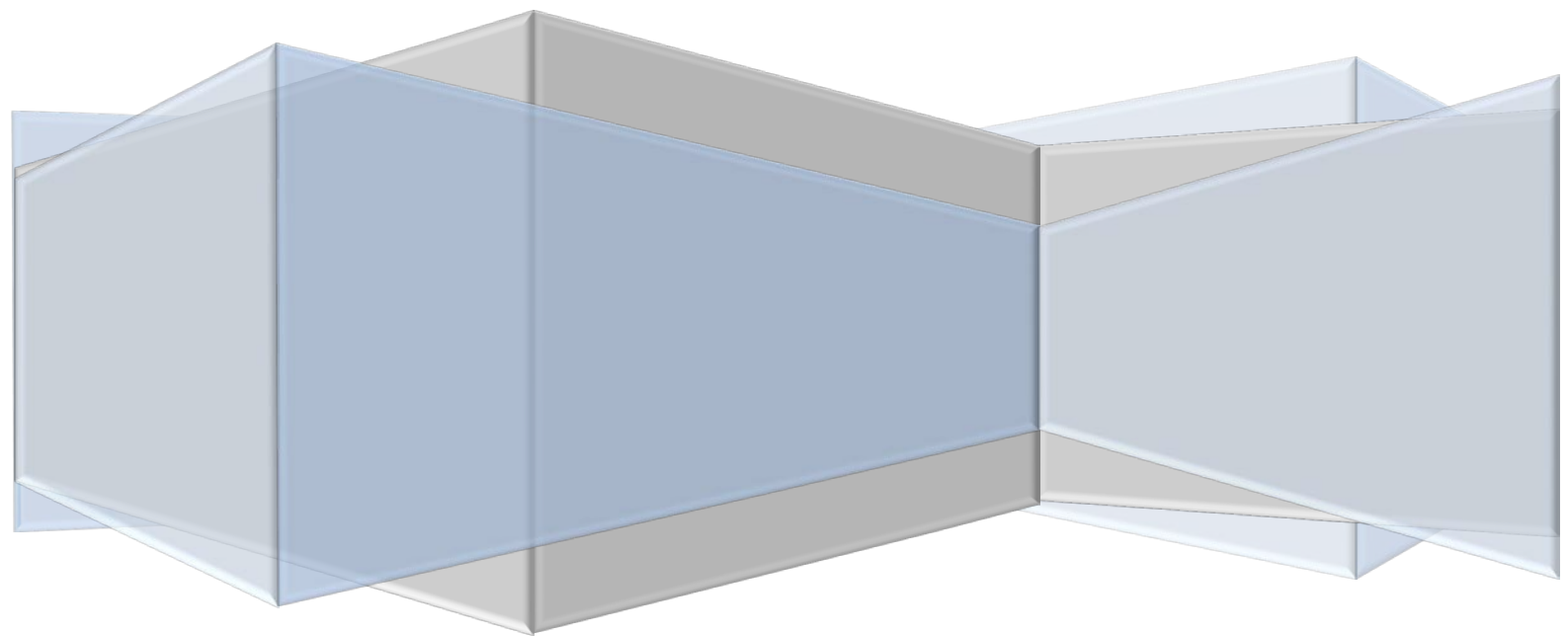




An independent investigation into the care and treatment of a mental health service user (Mr W)



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Acknowledgements to the family of Ian Dollery.¹

Caring Solutions would like to offer their deepest sympathies to the family of Ian Dollery. It is our sincere wish that this report does not contribute further to their pain and distress.

Caring Solutions also wish to thank Mr W for agreeing to meet with their investigation team. His contribution has been of great assistance in enabling an understanding of the events that led up to the incident in June 2015.

Acknowledgement of participants:

Caring Solutions' investigation team would like to acknowledge the contribution and support given by staff from Lancashire Care Foundation NHS Trust, Lancashire County Council, Lancashire Constabulary and Change, Grow, Live² during the course of this investigation. Their assistance has provided the investigation team with a comprehensive understanding of the pertinent issues in this case.

¹ Ian Dollery's family have requested that his full name is used in this investigation

² Change, Grow, Live [CGL](#)

1 Executive summary

1.1. Incident

- At approximately 23:00 on 18 June 2015 Mr W was witnessed repeatedly stabbing Ian Dollery³. The incident occurred in the garage of the Dollery home. Mr W was later arrested by the police in the locality of Ian Dollery's house. On his arrest Mr W was assessed and detained under Section 2 of the Mental Health Act 1983⁴ and was subsequently admitted to Ashworth Hospital⁵. His urine drug screen tested positive for cocaine, amphetamines⁶, methamphetamine⁷, morphine, cannabis and MDMA (ecstasy).⁸ At Ashworth Hospital Mr W was placed on a Section 3 of the Mental Health Act 1983⁹.
- Mr W and Ian Dollery were not known to each other. On 18 July 2016 Mr W was found guilty of the murder and sentenced to 23 years in prison.
- During Mr W's assessments at Ashworth Hospital he was given the following mental health diagnoses:

Paranoid Schizophrenia International Classification of Mental and Behavioural Disorders (ICD F20.0)¹⁰
Antisocial or Dissocial Personality Disorder (ICD F60.2)¹¹.

1.2. Involvement of Mr W and both families in Caring Solutions' investigation:

- Throughout their investigation Caring Solutions' investigation team have, on a number of occasions, met with Ian Dollery's wife and one of his daughters. They also met with Mr W. Mr W's mother declined to be involved in the investigation.

³ Mr Dollery's wife has requested that we use her husband's full name in this report

⁴ [Section 2 Mental Health Act](#)

⁵ [Ashworth Secure Hospital](#)

⁶ [Amphetamines](#)

⁷ [Methamphetamine](#)

⁸ Information taken from psychiatrist report 19 May 2016

⁹ [Section 3 Mental Health Act](#)

¹⁰ [ICD](#)

¹¹ [Antisocial Personality Disorder](#)

1.3. Involvement of Lancashire Care NHS Foundation Trust's community mental health service

- Mr W first came to the attention of mental health services on 28 August 1986, when he was admitted to a local hospital following an overdose. Mr W then had sporadic short-term contact with Lancashire Care NHS Foundation Trust's (LCFT) community mental health team (CMHT).
- During a CMHT assessment (12 February 2013) Mr W reported that he had for the last 20 to 30 years been experiencing auditory and visual hallucinations. He also disclosed that he was using legal and illegal substances to "manage his voices... and was imagining violence all the time [including] stabbing people."¹²
- Following this assessment a summary letter that was sent to Mr W's GP noted that:

"[Mr W's] problems are mainly [related] to an inability to control his anger, constantly fantasising and having thoughts of violence which he feels he is prone to act on when he is under the influence of alcohol ... I did not find convincing evidence of hallucinations"¹³.

- A safety profile in 2014 assessed that Mr W's risks were:

"Suicide, self-injury and neglect: assessed as low
Harm to others, and substances: assessed as being medium"¹⁴.

- The 'safeguarding' section documented that Mr W was:

"Deemed to pose a risk to children
Known Schedule One Offences
Significant allegations made of abuse or neglect of children/young people
Incidents of domestic violence"¹⁵.

- CMHT's assessments concluded that Mr W's mental health diagnoses were:

Mental and Behavioural Disorders, due to the use of opioids
Mental and Behavioural Disorders, due to the use of alcohol

¹² Referral, 4 August 2014, p1

¹³ Letter to GP, 9 October 2014

¹⁴ Safety profile, 7 July 2014, p3

¹⁵ Safety profile, 7 July 2014, p3

Possible Co-Morbid Psychosis (Not Otherwise Specified)¹⁶.

- Mr W was referred to CMHT on a number of occasions but did not attend (DNA'd) either the initial assessment or subsequent appointments.
- The last contact with the CMHT was a telephone conversation on 10 November 2014, when he agreed to attend his outpatient appointment. He DNA'd this appointment.
- At the time of the incident, Mr W was not in receipt of mental health services, having been discharged from the CMHT on 11 February 2015 after failing to attend two review appointments.

