed to stay with him and his mother Ms C who also acted as his carer over the Christmas period. Mr B contacted care coordinator 1 on 18 January to tell her that his child had been involved in an accident and sustained a skull fracture and spinal injuries. Mr B was prescribed diazepam<sup>2</sup> by GP 1 to help him sleep.

Ms C – Mr B's carer who had a background working as a mental health nurse - contacted care coordinator 1 in advance of Mr B's CPA review scheduled to take place on 14 March to advise that she

thought Mr B had increased his alcohol intake. She did not think he was taking drugs but was concerned he was becoming dependant on diazepam.

1 A care coordinator is responsible for managing the overall care of a service user. They have responsibility for the service user's care and treatment, and will liaise/coordinate with any other agencies involved. 2 Diazepam is a benzodiazepine used to treat anxiety disorders.

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5.3 2012...

Care coordinator 1 saw Mr B on 19 April and noted that he was well. Mr B reported that his mental state had been stable for a number of months and that the situation was good. Mr B's clinical records indicate that Mr B was having positive contact with his youngest child and that he was identified as the responsible parent due to their mother having difficulties. Social services were actively involved. Mr B's stability was noted again at a CPA review meeting with care coordinator 1 on 30 April. Clinical staff also noted that Mr B was due in court to answer charges of carrying a blade in public. He told staff that he intended to plead not guilty.

Ms C contacted care coordinator 1 on 30 May to say she thought her son was over using pain relief and that his behaviour had changed at home. Care coordinator 1 agreed to see Mr B when she returned from a period of leave. She saw Mr B with his carer on 2 July. Care coordinator 1 noted that his mood was elevated and he was 'ranting' about his past. Care coordinator 1 identified that his behaviour was indicative of the early stages of relapse. Mr B admitted taking higher doses of his prescribed medication and additionally diazepam that he had bought. They agreed to bring forward his appointment with consultant psychiatrist 1 and, that in the interim, care coordinator 1 would increase her visits to weekly. Mr B and Ms C were given the CRT phone number. However the situation changed; Mr B was noted to be less agitated and more settled on 9 July. Ms C expressed no further concerns.

No further concerns were identified throughout August (a CPA review took place on 2 August) and care coordinator 1 identified Mr B's risk as low. Mr B telephoned care coordinator 1 on 4 September, distressed that he had not received his benefits. Care coordinator 1 noted Mr B had a slight elevation in mood. Mr B told care coordinator 1 there had been an incident a few weeks earlier when he had been stopped by the police after leaving the house of one of his ex-partners. He was issued with a restraining order. Mr B did not give care coordinator 1 any other details.

Mr B was noted to be predominantly stable throughout October. The exception to this was shortly after 17 October [2012] (date unspecified) in which Ms C contacted care coordinator 1 to advise that Mr B had deteriorated and she suspected he was over using paracetamol and using cannabis. Care coordinator 1 subsequently saw Mr B and told him she thought he was deteriorating. He disagreed. Mr B agreed to care coordinator 1 increasing her visits but would not consider antipsychotic medication.

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Care coordinator 1 saw Mr B on 25 October when he was noted to be stable and there was no evidence of cannabis use.

Mr B's began to use cannabis in early November and his behaviour deteriorated. However his carer, Ms C, became physically unwell which forced him to 'get back on track'. He attended an outpatient appointment with consultant psychiatrist 1 and care coordinator 1 where he was noted to be stable and his risk remained low.

Care coordinator 1 tried to contact Mr B on 19 December but was only able to speak to Ms C who reported a significant improvement in Mr B. Ms C believed he remained drug free and was avoiding excessive alcohol.

5.4 2013

Care coordinator 1 noted **Mr B was stable in the early months of 2013**. Between 8 February and 2 May he cancelled a planned appointment with consultant psychiatrist 1 and was unable to keep an appointment with care coordinator 1. Care coordinator 1 saw Mr B on 2 May where he was noted to be mentally stable and his risk low. Care coordinator 1 recorded in the notes that Mr B was caring for his child with Ms C's support.

Consultant psychiatrist 1 and care coordinator 1 undertook a CPA review with Mr B on 9 May. Consultant psychiatrist 1 recorded **that Mr B had been symptom free for 18 months and had not taken psychotropic medication during this period**. Consultant psychiatrist 1 submitted a case summary to Mr B's GP that stated:

"[Mr B] has had recurrent psychotic episodes. The working diagnosis is schizoaffective disorder or bipolar affective disorder. However, illicit drugs have always been a prominent feature and both [Mr B] and his mother believe [Mr B] would remain well if he refrained from illicit drugs (which would be in keeping with a diagnosis of drug induced psychosis)... [Mr B] has a past history of violence unrelated to psychiatric disorder... there is a history of aggression during florid episodes of illness though risks have been minimal/not significant for some time."

Care coordinator 1 further detailed during the review that Mr B was caring for his child due to their mother experiencing problems. The review team concluded that Mr B's enhanced CPA status should change to non CPA with care coordinator 1 providing lead professional support. Consultant psychiatrist 1 agreed to withdraw from Mr B's care though could be contacted if needed.

Mr B contacted care coordinator 1 on 8 July asked care coordinator 1 to facilitate a prescription of short-term diazepam. Care coordinator 1 contacted social worker 1 who advised that Mr B had been seen regularly and that some changes in behaviour had been observed the previous week. Mr B appeared irritated and lost his temper. Care coordinator 1 detailed in the notes that there were inconsistencies in the information that Mr B had shared with social worker 1 in relation to not taking prescribed medication and his various diagnoses in terms of mental health.

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Care coordinator 1 visited Mr B at home the next day (Ms C was on holiday). He noted that Mr B had been in a recent car accident involving the police and Mr B had been bailed until September. Care coordinator 1 also noted that **Mr B had been using tramadol and diazepam that he had bought off the street the previous week**; and that he had ongoing physical health concerns. Care coordinator 1 identified some evidence of irritability and frustration though Mr B attributed this to a recent court case. Mr B indicated he might consider an oral antipsychotic treatment (recommended by consultant psychiatrist 1) if his thoughts became unmanageable or his mood deteriorated. Care coordinator 1 subsequently updated Mr B's GP and consultant psychiatrist 1. Care coordinator 1 also left messages with social worker 1 to contact her in relation to getting an update about the home visit. Care coordinator 1 arranged for GP 1 to give a short-term prescription of diazepam to Mr B.

