

1aMulti Agency Partnership Review into the death of Ms M in  
December 2015

Chair: Elizabeth Hanlon

Independent report writer: John Gilbert

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## Foreword by Elizabeth Hanlon

This multi-agency partnership review arises from the murder of Ms M, a twenty-three year old woman in December 2015 and the subsequent conviction of Mr O, a twenty-six year old male for that murder. Ms M lived with her parents at the family home located within the administrative boundaries of the Epping Forest District Community Safety Partnership (EFCSP). In December 2015, Ms M met Mr O, whom she had met through an Internet dating site, face to face for the first time. They met at a bar in East London, following which they took a taxi to a hotel in Hertfordshire, where he subsequently murdered her.

Following the murder, the EFSCP had to consider whether this tragic event fell within the definition of a Domestic Homicide. Given the apparent nature of the relationship between Ms M and Mr O, in that they did not co-habit and there was nothing to suggest that they had been in an intimate relationship, the EFSCP formed the view that a Domestic Homicide Review was not required, and they notified the Home Office to that effect.

The perpetrator, Mr O, was, at the time of the murder, a resident of Hertfordshire, living with his parents. Although Mr O had spent some time away from the family home, he had returned to live at the family home in May 2015, as part of bail conditions. He had been diagnosed as having an Emotionally Unstable Personality Disorder (EUPD) and was under the care of mental health services provided by the Hertfordshire University NHS Foundation Trust (HPFT).

Given the complexity of the case and that a number of agencies had been in contact with Mr O over an extensive period of time before he committed the murder, the Chief Constable of the Hertfordshire Constabulary, under the auspices of the Memorandum of Understanding, proposed a multi-agency review. However, since the case did not meet the criteria for a Domestic Homicide Review nor the criteria for a Safeguarding Adult Review, the decision was taken to establish a multi-agency partnership review, to include an independent investigation commissioned by NHS England, in order to determine the circumstances leading to the murder of Ms M and identify what lessons, if any, the various agencies might learn, either individually or collectively, from this tragic event.

As the Chairman of this Partnership Review Panel I would like to thank all those agency representatives who have participated, for their time, for their openness and their willingness to share information.

On behalf of all the Review Panel members I would also take this opportunity to extend the Review Panel's condolences to the family and friends of Ms M, and to all those who have been affected by her tragic death.

**Elizabeth Hanlon**  
**Chairperson of the Review Panel**

## 1. The Review Process

### Purpose

1.1 This review arises from the murder of Ms M on 24 December 2015. The victim, Ms M, lived within the administrative area of the Epping Forest District Community Safety Partnership (EFCSP), but the circumstances of this murder were deemed not to fall within the definition and remit of a Domestic Homicide Review (DHR).

1.2 Following the decision made by the EFCSP, the relevant agencies within Hertfordshire took the decision to instigate a formal review of the circumstances leading up to the murder of Ms M, in order to determine whether there were lessons that could be learnt. It was recognised that since the review was not a formal DHR, its processes were not constrained by the associated Home Office Guidance, although there was a need to maintain and respect confidentiality<sup>1</sup> and to understand the expectations of Ms M's family<sup>2</sup>.

1.3 It was further recognised that a number of the agencies involved in the review process were themselves undertaking internal reviews into the circumstances, and that this review process should therefore essentially be one of drawing together the learning from reviewing the outcomes of these separate reviews in order to distil key areas of learning.

1.4 In accordance with Article 2 of the European Court of Human Rights, the Investigation of Serious Incidents in Mental Health Services Guidance (November 2015) and the NHS England Serious Incident Framework March 2015, NHS England commissioned an independent review and appointed specialist independent consultants. The NHS England review is required to be published in the public domain and it was therefore agreed that it should be included in full in this report as an appendix. Furthermore, the recommendations and associated actions were to be included in those of the main Multi-Agency Review Report to ensure that where appropriate, outcomes and actions are co-ordinated.

1.5 It was agreed that formal terms of reference should be drawn up, such to include:

- (a) inter-agency arrangements;
- (b) internal recommendations;
- (c) information from both families; and
- (d) further steps as necessary

1.6 Finally, it was agreed that both families should be invited to participate in the review. If they declined to participate this would be respected but they would be offered a sight of the completed report for their comments, ahead of any publication.

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<sup>1</sup> Full personal details will be provided to Panel members for meetings, but any published or shared documentation will be redacted or anonymised

<sup>2</sup> Para. 5.12 of the Statutory Guidance suggests that where the criteria for a DHR are not met, there is merit in the relevant statutory agencies undertaking a less formal review into the circumstances of the homicide.

## Panel Membership

1.7 The Review Panel was constituted as follows:

Name	Position / Representing
<b>Full Panel Members:</b>	
Elizabeth Hanlon	Chair
Neeve Bishop	Head of Hertfordshire National Probation Service
Christine Carter	Independent Management Consultant (author of the HPFT internal panel review and IMR)
DCI Tracy Pemberton	Hertfordshire Constabulary
Kaushik Mukhopadhaya (Succeeded by Dr Asif Zia)	Director of Quality and Medical Leadership - Hertfordshire Partnership NHS University Foundation Trust (HPFT)
Dr Jane Padmore	Director of Quality and Patient Safety/Chief Nurse - HPFT
Mette Vognsen	Head of Independent Investigations, NHS England, Midlands and Eastern Region
Sarah Taylor	DA Partnership Manager, Herts County Council
<b>Panel attendees:</b>	
Acting DCI Neil Byrne	Avon & Somerset Constabulary
Julie Mills	Review Author, Avon & Somerset Constabulary
Martin Witchard	Hertfordshire Constabulary
Liz Chapman	SPO, National Probation Service
Nikki Willmott	Head of Safer Care & Standards, HPFT
Anne Richardson	Anne Richardson Consulting Ltd
Lawrence Moulin	Anne Richardson Consulting Ltd
Jo Jones	Avon & Wiltshire NHS
Kate Harvey	Hertfordshire National Probation Service
<b>Others:</b>	
Denise Hodgson	DA Business Support Officer
John Gilbert	Independent Report Author

## The circumstances of the death of Ms M in December 2015

1.8 Ms M was a twenty-three year old teacher, who lived with her parents in South East Essex. She taught history at a secondary school in north London. Ms M had first made contact with Mr O through an Internet dating website around two weeks before they arranged to meet for the first time face to face. They arranged to meet in a bar in East London (Shoreditch) on an evening in December 2015. Information gathered by the police investigation indicated they met sometime after 21.00 when Ms M sent a text to a friend to say Mr O had not arrived, but she texted again before midnight to say the 'date' was going

well. Evidence from a bill receipt indicated that the couple were in a bar at 01.30 am and shortly after 02.00 am a taxi received a request to pick them up.

1.9 Ms M accompanied Mr O, in a taxi, to a hotel in the Waltham Cross area of Hertfordshire. The reception staff reported they arrived at 03.30 am and Mr O appeared to be intoxicated and stumbled to the reception desk. Following checking in and requesting breakfast, around half an hour later Ms M telephoned reception from the room and requested toothbrushes and toothpaste from the hotel reception, which were delivered to the room. Ms M opened the door to the hotel staff to receive the brushes and appeared to the staff to be fine.

1.10 At some point over the next few hours Mr O murdered Ms M, and having done so reportedly wrapped her body in a sheet and duvet and left her body within the grounds of the hotel. At 06.25 am the door of the fire escape used by that floor at the hotel was found wedged open. At midday Mr O reportedly dropped the room keys off at the reception. The hotel housekeeping staff subsequently found all the bedding and towels were missing from the room.

1.11 Ms M's father reported her as missing to the Hertfordshire Constabulary the next morning as she failed to return home. He informed the Hertfordshire Constabulary that she had had been on a date with a man she had met on-line. Mr O was identified through Facebook by a friend of Ms M who had previously received information about Mr O from Ms M. Mr O was arrested and charged with the murder of Ms M after having told the Hertfordshire Constabulary where to find Ms M's body.

1.12 A post mortem examination concluded that the injuries on Ms M's body were consistent with strangulation, together with significant bruising and other injuries.

#### Scope of the Review and Terms of Reference

1.13 It was recognised that the Terms of Reference for this review needed to incorporate or encompass the Terms of Reference for the NHS England Review. The Terms of Reference needed to fully recognise the differences in the two reviews and in particular the fact that the NHS Review would be published. The final Terms of Reference were approved by the Panel at its meeting on 26 April 2017, as follows:

#### **Purpose of the Partnership Review (all agencies):**

- (1) to establish, within the period 1 July 2013 to December 2015, the circumstances leading to the murder of Ms M;
- (2) to establish whether there are lessons to be learned regarding the manner in which agencies and relevant professional officers worked, either individually or collectively;
- (3) where changes in policies and procedures are identified as a result of lessons learned, to make appropriate recommendations, establish timescales for their implementation and identify what is likely to change as a result;

- (4) to consider any published or available reports from participating agencies;
- (5) to consider whether any information known by individuals and/or agencies could or should have been shared with others;
- (6) to consider whether any family, friends or associates of Ms M and Mr O should be invited to participate in the review;
- (7) to consider whether any changes in policies and procedures identified in (3) above should be shared with agencies not involved in the review process;
- (8) to consider whether the conclusions and recommendations of this review should be published or otherwise made available, and if so, within what timeframe; and
- (9) to conduct the review in co-ordination with other review processes and in particular with that of NHS England.

#### **Purpose of the Review (NHS England)**

- (10) to investigate and examine the NHS contribution to the care and treatment of the service user from 2013 up until the date of the incident;
- (11) to examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user;
- (12) to review and assess compliance with local policies, national guidance and relevant statutory obligation;
- (13) to examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family;
- (14) to review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway;
- (15) to work alongside the multi-agency review panel and Chair to complete the review and liaise with affected families; and
- (16) to provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or separately.

#### Review Methodology

1.14 Although not a formal DHR, this Review was conducted along similar lines in order to provide a structure to the process. Individual management Reviews (IMRs) were sought from all agencies, organisations or individuals who had had contact with Mr O in the period 1 July 2013 to December 2015, as set out in the Terms of Reference. Five agencies organisations or

individuals provided IMR's including other relevant information. A list of the IMRs provided is set out in Appendix A.

1.15 In accordance with Department of Health Guidance following a death perpetrated by a user of NHS mental health services, NHS England Midlands and East Region commissioned its own independent investigation, through the appointment of specialised independent investigators, with particular skills and experience of dealing with mental health issues. The findings and conclusions of that review have been fully considered in the multi-agency review process. The NHS England review was independent from the Hertfordshire and Avon and Wiltshire Trusts and therefore provided an independent review of the Trusts' own internal reviews. The Executive Summary of that review is reproduced as Appendix B and the full version can be accessed on the NHS England website.

1.16 The initial meeting of this Multi-Agency Review Panel was held on 2 September 2016. The Panel met on a further five occasions prior to the production of this report. The families of both Ms M and Mr O were invited by the Panel Chair to meet with members of the Panel. The family of Ms M accepted that invitation and a meeting took place in November 2016, attended by the Chairperson, representatives of HPFT and the report author. Although contact was made with the family of Mr O they expressed a preference not to meet.

1.17 A detailed time line was constructed setting out all the key contacts between the agencies and Mr O for the period specified in the Terms of Reference. This time line is set out in full as part 4 of the report.

## **2. The Legal process**

### Coroner's Inquest

2.1 The Coroner for Hertfordshire was informed of the death of Ms M. The case was opened and adjourned pending criminal proceedings. On the basis that Mr O pleaded guilty to the murder of Ms M, the Coroner did not need to initiate a formal Hearing, and the case was closed.

### Criminal Process

2.2 Upon his arrest in December 2015, Mr O admitted to the murder of Ms M. He appeared in Court on 8 January 2016. He did not enter a plea at this hearing and he was remanded in custody

2.3 Mr O appeared again in Court in March 2016 when he entered a plea of guilty to the murder of Ms M. He was once more remanded in custody.

2.4 Mr O's sentencing hearing took place in June 2016, at St. Albans Crown Court. In his sentencing remarks, Judge Andrew Bright QC, made particular reference to the depravity of the offence and other aggravating factors that included the concealment of Ms M's body and the fact that Mr O was subject to a suspended sentence (with conditions) at the time of the murder. Judge Bright made reference to various psychiatric reports considered by the court

and their conclusions and stated that he was firmly of the view that Mr O posed a very great danger to women and young girls with whom he comes into contact in the future and once Mr O has served the minimum term set in prison, it would be necessary for a decision to be taken, guided by psychiatric opinion, as to when, if ever, it would be safe for Mr O to be released

2.5 Having taken all the various aggravating and mitigating factors into account, Judge Bright sentenced Mr O to a minimum term of twenty-six years in prison, that being the minimum time Mr O will spend in prison before he can be considered for parole.

### **3. Ms M and Mr O – background information**

#### Ms M

3.1 At the time of her death Ms M was twenty-three years of age. Ms M has been described as a thoroughly decent and innocent young woman, who, having completed her studies at Southampton University, was teaching history and politics at a North London secondary school. Her head teacher described her as an exceptional young person and a gifted teacher.

3.2 She lived with her parents at their family home in Essex. Ms M's mother described her as having a strong character, and someone who would not do anything silly. Her mother also described her as caring and thoughtful, always willing to help people if she could.

#### Mr O

3.3 At the time Mr O murdered Ms M he was 26 years of age. He was born in Enfield and the family moved to Cheshunt when he was 6 years old. He is the youngest of three siblings, having two older brothers, all of whom live at the family home.

3.4 Mr O was described by his parents as having had a fairly normal upbringing, with no mental health issues. As the youngest brother by some 10 years, he suffered from some sibling rivalry, but nothing considered as out of the ordinary. His parents report that as the youngest sibling Mr O had had a somewhat spoiled upbringing and found the word 'no' difficult to comprehend. He was described as academically bright, good at sports, but found maintaining friendships and concentration difficult. He often became jealous of those doing better than himself. He was also described as being attention seeking.

3.5 Mr O was relatively successful at examinations and obtained good grade 'A' levels. Mr O attended the University of Guildford, where it is reported that he drank a lot and used recreational drugs. He left Guildford after two years of study due to tensions with his then girlfriend, who considered him to be over controlling, and he continued his studies at the University of Cardiff, where in July 2012 he obtained a 2.2 honours degree in Business Management.

3.6 Following a year spent in Moscow, Mr O commenced an MA in Journalism at the University of Hertfordshire. During the latter part of this study, Mr O stated that his

relationship with his family was difficult. There were recorded incidents of violence in the home, involving Mr O, his father and brother, and his brother involved the police following an alleged assault by Mr O. In the event, the brother chose not to press charges and Mr O moved to Bristol, where he had an old friend.

3.7 Mr O found it difficult to hold down employment, often leaving a job soon after starting. He made a decision to commence training as a barrister, and in August 2015 sought employment as a paralegal. The commencement of this job was interrupted by the deterioration in his mental health.