1.4. Primary care

- From 1999 to 2009 Mr W was repeatedly presenting to both his GP and Accident and Emergency departments with various knife wounds, which he had sustained in physical fights, infections and deep vein thrombosis (DVT), which were the result of his ongoing intravenous drug use. Mr W was last seen by his primary care service on 17 September 2014, when a mental health review was undertaken. He was issued with prescriptions for the antidepressant Mirtazapine¹⁷ 30mg, and Naproxen¹⁸ for pain relief from an ongoing shoulder injury.

1.5. Substance misuse services' involvement

- In July 2013, due to the retendering of substance misuse services by Lancashire County Council, Mr W's treatment was transferred to the Change, Grow, Live (CGL) service Inspire¹⁹. Mr W's treatment programme involved a combination of pharmacological and psychosocial support. He was also given access to groups, one-to-one sessions with a key worker, medical reviews and a needle exchange programme.
- A Substance Use Risk Assessment was completed on 17 February 2015, which documented that Mr W had disclosed that:

“He [felt that] his mental health is a danger ... Risk of violence and harm to others is not limited to intoxication and he is capable of violence when sober or intoxicated”²⁰.

¹⁶ Letter to GP, 9 October 2014

¹⁷ [Mirtazapine](#)

¹⁸ [Naproxen](#)

¹⁹ Change, Grow, Live [CGL](#)

²⁰ Inspire Substance Use Comprehensive Risk Assessment, 17 February 2015

- Mr W's last contact with Inspire was on 17 June 2015, when he reported that his heroin consumption had increased to two bags a day and he was using crack cocaine "occasionally"²¹. At this review Mr W requested that his methadone prescription be reduced from 25ml by 1ml a week.

1.6. Forensic history

- At the time of Mr W's arrest he had 50 prior convictions for 102 offences. His convictions included possession of an offensive weapon and illegal substances, public order offences, and Section 47 assault²². He received sentences that included both probation orders and imprisonment. Two of Mr W's relationships involved incidents of domestic violence and during his last relationship there were 37 entries on the police's Protecting Vulnerable People database. Mr W had two criminal convictions for domestic violence. At the time of the incident Mr W was not in contact with the criminal justice system, last criminal conviction was on 5 December 2011.

1.7. Mr W's housing history

- From the point Mr W was released from his last prison sentence (7 December 2013) to the incident, he was homeless. In a letter (16 April 2013) to Mr W's GP, the CMHT consultant psychiatrist reported that "because of [Mr W's] past history he is now considered unhousable"²³.

Findings and recommendations

1.8. Mental health assessments and diagnosis

- In Caring Solutions' comprehensive review of Mr W's medical notes, it was evident that since his first presentation, in the 1990s, to mental health services, he was sporadically disclosing that he was experiencing psychotic symptoms. These included auditory and visual hallucinations, paranoid ideation, delusional beliefs, ideas of reference²⁴, and thought broadcasting²⁵, and at times it was observed that he was presenting with incongruent emotions²⁶. There was only one occasion, in 1995, when Mr W was prescribed the antipsychotic medication Chlorpromazine²⁷. At other times he was prescribed antidepressant medication.

²¹ Letter to GP, 14 January 2015

²² Section 47 Assault Actual Bodily Harm

²³ Letter to GP, 16 April 2013

²⁴ People talking about him

²⁵ Thought broadcasting is the belief that others can hear or are aware of an individual's thoughts

²⁶ A person's response does not match circumstances/situation

²⁷ Chlorpromazine antipsychotic medication [Chlorpromazine](#)

It is unclear, however, how compliant Mr W was with his prescribed medications.

- Mr W's continued substance misuse and sporadic contact with both LCFT and the substance misuse services and his inconsistencies in his self-reported accounts of his mental health symptoms and substance misuse all contributed to the difficulties that the various CMHT clinicians had in confirming a definitive mental health diagnosis. This also resulted in Mr W's risk assessments, treatment and care plans often being based on inaccurate information.
- Mr W also appeared to be largely unwilling and/or unable to consistently engage with either the CMHT or substance misuse services and he would usually disengage after the initial assessment appointment. Therefore, there was little opportunity for CMHT clinicians to undertake a comprehensive longitudinal assessment that could have informed the various mental health formulations, risk assessments, care and treatment plans.

1.9. Interagency communication

- On 28 February 2013, Mr W's care coordinator requested a Police National Computer (PNC) database check, which reported Mr W's extensive criminal history. There were also two occasions in July 2014²⁸ when CMHT's consultant psychiatrist discussed with the care coordinator the need to liaise with CGL Inspire in order to obtain information regarding their involvement with Mr W. The evidence indicates that this did not occur.
- Correspondence from both CGL Inspire and LCFT's CMHT were only sent to Mr W's GP. This lack of information sharing was of concern for Caring Solutions' investigation team for a number of reasons:
 - All agencies' risk assessments and care and treatment plans were being based on partial information provided solely by Mr W.
 - Staff from all involved agencies did not have sufficient knowledge of Mr W's risk profile to adequately protect themselves and to develop a safe working plan.
 - CMHT were not aware of Mr W's erratic compliance with his methadone prescriptions and therefore they were unable to assess the impact that this may have had on his mental health.
- The evidence also clearly indicated that all of the involved services were operating in isolation. There was no information sharing and this enabled Mr W to provide, at times, conflicting information about both his historic and his current situation without being challenged.
- It was reported by CGL to Caring Solutions' investigation team that there was and still is an absence of any substantive interagency protocols and that this

²⁸ 7 July and 21 July 2014

has resulted in practitioners often being reliant on local arrangements and relationships.

- Caring Solutions' investigation team would recommend that until such a protocol is developed, all agencies should, within the data protection guidelines, be copying their correspondence to all the involved services in order to establish and facilitate a culture of interagency information sharing.
- Patients should also be asked to give their consent for this to occur; if they refuse, then consideration should be given to the suitability and safety of the service provision to that patient.

1.10. Dual diagnosis (co-existing mental health and substance misuse problems)

- Dual diagnosis covers a broad spectrum of mental health and substance misuse problems that an individual might be concurrently experiencing. The nature of the relationship between these two conditions is complex.²⁹ Research has indicated that 30-50% of people with severe mental illness have co-existing substance misuse problems and that over 70% of people in contact with substance misuse services have co-existing mental health problems.³⁰
- It is recognised that one of the risks for patients, such as Mr W, with dual diagnosis is that “their co-existing problem(s) are often not detected or [are] overlooked and that this can result in misdiagnosis and inappropriate treatment”³¹.
- It has been suggested³² that one of the fundamental issues is that:
 - Substance misuse services often have limited expertise to work with people with more complex dual-diagnosis presentations and/or there is a general lack of attention given to a patient’s mental health issues.
 - Secondary mental health services often lack the skills for supporting patients with a dual diagnosis and do not have the knowledge and awareness of local substance misuse services.

These deficits can adversely affect the treatment outcomes for patients, such as Mr W, in both their engagement with the involved services and their recovery outcomes.

²⁹ For example, the destabilising and detrimental effects that substances can have on a patient’s mental health or on the medication they are being prescribed for their mental health symptoms, as well as the possibility that a patient may be self-medicating with substances, and therefore their underlying mental health symptoms may be obscured or exacerbated.

³⁰ Weaver, T., Charles, V., Madden, P. & Renton, A. (2002) Co-morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC): A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations. Department of Health/National Treatment Agency, London [Co morbidity](#)

³¹ [Mental health policy implementation guide: Dual diagnosis good practice guide](#)

³² [Mental health policy implementation guide: Dual diagnosis good practice guide](#)

- LCFT's Dual Diagnosis Partnership Protocol, which was in place at the time and is still in place³³, states its commitment to delivering:

“The optimum level of care for these Service Users ... The application of a 3 stage approach will require all clinical staff to consider the Service User’s needs at each step, ask pertinent questions of their own agency’s capability to respond independently to the needs of this Service User group and ultimately promote integration of all key partners where necessary.”³⁴

- Caring Solutions’ investigation team were unable to find any documented evidence of, or references to, the implementation of any of these three stages by the CMHT’s practitioners.

1.11. LCFT’s risk assessments

- In their review of the assessments undertaken, Caring Solutions’ investigation team have highlighted a number of deficits in the content within all three of Mr W’s safety profiles that were completed by the CMHT service. All the assessments failed to adequately identify the full extent of Mr W’s past and possible future risks of harm to himself and others. In all three safety profiles the assessor noted that information was not obtained from any other sources apart from Mr W.
- LCFT’s Clinical Risk Policy directs that:

“Effective communication and sharing information within the mental health team, with other relevant practitioners (including General Practitioners) and between agencies is essential”³⁵.