Care coordinator 1 spoke to Mr B over the phone on 12 July. No concerns were identified. Care coordinator 1 went on annual leave.

On return from leave care coordinator 1 had four messages from Mr B complaining that GP 1 would not give him more diazepam. Care coordinator 1 believed Mr B was showing signs of an early relapse and arranged an appointment with consultant psychiatrist 1 of 25 July. This appointment was confirmed with Mr B. Care coordinator 1 separately contacted Ms C who believed her son had returned to his old ways and was showing early warning signs of a relapse.

Mr B attended his appointment with care coordinator 1 and consultant psychiatrist 1 on 25 July. Mr B displayed early warning signs that his mental health was deteriorating by talking at length about his physical ailments. However there was no pressure of speech, no elated mood and his speech was normal. Mr B admitted to smoking cannabis though denied taking other illicit drugs or drinking excessively. **Consultant psychiatrist 1 assessed Mr B's behaviour as being reasonable and that the risk was contained. Mr B agreed to start taking olanzapine<sup>9</sup> at night.** It was further agreed that care coordinator 1 would continue to monitor the situation, and there would be further review with consultant psychiatrist 1. Consultant psychiatrist 1 and care coordinator 1 considered Mr B's risk and identified there was a potential risk of violence/aggression to others should his condition deteriorate, though at the time it remained 'minimal'. Mr B was placed back on enhanced CPA status.

Social worker 1 contacted care coordinator 1 on 5 August to report that she had learnt Mr B had been arrested by the police on 26 July in relation to an incident. It was understood several youths had attended Mr B's house late at night and that Mr B had chased them away. The police became involved and found weapons at Mr B's house (including a shotgun cartridge though no gun was found). Social worker 1 asked care coordinator 1 to prompt Mr B to contact her.

Care coordinator 1 spoke to Ms C the next day as Mr B was out. Ms C said she was aware of the situation – she had been home when Mr B was arrested. Ms C felt Mr B was improving though was unsure if he was taking his olanzapine. She agreed to let Mr B know care coordinator 1 was trying to contact him.

**9 It was recorded in the clinical notes on 1 August that Mr B was taking his olanzapine intermittently.**

Mr B contacted care coordinator 1 on 12 August. He told her he had been to court that day in relation to his younger child, having applied for full permanent parental responsibility. He was reported overall as being stable and said he had not had any cannabis in over a week and a half. He added he did not need prescribed olanzapine though was taking prescribed diazepam as required.

Mr B refused to attend an appointment for an electrocardiogram (ECG10) and routine bloods on 3 September. Mr B said that he did not need the tests because he was not taking his olanzapine.

Care coordinator 1 discussed with consultant psychiatrist 1 a request from Mr B to provide a letter of support to his solicitor. This related to a further court appearance where Mr B had been charged with refusing to supply a blood sample following an accident. Mr B said he had a needle phobia and wanted this to be documented. Care coordinator 1 agreed to review Mr B's clinical records to see if there was any information to support his view. She would also see Mr B with a view to exploring this with his GP and dentist.

Care coordinator 1 met Mr B at the Houghton Unit (a community team day unit) on 11 September. They explored Mr B's needle phobia<sup>11</sup> and actions to be undertaken in relation to this (e.g. Mr B was going to ask his solicitor to write to his GP). Mr B's mental health was recorded as stable. He reported no concerns with his mood, appetite, concentration or energy levels. There was no evidence of thought disorder, irritability, pressured speech or perception abnormality. Mr B's risk assessment was updated and his risk was recorded as low though there remained a risk of violence/harm to others. Mr B confirmed that he was not taking any medication but did have a supply of olanzapine and diazepam at home. He agreed to take his medication if his symptoms returned. Mr B was using minimal amounts of cannabis.

Mr B missed an appointment with consultant psychiatrist 1 on 12 September. Consultant psychiatrist 1 was unable to contact Mr B.

Care coordinator 1 was contacted by a colleague on 17 September who informed her that Mr B had allegedly been involved in the murder of Mr X. Care coordinator 1 contacted a member of the Criminal Justice Service who confirmed that Mr B was in custody.

Mr B was found guilty of murder at a Crown Court in 2014.

## 2. Daniel Johnson

Daniel Johnson, 32, spent 12 years in jail, starting at age 16, for participating in a violent murder, (DJ's his co-accused was the one who actually stabbed the victim) when he was 15. In 2008 he meets Gemma Finnigan. By all accounts they are very happy together and there is no domestic violence. DJ abuses Subutex (buprenorphine – a drug sometimes prescribed for opioid addiction). How and why he came to be on this medication is not addressed in the report. This medication has the known side effects of insomnia, depression, hostility, agitation, paranoid reaction, abnormal thinking, and confusion. Anxiety and nightmares are mentioned as uncommon effects in the Butran medication guide. It carries a black

box warning for abuse. RXisk.org lists “drug effect increased” as one of the side effects most frequently reported to the FDA. Yet despite DJ fitting the profile of a person suffering buprenorphine psychiatric side effects, this drug is not explored as a potential contributor to the psychotic episode that he experiences on Sept 13, 2103, in which he kills his girlfriend. Nor is there any consideration of the potential effect of the antidepressant that he was prescribed and took from November 2010 to mid-February, 2013, for which he did not get a prescription after that time. The antidepressant is not considered important enough to name. In the days leading up to the tragedy of Sept 13, DJ is reported by several people, especially Gemma, as not sleeping, and behaving very strangely. Despite 3 days of increasingly bizarre behaviour, which is reported by Gemma to DJ’s GP, nothing is done and he murders her while in this state. He is found guilty of murder with diminished responsibility and sentenced to 20 years. The review finds that the death was not predictable and it cannot conclude whether it was preventable. Several news articles refer to DJ as a “paranoid schizophrenic”, a diagnosis he never had before the killing. No mention of medication is made in the news.