3.8 Mr O himself stated that he encountered difficulties entering into and maintaining relationships with females. He admitted that he was often over controlling and that relationships could end acrimoniously.

3.9 Mr O's first known contact with mental health services was at the age of 19, when, whilst at Surrey University (Guildford), he took an overdose. At the age of 22, in 2011, Mr O took another overdose whilst working in the financial industry. In both instances Mr O stated that difficulties in relationships with girlfriends were instrumental in his self-harming. In both these instances Mr O received support from relevant mental health services.

3.10 The next known interaction with mental health services took place between July and October 2013, when he self-harmed by cutting his wrists, which required hospital treatment. He was treated in the community by HPFT South East Crisis and Assessment Team (SE CATT) and Cheshunt Community Mental Health Service (CMHS) and was discharged back into the care of his General Practitioner (GP). On discharge the Community Consultant Psychiatrist reported to Mr O's GP that he demonstrated elements of narcissism and was preoccupied with how others regarded him.

3.11 Early in 2015, whilst in Bristol, Mr O received treatment from the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). This arose as a result of an overdose, his fifth known episode of self-harm. It was also during this period that Mr O made threats to kill and sexually assault a known female and to kill a named Community Psychiatric Nurse, which resulted in him being arrested and remanded in Bristol Prison. After being in prison for a month, and on the basis that Mr O did not constitute a risk to the public, he was released from prison on 1 May 2015, and bailed to remain at his parents' home in Cheshunt, Hertfordshire with the added constraints of an electronic tag and a curfew from 7pm to 7am.

3.12 Soon after being released, Mr O self-harmed, and following a referral from the Acute hospital on 7 May 2015 he began a further episode of care with HPFT mental health services. His care involved two episodes of inpatient care in an acute mental health unit, supported in between by care from community based mental health services. Mr O continued to be under the care of HPFT mental health services up to the time of the murder of MS M.

#### 4. Timeline of Key Agency Interventions / Interactions

ASC = Avon & Somerset Constabulary			HC = Hertfordshire Constabulary		
AWP = Avon & Wiltshire Partnership NHS			HPFT = Hertfordshire Partnership University NHS Foundation Trust		
BCC – Bristol Crown Court			NPS = National Probation Service		
CC = Cambridge Constabulary			SE CATT = South East Crisis Assessment & Treatment Team		
CJFMHT = HPFT Criminal Justice & Forensic Mental Health Team			SP = Surrey Police		
CMHS = Community Mental Health Service			SWP = South Wales Police		
ETC = Electronic Tag Company					
	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
	<b>2009</b>				
1	14/11/2009	SP	Mr O seeking self-harm via overdose	Guildford	
2	14/11/2009	SP	Mr O cautioned for offence of battery against ex-girlfriend	Guildford	
	<b>2012</b>				
3	09/03/2012	SWP	Mr O, whilst under the influence of alcohol, caused criminal damage to home of ex-partner	South Wales	
	<b>2013</b>				
4	12/07/2013	HC HPFT	Mr O self-harming and taken to hospital by ambulance. No further police involvement. Referral to Cheshunt CMHS (Community Mental Health Service)	Hertfordshire	
5	19/07/2013 – 22/07/13	CHASE FARM HOSPITAL HPFT SE CATT	Mr O presented at A&E Chase Farm Hospital following an overdose of tablets and self-harm through ingestion of bleach. Three days as general hospital inpatient then referred to SE CATT	Enfield	SE CATT diagnosed “Adjustment Reaction”. Care subsequently transferred back to Cheshunt CMHS

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
6	30/07/2013	HC	Mr O cautioned for possession of cannabis in car	Cheshunt	
7	03/09/2013	HC CC	Two reports, one in CC and one in Herts. Both relate to Mr O's relationship with girlfriend. Mr O informed HP of a threat by girlfriend's father to harm him, and girlfriend informed CC of his threatening calls, messages and Facebook postings	Cheshunt	
8	01/10/2013	HPFT CMHS	Mr O saw Consultant CMHS Psychiatrist. Consultant concluded that clinically there were no features of any obvious psychiatric symptoms and recommended referral back to Mr O's GP	Cheshunt	
9	10/10/2013	CMHS	Discharged from care of HPFT. Mr O referred back to his GP	Cheshunt	
<b>2014</b>					
10	16/07/2014	HC	Police attended home address following allegation of assault by Mr O's brother. Brother alleges drug taking and deteriorating mental health.	Cheshunt	MR O arrested, but brother did not press charges

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
11	07/11/2014	ASC	Mr O alleges theft of property, but does not make formal complaint	Bristol	
	<b>2015</b>				
12	27/02/2015	AWP	Mr O presented at Bristol Royal Infirmary following self-harm (overdose)	Bristol	Potential diagnosis of a narcissistic personality disorder. Referred to Intensive Support Team. GP informed by letter.
13	03/03/2015	ASC AWP	ASC informed by AWP of concerns regarding Mr O expressing desires to hurt and rape women. ASC informed AWP that insufficient information on risk, and therefore no police action at this time,	Weston General Hospital	Matter handled by AWP Intensive Support Team. AWP staff concerned about Mr O's behaviour such that he would be visited by two CPNs
14	13/03/2015	ASC	Mr O allegedly sent malicious electronic communications to female acquaintance. No further action required following advice to victim.  Mr O seen by Psychologist and continued to talk about his		

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
		AWP	wish to hurt and rape. Advice to police that no further action required at this time.	Bristol	Forensic psychiatric advice available as support
15	15/03/2015	ASC AWP	Mr O reported missing by girlfriend. Initial contact made with Mr O who stated he needed no assistance. ASC decided, in view of potential risk, and following contact with AWP, to contact Mr O again to encourage meeting with police. He was seen at his home address by a police officer	Bristol	
16	20/03/2015	ASC AWP Prison Service	AWP called police to report call from Mr O threatening to kill, strip and rape his girlfriend's sister. Mr O also threatened to kill CPN. Mr O telephones police essentially repeating the same threat(s). Police call handler in extensive conversation with Mr O. Mr O seen by police and detained under S136 of Mental Health Act in the Mason Unit. Mr O released following assessment and immediately arrested for the Threat to Kill (TKK). Mr O charged with two offences of TTK. Remanded to Bristol Prison. Whilst in prison, Mr O self-harmed, was treated in an external hospital and then returned to the prison specialist Brunel Unit	Nailsea  Mason Unit  HMP Bristol  Brunel Unit	Intensive Support Team advised to have no further contact and that Mr O should be dealt with through the criminal justice system  Prison Service concluded no need for admission to prison hospital, but Mr O placed in single cell due to threats to others

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
17	15/04/2015	ASP BCC	Mr O pleads guilty to two counts of TTK. Remanded in custody		
18	23/04/2015	ASC BCC	Mr O released on bail from prison to reside at parent's home in Cheshunt, Hertfordshire. Conditions included electronic tag, a curfew between 19:00 and 07:00. Formally released from HMP Bristol on 1 May 2015.	Cheshunt	Mr O's health record did not pass to HPFT on referral, but AWP did provide comprehensive information to Mr O's GP
19	06/05/2015	ASC HC	Avon and Somerset Police informed that Mr O attempting contact via Facebook with female prison officers  Mr O contacts HC in "distressed state" requesting that he be sectioned. Mr O claimed that he was not taking his medication. Taken to PAH Hospital (Harlow) by ambulance for assessment. No further dealings by Hertfordshire Constabulary	Cheshunt	
20	07/05/2015	HPFT SE CATT	Mr O self-presented to Princess Alexandra Hospital, Harlow following self-harm. Referred to HPFT for in-patient treatment. Mr O referred to SE CATT for interim support.	Harlow Cheshunt	

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21	09/05/2015	HPFT SE CATT	Mr O assessed by SE CATT – referred to Acute Day Treatment Unit (ADTU)	Cheshunt	
22	11/05/2015	HPFT	First attendance at ADTU	Cheshunt	SE CATT risk assessment of Mr O indicated no risk to himself or others
23	26/05/2015	ASC BBC HPFT	Bail conditions amended to require Mr O's place of residence to also include any ward or hospital as directed by HPFT	Cheshunt	Bail conditions amended to reflect the need to enable Mr O's treatment/supervision
24	26/05/2015	HPFT	Mr O discharged from ADTU and transferred to local Community Mental Health Service (CMHS)	Cheshunt	Mr O discharged in his absence  Mr O diagnosed with Emotionally Unstable Personality Disorder (EUPD) by the ADTU Consultant Psychiatrist. This diagnosis remained consistent throughout Mr O's care

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
					pathway with HPFT secondary mental health services.
25	03/06/2015	HPFT CMHS	Care Co-ordinator contacts Mr O by telephone	Cheshunt	Care Co-ordinator reported to HPFT review panel that she found him intimidating and manipulative. However, this statement was not included in the clinical record and was not raised as a concern by the care coordinator at the time she was involved in his care.
26	04/06/15	HPFT CMHS	Mr O seen by Care Co-ordinator at CMHS team base – Holly Lodge. MR O reported fleeting suicidal thoughts. Care plan completed	Cheshunt	
27	10/06/2015	HPFT CMHS	Seen by Care Co-ordinator at CMHS base – Holly Lodge. Mr O reported fleeting suicidal thoughts. Care plan completed	Cheshunt	

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28	19/06/2015	Royal London Hospital	Mr O admitted to A&E at Royal London Hospital following significant self-harm requiring surgery.	East London	
29	23/06/2015	HPFT	Referral from Royal London Hospital for admission to mental health inpatient unit following discharge after surgery. Admitted to Swift Ward, Kingfisher Court, Radlett.	Kingfisher Court, Radlett	Mr O admitted to Swift Ward
30	24/06/2015	HPFT SWIFT WARD	Mr O baseline assessed.	Kingfisher Court, Radlett	
31	26/06/2015 29/06/2015 02/07/2015	HPFT SWIFT WARD	Mr O in inappropriate contact with female patients	Kingfisher Court, Radlett	Whilst in Swift Ward there were three reported incidents of Mr O making inappropriate sexual approaches to female service users.
32	06/07/2015	HPFT SE CATT	Mr O discharged from Swift Ward and transferred to care of SE CATT	Radlett to Cheshunt	Whilst on Swift Ward Mr O was diagnosed with Emotionally Unstable Personality Disorder (EUPD)

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ETC = Electronic Tag Company	

	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
33	13/07/2015	HC SE CATT	Mr O informed CATT that he had broken his curfew. Two Police officers visited Mr O at home. HP satisfied with Mr O's explanation for missing curfew deadline.	Cheshunt	Detailed within HPFT clinical notes and IMR and but no evidence for this within HC records or IMR
34	24/07/2015	HPFT SE CATT CJFMHT	Mr O gave consent and was referred to the CJFMHT (Criminal Justice and Forensic Mental Health Team) for a forensic psychiatric assessment.	Cheshunt	Referral received by CJFMHT on 24/07/2015
35	26/07/2015	HC HPFT CJFMHT	Call to police from CMHT treating Mr O's girlfriend stating that Mr O had threatened the service user's brother.	Cheshunt	
36	31/07/2015	HC SE CATT	Police accompany Mr O to hospital following threat/attempted suicide. Mr O re-admitted to Swift Ward	Kingfisher Court, Radlett	
37	02/08/2015	HPFT SWIFT WARD	Mr O detained under Section 5(2) of Mental Health Act – used as Mr O considered to be at risk to himself if he were to leave	Kingfisher Court	Temporary detention of an informal patient in order for Mental Health Act assessment to be arranged.
38	03/08/2105	HPFT SWIFT WARD	Mr O assessed by Consultant Psychiatrist, junior doctor, CATT	Kingfisher Court,	Further confirmation of

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
			CPN	Radlett	EUPD diagnosis
39	05/08/2015	HPFT SWIFT WARD CJFMHT	Mr O assessed by Forensic Consultant Psychiatrist	Kingfisher Court, Radlett	
40	07/08/2015	HC HPFT SWIFT WARD ETC	Hertfordshire Constabulary called following allegation from husband of service user of inappropriate sexual behaviour by Mr O  ETC wanting information on date of Mr O's release	Kingfisher Court Radlett	Detailed within HPFT clinical notes and IMR but no evidence of this call within HC records or IMR During this period on Swift Ward Mr O engaged in a number of "challenging" behaviours, including some which might have been considered a breach of his bail conditions
41	10/08/2015	HPFT SWIFT WARD CJFMHT BCC	Decision made to detain Mr O under Section 5(2) of the Mental Health Act. At the same time, he was transferred to the all-male Owl ward  Consultant Forensic Psychiatrist sent a letter to Bristol Crown Court offering a psychiatric report to assist in the sentencing	Kingfisher Court, Radlett	No response from BCC

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
			of Mr O.		
42	12/08/2015	HPFT OWL WARD	Mr O underwent Mental Health Act assessment.	Kingfisher Court, Radlett	Decision not to detain Mr O under the MENTAL HEALTH ACT – he agreed to remain in hospital as an informal patient on Owl Ward – with a behaviour contract.
43	18/08/2015	HC HPFT OWL WARD	Mr O reported to Hertfordshire Constabulary that hospital inmate had assaulted him. Dealt with by HPFT staff, no further action by Hertfordshire Constabulary	Kingfisher Court, Radlett	
44	26/08/2015	HC HPFT OWL WARD	Hertfordshire Constabulary respond to Mr O reporting his girlfriend had informed him that she was suicidal	Kingfisher Court, Radlett	Police make enquiries and girlfriend safe and well
45	03/09/2015	HC HPFT OWL WARD ETC BCC	Mr O telephones police to report actions of another service user. Police phone the ward and staff intervene to say the other patient is unwell.  Following telephone call from ETC to Mr O he removes the tag and reports to nursing staff that he is no longer required	Kingfisher Court, Radlett	

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
			to wear a tag. BCC informs hospital that Mr O no longer under curfew		
46	17/09/2015	HC HPFT OWL WARD	Mr O threatens to kill an unknown person prior to release from hospital. Hertfordshire Constabulary informed	Kingfisher Court, Radlett	Insufficient evidence to pursue, no further action.
47	18/09/2015	HPFT OWL WARD CMHS	Final CPA discharge review of Mr O's progress	Kingfisher Court, Radlett	Outcome included: Increase leave to parents, remove section 5(2), Court date set for 6/10/15, CMHS Psychiatrist to be probation psychiatric adviser (if BCC include probation in sentence)
48	20/09/2015	HC HPFT OWL WARD	Hospital inform police of Mr O's impending release on "Home Leave"	Kingfisher Court, Radlett	During period on Owl Ward Mr O continued with his challenging behaviour. His