- In the opinion of Caring Solutions’ investigation team, in order to have continually and effectively assessed Mr W’s risks of relapse, in his substance misuse and his mental health symptoms as well as his potential risk of reoffending, the assessors should have proactively sought the involvement of and obtained risk information from all services involved.
- Given the fundamental deficits identified within LCFT’s current safety profile pro forma, Caring Solutions’ investigation team recommends that a complete revision of this document is undertaken by LCFT.
- It was reported to Caring Solutions’ investigation team that since this incident, there have been a number of improvements within LCFT’s CMHT service:

³³ Protocol due to be reviewed October 2017

³⁴ LCFT’s Dual Diagnosis Partnership Protocol, p5

³⁵ LCFT Clinical Risk Management policy, January 2012, p6

- There are weekly meetings with LCFT's forensic service where patients who have significant forensic histories are discussed.
- Where required the forensic service will support the CMHT to develop risk management plans and they will undertake forensic risk assessments, such as HCR-20 assessments³⁶.
- Additionally the CMHT deputy manager is now the link person whose role it is to develop working relationships with external agencies and who is the point of contact when there are concerns about a particular patient.

1.12. Care planning and support

- It was evident that Mr W's interaction with both CGL Inspire and the CMHT was generally precipitated by him wanting either practical support with his benefits, housing, or help to get his methadone prescription reinstated.
- From 4 March 2013 to 18 July 2013, three care plans were completed by LCFT's CMHT. Caring Solutions' investigation team reviewed Mr W's care plans with reference to the LCFT Care Programme Approach Policy (July 2013) that was in place at the time. The policy emphasised that the:

“Two central components of the CPA are the role of the care co-ordinator who has overall responsibility for the coordination of the assessment and care planning processes in partnership with the Service User and Carer, and multidisciplinary team working.”³⁷

- Despite this directive that care plans and subsequent reviews should be collaborative with both the patient and other involved practitioners, there was no evidence that the CGL Inspire service or Mr W's GP were asked to contribute. Caring Solutions' investigation team also assessed that Mr W's care plans were minimal in both their content and in identifying what action(s) needed to be taken to support Mr W.

1.13. Safeguarding

- In October 2013 LCFT's Health and Safety Assessment (H&SNA)³⁸ documented the dates of birth of Mr W's two youngest children and the fact that both children were on the Child Protection Register. Mr W also disclosed in a CGL Inspire review that he still had access to his youngest child. LCFT's safeguarding policy identifies that:

³⁶ [HCR20 – Risk Assessment Tool](#)

³⁷ LCFT Care Planning Approach Policy, July 2013, pp5 & 9

³⁸ 9 October 2013

“The support and protection of children cannot be achieved by a single agency. Every Service has to play its part and all staff must have placed upon them the clear expectation that their primary responsibility is to the child and his or her family (Lord Laming 2003) ... [All staff] must be alert to the potential indicators of abuse or neglect for children and adults at risk and know how to act on those concerns in line with local guidance.”³⁹

- If there had, at the time, been a culture of interagency communication and information sharing within both secondary and third sectors, the potential risk to Mr W’s youngest child could have been shared and the appropriate action taken. Additionally, in light of the knowledge of Mr W’s history of domestic violence and the previous child protection concerns, consideration could also have been given to referring the case to the local Multi-Agency Safeguarding Hub (MASH)⁴⁰. MASH would then have been able to compile further intelligence from a wider range of sources, which would have enabled consideration to be given to the future risks to Mr W’s youngest child.

1.14. Housing

- The correlation between inadequate housing, unstable tenancies, homelessness and mental health is well recognised. It is reported that people who are homeless have 40-50 times higher rates of mental health problems than the general population and that they are one of the most disadvantaged and excluded groups in our society⁴¹.
- It was reported by Mr W’s CMHT care coordinator that Mr W had disclosed that his lack of affordable accommodation was, in part, preventing his recovery, as he was associating with his peers who were misusing substances and therefore it was difficult for him to reduce his own substance use. Apart from one occasion (27 February 2013), there was little evidence that Mr W’s housing difficulties were being addressed by his various CMHT care coordinators.
- Caring Solutions’ investigation team would suggest that housing must always be a priority focus for all the CMHT care coordinators, and they should always be making strenuous efforts to support patients, such as Mr W, to obtain and maintain affordable and secure housing.

³⁹ LCFT Safeguarding and Protecting Children and Adults Policy 2015, p13

⁴⁰ The primary purpose of Lancashire, Blackpool and Blackburn with Darwen’s Multi-Agency Safeguarding Hub (MASH) is to improve the timeliness and quality of information sharing and decision-making between agencies when a referral is made to the police and/or local authority due to concerns about the welfare of an adult or child. The aim is to reduce potential risk of harm to children, young people and adults and to ensure appropriate and coordinated services are offered. This could either be through prompt progression to a safeguarding assessment by the local authority or referral to support services.

⁴¹ [Department of Health, “No health without mental health: a cross-government mental health outcomes strategy for people of all ages”, February 2011](#)

1.15. Methadone collection

- Caring Solutions' investigation team undertook an audit of Mr W's methadone collections from the community pharmacists. From 18 August 2014 to the date of the incident, there were 186 methadone collections due, of which Mr W missed 56 collections. It was noticeable that 27 October 2014 to 20 January 2015 was the most chaotic period, with Mr W failing to collect 50% of his methadone prescriptions. There was no agency involved in Mr W's care who was undertaking an ongoing analysis of Mr W's methadone collections.
- Caring Solutions' investigation team noted that there appeared to be no consistency as to when the dispensing community pharmacists contacted CGL Inspire to alert them to the fact that Mr W had failed to make his collections.
- Caring Solutions' investigation team would recommend that the pharmacists' web-based electronic system PharmOutcomes develops a facility that immediately notifies a local authority and/or the prescribing agencies of any methadone collections missed by a patient.
- Additionally, Caring Solutions' investigation team suggests that regular shared care meetings should be convened with representatives from prescribing agencies, primary and secondary services, and community pharmacies. This would provide a regular forum not only to monitor and evaluate performance, but to resolve contractual issues; review the shared care provision; and monitor serious critical incidents, near misses and complaints relating to shared care services that are being investigated by the respective agencies.

1.16. LCFT's internal report (SIR) and action plan

- LCFT's internal post-incident review was approved by the Network and Medical Directors on 23 December 2015. The investigation concluded that:

"The root cause of the incident was an acute episode of paranoid psychosis brought on by what police described as a three day drugs binge ... A second root cause is that none of the Service User's associates who had witnessed and were concerned about his behaviour sought help for the Service User or raised the alarm."⁴²

- The SIR made seven recommendations. Caring Solutions' investigation team were provided with evidence that any actions that had not already been completed (March 2017) were currently embedded within the 2017/18 audit cycles. Caring Solutions' investigation team concluded that based on the evidence that was available, LCFT's SIR satisfied the SIR's key lines of

⁴² LCFT's SIR, p3

enquiry, and that their recommendations and the revised action plan were proportionate and appropriate.

1.17. CGL's post-incident report

- CGL Inspire's project manager completed a Management Investigation Report (7 September 2015), which included a comprehensive chronology of the service's involvement with Mr W. Caring Solutions' investigation team were provided with evidence of CGL's action plan. It was reported that CGL did not share the findings of their report with LCFT. CGL's senior manager also reported that they had not been given the opportunity to comment on the issues highlighted within LCFT's SIR.
- Caring Solutions' investigation team reviewed the 'Recovery orientated substance misuse treatment services in North Lancashire service specification (2012-2013)'. It was noted that it did not make any direct reference to the expectation that providers should work in partnership with other involved sectors when a serious incident occurs. This omission has been highlighted to the commissioner of substance misuse services.