### **Schizophrenic murderer 'possessed by the devil' freed from prison to kill girlfriend jailed for life**

<http://www.mirror.co.uk/news/uk-news/schizophrenic-murderer-possessed-devil-freed-4626188>

07:54, 14 Nov 2014

Updated 08:45, 14 Nov 2014

By Jeremy Armstrong

The family of victim Gemma Finnigan has demanded to know why they were never informed of the details of the shocking past of murderer Daniel Johnson

A family has demanded to know how a murderer was allowed out on licence to kill his girlfriend.

Daniel Johnson thought Gemma Finnigan, 24, had been possessed by Satan when he strangled and stabbed her 12 times.

The paranoid schizophrenic pleaded guilty to manslaughter yesterday and was sentenced to life with a minimum term of 20 years.

He had developed an interest in American conspiracy theories, would spend all night staring at the stars, spoke of spacecraft heading for earth, said he was the chosen one and claimed he was going to meet Simon Cowell.

He met Gemma - described as a ‘ray of sunshine’ by her family - in 2008. They set up home in Boldon Colliery, South Tyneside, and she became increasingly concerned about his erratic behaviour.

Newcastle Chronicle L-R (Gemma Finnigan's) Sister Kristi Allen, Cousin Tracey Legg, Friends Kayla McFarlane and Rachelle Bryne and Sister Sarah Finnigan. Friends and Family of the alleged murder victim Gemma Finnigan outside of Newcastle Crown Court ahead of the court case.

Family and friends: (L-R) Gemma Finnigan's sister Kristi Allen, cousin Tracey Legg, friends Kayla McFarlane and Rachelle Bryne and sister Sarah Finnigan

He killed her in a frenzied attack on September 13 last year.

Johnson, 33, first met Gemma while on day release from an open prison for the savage street murder of David Younas, who died in his fiancée's arms after being stabbed more than 10 times as the couple made their way home from a health club.

Johnson and a co-accused, who were both youths at the time, were given life sentences for the murder.

Now a serious case review will look at why Gemma's family were not informed about her killer's brutal past.

If they had known about his record, he would never have been allowed into their lives, Gemma's heartbroken mum Jennifer Finnigan said in a victim impact statement to Newcastle crown court.

She said: "I think of my little girl every day. She is the first thing I think of in the morning and she is the last thing I think of before I go to sleep.

"My three other daughters are all constantly upset at the loss of their sister and are angry and upset. Their lives have been turned upside down by their loss.

North News & Pictures Police and forensic teams attend the scene in Boldon, South Tyneside last year after 24-year-old Gemma Finnigan was found dead.

Crime scene: Police and forensic teams in Boldon, South Tyneside last year after 24-year-old Gemma Finnigan was found dead

"Gemma was a wonderful daughter and special to everyone who came into contact with her. She was what I would describe as a ray of sunshine.

"All she wanted was to help others and make people happy. I feel angry and let down by the probation service. They did not tell myself or Gemma about his involvement in the first murder. Had Gemma or I known about this we would never have welcomed him into our home and Gemma would still be here.

"Despite having a loving and supportive family, my life can never be the same. I have lost everything through the actions and hatred of Johnson.

"I hope he never gets out and is never allowed to harm anyone else."

Det Chief Inspector Steve Barron welcomed the verdict. He said:

“Johnson is a violent individual who attempted to argue he was insane at the time of the killing as an excuse for killing Gemma Finnigan.

It is clear he knew what he was doing and must now accept responsibility for his actions.

“Gemma died in tragic circumstances and our thoughts are with her family at this very difficult time. I would like to take this opportunity to thank them for the dignity that they have shown throughout our investigation.

“We worked closely with the CPS throughout the investigation and I’d also like to thank them for their support.”

### **South Tynside Domestic Homicide Review Overview Report Into the death of “Jessie”**

[http://www.hundredfamilies.org/wp/wp-content/uploads/2016/04/DANIEL\\_JOHNSON\\_-Sept\\_13-DHR\\_Full.doc](http://www.hundredfamilies.org/wp/wp-content/uploads/2016/04/DANIEL_JOHNSON_-Sept_13-DHR_Full.doc)

Report Author: Jill Holbert MA

Date: 19 October 2015

1.1 Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- (a) A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;
- (b) A member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death.

#### 1.3 Subjects of the review

Jessie	Age: 24	Deceased	Date of Death: [September 13] 2013
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Aaron	Age: 32	Perpetrator	Convicted: 2014
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Both the victim and perpetrator are of White British origin.

4.13 The time period covered by the review was from September 2006 until September 2013. It was acknowledged that this was a broad time-span, but was agreed as necessary in order to understand the unusual circumstances of how Jessie came to be in a relationship with Aaron while in custody and subsequent events, up to the death of Jessie.

10.4.7 [“Jessie”’s mother] had never observed or had any reason to suspect any domestic abuse in the relationship, and felt she would have known if this were the case. She described the relationship which Jessie and Aaron had as being very close, as a loving relationship, and that they always seemed happy together. She recalled an occasion when they had been riding on a bike, happy and laughing.

10.4.10 [“Jessie”’s mother] was aware that Aaron misused Subutex [Buprenorphine, sometimes used to treat opioid addiction], and stated that Jessie sometimes used to get this for him, because of his exclusion zone. She said that sometimes she offered to go and collect this for Jessie, as she was worried about Jessie going on her own.

10.4.11 In the days leading up to Jessie’s death, Jessie had contacted her [mother] about her concerns over Aaron’s strange and erratic behaviour, and his difficulty in sleeping. Mother had not known how to help, but had given Jessie information on a medication for Bipolar Disorder, and suggested that she look this up on the internet, to see if it might help.