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
			Mr O discharged on weekend leave		diagnosis was confirmed as Emotionally Unstable Personality Disorder (EUPD) with some dissocial and narcissistic characteristics.
49	21/09/2015	HPFT SE CATT	Transferred to the care of SE CATT whilst on leave from ward	Cheshunt	
50	22/09/2015	HC HPFT	Police visit hospital to interview Mr O re earlier threat to kill. Mr O on home leave at time of visit	Cheshunt	Detailed within HPFT clinical notes and IMR but no evidence of this visit within HC records or IMR
51	02/10/2015	HPFT OWL WARD	Mr O formally discharged by Owl Ward	Cheshunt	
52	12/10/2015	HPFT SE CATT	Transferred into the local care of Cheshunt CMHS.	Cheshunt	Whilst in this stage Mr O had five contacts with CMHS, the last of which was on 30/11/2015

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
53	19/10/2015	HPFT CMHS	Telephone call with Mr O – had run out of medication, prescription provided. Mr O reported no concerns and everything was fine, reported working remotely and sounded responsive	Cheshunt	
54	02/11/2015	HPFT NPS	Mr O reports to Community Mental Health service of a meeting that day with his Probation Officer	Cheshunt	
55	05/11/2015	NPS	PO contacted HMP Bristol to seek additional information regarding Mr O	Cheshunt	
56	06/11/2015	NPS	PO interviews Mr O for a second time	Cheshunt	PO has sufficient information to provide BCC with pre-sentence report
57	12/11/2015	HPFT CMHS	Reported to be bright and responsive and no concerns at home	Cheshunt	
58	30/11/2015	HPFT CMHS	Seen at Holly Lodge by Care Coordinator as planned. Mr O reported difficulty in concentrating on some things. Thoughts racing at times but rational. Denied any suicidal or self-harming thoughts. Mr O reported as responsive and	Cheshunt	This is the last contact Mr O has with HPFT

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
			communicating well.		
59	02/12/2015	BCC NPS	Mr O convicted at BCC on two counts of Threat to Kill. Rehabilitation Activity Requirement and Mental Health Treatment Requirement are conditions of 9 month suspended (for 2 years) sentence. Offender Manager appointed	Bristol Crown Court	
60	07/12/2015	HPFT CMHS	Care Co-ordinator attempts to contact Mr O by phone but is unable to make contact – voicemail message left for Mr O to contact her.	Cheshunt	
61	10/12/2015	NPS	Offender Manager session with Mr O	Cheshunt	
62	11/12/2015	NPS HPFT	Email from Offender Manager to Care Co-ordinator regarding Mr O's Mental health Treatment Requirement – asking how Mr O is progressing.	Cheshunt	
63	14/12/2015	NPS HPFT	Email from Care Co-ordinator to Offender Manager regarding Mr O's progress and reports she plans to visit him on the 11.01.16 and advising that to her knowledge there were no known risks or concerns at that time.	Cheshunt	

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	DATE	AGENCY/IES	DESCRIPTION	Mr O LOCATION	NOTES
64	17/12/2015	NPS	Offender Manager meeting with Mr O	Cheshunt	Mr O told Offender Manager that he was meeting women via dating websites
65	24/12/2015	HC	Body found at Theobolds Hotel. Ms M reported by her father as “missing”. Mr O arrested and charged with the murder of Ms M	Cheshunt	
66	25/12/2015	HC HPFT	HPFT informed by Hertfordshire Constabulary that Mr O arrested for the murder of “his girlfriend” (Ms M)	On remand	
67	30/12/2015	HC AWP	Hertfordshire Constabulary inform Mental Health Service of Mr O’s arrest for the murder of Ms M	On remand	

## 5. Key Events

The narrative that follows is based upon the content of IMRs, the timeline set out in section 4 above and is intended to provide the framework for the conclusions and recommendations that follow in this report.

### July 2013 to November 2014 (Timeline 4 to 11)

5.1 This period is when Mr O's mental health problems first become known to the agencies. There are two recorded instances of self-harm resulting in hospital attendances and referrals to local mental health services with an episode of care from July to October 2013. Assessments prior to Mr O's discharge from HPFT care in October 2013 indicated that there were no obvious psychiatric symptoms, there was no further role for secondary mental health services and that therefore Mr O should be discharged into the care of his General Practitioner with a suggestion that he would benefit from counselling. In July 2014 Mr O's brother reported him to the Hertfordshire Constabulary following an alleged assault at home and suggested that, in his opinion, his brother's mental health was deteriorating.

### February 2015 to 30 April 2015 (Timeline 12 to 18)

5.2 This period encompasses the time during which Mr O was residing in the Bristol area, staying with a friend. Mr O presented himself at Bristol Royal Infirmary having self-harmed and following a Mental Health Act Assessment it was concluded he had a Narcissistic Personality Disorder. He was referred to the AWP Intensive Support Team (AWP IST).

5.3 It was whilst Mr O was under the care of AWP IST that he first expressed a wish to harm and rape women, and he was reported to the Avon and Somerset Constabulary. Mr O referred to himself as a psychopath and that he had, in his younger years, harboured the thought of killing someone. Following the advice of a Psychiatrist, no further police action was taken since Mr O was considered to be under the care of the AWP IST. However, it appears that ASC did not record this incident onto relevant information systems, where those who later had cause to interact with Mr O, could have seen it.

5.4 On 13 March 2015 Mr O was seen by a psychologist and continued to express a wish to hurt and rape females, and to satisfy his own needs without concern for the consequences for others. Liaison with the Pathfinder Forensic Service Psychologist resulted in the advice that Mr O should be seen by a psychiatrist, and the Forensic Services would remain available to give advice.

5.5 On the same day, a female received a number of inappropriate sexual messages from MR O via her Facebook and LinkedIn accounts, which she reported to the ASC. The complainant wished the police to be aware but did not want them to intervene; fearing that to do so would antagonise Mr O further. The ASC handled the matter appropriately and the female victim was content to let matters rest.

5.6 On 15 March 2015, Mr O, having gone out and had not returned home as expected, was reported to the ASC by his girlfriend, as being missing. Mr O was contacted by the ASC

on his mobile phone and he stated that he was out drinking with friends and had missed his bus home. Mr O stated that he was fine and did not wish to meet a police officer. The ASC carefully considered the risks associated with Mr O, especially given his previous attempts at self-harm. Contact with the AWP IST suggested that he was no longer suicidal but did also mention his earlier threats to harm females. Eventually Mr O returned home where a return to home interview was undertaken by a police officer.

5.7 On 20 March 2015 the ASC received a call from a female member of the AWP staff in respect of Mr O threatening to kill, strip and rape his girlfriend's sister, who lived at the same address as Mr O and his girlfriend's family. Mr O had also threatened to kill a Community Psychiatric Nurse. The AWP staff member reported that Mr O became increasingly agitated throughout the call, suggesting that he would hold the AWP IST responsible for anything that he did, and that he should be locked up. The threat was taken seriously by the receiver of the call and represented an escalation in the violent and sexually threatening nature of Mr O's behaviour. Soon after, Mr O called the ASC stating that he was outside his home address and was harbouring thoughts of killing someone, and that the urge to do so was compelling. The ASC dispatched units to locate Mr O, whereupon he was detained under the Mental Health Act and admitted to a designated Place of Safety for assessment. A Mental Health Act assessment was undertaken and the Psychiatrist, formed the view that Mr O posed a risk to others, and his diagnosis recorded Mr O having strong narcissistic traits and psychopathic tendencies. The Psychiatrist advised that the IST should avoid contact with him and that Mr O should be managed not by mental health services but via the criminal justice service. The ASC were therefore informed that Mr O was likely to be released which could result in a danger to others. Following his release Mr O was immediately arrested by the ASC in relation to the two threats to kill he had made. He appeared in Court and following an assessment by the Court Referral and Assessment Service, Mr O was remanded to Bristol Prison.

5.8 During his episode of care with AWP in Bristol, Mr O's presentation appears to have been different from that demonstrated in his previous episodes of mental health care, notably in 2013, when the risks identified were those associated with self-harm. Although narcissistic traits had previously been identified in 2013 by both the SE CATT and the CMHS Mr O's clinicians (9 August and October 2013 respectively), no diagnosis of Personality Disorder had been made at that time. The shift in presentation in 2015 reflected threats to others, particularly females and together with other signs and symptoms led to an initial diagnosis by AWP of Narcissistic Personality Disorder. AWP subsequently described him as having strong narcissistic traits and psychopathic (dissocial) tendencies resulting in a diagnosis of Dissocial Personality Disorder. Whilst Mr O presented for the first time as a potential risk to others, he continued to present with a risk of self-harm, leading to his subsequent referral to the Prison's mental health service.

5.9 Whilst on remand in HMP Bristol, Mr O was seen by the prison mental health team. Mr O denied any intention to harm others but said that he did harbour thoughts of harming himself. Mr O was therefore not admitted to the prison hospital but, because of his previous threats to harm others, he was placed in a single cell. During his stay in HMP Bristol, there were two further episodes of self-harm, one of which resulted in a stay in the prison hospital. He was therefore transferred to the prison's specialist unit for men with mental health

problems, where he remained for the duration of his remand. Mr O made no further attempts at self-harm whilst in custody.

5.10 Mr O remained on remand in HMP Bristol until 23 April 2015 when, at Bristol Crown Court, he was released on bail to his parent's home in Cheshunt. His bail conditions included a 7pm to 7am curfew, electronic tagging and a requirement to co-operate with local mental health services. (These bail conditions were later changed to reflect the fact that Mr O was, at various times, under the care of HPFT in hospital rather than at his home address.) He was released from prison on 1 May 2015.

5.11 It appears that the ASC handled matters appropriately with the detention of Mr O to enable a Mental Health Act Assessment to be undertaken and then, upon his release from detention, his arrest for the two threats to kill. Steps were also taken to mark the potential victim's home address to ensure that Police Officers would be aware of the risk that Mr O potentially posed. However, it does appear that an additional step of making an application to monitor Mr O as a "Potentially Dangerous Person" was not followed through, seemingly on the basis that, since Mr O had been bailed to an address outside of the ASC area, it would be more appropriate for the receiving Police force to pursue appropriate actions.

5.12 It appears that ASC did not inform the Hertfordshire Constabulary of Mr O's history at the point at which he was bailed away from the ASC area to his parents' home in Hertfordshire. Given that AWP had effectively discharged Mr O when he was remanded into prison, AWP could not have known what action was to follow. They had, however, provided Mr O's GP with a detailed description of his diagnosis and treatment. Whilst there was no legal responsibility or requirement for the ASC to inform Hertfordshire Constabulary of Mr O's discharge into the Hertfordshire area, with details of his bail conditions and associated changes, such could have led to the authorities in Hertfordshire being better informed of the risks posed by Mr O once he was residing in their area. Had that transfer of information taken place, the Hertfordshire Constabulary would have been able to assess the risks posed by Mr O and share this assessment with partners, including HPFT.

#### May 2015 (Timeline 19 to 24)

5.13 On 6 of May 2015, female prison officers reported to ASC that Mr O had attempted to make contact with them via their social media accounts. This issue was correctly dealt with by the ASC in terms of their data systems, but the information was not relayed to the Hertfordshire Constabulary in whose area Mr O was now residing in accordance with his bail conditions. Whilst the Hertfordshire Constabulary may not have considered it necessary to intervene on the basis of this activity, it would nevertheless have usefully added to the intelligence overview of Mr O.

5.14 It should be noted that the National Probation Service had no dealings with Mr O at this point in time since they did not have a responsibility for monitoring persons who are released on bail pending a court hearing. Their remit is to manage persons who have been convicted of an offence and are awaiting sentencing, been given a community based sentence or have completed part of a detention based sentence but have been subsequently released back into the community.

5.15 Soon after Mr O's release from prison, he presented himself at Princess Alexandra Hospital (PAH) in Harlow, having self-harmed. It was reported that Mr O was feeling suicidal and his behaviour was disruptive. The HPFT helpline was contacted and a bed for Mr O was sought. No beds were available so it was arranged for Mr O to be assessed by the SE CATT the following day. As part of that process Mr O was risk assessed and referred to the Acute Day Treatment Unit (ADTU).

5.16 During May 2015, Mr O attended the ADTU on seven occasions. He had a range of interventions with a number of mental health practitioners within the ADTU multi-disciplinary team. He was reported as being generally calm with a stable mental state, although with low self-esteem. In discussions with staff, Mr O indicated that he had suggested that he ought to be considered a psychopath in order to obtain attention. Although Mr O made reference to his time in Bristol and having been treated by their Crisis Team, there appears no evidence to indicate that HPFT services identified Mr O's previous treating team (AWP) or made efforts to contact the service to ascertain Mr O's previous mental health history whilst in Bristol – particularly associated with his threats to kill. Later the Swift Ward Consultant Psychiatrist reported to the HPFT internal review panel, that she, on a number of occasions, asked Mr O about his previous treating team but he would not disclose to her any information on this. He frequently referred to having made threats to kill as a means of securing psychiatric help but does not appear to have disclosed information on the mental health care he received from AWP. HPFT services did not appear to have pursued this with any rigor to inform his mental health history, relying instead on Mr O's version and interpretation of events.

5.17 During this period of care within the ADTU, Mr O requested medication for depression. Mr O was diagnosed with Emotionally Unstable Personality Disorder (EUPD) and the evidence is that no medication is clinically effective for the treatment of such a disorder. However, it is appropriate to treat additional mental health problems with medication concurrently, and Mr O was prescribed Promethazine. Mr O reported that he stopped taking this medication as it made him feel drowsy and more withdrawn. The Consultant Psychiatrist also suggested that Mr O might benefit from psychological therapy.

5.18 Mr O attended ADTU on seven occasions during his two week episode of care and had one telephone contact. However, having disengaged to some degree, Mr O failed to attend his scheduled final attendance at ADTU and was therefore discharged in his absence, and his care transferred to the local Cheshunt Mental Health Services Team (CHMS).

### 3 June 2015 to 18 June 2015 (Timeline 25 to 27)

5.19 This section covers the short period Mr O was under the care of CMHS after discharge from ADTU and prior to his admission to hospital. In accordance with procedure, Mr O's Care Coordinator contacted him to make an appointment. Mr O stated that he was not coping well and wanted to participate in DBT. His Care Coordinator arranged to see Mr O the next day at the CMHS base. During that initial telephone call Mr O denied any suicidal, self-harm or homicidal thoughts.

5.20 Mr O did not attend the scheduled morning appointment, but did attend the following afternoon. His Care Coordinator described him as tearful and stating that he was desperate to receive some help. Mr O once again denied harbouring any thoughts of self-harm, suicide or homicide. His Care Coordinator reported to the HPFT internal review panel that she found him intimidating and did not want to visit him at his home address or alone. Given Mr O's history of threats to kill (females), all the contacts with Mr O by the Care Coordinator were undertaken at Holly Lodge, the CMHS team base, with other team members available if necessary. This was considered to be a proportionate precaution to take in the context of risk assessment, given that a female Care Coordinator had been allocated at that time.