1.18. LCFT's previous investigations

- Caring Solution's investigation team accessed a number of other independent homicide reports where the perpetrator was, at the time of the incident, in receipt of LCFT's community mental health services. In three cases the victim was known to the perpetrator, and two also had significant substance misuse issues. There are a number of concerning similarities and deficits within both these cases and Mr W with regard to risk assessment and risks management and information sharing between agencies. All of which is indicating to Caring Solutions' investigation team that LCFT has not yet introduced robust enough processes to resolve these issues and improve practice.

1.19. Support provided by LCFT to the families

- Caring Solutions' investigation team were satisfied that LCFT met its Duty of Candour⁴³ in relation to the involvement and support of the Dollery family.
- LCFT's Associate Director of Quality Improvement and Experience is currently meeting with members of the Dollery family in order to capture their story and experiences in a format that is meaningful to them. The aim is that this will be utilised as a learning tool within LCFT.

⁴³ [Duty of Candour](#)

- It was reported that LCFT's SIR investigation team did not make contact with Mr W's family either post-incident to offer them support or during the SIR investigation. Caring Solutions' investigation team would suggest that this was a missed opportunity to provide support to this family, who clearly would also have been deeply affected by the incident. They could also have provided valuable insights into Mr W's care and treatment from LCFT's services that could have further informed the SIR.

1.20. Predictability⁴⁴ and preventability⁴⁵

Predictability

- While analysing the evidence obtained, Caring Solutions' investigation team have borne in mind the following definition of a homicide that is judged to have been predictable, which is one where "the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it"⁴⁶.
- Throughout his adult life Mr W was living in the chaotic world of homelessness, substance misuse and poverty and he was often funding his lifestyle through criminality and survival crimes. He also had a significant forensic history of serious crimes against property and persons. Additionally, in the months leading up to this incident, Mr W was self-reporting that he was continuing to misuse substances, and it is now unclear how compliant he was with his methadone programme. Mr W was also consistently refusing or was unable to engage with a recovery programme provided by either CGL Inspire or LCFT's CMHT services. Clearly all these factors indicated that Mr W was at high risk both to himself and, based on his forensic history, to others.
- Based on the analysis of the evidence presented, Caring Solutions' investigation team have concluded that it was highly predictable that Mr W would offend again at some point either to fund his very extensive substance misuse and his unstable mental health. Additionally given Mr W's history it was also highly predictable that he would be involved in violence towards others. However, what was not predictable was that Ian Dollery was going to be his victim. Tragically, and clearly of little comfort to his family, Ian Dollery just happened to be in his garage at the time when Mr W was walking past.

⁴⁴ [Predictability](#) is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.

⁴⁵ [Preventability](#) – to prevent means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.

⁴⁶ [Munro, E. & Rungay, J. "Role of risk assessment in reducing homicides by people with mental illness". The British Journal of Psychiatry \(2000\), 176: 116-120](#)

Preventability

- A preventable incident is one for which there are three essential ingredients present: the knowledge, legal means and opportunity to stop an incident from occurring.
- Given Mr W's history, his lifestyle and his ambivalence and resistance to engaging with services and treatment regimens, Caring Solutions' investigation team have concluded that it was unlikely that Mr W would have engaged in a recovery or harm-reduction programme. Caring Solutions' investigation team have concluded that the involved practitioners did not, on that day, have the means, knowledge or opportunity available to prevent this incident occurring. Therefore, it has been concluded that this incident was not preventable.

1.21. Concluding comments

Mr W was clearly a very vulnerable and unpredictable individual who was a significant risk to both himself and others. Caring Solutions' investigation team would suggest that this case has highlighted that LCFT's current CMHT pathway does not have the resources to manage this type of patient. Further consideration needs to be given by both the commissioners and LCFT to developing a service that can be more responsive to the needs of this complex and transient patient group. Caring Solutions' investigation team are aware that some of the findings of this report may be difficult for the Dollery family to accept, but it is hoped that the report's findings and recommendations will provide them with, at least, some answers to their questions.

Recommendation 1

Lancashire County Council, Local Pharmaceutical Council, NHS England and services involved in the provision of shared care services in the Lancashire area.

- The revised contract for the provision of substance misuse services should identify how patients' records are to be transferred to a new provider.
- Lancashire County Council should convene regular Shared Care meetings, with representation from prescribing agencies, primary and secondary health services and community pharmacies. These meetings should provide a forum to:
 - Monitor and evaluate performance of agencies against their Shared Care contracts.

- Highlight and resolve any commissioning, contractual and agency concerns.
 - Review any serious incidents, near misses and complaints.
 - Oversee joint serious incident investigations.
- The Local Pharmaceutical Council, substance misuse services, NHS England should consider undertaking a review to ascertain the value of making an adjustment to the PharmOutcomes system so that it notifies all the involved shared care services when a supervised consumption patient has missed a single methadone collection. This review should take place within six months.

Recommendation 2

Lancashire Health and Wellbeing Board, Lancashire County Council (Public Health), Lancashire Clinical Commissioning Groups, Lancashire Care NHS Foundation Trust and provider(s) of substance misuse, housing and judicial services.

Lancashire Health and Wellbeing Board should assume responsibility for the coordination of a forum to develop and implement a local dual-diagnosis protocol that provides:

- A coordinated and collaborative whole system integrated pathway to support individuals who misuse substances so that they have access to high-quality physical and mental healthcare, housing and employment.
- A senior strategic board that oversees and monitors the implementation of the dual-diagnosis protocol across all of the health and social care sectors.
- Clarity with regard to interagency information sharing and the management of risk, shared care arrangements, including care coordination.
- Biannual meetings with representatives from all involved sectors with the aim of developing robust interagency relationships, to share lessons learned from serious incidents and to proactively identify and manage interagency issues.

Recommendation 3

Lancashire Care NHS Foundation Trust.

Lancashire Care NHS Foundation Trust should consider developing a new risk assessment tool that includes both a risks management and crisis plans which involves both the patient and all other involved agencies.

2 Incident

- 2.1 On the evening of 18 June 2015, Ian Dollery, aged 51, went to the cinema with his wife, daughter and her boyfriend. They returned to the family home at approximately 22:30. Mr Dollery and his wife were due to go on holiday the following day.
- 2.2 At approximately 23:00 Ian Dollery went with the family dog into the garage, which was situated at the back of the family home. His wife and daughter were sitting in the conservatory when they initially heard Ian Dollery talking to someone. Then they heard a loud scream. They both ran to the garage, where they saw Mr W repeatedly stabbing Ian Dollery.
- 2.3 Both Mrs Dollery and her daughter reported that when they entered the garage Mr W went to attack Mrs Dollery and her daughter forced him out of the garage with a broom.
- 2.4 Mrs Dollery ran to get help from their neighbours, while their daughter tried to help her father. Her boyfriend rang the emergency services.
- 2.5 At approximately 23:22 Mr W threatened a neighbour, who was in her garden. She also called the police.
- 2.6 On the arrival of the emergency services, Ian Dollery was in cardiac arrest. He was taken to hospital, where he was pronounced dead at 00:39 (19 June 2015).
- 2.7 At 23:39 Mr W was apprehended by the police. A knife, which had been handled by Mr W and had Ian Dollery's blood on it, was located in a nearby garden.
- 2.8 A post-mortem examination concluded that the cause of Ian Dollery's death was multiple stab wounds.
- 2.9 Ian Dollery and Mr W were not known to each other.
- 2.10 On his arrest Mr W was assessed and detained under a Section 2 of the Mental Health Act 1983⁴⁷. He was admitted to Ashworth Hospital⁴⁸ for further assessments where his section was subsequently replaced by a Section 3⁴⁹ of the Mental Health Act 1983.