10.5.5 Jessie had never disclosed any domestic abuse between her and Aaron to friends 1 and 2, and they were both totally shocked by what had happened. Jessie had mentioned minor arguments, and said that Aaron used to smash her ashtrays. Friend 1 said Jessie used to laugh about it and say she was fed up of having to keep buying new ashtrays. They also recalled an incident where Aaron had asked Jessie if she would wash and iron a shirt and take it to him, so that he could go out. Jessie had driven to him with the shirt, but he had thrown this back into the car and said that it was the wrong shirt. Jessie had sworn at him, and driven off. Friends 1 and 2 believed any arguments between the couple were routine, and felt that Jessie was able to stand her ground with Aaron.

10.5.6 Jessie had disclosed to friend 1 that Aaron used drugs (“Subbies”).

10.6.4 Jessie had told them that [“Aaron”] had been in prison for 12 years, due to his being present when his friend killed someone. She hadn’t seemed concerned by this.

10.6.9 On the Monday prior to Jessie’s death they said that Aaron had been due to start a college course, but then Jessie found out he had not turned up for this.

10.6.10 Jessie had come into work on that Monday and the next day, Tuesday, and had talked about Aaron not sleeping and being obsessed with his telescope, stars and planets. Jessie had been laughing, not taking him seriously, and calling him an idiot. However, on the Wednesday they noted a significant change in her, describing her as upset and anxious.

10.6.11 On the Thursday morning, Jessie had been dropped off at work by two of her sisters. They said that she was crying and emotional, because she had woken up to find Aaron praying over her, and saying that God had chosen him. She had spoken with her boss, who allowed her to leave work to try to arrange a doctor’s appointment for Aaron. They believe that Jessie then contacted her sister to pick her up and take her home.

10.6.12 Friend 3 said she had received a text from Jessie just before 10.00pm on the evening before her death, asking her to tell their boss that she wouldn't be at work the next day, and that Aaron had not gone to see the Doctor.

10.7.2 The perpetrator's mother was very upset by what had happened to Jessie. She stated that she felt that she had "lost both a son and someone (she) viewed like a daughter". She stated that her initial reaction when she had heard what Aaron had done was one of anger, shock and horror. This was before she had known or understood that he was ill. She said they were devastated by what had happened, and could not believe it.

10.7.14 [His mother] described Aaron as "not being able to sit still for a minute" and as being "on edge" all the time. This was linked to him always feeling he was looking over his shoulder. She also said that if she telephoned him, he would often respond by asking if one of his sisters or someone had been talking about him.

## BACKGROUND

11.1 At the time Jessie met Aaron he was serving a life sentence for murder, which carried a minimum ten-year tariff. The offence was committed with another youth and was an unprovoked attack. Aaron was aged 15 at the time. Both he and his co-accused were sentenced on a joint enterprise basis. Aaron struggled to accept the sentence, and so served a total of 12 years imprisonment.

11.2 Jessie first met Aaron in 2008 whilst he was in custody, placed in an open prison. Aaron was allowed community visits at the time, as part of his resettlement day release. It is believed that they were introduced through another inmate. At the time Jessie was aged 19, and resided with her mother, her mother's partner, two siblings aged 12 and 15 years, older sister, and nephew aged 4.

11.3 Aaron was released from custody in 2008 and resided in approved premises until April 2010. On acquiring his own tenancy Jessie moved in with him, where they lived together until the time of her death. There were no other residents living at the address.

11.4 Information received from Jessie's family and friends is that Jessie worked at a café run by an extended family member and also at the racecourse on event days.

11.5 Three days prior to her death Jessie contacted her mother in tears about Aaron's behaviour, which she described as erratic and strange. Over the following two days a number of telephone and text exchanges took place between Jessie and her Mother, relating to Aaron having problems sleeping and his refusal to see a G.P.

11.6 Two days prior to the death of Jessie, following a visit from her brother, Aaron's sister telephoned Jessie to express concern regarding changes she had observed in his behaviour. Jessie was said to have been relieved to be able to discuss the concerns with someone else who had also noticed the changes.

11.7 At approximately 12:30pm on the day before Jessie's body was discovered, Jessie attended the G.P. Practice where her partner Aaron was registered. She spoke to the receptionist, and asked to speak with someone regarding the concerns she had in relation to her boyfriend, who was a patient at the practice. A G.P. then saw Jessie, who expressed her concerns about her partner's strange behaviour. She explained that he had been watching American conspiracy-theory DVDs, talking constantly and laughing about them. G.P. documentation shows that Jessie said Aaron "was sleeping, but bouncing out of bed"; and the G.P. recorded that they thought Aaron "could be manic to some degree". In a Police statement, the G.P. described Jessie as looking "worried, emotional and upset" by Aaron's erratic behaviour.

11.8 The G.P. made an appointment to see Aaron at 3:00pm the same day, if Jessie could get him to attend. According to the G.P. Police statement, Jessie later called the G.P. Practice to cancel the appointment.

11.9 On the evening prior to the discovery of Jessie's body, the perpetrator's sister visited the couple. They said to Aaron that he really should see a doctor but Aaron said "that he hadn't cracked up and that he would rather go and top himself." Aaron said at one point about Jessie, "she thinks I've cracked up, she's got no faith in us. She thinks I'm gonna top her because I'm happy". She described Aaron as "hyper", fiddling with leads, and going in and out of the bathroom. After going home, Aaron's sister had a text exchange with Jessie, and had telephoned and spoke to both at around 10:00pm before retiring to bed. Aaron told her he "was alright", and Jessie said she "felt safe" and was more worried about him.

11.10 At 8:00am on the day that Jessie's body was discovered, Police received a report of an intruder at a college in a neighbouring authority. Police approached the male intruder, now known to have been Aaron, and found him to be in a confused state and possibly under the influence of drugs. He was arrested on suspicion of driving while unfit through drink or drugs.

13.10 Aaron was seen by his G.P. Practice on 8 separate occasions between November 2010 and June 2011, with stress/depression. During the initial consultation Aaron disclosed that he had been in prison from the age of 15 years to 27 years, serving a sentence for murder, that he had a "Probation Officer", and that he was not allowed to go to the area where his family lived. He also said that he had been depressed for decades, particularly during the last 2 years, since being released from prison. His sleep pattern was poor- only 2 hours per night since his release-; he slept during the day, and was experiencing nightmares- 'wakes in a fright thinking he is still in prison'. He also twice denied any illicit drug use during the initial consultation.