5.21 The Care Coordinator agreed to pursue the option of psychological therapy, although its provision would have been subject to the agreement of a Consultant Psychiatrist and a full psychological assessment undertaken by a clinical Psychologist. The CMHS Doctor also agreed to prescribe anti-depressant medication based upon Mr O's presentation, which included presenting as tearful and expressing his desperation to obtain help.

5.22 Further attempts were made by the Care Coordinator to contact Mr O but were unsuccessful, despite leaving voicemail messages etc.

#### 19 June to 6 July 2015 (Timeline 28 to 32)

5.23 On 19 June 2015 Mr O was admitted to A & E department at the Royal London Hospital, following a significant self-harm injury that required surgery. The Royal London Hospital contacted HPFT and following an assessment by the SE CATT, Mr O was voluntarily admitted to Swift Ward, the Kingfisher Court Inpatient Unit, in Radlett, Hertfordshire on 23 June 2015. Upon admission Mr O had clips in his arm wound, was wearing his electronic tag (part of his Bristol Crown Court bail conditions) and his diagnosis remained as EUPD.

5.24 On 24 June 2015, Mr O was examined on Swift Ward by a Junior Doctor. Mr O explained his situation and stated that he falsely reported psychopathic traits and a wish to harm and kill females as a means of gaining attention. He said he had intended that this would result in his hospital admission, but it had instead resulted in criminal charges and a potential prison sentence. That same day Mr O underwent a baseline assessment carried out by a Consultant Psychiatrist, a Specialist Doctor, the ward Staff Nurse and a SE CATT Nurse. The outcome of the assessment was that Mr O had self-harmed due to his low mood and his impulsivity. A treatment plan of medication plus escorted leave within the hospital grounds was put into place.

5.25 In the days that followed this assessment there were three reported observations of inappropriate closeness to two female patients by Mr O. Following the first of these observations the Swift Ward nursing staff suggested that Mr O be transferred to a male ward. This suggestion was not implemented although the clinical record indicates the ward staff remained vigilant and intervened when necessary to ensure the safety of other service users. Mr O's presentation and behaviour continued to be closely monitored and reviewed by the multi-disciplinary team

5.26 On 30 June 2015, Mr O underwent a further assessment by a team of clinicians of similar makeup to those undertaking the initial baseline assessment, although this time MR O's parents were also present. A diagnosis of EUPD was confirmed. It was also reported that Mr O continued to demonstrate challenging behaviours and remained very friendly with a female patient. Mr O's care plan included a change in his medication regime and meetings with the ward psychologist. As a voluntary inpatient, he agreed to the changes in his care plan and was given a predicted discharge date of 15 July 2015.

5.27 On 2 July 2015 Mr O had a consultation with the ward clinical psychologist. The psychologist reported that Mr O appeared tearful and distressed and described how he felt disconnected from the world. The psychologist agreed to continue to explore these concerns with Mr O. Later that same day Mr O was once more reported to be acting inappropriately with a female patient. Ward staff considered it necessary to maintain observation of Mr O whilst he was in the company of other patients.

5.28 Over the next few days leading up to his discharge from Swift Ward, Mr O was reported to be engaging with his treatment plan, with improved mood and no thoughts of suicide or self-harm. His diagnosis was reaffirmed as EUPD. On 6 July 2015 Mr O was discharged into the care of the SE CATT with a care plan that seemed only to include ongoing medication, subject to Mr O's agreement.

#### 7 July to 31 July 2015 (Timeline 33 to 36)

5.29 This section deals with the care of Mr O by SE CATT prior to his readmission to Swift Ward at the start of August 2015. SE CATT supported Mr O through a combination of home visits and telephone contacts, which took place once every two to three days. During the initial period Mr O reported that he felt he was getting better every day and was pleased with his progress.

5.30 On 24 July 2015 Mr O was asked by his Care Coordinator to give his consent to him being referred to the Criminal Justice and Forensic Mental Health Team (CJFMHT). Mr O consented to that request.

5.31 The referral to the CJFMHT was considered to be comprehensive, and although it contained no reference to any treatment received by Mr O from the AWP (which was not known at that time to HPFT practitioners), it did include references to his threats to kill together with his reasons for bail and associated bail conditions. The referral states that Mr O's diagnosis was one of EUPD, and made reference to him being a potential risk to himself and others.

5.32 When interviewed by the HPFT internal review panel, Mr O's Care Coordinator stated that a referral to the CJFMHT had been considered whilst Mr O was an inpatient on Swift Ward. The Care Coordinator had visited the ward and attended Mr O's review meetings. The Care Coordinator said she was of the view that Mr O's discharge from hospital was premature and should have awaited a referral to the CJFMHT, alongside a further consideration of psychological therapies. By the time the assessment had been agreed and a Consultant Forensic Psychiatrist appointed on 5 August 2015, Mr O had been readmitted to Swift Ward.

5.33 On 28 July 2015 Mr O attended at the CMHS base for a meeting to discuss the transfer of his care from SE CATT to the Cheshunt CMHS. At this meeting it was reported by his girlfriend, who was also a service user that Mr O had threatened to cut her brother's throat. Although Mr O's girlfriend had reported this to her Care Coordinator in confidence, the Care Coordinator quite properly reported this threat to the Hertfordshire Constabulary. Mr O was very unhappy that the police had been involved, stated that his threats had been taken out of context and that he would never do such a thing. He also stated that the incident would likely cause him not to say things, even in confidence, in the future.

5.34 At the SE CATT discharge meeting on 28 July 2015, Mr O reported himself to be well, not in crisis but wanting ongoing help. He agreed to work with the Cheshunt CMHS and was discharged into their care. The clinical record refers to the referral having been made to the CJFMHT who would be considering the case on 3 August 2015, thereby providing a specialist forensic consideration of Mr O's history and presentation and subsequently advise on his management.

5.35 The response of the Hertfordshire Constabulary to this threat appeared to be inadequate. The threat to kill was not properly reported or logged as a potential crime and the incident was effectively downgraded to one of a non-crime domestic incident. Although Mr O's girlfriend declined to provide a statement, the Hertfordshire Constabulary could have followed the matter up more closely, especially given the known reasons why Mr O was on bail at that time. Indeed, Mr O himself stated at a later meeting with his Care Coordinator, that he was relieved that nobody had contacted him about his threat to kill (assumed as a reference to potential police intervention).

5.36 Mr O's Care Coordinator reported to the HPFT internal review panel that she found him intelligent but manipulative. She also considered him to be intimidating and uncomfortable, and that she would never visit him alone. She further stated that Mr O constantly denied any responsibility for his own actions.

#### 1 August to 9 August 2015 (Timeline 37 to 40)

5.37 On 1 August 2015, having earlier threatened to take his own life at his Cheshunt home address, Mr O was taken by the Hertfordshire Constabulary to the Lister Hospital A&E department, Stevenage. The Hertfordshire Constabulary considered him to be at high risk of further self-harm and therefore remained with him at A&E, although there was no further police action. The Review Panel noted that this was the tenth known attempt by Mr O to self-harm.

5.38 In discussion with the Community Psychiatric Nurse (CPN) who undertook Mr O's assessment, this incident had resulted from an argument with his parents, following his disclosure to them of his recent threat to kill his girlfriend's brother. He stated that he felt his only escape from the associated distress was to take his own life. The CPN formed the view that there were no psychotic features in Mr O's presentation and nor was there any evidence of a depressive illness. The CPN concluded that his behaviour fell within his existing diagnosis of EUPD, and that Mr O should be offered informal admission back to Swift Ward. Mr O was

readmitted that same day. Mr O's care plan on admission included 10 minute observations, a physical examination, continuation with current medication and a review on the following Monday (3 August 2015).

5.39 There were a number of incidents over the weekend where Mr O exhibited challenging behaviour. These included being found with a female patient in his room, climbing onto a garden shed and meeting with another female service user (whom he had known from his previous admission). When challenged regarding these events Mr O became very irritable and unpredictable, and demanded additional / stronger medications. Ward staff were sufficiently concerned regarding his likelihood of self-harm that a Consultant Psychiatrist took steps to detain Mr O in the ward under the terms of Section 5(2) of the Mental Health Act<sup>3</sup>.

5.40 On 3 August 2015 Mr O underwent a further baseline assessment with a Consultant Psychiatrist, a junior doctor, a ward staff nurse and a CPN from the SE CATT. During the assessment Mr O once more asserted that his threats to kill and obtain sexual gratification through such actions were made by him in an attempt to gain admission to a psychiatric unit.

5.41 Following the baseline assessment, Mr O's diagnosis was confirmed as EUPD. Mr O stated that he did not wish to return home and threatened to kill himself. Mr O's care plan remained essentially as the previous care plan, and a prospective discharge date of 11 August 2015 was set.

5.42 Following the assessment, Mr O again displayed inappropriate and challenging behaviour, in that he set fires in the ward garden and had an altercation with another male patient. Mr O denied setting the fires deliberately; he was placed on one to one observations. A further meeting with the Consultant Psychiatrist followed, where Mr O demanded stronger medication, which the Consultant refused to prescribe. Mr O was reported as being quite threatening throughout this meeting.

5.43 On 5 August 2015 the assessment by the CJFMHT Consultant (Community Forensic Psychiatrist) took place. The CFP reported Mr O as having engaged reasonably well, although his behaviour was changeable. The CFP stated that in his view there were no psychotic symptoms. The CFP stated that Mr O was of the opinion that he was suffering from something more than EUPD and that mental health services too easily dismissed persons with problems such as his. The assessment also considered Mr O's recent behaviours on Swift Ward.

5.44 The CFP discussed his assessment with the Swift Ward Consultant Psychiatrist. The CFP's conclusions can be summarised as follows:

- Mr O's history is suggestive of EUPD with some dissocial and narcissistic traits
- Mr O was on bail related to two serious offences of threat to kill
- Bristol Crown Court should be asked to provide details of the case, since current information had been provided only by Mr O himself

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Section 5(2) of the Mental Health Act 1983 enables an appropriately qualified medical practitioner to detain a patient in hospital for a period up to 72 hours

- there might be a case for an Interim Hospital Order within a Personality Disorder Low Secure Unit
- Mr O's case would be further discussed at the CJFMHT referrals meeting

5.45 The CFP wrote to the Case Progression Manager at Bristol Crown Court suggesting that the Court might find a psychiatric report helpful in dealing with Mr O's sentencing. The CFP specifically mentioned the possibility of Mr O being detained in a Low Secure Unit (LSU) as part of any eventual sentence. It appears that the Court did not respond to the CFP's letter, despite him following the matter up.

5.46 Following the review undertaken by the CFP, Mr O was routinely reviewed on the ward by the Ward Psychiatrist and a Ward Staff Nurse. During one of the ward reviews it was reported that Mr O had been seen drinking wine with another patient who was unwell and under the care of SE CATT. Mr O considered himself to be agitated and said he was concerned about the forthcoming sentencing hearing in Bristol. He stated that he felt suicidal and demanded additional medication. As previously, this demand was refused since Mr O was not considered to need it. Mr O became very threatening, and ward staff were informed that should Mr O become aggressive or violent, given that he was considered mentally competent to make decisions, the police should be called. Mr O did not agree to the change in his medication regime, and he was not allowed further authorised leave from the ward. His predicted discharge date was amended to 15 August 2015.

5.47 Further to the drinking incident referred to in 5.45 above, on 7 August 2015 the husband of a SE CATT patient made a complaint suggesting that Mr O had had sexual contact with his wife, the patient referred to. It was suggested that the police should be informed, but there is no evidence that this ever happened. However, the matter was dealt with through Safeguarding Protocols whereby an experienced practitioner, who was not involved in the service area in question, undertook a safeguarding fact finding investigation. The patient (alleged victim) denied any sexual activity took place, did not have concerns about the event and stated that she did not wish to pursue the matter. This resulted in the conclusion that the case would not meet the 'significant harm' criteria for the case to be taken forward as a safeguarding concern and it did not, therefore, involve any referral being made to the police. The safeguarding investigator continued to follow up the patient, whose mental state was reported as remaining stable.

5.48 A couple of days later Mr O was visited by a former female patient, and both were informed that the visit could only take place in the communal lounge. Mr O's request to go to the café with his visitor was denied, since he was not permitted to leave the ward area in keeping with his care plan. Mr O became very agitated and indicated that he wanted to discharge himself. When the discharge process was explained to him, Mr O agreed to remain on the ward.

5.49 Mr O was seen by the Ward Consultant Psychiatrist on 9 August 2015. She explained to Mr O that his behaviour towards other females was unacceptable and that he was not allowed to have female visitors. Mr O's care plan was amended to reflect his temporary detention under Section 5(2) to prevent his self-discharge, the need for a Mental Health Act Assessment, to have no female visitors and a transfer to the male only Owl Ward.

5.50 Mr O was placed under Section 5(2) of the Mental Health Act on the evening of 10 August 2015. Preparations were commenced for Mr O to undergo a Mental Health Act Assessment on 11 August 2015 with a view to his detention for further assessment and treatment and possible consideration of a transfer to a Low Secure Unit (LSU) should the recommendation of a section 38 Hospital Order be accepted as part of his forthcoming sentence by Bristol Crown Court. Access to an immediate LSU placement through any other route would not have been certain given Mr O's presentation at the time. Whilst Mr O agreed to the transfer to Owl Ward, he was angry about the continued restriction on him meeting with female visitors.

5.51 The Swift Ward Consultant Psychiatrist had assessed Mr O across his two admissions. At Mr O's first admission she was aware of his history of attempted suicide, but, although she was aware that he was wearing an electronic tag, she was unaware exactly why. She questioned Mr O about his time spent under the care of AWP, but he declined to provide information regarding his care or his AWP treating team.

5.52 However, by the time of Mr O's second admission, the Swift Ward Consultant Psychiatrist considered his presentation to be very different. She considered Mr O's behaviour to be alarming and troublesome. She had also become aware of Mr O's threats to kill and sought information from Bristol Crown Court, which failed to respond to her requests. She was also unaware of Mr O's treatment whilst under the care of AWP. She reported to the HPFT internal review panel that had she had access to all the clinical information, she might have sought the intervention of the CJFMHT much sooner.

5.53 The Swift Ward Consultant Psychiatrist diagnosed Mr O with Anti-Social EUPD. She reported to the HPFT internal review panel that she found Mr O to be intimidating and frightening and that he had threatened her on a number of occasions when she had not agreed to his demands for further medication. She was also of the view that the Swift Ward staff also found Mr O difficult to look after, in the main due to his predatory and inappropriate behaviour towards female patients. She believed that the most appropriate approach to Mr O's treatment was to recommend to Bristol Crown Court a Section 38 Interim Hospital Order for transfer to a LSU as part of the Court's sentencing regime which might result in a more thorough assessment of Mr O's presentation and treatment needs. It should be noted however, that this would have required Mr O to be detained on an acute mental health unit (following a Mental Health Act assessment) for several weeks from the date of the Mental Health Act assessment on 12 August 2015 to the date of his sentencing hearing on 2 December 2015.