⁴⁷ [Section 2 Mental Health Act](#)

⁴⁸ [Ashworth Secure Hospital](#)

⁴⁹ [Section 3 Mental Health Act](#)

- 2.11 On 18 July 2016 Mr W was found guilty of murder and was sentenced to 23 years in prison.
- 2.12 At the time of the incident, Mr W had been homeless for a considerable period of time. He reported that he had been “sofa surfing”⁵⁰ with various friends.
- 2.13 Police reports indicate that in the days preceding the incident, Mr W had been staying with friends in a property that backed onto the same alleyway as the Dollery family’s home. A police officer had encountered Mr W when she visited this property on the evening of 17 June 2015. The officer reported that Mr W appeared coherent and did not seem to be under the influence of any substances.
- 2.14 On admission to Ashworth, Mr W denied having any memory of the incident, reporting that he had only taken his prescribed methadone, having stopped his prescribed Mirtazapine⁵¹ some three to four months earlier. However, Mr W’s urine drug screen, which was undertaken after his arrest, tested positive for cocaine, amphetamines, methamphetamine⁵², morphine, cannabis and MDMA (ecstasy).⁵³
- 2.15 Two of Mr W’s associates reported to the police that in the two weeks prior to the index offence, Mr W’s drug use had increased and that as well as his prescribed methadone, he was using a combination of intravenous heroin and amphetamines and drinking super strength lager. During the police investigation, a friend of Mr W reported that on 17 and 18 June 2015 she was increasingly concerned about Mr W’s behaviour, as he was saying that “people were going to die and people were on his chore list from Satan ... that he was the son of Satan”⁵⁴. She had thought that he was under the influence of drugs.

Mr W’s last contact with secondary mental health services

- 2.16 Mr W had a history of sporadic short-term contact with Lancashire Care NHS Foundation Trust’s (LCFT) community mental health team (CMHT).
- 2.17 At the time of the incident, Mr W was not in receipt of mental health services, having been discharged from the CMHT on 11 February 2015 after

⁵⁰ [Sofa surfing Definition](#)

⁵¹ Mirtazapine atypical antidepressant [Mirtazapine](#)

⁵² [Methamphetamine](#)

⁵³ Information taken from psychiatrist report 19 May 2016

⁵⁴ Report in LCFT SIR p16

failing to attend two review appointments. The last contact with the CMHT was a telephone conversation on 10 November 2014, when he was contacted by phone and agreed to attend his outpatient appointment the same afternoon. He did not attend (DNA'd) this appointment.

2.18 Prior to Mr W's index offence, his mental diagnoses were:

- Mental and Behavioural Disorders, due to the use of opioids
- Mental and Behavioural Disorders, due to the use of alcohol
- Possible Co-Morbid Psychosis (Not Otherwise Specified).

2.19 It was also documented that "the evidence for psychosis in the context of [Mr W's] alcohol intake and misuse of substances is not very strong"⁵⁵.

2.20 During Mr W's assessments at the high-secure hospital, he was given the following mental health diagnosis:

- Paranoid Schizophrenia International Classification of Mental and Behavioural Disorders (ICD F20.0)
- Antisocial or Dissocial Personality Disorder (ICD F60.2).

Mr W's last contact with primary health care service

2.21 Mr W was last seen by his primary health care service on 17 September 2014, when a mental health review was undertaken. He was issued with a prescription for Mirtazapine 30mg and Naproxen⁵⁶ for pain relief for an ongoing shoulder injury.

Change, Grow, Live (CGL)⁵⁷

2.22 From July 2013 Mr W had ongoing contact with CGL's local service Inspire, which was prescribing and managing his methadone programme.

2.23 In the six months prior to the event, Mr W would often miss appointments with his Inspire key worker and on numerous occasions he failed to pick up his methadone prescription from the dispensing community pharmacy.

2.24 A Substance Use Risk Assessment was completed on 17 February 2015, which documented that Mr W reported that "he feels his mental health is a

⁵⁵ Letter from consultant psychiatrist to CK's GP 16 April 2013

⁵⁶ [Naproxen](#)

⁵⁷ Change, Grow, Live [CGL](#)

danger ... Risk of violence and harm to others is not limited to intoxication and he is capable of violence when sober or intoxicated.”⁵⁸

- 2.25 Mr W was last seen by his key worker on 11 June 2015. On Mr W’s insistence his methadone dose was to be reduced from 25ml by 2ml each week.
- 2.26 On 19 June 2015 the dispensing pharmacy reported to CGL’s Inspire service that Mr W had not collected his methadone on 18 June 2015.

3 Independent investigation

- 3.1 From 2013 NHS England assumed overarching responsibility for the commissioning of independent investigations into mental health homicides and serious incidents. On 1 April 2015 NHS England introduced its revised Serious Incident Framework ⁵⁹, which aims:

“To facilitate learning by promoting a fair, open and just culture that abandons blame as a tool and promotes the belief that an incident cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring.”⁶⁰

- 3.2 The criteria for the commissioning of an independent mental health homicide investigation within the Serious Incident Framework are:

“When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care programme approach, or is under the care of specialist mental health services, in the 6 months prior to the event.”⁶¹

- 3.3 The Serious Incident Framework also cites that a standardised approach to the investigation of such incidents is to:

“Ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. Facilitate further examination of the care and treatment of the patient in the wider context and establish whether or not an incident could have been predicted or prevented, and if any lessons can be learned for the future to reduce the

⁵⁸ Change, Grow, Live CGL, Inspire Substance Use Comprehensive Risk Assessment 17 February 2015

⁵⁹ [NHS Serious Incident Framework 2015](#)

⁶⁰ [NHS Serious Incident Framework 2015](#) p10

⁶¹ [NHS Serious Incident Framework 2015](#) p47

chance of recurrence. Ensure that any resultant recommendations are implemented through effective action planning and monitoring by providers and commissioners.”⁶²

3.4 In February 2016 NHS England (North) commissioned Caring Solutions to undertake an investigation into the events that led up to the homicide of Ian Dollery on 18 June 2015.

Purpose and scope of the investigation

3.5 The full Terms of Reference (ToR) for this investigation are located in appendix 1.

3.6 Briefly the aim of this investigation is to:

- Compile a comprehensive chronology of events leading up to the homicide.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the perpetrator’s first contact with services to the time of the offence.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the perpetrator harming themselves or others.
- To consider whether the incident on 18 June 2015, which led to the death of Ian Dollery, was predictable⁶³ or preventable⁶⁴.
- Review the trust’s internal investigation and assess the adequacy of its findings, recommendations and action plan.
- To review how the trust provides aftercare and support to families affected by homicide or other serious incidents and to identify any learning opportunities.
- Consider and report on any recurrent features/findings and recommendations from previous independent investigations.

⁶² [NHS Serious Incident Framework 2015](#) p48

⁶³ [Predictability](#) is “the quality of being regarded as likely to happen, as behaviour or an event”. We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.

⁶⁴ [Preventability](#) – to prevent means to “stop or hinder something from happening, especially by advance planning or action” and implies “anticipatory counteraction”; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.

- 3.7 NHS England have directed that only a limited number of Specific, Measurable, Attainable, Relevant and Timely (SMART)⁶⁵ recommendations should be made by Caring Solutions' investigation team.
- 3.8 Following the acceptance of the findings of this report's findings and recommendations agencies will develop their agencies action plans which will then be approved through their governance structures.
- 3.9 After the report has been published, Caring Solutions will agree with NHS England (North) the timetable and format to review the stakeholders' implementation of their action plans.

Caring Solutions' investigation team

- 3.10 Caring Solutions (UK) Ltd is a mental health and learning disability consultancy company that has extensive experience in undertaking complex investigations following serious incidents and unexpected deaths within health and social care sectors.
- 3.11 The lead investigator for this case was Grania Jenkins. Grania is a senior mental healthcare, performance and quality professional who has worked in primary, secondary and third sectors. Grania has extensive experience of undertaking investigations into suicides and unexpected deaths, critical and serious incidents, complaints, and cases of gross misconduct, as well as root cause analysis investigations and thematic reviews. Since 2014 Grania has been the lead investigator for homicide investigations under NHS England's Serious Incident Framework.
- 3.12 Dr Martin Lawlor is a consultant psychiatrist at the Carraig Mor Assertive Care Service, Mercy University Hospital and Cork and Nua Healthcare. He also practices at Inmind Healthcare's Specialist Women's Personality Disorder Service in Leeds. Dr Lawlor is the Chief Executive Officer of the Centre for Recovery and Social Inclusion⁶⁶, a charitable mental health foundation. He holds a Clinical/Adjunct Senior Lecturer position at University College Cork and is the Programme Lead and Medical Director of State of Mind Ireland. His clinical and research interests include resilience and recovery based practices, promoting mental fitness, and clinical leadership.
- 3.13 Richard Brown: MRPharmS Chief Officer, Avon Local Pharmaceutical Committee (LPC): is a qualified pharmacist with nearly 20 years'

⁶⁵ [SMART](#)

⁶⁶ [State of Mind, Centre for Recovery and Social Inclusion](#)

experience in community pharmacy services in a wide range of roles from pharmacy manager, Area Manager, Operations Manager with responsibility for Clinical Governance. Richard has also worked with Public Health Departments, Clinical Commissioning Groups and NHS England to ensure pharmacies are fit for purpose and delivering service to the required standards. This also includes being present on a number of committees including Shared Care Committees that provide the Governance and Scrutiny of services delivered to clients suffering from substance misuse.