Over this 7-month time period, he was provided with sickness certificates, prescribed anti-depressants, and referred 3 times (Nov 2010, Jan 2011 and June 2011) to the Primary Care Mental Health Team (PCMHT). He did not attend any appointments, and the G.P. was notified that he had been discharged after each episode, when attempts were made to make contact 'via letter at various intervals' following each referral.

Page 38 - Aaron was reviewed by his G.P. a further 3 times, on a monthly basis, around his mental health issues. Medication was increased on 14/04/11.

15.2 National Probation Service (NPS) and Northumbria Community Rehabilitation Company (CRC)

With regard to Aaron’s involvement with his G.P., Offender Manager 2 repeatedly relied on Aaron’s self-report and did not contact the G.P. to seek verification of his accounts. This was the case when Aaron said he was no longer being prescribed antidepressant medication (February 2013). It is already Northumbria CRC policy and MAPPA guidance that where a service user is involved with a G.P. or other treatment provider in connection with issues which could have a bearing on their risk to others, risk to themselves, or risk of reoffending, regular contact with the treatment provider should be maintained by the Offender Manager. This was an omission on the part of one Offender Manager rather than a gap in policy or procedure.

**Buprenorphine Side Effects– (Drugs.com and Rxisk.org)**

Drugs.com: <https://www.drugs.com/sfx/buprenorphine-side-effects.html>

Psychiatric

Very common (10% or more): Insomnia (up to 28%), withdrawal syndrome (up to 24%), anxiety (up to 14%), depression (up to 13%)

Common (1% to 10%): Hostility, agitation, paranoid reaction, thinking abnormal, confusion

Uncommon (0.1% to 1%): Affect lability, depersonalization, libido decreased, nightmare, euphoric mood, psychosis, hallucination, euphoria

Very rare (less than 0.1%): Dependence, mood swings

Rxisk.org : <http://rxisk.org/drug/383/buprenorphine/>

Buprenorphine Side Effects reported to FDA since 2009, when drug approved - Rxisk.org

	# Reports	PRR
Insomnia	297	0.7
Confusional state	259	0.9
Depression	251	0.5
Agitation	101	0.7
Delirium	90	1.6

Hallucinations	226	0.2
Paranoia	37	1.0
(other) Drug effect increased	318	45.9

16.3 After considering all of the information provided the Review Panel concluded that the death could not have been predicted... The Review Panel felt it was not possible to reach a conclusion as to whether the death was preventable.

3.7 In late 2014, Aaron pleaded guilty to manslaughter by reason of diminished responsibility and was sentenced to life imprisonment with a minimum term of 20 years. The Judge concluded that Aaron is a 'lethal risk to society'.

### 3. James Stokoe (murder-suicide)

In December, 2012, a 79-year-old pensioner, James Stokoe, married 56 years, learns that he has invasive bladder cancer. Radical radiotherapy is recommended, to commence March 7, 2013. On March 6, he attempts suicide by running a hose from his car exhaust into his car, but his daughter-in-law happens by and rescues him. He is taken to hospital and a special team for Older Persons Mental Health gets involved. Over the next two months, this team constantly grills JS frequently about thoughts of harming himself or others. He is considered at high risk of suicide. JS reports significant marital disharmony and does not want his wife involved in his treatment. The independent review makes reference (See S 4.5) to JS reporting thoughts of harming his wife, but supporting detail provided are not compatible with this statement. A psychiatrist takes a statement from JS to mean that he is troubled by intrusive thoughts and on March 11 prescribes Olanzapine to him, despite being aware there is no evidence of hallucinations or psychosis. On March 27 JS states that he is not longer taking the olanzapine. He appears to be fine for several weeks. On April 15 he reports that the atmosphere in his home is "bad". On April 29 appears anxious and frightened, and it comes out that he has accused his wife of having an affair with the neighbour across the road, and a bin man, and of spending all his money. The reaction to this dramatic change in JS was to review his diagnosis, a response that the review team confirms as appropriate. The following day a CSW from the Trust team visits JS who is in a state of extreme anxiety. On May 1 he stabs his wife to death, and commits suicide. The news never mentions the olanzapine, and the review decides that the death was neither predictable nor preventable.

#### May Stokoe death: 'Missed chances' to identify husband's risk – (BBC News)

<http://www.bbc.com/news/uk-england-tyne-29048571>

3 September 2014

## Tyne & Wear

The death of a woman who was stabbed by her husband could have been prevented if missed opportunities had been identified, a review has found.

May Stokoe, 79, was attacked by her husband of 56 years, James, also 79, in a bedroom at their Sunderland home in May 2013. He then killed himself.

Before their deaths, Mr Stokoe spoke about hurting or killing his wife.

However, he was "at no point" classed as a "high risk" to others, a domestic homicide review has found.

At an inquest in January it was concluded Mr Stokoe killed himself and his wife was unlawfully killed.

The domestic homicide review, which was carried out by the Safer Sunderland Partnership and refers to the couple as Mr Y and Mrs Y, covers the year leading up to their deaths.

The review found Mr Stokoe had a history of depression and had also been diagnosed with cancer.

'Virtually invisible'

In March 2013, Mr Stokoe was found by his daughter-in-law during what appeared to be a suicide attempt. As a result, he had regular visits with Northumberland, Tyne and Wear NHS Foundation Trust's (NTW) Mental Health Crisis Team.

One of the "key concerns" identified by the review was that Mrs Stokoe remained "virtually invisible" despite her presence during much of her husband's contact with NTW and "little was known" about her experiences or views throughout the period.

It was also found that at "no stage" was she considered as a potential victim of abuse or violence and as a result remained outside of all subsequent assessments and decision making.

Mrs Stokoe had also disclosed two days before their deaths that her husband had accused her of having affairs and of spending his money.