5.54 The outcome of Mr O's forensic assessment was not recorded in the electronic patient record system until 10 August 2015, by which time Mr O had been transferred to Owl Ward and was under the care of a different Consultant Psychiatrist. Furthermore, the treatment regime changed under the Owl Ward Consultant Psychiatrist, and the suggestion that Mr O be dealt with through an Interim Hospital Order abandoned as an unnecessary course of treatment to pursue. The CFP reported to the HPFT internal review panel that it had been the intention for the Owl Ward Psychiatrist to attend a meeting of the CJFMHT, but in the event he was unable to do so and sent his Junior Doctor in lieu. Additionally, by the time this

meeting took place, the Owl Ward Consultant Psychiatrist had formed the view that Mr O's presentation had changed and that therefore admission to the forensic service was deemed unnecessary as the immediate risks he posed in the hospital setting could be managed on a male only acute inpatient unit.

#### 10 August to 20 September 2015 (Timeline 41 to 48)

5.55 On the evening of 10 August 2015 Mr O was transferred to the all-male Owl Ward, with the intention of his undergoing a Mental Health Act Assessment the following day. However, Mr O's detention under section 5(2) applied only to Swift Ward and therefore became invalid upon his transfer to Owl Ward. Therefore, Mr O, who had throughout his treatment been a voluntary inpatient, had to be asked to remain in the hospital. The restriction to allow him to see his girlfriend prompted him to demand his discharge, and therefore he was detained under the auspices of Section 5(4)<sup>4</sup> of the Mental Health Act. This led to Mr O becoming verbally argumentative and aggressive towards ward staff. The Owl Ward Consultant Psychiatrist subsequently placed Mr O under Section 5(2), which allowed him to be detained on the ward pending the Mental Health Act Assessment.

5.56 During discussions with the Ward Psychiatrist, Mr O was aggressive and challenging, especially regarding his medication regime. Despite his threats to self-harm, the Psychiatrist formed the view that Mr O was just angry and not actively suicidal or psychotic. The Mental Health Act Assessment was scheduled for early the following day.

5.57 On 12 August 2015 Mr O underwent a Mental Health Act Assessment. In accordance with approved process this was undertaken by an Approved Mental Health Practitioner (AMHP) who, in this case, was a Mental Health Nurse, together with two Approved Doctors (under Section 12 of the Mental Health Act). One of these Doctors was the Owl Ward Consultant Psychiatrist and the second was another HPFT Consultant Psychiatrist – not previously involved with Mr O and therefore independent. The paperwork associated with the Assessment recorded Mr O's recent history, and the reason for his recent detention and his transfer from Swift Ward to Owl Ward. In accordance with good practice the AMHP also spoke to both of Mr O's parents, his father having a role under the Mental Health Act as Mr O's nearest relative and therefore having a right under Section 3 of the Mental Health Act to object to Mr O's potential detention. Mr O's mother provided some insight into his upbringing, especially around his reluctance to accept the word 'no', and his inability to stick with things. Mr O's father did not think it appropriate to detain Mr O, if all that was doing was stressing him and potentially making matters worse. The AMHP spoke to the Owl Ward Team Leader who stated that, even though less than 24 hours had elapsed since his transfer, Mr O had been settled and presented no concerns.

5.58 The outcome of the Mental Health Act Assessment can be summarised as follows:

(1) Mr O was diagnosed with EUPD. Mr O had the capacity to make informed decisions and was therefore able to give his consent to remain on Owl Ward as an informal patient;

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<sup>4</sup> Section 5(4) of the Mental Health Act 1983 enables an appropriately qualified nurse to detain a patient for up to 6 hours to enable an assessment by a qualified medical practitioner

- (2) Mr O's exhibited symptoms of emotional instability that impacted upon his ability to interact with others. MR O did not require compulsion for these symptoms to be managed;
- (3) Mr O's history of making threats to harm females and others was noted along with Mr O's statements that he did not mean anything by the threats, which were essentially attention seeking. It was concluded that since he was an in-patient in an all-male ward, and female visitors were restricted, this could equally be managed without compulsion; and
- (4) It was concluded that Mr O did not require to be detained under the Mental Health Acts and he should continue his stay on Owl Ward on an informal basis

On being given this outcome Mr O was asked whether he consented to remain on Owl Ward informally, which he did. In addition, Mr O agreed to a behavioural contract regarding the rules and terms of his admission. The AMHP informed Mr O's father of the outcome of the Mental Health Act Assessment.

5.59 The Owl Ward Consultant Psychiatrist reported to the HPFT internal review panel his impression of Mr O as follows:

- it was clear that Mr O had a Personality Disorder
- he was struck by Mr O's intelligence and charm
- Mr O was able to present himself positively
- Mr O had a psychopathic approach to satisfying his own needs

The Owl Ward Consultant went on to say that in his view Mr O did not pose a risk to others, despite his signs of predatory sexual behaviour. Therefore, in his view a specialist forensic assessment was not required. It should also be noted that guidance on the implementation of a Mental Health Act assessment requires the assessing team to take the 'least restrictive approach' and, where the patient is compliant, to use informal/voluntary inpatient admission and associated treatment before implementing formal detention under the Mental Health Act.

5.60 After the Assessment, Mr O was broadly compliant although sometimes argumentative about his medication regime. However, over the following days Mr O began to push the boundaries of his agreed behavioural contract, including meeting with other patients outside of the ward.

5.61 On 18 August 2015 Mr O reported to the Hertfordshire Constabulary that another inpatient had assaulted him. Staff intervened and Mr O chose not to pursue the matter further with the Hertfordshire Constabulary. On that same day a meeting took place involving Mr O, the ward team and his girlfriend. This meeting was intended to determine whether she fully understood Mr O's history and to assess any risk that Mr O presented to her. Mr O's girlfriend was a former patient on Swift Ward; she stated that she understood Mr O's background and essentially felt safe with him. It was therefore agreed that they could meet, but only in communal areas and not in Mr O's room.

5.62 On 20 August 2015 the Owl Ward Psychiatrist met with the Consultant Forensic Psychiatrist to discuss the future management of Mr O. The CFP reaffirmed his view, shared by the Swift Ward Consultant Psychiatrist, that Mr O warranted assessment under Section 38

of the Mental Health Act<sup>5</sup>. At that meeting the CFP was informed that Mr O was complying with the terms of his behavioural contract, despite the fact that MR O had not been doing so as set out in paragraph 5.59 above. At the conclusion of the meeting, both Psychiatrists agreed that the risk of Mr O actually carrying out a threat to kill and/or rape was low. The Owl Ward Psychiatrist confirmed his view that Mr O's symptoms or behaviour did not warrant a further Mental Health Act Assessment and that a transfer to a LSU was also not warranted. He stated that he intended to approach Bristol Crown Court with a view to presenting pre-sentencing psychiatric recommendations.

5.63 On the same day, Mr O was informed that the husband of a female patient had accused Mr O of raping her. Mr O's account was that he had shared wine with her and that the sexual contact had been consensual but had not included intercourse. The following day Mr O had an altercation with two patients on the Ward that required Ward staff to intervene. Over the next few days Mr O was broadly compliant, although on 26 August 2015, Mr O reported to the Hertfordshire Constabulary that his girlfriend was feeling suicidal

5.64 A review of Mr O's care took place on 8 September 2015, undertaken by the Speciality Psychiatrist and Owl Ward nursing staff. This meeting included issues such as Mr O's medication and his acceptance of the rules and authority of the staff. There was a discussion regarding Mr O's care once discharged back into the community, and the plan was agreed as follows:

- preliminary pre-discharge meeting on 18 September 2015
- Owl Ward Consultant to complete and submit his report to Bristol Crown Court
- Owl Ward Consultant to request sight of the psychiatric report already submitted to the Court
- changes to Mr O's leave from the Ward, to include 2 hours unescorted to the shops and 8 hours with his parents

Mr O agreed to these terms.

5.65 Subsequently Mr O breached his behavioural contract by interfering with, and influencing the, care of other service users on the Ward through encouraging them to challenge the authority of the staff, and by using a planned unescorted visit to the shops to visit his former girlfriend on Swift Ward.

5.66 On 15 September 2015, following the Ward round, Mr O's unescorted leave was restricted until further review. Mr O could still, however, go on escorted leave with staff or in the company of his family. Two days later Mr O challenged his behavioural contract with the Speciality Psychiatrist, particularly the restriction on seeing females on other Wards. Mr O became very aggressive and the Speciality Psychiatrist sought the advice of the Consultant Psychiatrist. The Consultant Psychiatrist agreed to put Mr O under a Section 5(2) of the Mental Health Act to restrict his activities, on the basis that Mr O had a mental disorder.

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<sup>5</sup> Section 38 of the Mental Health Act 1983 deals with Interim Hospital Orders, and provides for a course of mental health treatment following being found guilty of an offence, rather than imprisonment

5.67 On 17 September 2015 Mr O was reported as saying that *“when I leave or am discharged I will kill someone – document that [name of nurse]. I will kill someone when I leave, you must document that”*. This threat was quite properly reported to the Hertfordshire Constabulary, who initially took the report seriously and contacted the ASC to ensure that they were aware. However, by the time the Hertfordshire Constabulary arrived to interview him on 22 September 2015, Mr O had been discharged from the Ward. Furthermore, although the Hertfordshire Constabulary had Mr O’s home address, they did not seek to interview him there either.

5.68 On 18 September 2015 the Care Programme Approach (CPA)<sup>6</sup> meeting was held, this being the last meeting to plan Mr O’s discharge. Those present included the Owl Ward Consultant Psychiatrist, the Ward Doctor, the Ward Staff Nurse, the Cheshunt CMHS Consultant Psychiatrist, the CMHS Care Coordinator and Mr O’s parents. The meeting was comprehensive and covered all aspects of Mr O’s behaviour whilst under the care of HPFT and set out the reasons for Mr O’s bail from Bristol Crown Court. It is interesting to note that one of the issues Mr O wished specifically to be included in the notes was his threat(s) to kill. Once again he maintained that these threats were not real but *“to show how ridiculous everything is. It’s a search for the ultimate truth.”* The meeting included a review of risk assessment that concluded that Mr O’s threats to kill and the associated risk to other females that would need to be assessed on an on-going basis. The risk to him was assessed as low, but it was identified that there was an ongoing risk of impulsive behaviour.

5.69 The outcome of the CPA can be summarised as follows:

- continue with current medication
- increase Mr O’s leave with his parents with SE CATT support
- first day of leave to be immediate but back to hospital same day
- overnight leave with parents on Sunday 20 September 2015, but Mr O must tell Bristol Crown Court of his location
- Consultant to discharge him from Section 5(2) (of the Mental Health Act)
- CMHS Consultant agreed to be Mr O’s Probation Psychiatric Supervisor if the Court agreed to probation

5.70 Prior to the CPA, Mr O had made four threats to kill, two in Bristol (for which he was on bail pending sentence), one whilst under the care of SE CATT and one whilst on Owl Ward. Whilst the four threats to kill had been recorded in the HPFT clinical records, they had not been fully reflected and recorded as part of the CPA assessment of the risk Mr O posed to others.

5.71 In the days following the CPA meeting, Mr O continued to push the boundaries of his behavioural contract by being argumentative and manipulative, and by refusing to recognise that there was anything wrong in threatening to kill someone upon his release. In addition, there was an issue with another patient, which required staff intervention with Mr O being reminded of his agreement to behave appropriately on the Ward. There were two further incidents later that same evening.

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<sup>6</sup> Care Programme Approach – used to plan people’s mental health care and how mental health services can provide support

5.72 On 20 September 2015 Mr O's father arrived on Owl Ward to take Mr O on home leave as agreed. Mr O was provided with SE CATT and the Mental Health Helpline numbers should he need assistance. The Hertfordshire Constabulary were informed that Mr O had been given unescorted home leave to his parent's home address.

#### 21 September to 30 November 2015 (Timeline 49 to 58)

5.73 Mr O returned to Owl Ward on 21 September 2015 for an assessment by SE CATT prior to his formal discharge. A SE CATT CPN undertook the assessment. The assessment record made by the CPN only made reference to the threats to kill that were the subject of Mr O's appearance in Court, and not to the two most recent threats whilst Mr O was on Owl Ward. The assessment was otherwise robust and identified the key issues relating to Mr O's mental health past and his risks. The plan was:

- short term support from SE CATT
- no females to see Mr O unaccompanied

5.74 Following the SE CATT assessment, Mr O returned home to his parents' address on home leave. There is some confusion as to whether Mr O should have been on overnight leave and therefore return to Owl Ward on 21 September 2015, or, as suggested by the CPA notes, the leave was for a week, with Mr O due back on the Ward by 25 September 2015. During this period of absence, a police officer attended Owl Ward to interview Mr O regarding his most recent threat to kill. Staff appeared to have no clear idea of the detail of Mr O's leave from the Ward and no contact was made with him. However, SE CATT did make contact with Mr O during his leave period via telephone conversations, home visits and consultations.

5.75 Mr O did not return to Owl Ward on 25 September 2015, and was still absent on 28 September 2015 when the Owl Ward Consultant Psychiatrist noted that Mr O was not present on the Ward. The Consultant issued an instruction that should Mr O return to the Ward, he should not be re-admitted without the Consultant's express agreement. This instruction was apparently due to an incident involving Mr O, who, having allegedly taken cocaine telephoned SE CATT and demanded to be re-admitted to Owl Ward. Following telephone conversations between Mr O and SE CATT, Mr O eventually returned home, and SE CATT contacted Mr O on 28 September 2015. The Owl Ward Consultant Psychiatrist stated that he saw no reason why Mr O should be in hospital, and given the incident when he reported taking cocaine, that Mr O should not be re-admitted without a prior discussion with him.

5.76 Over the same period of time, Mr O remained under the care of SE CATT, which had contact with him on a number of occasions, either at home or via the telephone. On those occasions Mr O reportedly seemed bright in mood and appeared to be coping well, other than the cocaine event referred to in 5.75 above. However, Mr O also reported that he had no information from Owl Ward regarding his formal discharge into the community. On 29 September 2015 Mr O informed SE CATT that he only wanted them to contact him by telephone. This demand was based upon his recent wish to be re-admitted following the alleged illicit drug related event in London, which did not result in any action.

5.77 On 2 October 2015, SE CATT was advised that Mr O was to be discharged from Owl Ward, and therefore ward leave no longer applied. SE CATT raised no objection to this but did point out Mr O's refusal to fully engage with the team. SE CATT was to arrange a meeting with them, Mr O and Cheshunt CMHS to discuss his care handover. The Care Coordinator advised SE CATT that given Mr O's history and previous threats to kill, she would only meet with Mr O at the CHMT base, and not at his home address.