- 3.14 Ray Galloway retired as a detective superintendent in January 2013. Prior to his retirement his position was that of senior investigating officer, he had primary responsibility for the investigation of homicides and serious and organised crime and the management of covert operations. Upon his retirement, Ray took on the role of director of the independent investigation into the activities of Jimmy Savile, based at the Leeds General Infirmary. He continues to present at safeguarding conferences on the lessons to be learned from the Savile investigation and the management of risk. Ray has acted as the Dollery family liaison through the course of this investigation and has supported them in developing an impact statement.
- 3.15 Dr Cheryl Kipping: prior to becoming a dual-diagnosis consultant nurse Cheryl has worked in both clinical and managerial posts in mental health and substance misuse services. She has also undertaken research at the National Nursing Research Unit, King's College London. She was Co-editor of the Advances in Dual Diagnosis journal from 2008 to 2011 and has provided expert dual-diagnosis advice both nationally and internationally, including to the Health Advisory Service, the National Mental Health Development Unit/CSIP, DH, NICE, NHSE, the All Party Parliamentary Group on Complex Needs and Dual Diagnosis, PHE, and the Supreme Council of Health Qatar. Cheryl has also advised the panel on the most recent research and governmental strategies into the commissioning of substance misuse services and treatment guidelines. Cheryl has undertaken a review of Mr W's substance misuse history, the support provided to Mr W with regard to his substance misuse.
- 3.16 The report was peer-reviewed by Colin Dale, Director of Caring Solutions Ltd.

Interviews

- 3.17 As this investigation was commissioned by NHS England, the primary focus of the investigation will be on LCFT's services. However, we will also be reviewing and commenting on the involvement of the other involved sector, the CGL's Inspire service, which was commissioned by Lancashire County

Council to provide recovery-orientated substance misuse treatment services in North Lancashire from July 2013.

- 3.18 CGL Inspire and their commissioner have fully engaged with this investigation process and have welcomed our review of their service provision and their post incident report,
- 3.19 Caring Solutions' investigation team were asked by Lancashire County Council's public health specialist to review and comment, with reference to the investigation of serious incidents, on the contract that was being prepared as part of the retendering of substance misuse services in Lancashire.
- As part of this investigation, Caring Solutions' investigation team interviewed the following personnel from Lancashire Care Foundation Trust's (LCFT):
 - Head of Investigations and Learning, who was the author of the internal Serious Incident Report (SIR) that was completed after the incident
 - Head of Nursing – Mental Health Network
 - Clinical Director (telephone interview)
 - Consultant Psychiatrist, community mental health services
 - Community Psychiatric Nurse, who was Mr W's care coordinator
 - Team Manager for community mental health services
 - Head of Operations for Mental Health
 - Associate Director of Quality Improvement and Experience (telephone interview).
- 3.20 Caring Solutions' investigation team also interviewed the following members of CGL's senior management team and staff at the CGL Inspire service:
- Deputy Director of Nursing and Clinical Practice
 - Clinical Services Co-ordinator
 - Partnership and Recovery Lead
 - Practitioners and managers from the Inspire service.
- 3.21 Caring Solutions' investigation team interviewed two senior GPs at the primary care service where Mr W was last registered as a patient.

3.22 Caring Solutions' investigation team also undertook interviews with:

- Clinical Commissioning Group (CCG) Programme Director for Mental Health
- Lancashire County Council's public health specialist, who has responsibility for the commissioning of substance misuse services in Lancashire
- Lancashire Constabulary Senior Investigating Officer (SIO) for the case.

3.23 Caring Solutions' interviews are managed with reference to the National Patient Safety Agency (NPSA) investigation interview guidance⁶⁷ and adhere to the Salmon/Scott principles⁶⁸.

3.24 Where relevant we have referred to LCFT's and other stakeholders' policies that were in place at the time and also those that have subsequently been reviewed.

3.25 We have also referred to the various Department of Health (DH) guidelines and the Royal College of Psychiatrists' best practice⁶⁹ guidelines as well as to the relevant NICE⁷⁰ guidance.

Methodology

3.26 Where relevant Caring Solutions' investigation team have utilised a root cause analysis (RCA) as the methodology that underpinned the investigation.

3.27 RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that lead to an incident. It is an iterative⁷¹ structured process that has the ultimate goal of preventing future adverse events by the elimination of latent errors. RCA provides a systematic process for conducting an investigation, looking beyond the individuals involved and seeking to identify and understand the underlying system features and the environmental context in which an incident occurred. It also assists in the identification of common risks and opportunities to improve patient safety

⁶⁷ National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: Investigation interview guidance [NPSA](#)

⁶⁸ The 'Salmon Process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere. [Salmon/Scott](#)

⁶⁹ [DH \(March 2008\). Refocusing the Care Programme Approach Policy and Positive Practice and Code of Practice Mental Health Act 1983 \(revised\)](#)

⁷⁰ NICE: National Institute for Health and Care Excellence [NICE](#)

⁷¹ Iteration is the act of repeating a process with the aim of approaching a desired goal, target or result

and informs recommendations regarding organisational and system learning.

- 3.28 As far as possible, we have tried to eliminate or minimise hindsight or outcome bias⁷² in our investigation. We analysed information that was available to primary and secondary care services at the time. However, where hindsight has informed our judgements, this has been identified.

Anonymity

For the purpose of this report:

- 3.29 The identities of all those who were interviewed have been anonymised and they will be identified by their professional titles.
- 3.30 The patient is referred to as Mr W.
- 3.31 The family have requested that Ian Dollery is referred to by his name within this report.

4 Involvement of families and Mr W

- 4.1 NHS's Serious Incident Framework directs that all investigations should:

“Ensure that families (to include friends, next of kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations.”⁷³

- 4.2 As part of all Caring Solutions investigations, we will always try to obtain the views of the patient and the families of both the victim and the perpetrator, not only in relation to the incident itself, but also their wider thoughts regarding where improvements to services could be made in order to prevent similar incidents from occurring again.

Ian Dollery's family:

- 4.3 Although this report focuses on Mr W and the care and treatment he received from the various organisations, Caring Solutions' investigation team have, throughout their investigations, kept at the forefront of their

⁷² Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. ([NPSA 2008](#))

⁷³ NHS England, Serious Incident Framework: Supporting learning to prevent recurrence, p48 [NHS Serious Incident Framework](#)

minds both Ian Dollery and the devastating and profound effects that this homicide had and continues to have on his family.

- 4.4 We met with Mrs Dollery and one of her daughters on several occasions and have been extremely grateful for the information they have provided, which has been essential in assisting us to develop the chronology of events that led up to the incident itself. They have received bi-monthly reports on the progress of this investigation from NHS England.
- 4.5 Caring Solutions' investigation team extended, via Mrs Dollery, the invitation to Ian Dollery's other children to be involved in the investigation. As they have not made contact it has been assumed that they did not wish to be involved.
- 4.6 Ian Dollery's family reported to Caring Solutions' investigation team that apart from the devastating effects this incident has had on the extended family, they also had particular concerns about:
- How a person such as Mr W, who had multiple and complex social, substance misuse and psychological issues as well as an extensive criminal history, could be unsupervised within the community.
 - What improvements have been implemented since the incident, particularly with regard to interagency communication, information sharing and service provisions within the area?
 - The application of the definition of predictability and preventability of the incident within this report.
 - The support they have been offered since the incident.

Caring Solutions' investigation team have endeavoured to address their questions and concerns throughout this report.

Mr W and his family:

- 4.7 Caring Solutions' investigation team met with Mr W on one occasion. He was able to provide background information and insights into his life, as well as some reflections on what led up to the incident itself.
- 4.8 Mr W's mother has declined to be involved in this investigation.
- 4.9 Mr W and both families will be offered the opportunity to be provided with a copy of our report. If they wish Caring Solutions' lead investigator will meet with them to provide verbal feedback on the report's findings and recommendations.