The review found that "at no point" was Mr Stokoe assessed by NTW as presenting a high risk to others, namely Mrs Stokoe, and as such no action was taken to directly manage this.

However, it was noted that staff had not had "specific training" in relation to domestic abuse, therefore they could not be "reasonably expected" to have such knowledge.

The review panel concluded that although Mrs Stokoe's death was not predictable, it could have been prevented in light of the missed opportunities.

Chair of the review, Michelle Meldrum, said: "This was a tragic case and deeply distressing for all those involved. I would like to express my sincere condolences to their family.

"We are determined to learn from this and have already taken action to address each and every one of the recommendations it makes."

The panel recommended 10 recommendations as a result of the review, including mandatory domestic violence training for front-line staff.

## **Independent investigation into the care and treatment of Mr A– A report for NHS England, North Region**

<http://www.hundredfamilies.org/wp/wp-content/uploads/2016/04/JAMES-STOKOE-May-13.pdf>

December 2015

1.1 Background to the independent investigation On 1 May 2013, Mr A, aged 79 years, stabbed and killed his wife. He then committed suicide. At the time of the incident, Mr A was in receipt of older persons' specialist mental health services provided by Northumberland, Tyne and Wear NHS Foundation Trust. He had been under its care since March 2013.

### 7 Formulation Of Diagnosis And Subsequent Management

...Mr A's records from 6 and 7 March are consistent with a presumptive diagnosis of depression in the context of serious and acute physical health problems triggering the suicide attempt. This was consistent with the documentary evidence available at the time. This presumptive diagnosis was appropriate at this stage. Mr A's records make reference to Mr A's "demon thoughts", which could indicate psychosis. On 9 March Mr A was noted to be experiencing command hallucinations, and he was concerned that the thoughts might get worse and that he might harm someone or expose himself. Appropriate arrangements were made for a consultant psychiatrist assessment to be completed on 11 March.

Consultant psychiatrist 1 undertook a thorough examination and gave careful consideration to Mr A's "demon thoughts", which, he concluded, were more likely to be intrusive thoughts than either auditory hallucinations indicating a psychotic episode or a primary feature of depressive illness. Consultant psychiatrist 1 prescribed seven days' supply of olanzapine. This was a reasoned clinical judgement. His differential diagnosis also included a stress-induced psychotic episode as well as depressive illness. This was appropriate.

Over the following six weeks, while Mr A was monitored closely by the clinical team, his depression improved but on occasions he was noted to be anxious. Late in March, Mr A discontinued taking olanzapine.

Mr A's "demon thoughts" fluctuated in intensity. They appeared to resolve from 14 March to 24 April. They became more intense by 29 April when he also revealed, for the first time, that he had thoughts about his wife having an affair with a neighbour and a bin man. As a consequence, it was agreed that his

diagnosis should be reviewed by consultant psychiatrist 1. This was an appropriate action. Mr A was not seen by consultant psychiatrist 1 before his death two days later.”

## 5 Chronology of care and treatment

Records show that Mr A had a history of depressive episodes in 1987 and 1990, which were managed by his GP. He was prescribed antidepressant medication, which he continued to take over several years.

In December 2012 Mr A was diagnosed with a bladder tumour and had surgery. This indicated that he had invasive bladder cancer. He was also diagnosed with an aortic aneurysm.

Mr A underwent an aortic aneurysm repair on 22 January 2013.

Mr A was seen by doctors at an outpatient clinic at Sunderland Royal Hospital to discuss the treatment of his bladder cancer. The doctors confirmed that radical radiotherapy would be the best form of treatment. His course of treatment was planned to take place between 7 March and 3 April 2013.

On 6 March 2013, Mr A attempted suicide by connecting a hosepipe from his car exhaust into the interior of the car and then sitting in the car in the garage with the engine running and the windows closed. Mr A was alone at the time; his wife had gone shopping. His daughter-in-law, Ms C, found him and took him to the Emergency Department at Sunderland Royal Hospital later the same day.

Mr A was assessed by a duty doctor at Sunderland Royal Hospital who noted that Mr A was known to have bladder carcinoma (with planned radiotherapy) and that he had a recent endovascular repair of an aortic aneurysm. He recorded that Mr A had been alone at home when his wife had gone shopping, and that he had impulsively wanted to end his life because he did not want to be a burden to anyone. The doctor recorded that Mr A was glad to be alive, and the doctor did not identify any previous history of overdose or active involvement with mental health services. Mr A had no clinical complaints, such as headache, nausea, breathlessness, chest pain or any other physical symptoms. The doctor noted that Mr A was anxious: his speech was normal, but he avoided any eye contact. The doctor described Mr A's mood as "subjectively low but objectively reactive during consultation". There was no evidence of thought disorder, psychosis or behavioural abnormality.

The duty doctor assessed Mr A using the Beck depression inventory. The results showed that Mr A was a high risk of suicide, so the doctor referred him to the mental health IRT.

Two nurses from the IRT carried out a core mental health crisis assessment, which included completion of a FACE risk assessment. Mr A's wife and daughter-in-law were present when this assessment took place. Mr A confirmed he was happy for them to be present, and declined the opportunity to be seen alone. Mr A described being particularly stressed about his physical health and being convinced he was dying, saying he had had haematuria (blood in urine) for the preceding two weeks. Mr A expressed concern about starting radiotherapy the following day, and felt guilty that other people had to provide transport for him so that he could get to the hospital.

Mr A told nursing staff that he had felt like killing himself the night before, but had not acted on his thoughts. When his wife had gone out he told staff that he felt overwhelmed with stress, which is when he decided to attach the pipe to the car exhaust. His daughter-in-law, Ms C, then came around unexpectedly and found him. He told the nurses that he had no thoughts of harming himself, and that he wanted help to cope with his stress, anxiety and the bad thoughts in his head. The assessment record shows that Mr A's wife and daughter-in-law told the nurses that he had experienced poor sleep pattern, poor appetite and weight loss over recent weeks, and that he was irritable. They also informed the nurses that he no longer wanted any of his treatment, and had started withdrawing to his bedroom.