5.78 On 5 October 2015, at a doorstep meeting with SE CATT, Mr O stated that he had been unaware of his discharge from Owl Ward and that he was becoming distressed regarding his forthcoming Court appearance. He claimed to be suicidal and sought admission to the Ward. SE CATT offered support which Mr O declined. Later that same day Mr O telephoned SE CATT in a distressed state, threatening to harm himself in order to get re-admitted to hospital. Mr O declined a home visit and therefore, given his unwillingness to engage with SE CATT directly, he was advised that if he felt suicidal or wanted to self-harm, he should attend A&E where he would be seen by mental health specialists.

5.79 Contact between Mr O and SE CATT and his Care Coordinator over the next few days appeared to show Mr O in reasonable spirits other than his on-going concern regarding his forthcoming Court appearance. Mr O was particularly concerned that he might receive a suspended sentence with Probation Service supervision.

5.80 A joint meeting between Mr O, SE CATT, a Community Mental Health Nurse and his Care Coordinator was scheduled for 12 October 2015. At that meeting Mr O appeared positive, stating that he had a new job as a paralegal. Mr O denied any negative or suicidal thoughts. It was agreed that SE CATT would discharge him from the CATT caseload and that his Care Coordinator would take over his care.

5.81 A week later Mr O contacted the CMHS asking for a prescription. The Owl Ward Consultant Psychiatrist provided the relevant prescription and Mr O agreed to collect it from the CMHS base. Mr O was described as bright in mood and responsive throughout these contacts. The next contact with Mr O was on 2 November 2015, following a meeting Mr O had had with his Probation Officer (PO). This meeting with the PO was in relation to the pre-sentence report being prepared for the Court. Mr O indicated that the meeting had not gone particularly well, due to differences of opinion. Nevertheless, Mr O was reported as being bright in mood. A further meeting with Mr O was arranged for 12 November 2015.

5.82 On 6 November 2015, the PO held a second meeting with Mr O that was described as more useful, insofar that the PO was able to gather sufficient information to be able to prepare Mr O's pre-sentence report.

5.83 Mr O did not attend the meeting with his Care Coordinator on 12 November 2015, but telephoned to say that he had forgotten. He stated that he was doing well and he was reported as sounding bright in mood and responsive. Mr O informed the Care Coordinator that his sentencing hearing was set for 2 December 2015 and she arranged to contact Mr O by telephone the following week.

5.84 The record shows no further contact with Mr O until 30 November 2015, two weeks later, when the Care Coordinator met him at the CHMS base. At this meeting Mr O presented as more unsettled. He reported difficulties in concentrating on tasks, and reported losing interest in things he was working on. He asked whether he could be prescribed something to help him concentrate more. He stated that he had no suicidal or thoughts of self-harm and that he had not taken any illegal drugs. Mr O reported that he was concerned about the forthcoming sentencing hearing at Bristol. Mr O presented as being responsive and communicative. The Care Coordinator said that she would contact Mr O again after the Court hearing on 2 November 2015. The record shows that this was the last contact with Mr O by HPFT staff.

#### 1 December 2015 to 30 December 2015 (Timeline 59 to 67)

5.85 On 2 December 2015 Mr O appeared for sentencing at Bristol Crown Court, having previously pleaded guilty to two offences of a threat to kill on 15 April 2015. Mr O was sentenced to nine months in custody, suspended for twenty-four months, subject to the following requirements:

- (i) a 15 day rehabilitation activity requirement; and
- (ii) a 12 month Mental Health Treatment Requirement (MHTR)

In determining an appropriate sentence, the Judge had available to him two psychiatric reports and possibly one letter which had been previously sent by the HPFT Forensic Psychiatrist. The two reports, written at different points in time, described what appeared to be a fluctuating level of risk. One report suggested that Mr O did not pose any greater risk than other young males seeking serial sexual partners, and that he could be managed through a Mental Health Treatment Requirement. However, the second Psychiatrist's report stated that he was unable to reassure the Court that Mr O did not pose a serious risk to others, and that it was unlikely that any psychiatric intervention would alter Mr O's risk profile in the short to medium term. On that basis he felt that Mr O would be better managed within the Criminal Justice and Probation systems. The letter referred to the above requirements that recommended Mr O should be detained via an Interim Hospital Order. The Judge would have carefully weighed the guidance presented to him in determining an appropriate sentence, but the differing professional views on the appropriate management of Mr O demonstrate how difficult that final judgement was.

5.86 On 3 December 2015 Mr O had his initial meeting with his Probation Officer. Mr O was not managed as a domestic abuse perpetrator, although he was identified as being a high risk to others. In particular, the Probation Officer (PO) identified Mr O as posing a high risk of serious harm to adult women and future sexual partners.

5.87 On 7 December 2015, the Care Coordinator telephoned Mr O, but he did not return her call. She did however learn that the Mr O's Probation Officer/Offender Manager planned to see Mr O on 11 January 2016.

5.88 On 10 December 2015, Mr O agreed his sentence plan with his PO, which was based around working with the Sex Offender Treatment Unit to determine ongoing risk. This work was intended to require Mr O to address issues such as actions, belief, intent, feelings, denial,

blame and the effects of his actions on others, with an intention of changing his behaviour. At a meeting on 17 December 2015, Mr O informed the PO that he was meeting females through Internet dating sites and that he saw no value in male friends. He also admitted that he had an ability to manipulate others.

5.89 The final meeting, between Mr O and his PO took place on 21 December 2015 when Mr O reflected upon discussions at earlier meetings and considered setting some goals. On that same day, Mr O's PO met with the NPS Sex Offender Team to discuss the management of Mr O. At this point the OM was concerned about Mr O's sexualised language and threats of sexual violence.

5.90 Mr O's conviction did not meet the threshold for management under Multi-Agency Public Protection Arrangements (MAPPA)<sup>7</sup>. However, multi-agency management was delivered through the MHTR, supported by CPA.

5.91 Mr O's sentence imposed a Mental Health Treatment Requirement. Hertfordshire Probation, jointly with HPFT, has in place a protocol for building contact between the Probation Service and Mental Health Services<sup>8</sup>. It provides for, inter alia:

- the Offender Manager (Probation Officer) to instigate the process by contacting Mental Health Services
- details of appointments with Community Psychiatric Nurses to be notified in advance
- mental health providers to notify the National Probation Service within 24 hours of a failure to attend a treatment session
- three way meetings
- specific detail of the proposed treatment regime
- dates of Care Programme Approach meetings
- attendance of the National Probation Service at Care Programme Approach meetings.

5.92 It appears however, that Mr O's Probation Officer did not implement the above protocol in an expedient manner, and in particular did not contact Mr O's Community Psychiatric Nurse/Care Coordinator at an early stage. Nor did the Probation Officer contact the Community Consultant Psychiatrist who was the named Psychiatric Supervisor for Mr O under the Mental Health Treatment Requirement, either to inform him of the implementation of the Mental Health Treatment Requirement as part of Mr O's sentence, or to establish a meeting to agree Mr O's care plan. Furthermore, although the National Probation Service had access to The Personality Disorder Offender Management Pathway, which is specifically designed to enable Probation Officers to engage with Personality Disorder offenders, Mr O's PO stated that although the intention had been to refer Mr O to this pathway, at the time there were resourcing issues.

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<sup>7</sup> 'Multi-agency Public Protection Arrangements' (MAPPA) are designed to support assessment and management of the risks posed by sexual and violent offenders. Guidance on the use of MAPPA is published by government for the police, prison service and probation trusts. It contains guidance on risk assessment and information sharing. MAPPA offenders are managed at one of three levels according to the extent of agency involvement needed

<sup>8</sup> "Mental Health Treatment Requirements – Guidance for Psychiatrists and Health Staff" and "Mental Health Treatment Requirements – Guidance for Probation Staff"

5.93 On 23 December 2015 Ms M went on a date with Mr O, having met each other earlier through an Internet dating site. Following a meeting in a public house in London, in the early hours of 24 December 2015 Ms M went with Mr O to a hotel in Hertfordshire, where he murdered her.

5.94 Ms M's father reported her to the Hertfordshire Constabulary as a missing person. Mr O was arrested for the murder of Ms M and remanded in custody. The Hertfordshire Constabulary informed HPFT of the murder on 30 December 2016.

## 6. Conclusions

6.1 In drawing conclusions from the information provided, the Review Panel has endeavoured to avoid the application of hindsight and has sought only to assess the actions of the agencies involved based upon information that they could reasonably have been expected to be aware of at the time.

6.2 Of the 600 or so homicides each year, around 11% (65) are committed by persons in contact with mental health services. Therefore, agencies will rarely come across individuals with the complexities of presentation as demonstrated by Mr O. This rarity means that the management of individuals such as Mr O is extremely challenging, and that there are difficult judgements to exercise in respect of the most appropriate management regime. In general terms it is the National Health Service that tends to manage those where the greatest risk is identified as being to themselves, whereas persons who pose a risk to others tend to be managed through the criminal justice system. Notwithstanding this general approach, the National Health Service will often find itself managing those who have been referred directly as part of Court sentencing or by way of transfer from the normal prison system, within the secure hospital system.

6.3 Therefore, the management of Mr O should not have been seen as either a 'legal' problem or a 'health' problem, but one where it was accepted that Mr O would pose a challenge to all agencies and his successful management would require those agencies to have access to relevant information, to undertake risk assessments based fully upon that information and to all be involved in the assessment process.

6.4 Based upon all the clinical and psychiatric evidence provided to it, the Review Panel is satisfied that Mr O's diagnosis of EUPD was wholly correct. However, experts also state that it would have been extremely difficult for HPFT psychiatrists to have accurately predicted Mr O's behaviour prior to him murdering Ms M, and that only now, after the carrying out of the murder, and subsequent additional assessment, can it be said with any certainty that Mr O is an extremely dangerous individual.

6.5 Despite these difficulties, the Review Panel has concluded that there are lessons to be learned from the tragic death of Ms M and the treatment / management of Mr O leading up to her murder. These are set out below.

6.6 The conclusions that follow are based upon those contained within the Independent NHS Review of HPFT (see Appendix B) and those formulated by the Review Panel as part of multi-agency considerations.

### (a) Mental Health

6.7 The Review Panel noted that within their IMR, HPFT made significant reference to the fact that they had to treat Mr O without any knowledge of his care by AWP. Whilst it is the case that Mr O refused to provide any information to HPFT clinicians regarding his care under AWP, there did not appear to be any attempt made by HPFT to contact AWP to seek information regarding Mr O's treatment and care. Furthermore, after Mr O was discharged

into remand in Bristol Prison, AWP had written to Mr O's GP setting out the comprehensive details of his presentation and treatment etc. In considering whether HPFT should have sought this information, the Review Panel was fully aware of the current legal structures that state that patient data should only be shared without patient consent where there is an assessed risk to the patient or to others through the information not being shared.<sup>9</sup> On this basis the Review Panel concluded that there was no legal or procedural bar to HPFT seeking relevant information from AWP or other clinicians regarding Mr O's previous care. Furthermore, HPFT has a policy that sets out good practice in obtaining information in similar circumstances.

6.8 As stated in paragraph 6.2 above, the Review Panel has recognised the difficulties faced by HPFT clinicians in managing Mr O. Not dissimilarly to the psychiatric advice presented to the Judge at Bristol Crown Court, senior clinicians managing Mr O held differing views as to the level of risk he posed to himself and to others, and how those risks should be managed. The Review Panel fully accepts that such differences are not unusual in such complex cases, but has concluded that where such differences existed, mechanisms should have been in place to enable those differences to be fully explored amongst all those dealing with Mr O, in order to form a consensus view in relation to risk management and the delivery of appropriate care. This lack of a defined mechanism may well have resulted in opportunities to manage Mr O via different care pathways being missed, including for example, through the forensic route involving detention and additional mental health assessments.

6.9 Once on Owl Ward, Mr O again pushed the boundaries of his behavioural contract, to the extent that this could have triggered a Mental Health Act Assessment. Alternatively, Mr O could have been reported to the Hertfordshire Constabulary for potential breaches of his bail conditions. The Review Panel has concluded that Mr O's risk to others was possibly underestimated by virtue of him now being on an all-male ward, where he could not be a risk to females in the inpatient environment. There was however, no apparent consideration of whether he posed a potential risk to females other than in the hospital environment.

6.10 The Review panel has concluded that whilst Mr O's eventual discharge from Owl Ward was properly planned, his period of ward leave was poorly managed. What should have been a short period of weekend leave at his parent's home, with the support of SE CATT, somehow became extended leave, seemingly without Owl Ward staff being aware of the exact arrangements. Furthermore, whilst Mr O was on this extended leave, he was involved in alleged drug taking whilst on a visit to London. Mr O was eventually discharged from Owl Ward in his absence, with the Consultant Psychiatrist directing that should Mr O attempt to return to the Ward, he should not be re-admitted without reference to him.

6.11 The Review Panel has concluded that the issues raised above demonstrate that the risk assessments associated with Mr O's care planning by HPFT were inadequate. Whilst the risk assessments did consider Mr O's risk of self-harm, the risk he potentially posed to others was much less well elaborated. At the very least, the risk assessments should have considered what action would be taken in the event that Mr O's presentation changed.

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<sup>9</sup> Caldicott Principles (as revised 2013)

(b) Probation Services

6.12 The Review Panel has concluded that following Mr O's sentence at Bristol Crown Court, which included a Mental Health Treatment Requirement, previously adopted local Hertfordshire protocols were not followed. In particular, the HPFT Psychiatric Supervisor and Care Co-ordinator were not formally advised of this element of the sentence. Although the Offender Manager (Probation Officer) did liaise by email with the Care Co-ordinator on Mr O's progress, no initial meeting was organised by the Offender Manager with the Psychiatric Supervisor and Care Co-ordinator, in accordance with the local Hertfordshire Guidance, to agree treatment objectives and outcomes for Mr O. No collective proactive plans were put in place to manage this and follow up with an agreed care plan for Mr O following his sentencing. The period between Mr O's sentence on 2 December 2015 and the homicide on the 24 December 2015 was twenty-two days and the period between the Offender Manager's first contact with the Care Co-ordinator on 11 December 2015 and the homicide was thirteen days.

6.13 The Review Panel has noted that both the HPFT clinicians involved and the Offender Manager had little or no experience of MHTRs, which are not widely used. Furthermore, the Review Panel has noted that the protocols referred to above were, at the time of Mr O's sentencing, more than three years old (dated July 2012) and therefore concluded that OMs/POs were, given the relative rarity of the use of MHTRs by the Courts, probably unaware of their existence.

(c) Hertfordshire, and Avon and Somerset Constabularies

6.14 The Review Panel has concluded that the Avon and Somerset Constabulary handled Mr O appropriately throughout their contacts with him prior to his remand to Bristol Prison. ASC have highlighted some issues in their IMR regarding the passing of information on to other agencies.

6.15 The Review Panel has concluded that the Hertfordshire Constabulary failed to deal adequately with the threat to kill that Mr O made immediately prior to his discharge from Owl Ward, in that they failed to attend to interview him whilst he was still in hospital or at his home address. It should, however, be noted that even if the Hertfordshire Constabulary had acted correctly in interviewing Mr O, the evidence and information available would in any case have not met the threshold required for further proceedings against him.