5 Background information

Mr W's childhood, family and education

- 5.1 Mr W was the eldest of three children. They were brought up in what was described⁷⁴ as a highly religious and strict household. When Mr W and his siblings were young, their mother remained at home to look after them. It is reported⁷⁵ that as a young child, Mr W met all his developmental milestones.
- 5.2 Mr W's junior schooling reported no particular issues, either academically or behaviourally. However, shortly after starting secondary school, he was placed in a remedial class due to literacy difficulties.
- 5.3 By his third year, Mr W reported⁷⁶ that, with his parents' permission, he began to stay away from school to help his father with repairing cars.
- 5.4 A letter from a consultant psychiatrist (16 December 1992) documented that Mr W's parents reported that their son "had behavioural problems since the age of thirteen and [had] been frequently involved in violence ... he had problems at school ... he did not attend school regularly."⁷⁷
- 5.5 Mr W reported that when he was at school he had been involved in "perhaps 30 fights"⁷⁸, which he described as "playground stuff"⁷⁹, although he was never suspended or expelled.
- 5.6 Mr W's mother reported that up to the age of 16, her son had a wide circle of friends and attended local clubs and sporting activities.⁸⁰
- 5.7 Mr W left school at the age of 16 with no formal qualifications. He commenced a course in motor mechanics but left after 12 months, reportedly because he did not get on with the course leader.
- 5.8 On 2 February 2000 Mr W reported to his GP that he was employed as a kitchen assistant. Mr W reported to Caring Solutions' investigation team that from this point, apart from some casual employment, he was claiming sickness and unemployment benefits.

⁷⁴ Psychiatric report 20 April 2016

⁷⁵ Psychiatric report 15 April 2016

⁷⁶ Psychiatric report 15 April 2016

⁷⁷ Psychiatric report 15 April 2016

⁷⁸ Psychiatric report 15 April 2016

⁷⁹ Psychiatric report 15 April 2016

⁸⁰ LCFT's Post-Incident Review p4

- 5.9 At the age of 17 (1984) Mr W was stabbed at a takeaway restaurant. His mother reported that after this incident, her son's behaviour began to change and he began to carry a knife. She reported that a week after this incident, Mr W stabbed someone, although he was not prosecuted. She also reported that it was after this incident that Mr W began to associate with a different peer group and began to misuse substances, including illegal drugs.
- 5.10 At this time Mr W had been living in the family home, but due to an argument with his parents he moved out into various rental properties.
- 5.11 In May 1994 it was documented by a consultant psychiatrist that despite Mr W accusing both members of his family and his girlfriend of tampering with his medication and drugs and "making his life difficult"⁸¹, they continued to be "extremely supportive"⁸².
- 5.12 By the time of the incident in 2015, Mr W was estranged from members of his family, although it is documented that he was maintaining some contact with his mother and that he gave the CMHT his mother's address as his point of contact.

Mr W's relationship history and parental responsibilities

- 5.13 Mr W reported that he had four significant relationships in his adult life.
- 5.14 During the first relationship, Mr W took an overdose (1986). He was referred to a psychiatrist, who documented that the couple had a planned pregnancy and had plans to get married. However, it was documented that there were tensions within the relationship, as Mr W was refusing to obtain employment. At the time of the overdose, Mr W's fiancée had moved back to her family home. Later that year they had a son.
- 5.15 In 2016 Mr W reported that after this relationship ended, he had little contact with their son and had not seen him since his father's funeral in 2008.
- 5.16 Mr W's second significant relationship also lasted for about four years and they had a child together. Mr W reported that he had not had contact with his daughter since she was six months old.
- 5.17 Mr W's third relationship lasted just over a year and he had another son. At the time of Mr W's arrest for the murder of Ian Dollery, this child was nine

⁸¹ Letter 18 May 1994

⁸² Letter 18 May 1994

years old. Mr W reported to Caring Solutions' investigation team that he had regular contact with this child. However, it was documented in LCFT's Serious Incident (SIR) that Mr W only had supervised telephone contact with this child.

- 5.18 Mr W's prison OASys record, which was accessed as part of a psychiatric report (2016), indicated that there was one incident of domestic violence within this relationship (July 2005), in which Mr W had locked his girlfriend in the house and she had sustained some bruising.
- 5.19 Mr W's most recent relationship lasted seven years. From the evidence that we have obtained, it appears that this relationship was volatile, involving incidents of domestic violence and alcohol and substance misuse.
- 5.20 There were frequent occasions when police responded to physical and verbal altercations between Mr W and his girlfriend. Often she would either refuse to make a statement or withdraw her complaint.
- 5.21 There were 37 entries on the Protecting Vulnerable People Database. All the entries related to domestic violence between Mr W and his girlfriend. There were two criminal convictions:
- In January 2010 Mr W was found guilty of battery.
 - In December 2011 Mr W was found guilty of Grievous Bodily Harm (GBH).

6 Mr W's physical health 1985-2009

- 6.1 Mr W's medical records, which have been reviewed⁸³ as part of this investigation, indicated that Mr W experienced no significant physical health issues during his childhood.
- 6.2 It was noted that at the age of 17 (1985), Mr W was stabbed in the chest at a takeaway restaurant, which resulted in a left-sided hydropneumothorax.⁸⁴ He spent a week in hospital, and it was documented that he made a full recovery.
- 6.3 In the same year, Mr W presented himself at an Accident and Emergency (A&E) department with a fractured right fourth metacarpal⁸⁵, which it is documented that he had sustained during a fight. The following year he

⁸³ Medical records available from 2 December 1976

⁸⁴ Hydropneumothorax is defined as the presence of both air and fluid within the pleural space surrounding the lung

⁸⁵ Metacarpal bone of the ring finger

again attended A&E having put his hand through a window; the circumstances were not documented.

- 6.4 On 26 June 1989 Mr W sustained lacerations to his hand, which he reported he had sustained in a fight. His radial nerve in his index finger was damaged, causing a loss of sensation.
- 6.5 Later that year Mr W dislocated his right shoulder, which appeared, from our review of his medical notes, to cause him ongoing pain until the incident in 2015.
- 6.6 On 29 July 1992 Mr W was admitted to hospital having again been stabbed, this time in his abdomen. There was no evidence of any significant injury and he was subsequently discharged.
- 6.7 On 5 December 1997 Mr W was again admitted to hospital having been stabbed several times and having sustained an injury to his hand. He did not require surgery and was discharged on 7 December 1997.
- 6.8 On 16 April 1998 Mr W attended A&E with a stab wound to his thigh that required stitches. Later that year (2 July) Mr W again presented himself at A&E with multiple stab wounds.
- 6.9 On 9 February 1999 Mr W presented to his GP with what was documented as an abscess on an injection site. At the next GP visit (8 June 1999), Mr W disclosed the extent of his intravenous drug use. It was documented that Mr W needed to be tested for hepatitis B and C⁸⁶ and human immunodeficiency virus (HIV).⁸⁷ There was no evidence that these tests were completed.
- 6.10 Mr W presented himself to his GP on 29 December 1999, reporting that he had just been released from a four-month prison sentence for a breach of a probation order. He reported that while in prison, he had been prescribed nitrazepam⁸⁸ (5mg) and diazepam (5mg).
- 6.11 In March 2002 Mr W was removed from a primary care list due to his “regular verbal abuse”⁸⁹.
- 6.12 On 31 July 2002 Mr W was admitted to hospital for the drainage of an abscess and deep vein thrombosis (DVT) in his left groin, which was the result of his ongoing intravenous drug use. He was discharged on 9 August

⁸⁶ [Hep B/C](#)

⁸⁷ [HIV](#)

⁸⁸ [Nitrazepam](#)

⁸⁹ Letter 13 March 2002

2002 with a prescription of warfarin⁹⁰; however, this medication was subsequently stopped, as Mr W failed to attend any appointments at the warfarin clinic.

- 6.13 In 2004⁹¹ Mr W was treated with antibiotics due to a tooth abscess, which was noted as being due to his poor dental hygiene.
- 6.14 On 24 February 2009 Mr W was admitted to hospital with another DVT, again caused by his ongoing intravenous drug use.