The mental state examination recorded that Mr A was casually dressed and well kempt. He was pleasant, polite and amenable to engage with appropriate rapport. He maintained good eye contact throughout the assessment; his speech was described as normal in rate, volume and tone. His thoughts were noted as being constantly negative about his own mortality with reference to his friends/neighbours also all being ill or dying.

The FACE risk assessment indicated that Mr A had a significant risk of suicide, but there was no indication that Mr A intended to harm anyone else. Mr A denied any further thoughts, plans or intent to commit suicide, and said that he was willing to attend his radiotherapy appointment on 7 March. He also agreed to engage with mental health services so that they could help him cope with his low mood, stress and anxiety. The nurses advised that, because of Mr A's age, he would be referred to the Older People's Services. He would be seen on a daily basis to monitor his risk, commencing the following day after his radiotherapy appointment.

The nurses identified that Mr A would require health education and management for his stress and anxiety, and that a further medical mental health review might be necessary. Mr A was placed on enhanced care co-ordination due to the significant stress and worries he experienced in relation to his physical health.

The family of Mr A have commented that they raised their concerns during this assessment that Mr A was scared of hurting his wife and requested Mr A was admitted to hospital. This was not noted in Mr A's records.

On 7 March 2013 members of the Mental Health Initial Response Multi-Disciplinary Team (MDT) meeting reviewed Mr A's care and treatment. Although Mr A had been referred to the Older People's Services, the teams agreed that a short period of joint working would be beneficial, so some joint visits were arranged.

A visit took place on 8 March 2013, the day after Mr A's first radiology treatment. Records show that Mr A was very pleasant, and that his wife was at home throughout the period of the visit, but only attended half the session with Mr A.

The nurses assessed Mr A and felt that the decision to harm himself did not appear to be altogether impulsive. In talking with Mr A, they felt there had been a gradual decline in his mental health and

depressive features had come to a peak the day before the incident. Mr A said his behaviour had been out of character, that he had been feeling a lot better, and having slept well he was keen to put the event behind him. Mr A's wife, who was present at that point, said she felt he was considerably improved from the days leading up to the incident. There then followed a lengthy discussion about Mr A's attitude towards his physical illness, and about Mr A not wanting people to help him.

The nurses also carried out a mental state assessment and recorded their observations. They noted that Mr A displayed full insight and capacity throughout the session. There was no evidence of psychosis or major mental illness, although his wife did mention that he had previously referred to "demon thoughts" in his head. This was explored further and the nurses felt that these were "intrusive thoughts" relating to anxiety and distress. Mr A said these thoughts had now gone, but acknowledged that they had been present in the few days before the incident. The nurses felt that Mr A may have been expressing some mild to moderate depressive symptoms, exacerbated by his emotional feelings of guilt and concern relating to his physical health...

On 11 March the IRT agreed the Older People's team would take full responsibility for the care of Mr A. A medical assessment was conducted by consultant psychiatrist 1 accompanied by a CPN (CPN 1). Mr A described "the demon in his head". Consultant psychiatrist 1 questioned him further about this, and noted that Mr A appeared to be describing intrusive thoughts and that he did not seem to hear voices. Consultant psychiatrist 1 could not rule out the possibility that Mr A was experiencing auditory hallucinations, but noted that the intrusive thoughts were likely to be related to stress. His diagnosis was Mr A had intrusive thoughts rather than stress-induced psychosis. Consultant psychiatrist 1 prescribed seven days' supply of 5 mg of olanzapine (an antipsychotic). Consultant psychiatrist 1 also recorded that he offered Mr A admission to hospital, but that the patient declined...

On 12 March, ...CPN 1 visited Mr A and noted that he was settled. A geriatric depression scale assessment indicated Mr A's mood to be normal. Mr A reported that he was having strange thoughts, but did not experience any suicidal thoughts. Mr A requested that his wife Mrs A was not informed that his daughter-in-law Ms C was keeping his medication.

On 13 March, CPN 1 visited Mr A with a community support worker (CSW 1). CPN 1 noted that Ms C was continuing to keep Mr A's medication and provide it to him daily...

During the visit by CSW 1 on 14 March, Mr A explained that he and his wife had not spoken for ten years before his diagnosis of cancer.

In spite of Mr A's expressed preference for phone calls rather than visits at the weekend, CPN 2 visited Mr A at his home on Saturday 16 March, and noted that Mr A was feeling well and that his mood appeared good. Mr A was not experiencing thoughts about suicide, self-harm or harming others. It was confirmed that another home visit would take place the following day.

CPN 2 visited Mr A again on 17 March, and noted tension between Mr A and his wife. Mr A felt he was a burden to his family, but was not experiencing any thoughts of suicide, self-harm or harming others. No signs of anxiety or psychosis were recorded. Daily visits were to continue.

The visit on 18 March noted that Mr A was positive and no risks were identified.

On 19 March Ms C, contacted CPN 1 because Mr A had finished his supply of medication. CPN 1 requested a prescription from Consultant psychiatrist 1 and this was provided to Mr A later that day during the daily home visit.

Further home visits continued between 19 and 21 March. Mr A was noted to be positive. On 21 March CPN1 discussed Mr A with consultant psychiatrist 1. They agreed to reduce visits to twice per week.

During a home visit on 22 March, Mr A was noted to be well and it was agreed with him to reduce visits to twice a week. Contact numbers were provided to Mr A if he needed additional support.

CSW 1 visited Mr A on 25 March. Mr A reported that the tension between him and his wife was detrimental to his mood. Mr A denied any thoughts of suicide, self-harm or harming others. Mr A discussed stopping his olanzapine, but when Mrs A entered the room, Mr A stopped talking about his medication. CSW 1 agreed to discuss the medication with CPN 1 and arranged an appointment to see Mr A on 8 April, after her annual leave.

During the visit on 27 March, Mr A told CPN 1 that he had stopped taking his olanzapine during the previous week. Mr A had not been experiencing any intrusive thoughts. CPN 1 noted a tense atmosphere when Mrs A entered the room. CPN 1 arranged a further visit for 2 April, and confirmed that Mr A would contact services if he required additional support.