6.16 There were a number of occasions in relation to both Constabularies where relevant information on Mr O was not properly recorded on relevant databases and therefore was not available to other forces when Mr O moved into their area. The Review Panel has concluded that this lack of information sharing has the potential to seriously affect the ability of the receiving Constabulary to manage persons with mental health issues appropriately.

(d) Criminal Justice System

6.17 The Review Panel recognises that Judges, when sentencing, are required to adhere to Home Office guidelines. These require that whenever appropriate and safe, a sentence should seek to deal with an offender in the community rather than in custody. In this case, the psychiatric advice provided to the Judge did not appear to suggest that Mr O posed a risk to the community at large or in particular, females, and therefore Mr O could be effectively managed in the community through the imposition of a MHTR as part of a community based sentence.

6.18 Therefore, the Panel has concluded that, given that Mr O had pleaded guilty and the guidance provided by the expert psychiatric advisers to the Court, there is nothing to suggest that the sentence given to Mr O was inappropriate. The alternative, that being a period in custody, would have done little, if anything, to deal with Mr O's mental health presentation and in any event would most likely have been for a relatively short period, followed by a release on licence. Furthermore, a custodial sentence and eventual release on licence would not have enabled the application of a MHTR, which was intended to best manage Mr O's complex presentation.

(e) Information sharing

6.19 The Review Panel has recognised a common theme within the IMRs relating to a failure of agencies to adequately record data on corporate systems and/or to ensure that relevant agencies both within and outside of their operational areas are fully informed of the circumstances of a particular case under management. The Review Panel is aware of the Caldicott Principles, which seek to ensure the privacy of, and the controlled sharing of, personal medical information. However, these Principles, and in particular Principle 7 (introduced in April 2013) do not preclude the sharing of information provided that it:

- (a) is controlled by a Caldicott Guardian;
- (b) only includes information which is necessary; and
- (c) is clearly in the best interests of the patient.

On this basis, the Review Panel has concluded that there were a number of occasions when, if the relevant agency or agencies had had access to all the information that was available, the management of Mr O might have been undertaken differently and/or more appropriately.

6.20 The Review Panel has also concluded that the need to share information, in accordance with legal requirements and good practice needs to extend beyond 'police to police' or 'NHS to NHS' to ensure as far as possible that the fullest possible information is available to any relevant professional or agency dealing with a complex individual such as Mr O.

## 7. Recommendations

7.1 The Partnership Review Panel has formulated a number of multi-agency recommendations based upon the conclusions drawn in part 6 of this report. In so doing, the Review Panel fully endorses and has incorporated the recommendations of the Independent NHS England Review, set out in recommendations 1 to 4 below.

7.2 The Partnership Review Panel has considered all of the recommendations contained within the IMR's of the participating agencies. Whilst endorsing these recommendations in general, these are not set out in detail below, but can be found within those agencies' IMRs, which are listed in Appendix A of this report.

Independent NHS England Review	
1.	<p>That the current practice within HPFT for assessing risk be thoroughly reviewed as a matter of urgency. Training in risk assessment should then be refreshed in accordance with best practice and the evidence concerning the most effective way to support staff in delivering a high standard of safe care. This review should involve developing a range of skills including:</p> <ul style="list-style-type: none"> <li>• Taking a multifactorial history and make a case formulation</li> <li>• Risk assessment and risk reduction planning</li> <li>• How to integrate risk assessment and reduction as part of the overall Care Plan</li> <li>• Strengthening the audit process to assure the quality of risk assessment and care planning</li> <li>• Strengthening systems to ensure the multidisciplinary review of complex cases</li> <li>• Full implementation of the personality disorder care pathway</li> </ul>
2.	<p>That steps are taken to ensure that HPFT relevant policies relating to inter-agency communication are implemented fully and that:</p> <ul style="list-style-type: none"> <li>• Staff are aware of the relevant policy documents and existing national guidance and are enabled to use them at critical points in care.</li> <li>• Staff are aware of and understand issues relating to patient confidentiality, and when confidentiality can, or must, be breached.</li> <li>• The recent strengthening of capacity and awareness within HPFT of systems to gather information about individuals from other NHS organisations or agencies be shared more widely across the Trust.</li> <li>• The Trust develops, in conjunction with Primary Care Services, a standard information sharing protocol with GPs</li> </ul>
3.	<p>That, given that Mental Health Treatment Requirements are not used by the Courts frequently, HPFT should:</p> <ul style="list-style-type: none"> <li>• Develop staff knowledge and skill in relation to the use of Mental Health Treatment Requirements</li> <li>• In conjunction with Probation Services develop resources and expertise to support staff when a Mental Health Treatment Requirement is applied, and review the use of current guidance/protocols.</li> </ul>

	<ul style="list-style-type: none"> <li>• Ensure that when a Mental Health Treatment Requirement is applied by a Court, the Trust supports Probation Services in drawing together the immediate staff involved so they can develop a shared understanding of their roles and responsibilities in meeting the requirements of the joint protocol</li> </ul>
4.	<p>That HPFT further strengthens its practice in relation to patient discharge to build on and extend existing good practice within HPFT to:</p> <ul style="list-style-type: none"> <li>• Ensure discharge meetings always occur</li> <li>• Ensure there is a full discharge CPA</li> <li>• Ensure a crisis team discharge to a community team does not normally occur without a meeting with the care coordinator present</li> <li>• Continue to deliver a 72-hour follow up (which exceeds the current national standard of 7 days).</li> </ul>
<b>Partnership Review Panel</b>	
1.	That NHS England remind all NHS Mental Health Services of the importance of information sharing, within the confines of the Caldicott Principles and associated guidelines, when high risk patients move or are transferred between NHS administrative areas.
2.	That Hertfordshire Partnership University NHS Foundation Trust and Avon and Wiltshire NHS Trust should review and revise discharge procedures so that when a patient who is considered to present a potential significant physical risk to the public is discharged back into the community, the local police constabulary is informed of that discharge, with the details of the potential risk. Procedures to be shared with NHS England for dissemination of wider learning.
3.	That the National Probation Service provide guidance to all relevant staff in respect of the application of Mental Health Treatment Requirements with particular emphasis on the importance of timely contact with local Mental Health Services following sentencing.
4.	That the National Probation Service, in conjunction with local Mental Health Services, develop new or update existing protocols for the implementation of Mental Health Treatment Requirements to include, in particular, clarity around implementation timescales and agency responsibilities.
5.	That Police Constabularies should take steps to ensure that when an individual diagnosed as suffering from mental health issues is released under investigation or bailed to reside in another constabulary area, the receiving constabulary is notified and provided with all appropriate information.
6.	That HPFT, the Hertfordshire Constabulary and the Probation Service, through the auspices of the Hertfordshire Safeguarding Adults Board, develop and implement a programme of joint training to better inform relevant officers of the complex interactions between mental health services and the criminal justice system.

7.	That in conjunction with the Hertfordshire Clinical Commissioning Group, deliverers of primary care services be informed of the need to share essential patient clinical information with other health service providers, in accordance with the Caldicott Principles and existing information sharing protocols and guidelines.
8.	That the Partnership Review Panel reconvenes six months from the date of publication of the Partnership Review report to review the implementation of: <ul style="list-style-type: none"><li>• the relevant Trusts' and agencies' recommendations and associated action plans set out within their IMRs; and</li><li>• the Partnership Review Panel's cross-agency recommendations.</li></ul>

## **Appendix A – Individual Management Reviews Received and Reviewed**

1. Hertfordshire Partnership University NHS Foundation Trust
2. Avon and Somerset Constabulary
3. Avon and Wiltshire NHS Trust
4. Hertfordshire Constabulary
5. National Probation Service

# REPORT OF THE INDEPENDENT REVIEW INTO THE NHS CARE AND TREATMENT PROVIDED TO MR O

## Confidential

**Contract reference:** Mr O  
**Incident type:** Homicide  
**Date of Incident:** 24th December 2015

**Report prepared by:** Lawrence Moulin  
Anne Richardson Consulting Ltd

**Investigators:** Dr Hugh Griffiths MB BS FRCPsych  
Mr Lawrence Moulin BA, MSc, MBA, C Psychol  
Ms Anne Richardson BSc MPhil FBPsS  
Ms Lisa Haywood, lay member

**Date of report:** 24<sup>th</sup> January 2018

## ANNE RICHARDSON CONSULTING LTD



*EXPERIENCE, KNOWLEDGE AND EXPERTISE IN MANAGING RISK*

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## EXECUTIVE SUMMARY

### 1. Introduction

- 1.1. This is the report of an independent review commissioned by NHS England into the care and treatment provided to Mr O, who was a patient of Hertfordshire Partnership University NHS Foundation Trust (HPFT) when on 24<sup>th</sup> December 2015 he met and then killed Ms M.
- 1.2. This review was carried out alongside a multi-agency review which included Hertfordshire Partnership University NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, the National Probation Service, Avon and Somerset Constabulary, and the Hertfordshire Constabulary, under the auspices of the Hertfordshire Domestic Abuse Partnership.
- 1.3. This report will focus specifically on the NHS care given to Mr O and communication between services. The multi-agency review has both informed and been informed by this report, and identifies the multi-agency learning.
- 1.4. We would like to extend our sincere condolences to the family of Ms M for the terrible and tragic loss of a much loved daughter. We hope that the impetus and challenge within this and the multi-agency report will lead to changes in services and across agencies.
- 1.5. We would like to thank all the staff in the NHS, two Police constabularies, the Probation services, and the Hertfordshire Domestic Abuse Partnership for their support in this investigation. Our primary aim, as with all investigations into NHS treatment and care, is to learn lessons from this case and to help improve services, making them safer.
- 1.6. Appendix 1 of the report contains the Terms of Reference for the investigation. Appendix 2 contains details of the investigation team and Appendix 3 lists the documentation the team reviewed, which included NHS case notes, Trust policies, and copies of internal reviews carried out by the NHS, Police and Probation service. Appendix 4 lists the witnesses interviewed, and Appendix 5 gives a summary of chronology of the NHS care Mr O received. There are no significant inconsistencies across this information and the team has no reason to doubt its reliability.

## **2. Findings**

### **2.1. Context of this review**

- 2.1.1. Homicides by people in receipt of mental health services are extremely rare. Overall, of around 600 homicides per year, 11% or 50-60 per year are committed by people in contact with mental health services, a number that has been falling

since 2008.<sup>10</sup> Whilst there would never be an excuse for failing to diagnose, assess or manage the risk of harm that might be presented by such individuals, individual clinicians will rarely see service users who pose so severe a threat, because their numbers are very low; this makes the management of risk to others especially challenging.

2.1.2. Mr O was diagnosed as having an Emotionally Unstable Personality Disorder (EUPD), with narcissistic and dissocial (psychopathic) traits. EUPD is a relatively uncommon condition (a prevalence rate of perhaps no more than one or two per cent) characterised by fluctuations in, and difficulty managing mood. A Dissocial Personality Disorder is characterised by disregard for the feelings of others and an inability to modify behaviour in response to adverse events; it may also feature a relatively low threshold for violence, a tendency to blame others and a wide range of interpersonal and social disturbance.

2.1.3. Mr O's behaviour was highly volatile, with rapidly changing mood, and he presented different challenges and risks. At times he was provocative towards staff from statutory agencies and he used implicit and explicit threats on occasions. However, he was intelligent and could also be socially very engaging.

2.1.4. With this range of behaviour it was likely that Mr O would come to the attention of the Police, Criminal Justice System and NHS organisations. It was therefore not a question of whether he presented a 'legal' problem or a 'health' problem, Mr O was likely to engage with and challenge all of the agencies, and they needed to find ways to work together to manage his behaviour.

2.1.5. NICE guidance, published to inform NHS Clinical Commissioning Groups about the care requirements for people with a Personality Disorder (PD) of this type, emphasizes the importance of inter-agency collaboration, multi-disciplinary care planning, risk assessment and management for what can be amongst the most challenging of all mental health conditions.<sup>11</sup>

## **2.2. Summary of the care and treatment provided to Mr O**

2.2.1 Mr O was born in Enfield in 1989 the youngest of three brothers, and his family moved to Hertfordshire when he was 6 years old. He was reported to be successful both in sport and academically, going on to attend university and study at Masters Level.

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<sup>10</sup> National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) Annual Report and twenty year review. <http://research.bmh.manchester.ac.uk>

<sup>11</sup> National Institute of Health and Care Excellence (2009) 'Personality disorders: borderline and antisocial' [www.nice.org.uk/guidance/cg77](http://www.nice.org.uk/guidance/cg77)

- 2.2.2 Records indicate that Mr O had been identified at the University of Surrey as having harmed himself in 2009 and 2010 with a further episode in Wales in 2011. He first came to the attention of Hertfordshire Partnership University NHS Foundation Trust (HPFT) in July 2013 after an episode of self-harm led to attendance at an Accident and Emergency department, and he was referred to HPFT. He was supported by HPFT community services and was discharge from their care in October 2013.
- 2.2.3 There are no records suggesting that between the end of this episode of NHS care in 2013 and February 2015 Mr O received any input from mental health services.
- 2.2.4 In February 2015 following an episode of self-harm Mr O came under the care of the Intensive Support Team of Avon and Wiltshire Mental Health Partnership Trust (AWP) where he was living at that time with his girlfriend and her family. During this period of NHS care he disclosed violent fantasies of murdering women and raping them. On 20<sup>th</sup> March 2015 he reported specific thoughts of killing and raping his girlfriend's sister, and made a threat to kill an AWP Community Psychiatric Nurse. He was detained by police under Section 136 of the Mental Health Act, but following a Mental Health Act assessment he was determined not to be suffering from a mental disorder. Given the risk he posed he was immediately arrested for threats to kill and remanded in custody at HMP Bristol.
- 2.2.5 During March and April 2015 he remained in HMP Bristol. Some assessment work was carried out by the mental health prison in-reach service which was delivered by a group of health organisations including AWP; however due to his short stay no active treatment was commenced.
- 2.2.6 Having pleaded guilty to two threats to kill, in early May 2015 as a condition of bail, Mr O returned to his parents' home to await sentencing from Bristol Crown Court. Within two weeks he had called the police to request that he be sectioned under the Mental Health Act, had engaged in self harm which required his treatment at Accident and Emergency, and was re-referred to HPFT. He was initially seen by the crisis team, and referred to the Acute Day Treatment Unit. From there he was transferred to the care of the community team.
- 2.2.7 In mid-June 2015 Mr O was admitted to the Royal London Hospital after having self-harmed; his injuries were so serious that they warranted surgery and were life-threatening. He was then referred for inpatient care on Swift Ward at HPFT, and after three weeks he was discharged to community support.
- 2.2.8 At the end of July 2015 police were informed that Mr O had made a threat to kill his girlfriend's brother and, after threats and suicide attempts at the beginning of August, Mr O was readmitted to Swift ward. During his following 8 weeks in hospital there were concerns raised about sexual relationships with vulnerable female patients on the ward, such that he was moved to an all-male ward. Case

notes suggest he posed a significant challenge to safe ward management, for example by setting fire to items in the garden area of the ward.

- 2.2.9 While he was under the care of community services prior to his August admission an assessment was requested from the Trust's Forensic services and this was carried out in early August by the consultant forensic psychiatrist FCP1.
- 2.2.10 Swift ward consultant CP1 and the forensic consultant FCP1 agreed that Mr O needed a detailed and comprehensive forensic assessment in a more structured environment, and that it might be possible to apply a Section 38 Interim Hospital Order when his case came to Bristol Crown Court. FCP1 therefore wrote to Bristol Crown Court suggesting this. No response was received. CP1 also recommended that Mr O be held under Section 3 of the Mental Health Act pending his attending court.
- 2.2.11 When he insisted he was going to leave the ward on 10<sup>th</sup> August, Mr O was held under Section 5 (2) of the Mental Health Act (MHA). This section allows a person who is currently an informal patient on a ward and who expresses the intention to leave to be held for up to 72 hours for a further assessment if clinicians believe they may pose a risk to themselves or others. On 11<sup>th</sup> August due to his behaviour Mr O was moved to Owl Ward within HPFT, an all-male ward with access and exit controlled, under the care of the ward consultant CP2.
- 2.2.12 A Mental Health Act Assessment was carried out on 12<sup>th</sup> August by two consultants and an Approved Mental Health Practitioner. In that assessment Mr O confirmed that he would stay on Owl Ward voluntarily, and be bound by a behavioural contract. In the light of the Mental Health Act guidance on using the least restrictive care setting possible, and on the basis that Mr O had agreed to stay voluntarily, the assessing team agreed Mr O did not require to be detained under the Mental Health Act at that time.
- 2.2.13 The Mental Health Act Assessment was carried out thoroughly, and reached its conclusion in the context of the information the assessors had at that point in time. The assessing team were aware of the view of CP1 that Mr O should be held under Section 3 of the Mental Health Act, and of FCP1's proposal that the Court should direct an Interim Hospital Order, although FCP1's report was not completed so it was unavailable to the assessing team. These views were not reflected in the outcome of the assessment.
- 2.2.14 Following the assessment, CP1 met CP2 to discuss their different views on detaining Mr O, but did not reach a shared view. CP2 and FCP1 reviewed Mr O's care and, on an understanding that Mr O was responding to strict boundaries and compliant with his treatment plan, they reached a view that the risk of him actually carrying out the threats to kill and rape were low and an Interim Hospital Order was not required.
- 2.2.15 Mr O remained on Owl ward for 6 weeks, and showed similar challenging behaviours to those he had shown on Swift Ward. In this period of his care there

was no evidence of a clear assessment of Mr O's risks, or a comprehensive, coherent care plan, leading to the delivery of a consistent care package. During his time on Owl Ward Mr O broke his behavioural contract, and may have broken his bail conditions as well. Routes were open to action under the Mental Health Act or the legal system, but these were not taken. This was arguably a missed opportunity for moving to a more structured environment where a more detailed assessment could have been undertaken.

2.2.16 As is noted above, FCP1 wrote to Bristol Crown Court on 10<sup>th</sup> August suggesting that the Court make an Interim Hospital Order and Mr O be admitted to a Low Secure forensic ward. There is no record of the receipt of this letter or any response from the Court to it. In addition to the letter sent to the court by FCP1, two court reports were requested. One was provided by CP2, Mr O's consultant on Owl Ward at that time, the other by an independent consultant psychiatrist.

2.2.17 The independent psychiatrist took the view that Mr O did not suffer from a mental disorder that would make detention under the Mental Health Act appropriate. However, he considered that Mr O presented a significant risk of harm to himself, and that his level of risk fluctuated and would depend on situational factors. He felt it was almost impossible to give a reliable comment on the risk Mr O posed to others, due to limited information about him, but he was seriously concerned about his threats to kill.

2.2.18 He concluded that it was unlikely that any psychiatric treatment would alter Mr O's risk profile in the short to medium term, and that risk management should therefore rely on the criminal justice system and Probation services.

2.2.19 CP2 who wrote the second court report considered that Mr O's greatest risk related to himself; he had made several impulsive but very dangerous suicide attempts and remained at high risk. He did not believe it was ever Mr O's intent to kill anybody, nor did he think he was ever likely to do so in the future. CP2 said that Mr O did not need ongoing hospital treatment, although might need brief admissions in times of crises, and suggested the Court direct a Mental Health Treatment Requirement (MHTR).

2.2.20 Three experienced senior consultants had reached different conclusions. This reflected the difficulties for experienced professionals to develop a coherent formulation of the challenges Mr O presented; how to assess his risk, and develop a coherent care plan to meet his needs with integrated risk management.

2.2.21 In September 2015 Mr O went on leave, to be supported by Community Mental Health Services. There was some confusion after he went on leave about whether and when he was due to return to hospital. On 2<sup>nd</sup> October Mr O was formally discharged from the Ward, and he saw his care coordinator on a routine basis. The lack of clarity about risk or plans to minimise risk may have left community staff vulnerable.

- 2.2.22 Having pleaded guilty of making two threats to kill in April, on 2<sup>nd</sup> December at Bristol Crown Court Mr O was sentenced to a Rehabilitation Activity Requirement and a MHTR, with a 9 month prison sentence suspended for two years.
- 2.2.23 A Probation Officer was appointed and completed the sentence plan with Mr O two days after the court hearing. However, this was not agreed or shared with Mr O's Community Psychiatrist or CPN, who were part of the HPFT community team, as the guidance indicates. There was an email exchange between the Probation Officer and the CPN on 14<sup>th</sup> December, the Community Psychiatric Nurse (CPN) reported that Mr O was settled and motivated, with no known current risks or concerns. This was the only contact between them before the homicide. There was no contact between the Probation Officer and the Community Psychiatrist CP3.
- 2.2.24 The imposition of a MHTR offered a final opportunity to create a single, comprehensive care plan including therapy input, and a fresh review of risk. However, there was no meeting to make a risk assessment or develop a coherent multi-agency plan.
- 2.2.25 In mid-December Mr O saw his GP for repeat medication, his final contact with a member of NHS staff prior to the homicide. At that point his mental state did not give cause for concern and the GP did not judge Mr O to present a threat.
- 2.2.26 On 23<sup>rd</sup> December Mr O met Ms M, with who he had been in contact through an internet dating site, and she was found dead on 24<sup>th</sup> December 2015.

## **2.3 Risk assessment, prediction and management**

- 2.3.1 Risk assessment should always involve a thorough, up-to-date, comprehensive assessment of all the factors associated with the prediction of risk, and the consequences for the patient and other people. It should include information about the likely causes of risk; the triggers for risky behaviour, and information about the potential impact. The factors which are typically associated with risk include diagnosis, past behaviour, substance misuse, thoughts, intentions and/or mood.
- 2.3.2 Mr O's diagnosis of Emotionally Unstable Personality Disorder is associated with a 10% risk of death by suicide and Mr O's history was characterised by a pattern of significant self-harm. He threatened suicide several times and this is noted in the reports for the Court. The notes also record that Mr O had behaved in a threatening way towards vulnerable young women, one reason he had been moved to an all-male ward whilst he was under the care of HPFT. However, whilst HPFT completed risk screening assessment forms regularly for Mr O whilst he was in their care, the forms do not include explanations for the ratings of risk that were given and the plans for his care do not contain a clear statement about how risks could be mitigated.

2.3.3 Care Plans should always contain a comprehensive, integrated risk management/reduction plan. However, there is only limited evidence that action was taken to actively manage or minimise the risk that Mr O presented. Whilst there is one comment in the notes advising that he should be seen by two members of staff and never by an unaccompanied female, the notes do not contain a formulation of Mr O's problems or a statement of causes, triggers or possible impacts of risk. Furthermore, he did not have a final, agreed care plan when he was discharged from Owl Ward that was coordinated between the NHS and other agencies.

2.3.4 Exact predictions of risks for individuals are very difficult; for example, over a 10 year period, 3% of people with a mental health problem who have made threats to kill will go on to commit a homicide. Furthermore, such tragic events are statistically very rare. We cannot say with any confidence that the tragic death of Ms M could have been prevented. However, we can say that there were shortcomings in the way that Mr O's level of risk was assessed and managed.

## **2.4 Communication, within the NHS and between agencies**

2.4.1 During our interviews and in the HPFT internal report it was clear that HPFT lack of information about Mr O's previous care was considered to have been one of the critical factors hindering appropriate risk assessment and management. There were three potential sources of information that might have been available to HPFT: AWP, the prison and Mr O's GP.

2.4.2 AWP considered that Mr O's episode of care from the Trust ended when he was detained by police, and they acted in a reasonable and timely manner in that within days of his discharge a comprehensive report was sent to Mr O's GP. Whilst Mr O was in prison the in-reach team carried out an assessment, but during his short stay no treatment plan was created, and on his release, there was no communication from the in-reach team to his GP.

2.4.3 GPs can act as a central point of communication about NHS patient care. However, when Mr O returned to Hertfordshire and presented once again to secondary care mental health services, the discharge report from AWP to the GP was not shared with HPFT even though the Trust routinely sent updates on his care to the GP. Mr O was consistently reluctant to share information about his previous episodes of care, but HPFT did not contact AWP directly, as policies suggest should have happened.

2.4.4 The lack of a single, coherent overall view of Mr O's history and care created a gap at the heart of care planning and risk assessment. It also hampered inter agency working.

## **2.5 A Talking therapy/Personality Disorder pathway.**

2.5.1 Mr O made multiple requests for some type of talking therapy and the notes show that similar requests were made by those caring for him, in AWP and in HPFT. Medium to long term talking therapies are the treatment of choice for people with a personality disorder, although commitment and engagement by the patient is needed, and the evidence for their effectiveness is only moderate. No structured and ongoing talking therapy was ever delivered to Mr O during the period of his care with either AWP or HPFT.

## **2.6 Alcohol/substance abuse**

2.6.1 Like the requests for talking therapy, references to the misuse of alcohol and illegal drugs appear in the clinical notes and police records, but Mr O's drug use does not seem to have been fully assessed. Considering that Mr O was noted to be impulsive and changeable, a full assessment of his alcohol and/or drug use would have supported the understanding of the challenges he posed.

## **3. Conclusions and recommendations**

- 3.1 This is a report of a comprehensive investigation into the NHS care provided to Mr O prior to the tragic death of Ms M at his hand in December 2015. The work was undertaken alongside a multi-agency review by Hertfordshire Partnership University NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, the National Probation Service, Avon and Somerset Constabulary, and the Hertfordshire Constabulary.
- 3.2 The complexity of the challenge that Mr O presented, coupled with the relatively low probability in statistical terms that his threats would be followed through, made it difficult for those assessing him. On a number of occasions senior clinicians had different opinions about the level of risk he presented.
- 3.3 Whilst disagreement among professionals is not unusual, especially in such complex cases, it is essential that there is a mechanism to solicit expert opinion and discuss the implications within the multi-disciplinary team. In this way, a consensus can be reached about the steps that should be taken to mitigate risk and how to deliver care safely and effectively. Recommendations relating to this can be found in Section 4.4.2
- 3.4 The investigation team considered all the information gathered in the course of the review. While statistically people who self harm or threaten to kill pose a risk to themselves or to others there was no way for staff from any agency to determine whether Mr O was one of the 97% of people who only make threats or one of the 3% who carry threats through. Three experienced clinicians reached different views on the best course of treatment for Mr O, and the clinical records show that neither incarceration in Prison nor being held on a hospital ward with controlled access had an impact on Mr O's behaviour. We conclude therefore that the tragic death of Ms M could not have been predicted with the degree of certainty that would have made it possible to prevent.

## **4. Recommendations**

In considering recommendations arising from the NHS care delivered to Mr O we have focussed on HPFT, they delivered the care of longest duration to Mr O, and he was in their care at the time of the homicide. There are no recommendations for the other NHS providers.

#### 4.1 Risk assessment and management

We recommend that in the light of this report within 6 months current practice in HPFT for assessing risk be thoroughly reviewed and in the light of that a plan developed. Over the following 12 months training in risk assessment should be refreshed in line with current best practice and evidence concerning the most effective way to support staff to deliver a high standard of care.

	<p>We consider that areas requiring strengthening include:</p> <ul style="list-style-type: none"> <li>• Taking a multifactorial history and case formulation</li> <li>• Risk assessment and risk reduction planning</li> <li>• How to integrate risk assessment and reduction as part of the overall Care Plan</li> <li>• Strengthening the audit process to assure the quality of risk assessment and care planning</li> <li>• Strengthening systems to ensure the multidisciplinary review of complex cases</li> <li>• Full implementation of the personality disorder care pathway</li> </ul>
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#### 4.2 Communication

We recommend that in the next 6 months the in service training programme is reviewed, alongside staff access to HPFT policy documentation, to ensure that HPFT relevant policies relating to inter-agency communication are implemented fully such that:

	<ul style="list-style-type: none"> <li>• Staff are aware of the relevant policy documents and existing national guidance and are enabled to use them at critical points in care.</li> <li>• Staff are aware of and understand issues relating to patient confidentiality, and when it can (or must) be breached.</li> <li>• There has already been a strengthening of capacity and increased awareness within HPFT of systems to gather information about individuals from other NHS organisations or agencies. This needs to be shared more widely across HPFT.</li> <li>• In conjunction with primary care HPFT develops a standard information sharing protocol with GPs.</li> </ul>
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#### 4.3 Mental Health Treatment Requirement training

We recommend that in the next 6 months changes be made to the in service training programme so all staff are made aware of the use of Mental Health Treatment Requirements (MHTR) that may be applied by the Court and, given that MHTRs are not used frequently:

	<ul style="list-style-type: none"> <li>• Over the next year HPFT and probation services develop resources and expertise to support staff when an MHTR is applied, and review the use of current guidance.</li> <li>• Ensure that when an MHTR is applied by a Court HPFT supports</li> </ul>
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	<p>Probation services to draw together the immediate staff involved so they can develop a shared understanding of their roles and responsibilities in meeting requirements of the joint protocol.</p>
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**4.4 Discharge process**

We recommend that HPFT further strengthens its practice in relation to patient discharge to build on and extend good practice extant in HPFT to:

	<ul style="list-style-type: none"> <li>• Ensure discharge meetings always occur</li> <li>• Ensure there is a full discharge CPA</li> <li>• Ensure a crisis team discharge to community team does not normally occur without a meeting with the care coordinator present</li> <li>• HPFT has focused on delivering 72 hour follow up, which is a higher standard than the national requirement of follow up at 7 days. We commend this and would urge continued support for 72 hour follow up.</li> </ul>
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