Ms C contacted CPN 1 later that day. She was concerned that Mr A had not been taking his olanzapine. CPN 1 recorded that Ms C had not noted any deterioration of Mr A's mood. Mr A was managing well, and Ms C would contact services if he required further support.

The notes of the next visit on 2 April say Mr A had no suicidal thoughts. Mrs A was present during the visit, and spoke to CPN 1 about problems with her knees. When Mrs A left the room, Mr A told CPN 1 that Mrs A was concerned only with her own health issues. Mr A confirmed that he was no longer taking olanzapine.

On 3 April, CPN 1 discussed Mr A's presentation with consultant psychiatrist 1. No intrusive thoughts were noted, and they therefore agreed to reduce the number of visits to weekly, and Mr A was scheduled to be discussed at the MDT meeting two weeks later.

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CPN 1 visited Mr A on 5 April. Mr A had finished his radiotherapy sessions and was positive about the future. His risk of suicide and harm to others was recorded as low. Mr A was informed the visits would be reduced to one per week.

The following week, CSW 1 visited Mr A on 12 April. Mr A's mood remained positive; he was aware that CPN 1 would be discussing his discharge from services with Consultant psychiatrist 1.

On 15 April, CPN 1 received a phone call from Ms C, who reported that Mr A was unhappy that Mrs A was not talking to him, and the atmosphere was bad. Mr A stated Mrs A is regularly present during visits and he therefore cannot talk to CPN 1 or CSW 1. Ms C had offered Mr A the opportunity to be seen at her home but he declined this.

CPN 1 visited Mr A the following day, 16 April. Mrs A remained in the kitchen during this visit. Mr A reported that the atmosphere had improved, and he had been out shopping with Mrs A. There was no evidence of intrusive thoughts and his mood was good. CPN 1 agreed to discuss discharge from services with consultant psychiatrist 1.

On 24 April CSW 1 was greeted by Mrs A in the garden before she entered the house. Mrs A confirmed she had been arguing with Mr A as he had been preoccupied with his health. Mr A was positive, but felt anxious about the side-effects of his radiotherapy treatment. Mr A requested medication for his anxiety and discussed with CSW 1 that medication would not remove the difficulties in his relationship with Mrs A. CSW 1 recommended distraction and they discussed Mr A going out, visiting friends and helping the family. Mr A denied any intrusive thoughts, but requested contact numbers for further support.

CPN 1 visited on 29 April and spoke to Mr A alone. Mr A described voices in his head which he described as his own thoughts trying to take over. Mrs A entered the room and told CPN 1 that Mr A had been having thoughts telling him to hurt her but she should not worry as he would never do so. CPN 1 noted that Mr A had accused Mrs A of having an affair with a man across the road and a bin man. Mr A was noted to be hesitant in his speech, and appeared anxious and frightened when talking about his thoughts, but denied thoughts of harm to himself or others. CPN 1 confirmed that Mr and Mrs A had contact numbers for crisis services, and that CPN 2 would discuss the current situation with consultant psychiatrist 1 the following day. CPN 1 discussed the situation with CPN 2.

CSW 1 visited Mr A during the morning of 30 April and noted that Mr A was a little anxious, had trouble breathing, had warmth in his ear, and could hear his own heart beating. Mr A denied that these could be symptoms of anxiety. He was advised to contact his GP or go to the walk-in centre if he was concerned about his symptoms.

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Mr A asked Mrs A if she would go to the GP with him. Mrs A refused and stated she was due to speak to her GP that afternoon as she was stressed with Mr A. Mrs A was tearful during the visit, and stated that Mr A had accused her of having affairs and stealing money. Mr A initially denied this behaviour, and then said that he had only been joking.

CSW 1 clarified that Mr A was not taking olanzapine because he thought it was a sleeping tablet. Mr A confirmed he was experiencing thoughts which he found difficult to describe. When asked directly if Mr

A was experiencing thoughts to harm himself or others, Mr A did not give a definite answer, he only stated that he would not act on any thoughts.

CSW 1 informed Mr A that she would discuss his current presentation with Consultant psychiatrist 1 that afternoon. Mr A left the house at the same time to attend the walk-in centre.

CSW 1 discussed the visit with CPN 2, and indicated that Mr A was anxious, but she was not concerned about his mood since Mr A had requested medication for his anxiety. CPN 2 relayed this information to consultant psychiatrist 1, who agreed to review Mr A the following day.

On 1 May CPN 2 attempted to contact Mr A several times by telephone. There was no reply and the mailbox on his phone was full, so she was unable to leave a message. CPN 2 updated consultant psychiatrist 1, who also attempted to contact Mr A to arrange a visit that afternoon. Consultant psychiatrist 1 was also unable to contact Mr A, and obtained a mobile number from his records. This number belonged to Ms C, Mr A's daughter-in-law. Ms C advised Mr A was probably out, and consultant psychiatrist 1 agreed that he would visit the following day at 9:30 am. Ms C advised consultant psychiatrist 1 that Mr A was lower in mood but had not expressed any thoughts of harming himself or others.

Ms C then attempted to contact Mr and Mrs A. As the call was diverted to answer phone, Ms C decided to drive to their house.

The police contacted the trust that afternoon to advise that Mr and Mrs A had been found dead at their home address.

#### 4.5 Predictability and preventability

4.5.1 Predictability We found Mr A spoke about thoughts of harming his wife, but had no plans to do so. Staff had no information from Mr A or his wife or daughter-in-law about any previous incident when he had caused her physical harm. When examined on 29 and 30 April, Mr A was cooperative with staff and was not obviously psychotic.

Based on this evidence, we concluded the incident on 1 May 2013 when Mr A killed his wife was not predictable.

4.5.2 Preventability We concluded there is no evidence to suggest that any specific alternative course of action by the trust could have prevented the incident, given that Mr A had no plans to harm his wife when seen on 29 and 30 April 2013. Mr A could not be detained as he did not meet the criteria of the Mental Health Act (MHA).