7 Mr W's forensic history

- 7.1 Mr W reported⁹² that his first criminal activity was carried out at the age of five, when he climbed through a window to steal money from a gas meter. However, there was no further collaborative evidence to verify this incident.
- 7.2 At the time of Mr W's arrest in 2015, he had 50 prior convictions for 102 offences. His first conviction was in December 1984 and his last was on 5 December 2011.
- 7.3 His convictions included the following offences:
- December 1984: Mr W aged 17 was convicted for possession of an offensive weapon in a public place. He received a Conditional Discharge (12 months) for this offence and was ordered to pay £25 costs.
 - March 1987: Mr W was convicted of a Section 5 Public Order Offence. He received a 12-month Probation Order and was fined £17 court costs.
 - March 1988: Mr W was convicted of possession of an offensive weapon in a public place and a non-dwelling burglary. He received a two-year Probation Order.
 - March 1990: Mr W was convicted of an S20⁹³ wounding offence, which involved "biting someone's ear off"⁹⁴. He received six months' imprisonment, suspended for two years, and was ordered to pay £750 compensation and £10 court costs.

⁹⁰ Warfarin is part of a group of medicines called anticoagulants [Warfarin](#)

⁹¹ 13 August 2004

⁹² Psychiatric report 20 April 2016

⁹³ S20 Malicious Wounding/Inflicting Grievous Bodily Harm

⁹⁴ Psychiatric report 19 June 2015

- September 1990: Mr W was convicted of S20 Wounding and Possession of an Offensive Weapon in a Public Place. This incident involved Mr W stabbing the victim. Mr W was sentenced to six months' imprisonment for the wounding offence, to run consecutively with other sentences.
- February 1995: Mr W was convicted of two incidents of Section 47 assault.⁹⁵ He initially received three months' imprisonment; however, on appeal this was changed to a 12-month Probation Order.
- February 1997: Mr W was arrested for attempted murder. During a fight Mr W stabbed an individual with a large kitchen knife. The case was subsequently discharged.
- February 2001: Mr W was convicted of Affray and Possession of an Offensive Weapon, which was a 14-inch serrated kitchen knife. His victim was a female. On interview Mr W stated that the dispute was an ongoing feud among local drug users. He received a 12-month Conditional Discharge.
- October 2002: Mr W was convicted of a Section 5 Public Order offence.⁹⁶ He received a fine of £100 and was ordered to pay costs of £70.
- January 2010: Mr W was convicted of S39 Assault. The victim was a female with whom Mr W was in an intimate relationship. He received a Community Order and a 12-month Supervision Requirement.
- September 2011: Mr W was arrested for Section 47 Assault. His victim was the same female who was involved in the previous incident.
- 5 December 2011: Mr W was arrested for Section 20 Wounding, again involving the same victim. Mr W received a sentence of 14 months and 6 days' imprisonment for this offence.

7.4 In addition Mr W had:

- 5 convictions for drug offences (1996-2003)
- 2 convictions for fraud (1995-2000)
- 48 convictions for theft (including shoplifting and burglary) (1986-2009)

⁹⁵ Section 47 Assault Actual Bodily Harm : a person is guilty of an offence if any assault results in injury causing actual bodily harm.

⁹⁶ Section 5 offence: person is guilty of an offence if he: (a) uses threatening [or abusive] words or behaviour, or disorderly behaviour, or (b) displays any writing, sign or other visible representation which is threatening [or abusive], within the hearing or sight of a person likely to be caused harassment, alarm or distress thereby. [Section 5](#)

- 23 offences relating to police/courts/prisons (1989-2010)
 - 8 miscellaneous offences⁹⁷ (1996-1998).
- 7.5 Following Mr W's conviction in 1995, he was required to attend an anger management course and counselling to address his drug issues. His responses to both interventions were described as being "poor"⁹⁸.
- 7.6 There were also references within Mr W's probation records that he frequently failed to attend appointments, there was poor cooperation with supervision orders and on several occasions he breached the restriction orders imposed by the court – for example, contact with his long-term girlfriend, who had been the victim of several assaults.
- 7.7 During his assessments in 2015/2016, Mr W reported that between the ages of 16 and 30 he would often carry a knife to defend himself, but he denied ever having committed any Section 18 wounding.⁹⁹ Also that between the ages of 16 and 21, he had been frequently involved in physical altercations, and he admitted that he "enjoyed and [got] satisfaction out of fighting"¹⁰⁰.
- 7.8 At the time of the incident Mr W was not in contact with judicial services.

8 Mr W's psychiatric history 1986-2005

- 8.1 On 28 August 1986 Mr W was admitted to hospital having taken an overdose of 10 erythromycin tablets with 5 pints of alcohol. He was assessed by the on-call psychiatrist, who documented that Mr W reported there had been increasing tensions between Mr W and his pregnant girlfriend about the fact that he was refusing to obtain employment. It was assessed that Mr W was not presenting with any symptoms of depression, and he was subsequently discharged from the service.
- 8.2 Mr W's GP notes documented that in 1987 Mr W "intentionally harmed [himself] with a sharp object". There were no further details documented about this incident.
- 8.3 At his GP's request, Mr W was assessed by a psychiatrist on 7 December 1992. The GP requested the assessment in order to ascertain both a diagnosis and an opinion as to whether Mr W was suffering from a

⁹⁷ Miscellaneous offences such as resisting arrest, disorderly conduct and public intoxication

⁹⁸ Psychiatric report 19 June 2015

⁹⁹ Section 18: refers to the requirement of specific intent to wound

¹⁰⁰ Psychiatric report 12 April 2016

“significant psychiatric illness”¹⁰¹. Prior to the assessment, Mr W’s parents reported to the psychiatrist that their son had had behavioural problems since the age of 13 and was frequently involved in violence.

8.4 During the assessment Mr W disclosed that he was hearing voices and was seeing himself at the “scenes of violence”¹⁰². Mr W reported that these visualisations initially involved fighting; however, following the incident in which he was first stabbed, they had changed to him actually stabbing other people. He disclosed that since his most recent stabbing, he had visualised shooting people. He also admitted to being frequently involved in violent incidents and assaults and that on one occasion he had bitten someone’s ear off. He reported that he had been imprisoned for two years after he had stabbed someone.

8.5 Mr W disclosed that on such occasions he felt “totally uncontrollable and does not care for the consequences of his actions”¹⁰³ and that when he had been drinking alcohol, these violent episodes occurred more frequently. He also disclosed that he had previously used heroin but that the GP was now prescribing him methadone.¹⁰⁴

8.6 The consultant psychiatrist concluded that his overall impression was that Mr W may have an:

“Episodic dyscontrol syndrome, where he [had] outbursts of rage and aggression with intervening periods where he was quite placid and easy going. However his forensic history and substance and alcohol abuse cannot totally be accounted for because of the episodic dyscontrol. There are clearly problems with [his] personality.”¹⁰⁵

8.7 The consultant psychiatrist advised Mr W’s GP that as there was a family history of both mental illness and uncontrolled epilepsy, he intended to refer Mr W for an electroencephalogram (EEG) in order to eliminate the possibility that Mr W was experiencing “focal temporal-lobe dysrhythmia which is sometimes associated with aggression”¹⁰⁶. He also suggested that the GP prescribe Mr W Tegretol¹⁰⁷ 100mg x 3 daily.

¹⁰¹ Letter to GP

¹⁰² GP notes 2 December 1992

¹⁰³ Letter to Mr W’s 16 December 1992

¹⁰⁴ Methadone is an opiate substitute medication used for the treatment of heroin dependency [Methadone](#)

¹⁰⁵ Letter 16 December 1992

¹⁰⁶ Letter 16 December 1992

¹⁰⁷ Tegretol (carbamazepine) is used to treat seizures, nerve pain and bipolar disorder [Tegretol](#)

- 8.8 It was documented, in a letter dated 27 January 1993, that an EEG had been undertaken but that the results were not available.
- 8.9 On 27 January 1993 Mr W's psychiatrist made a referral to a forensic psychiatrist, asking for an assessment, as he reported that Mr W had stabbed his father again. It was documented that he had been told that Mr W had "stabbed his father before and that [his father] now wears protective clothing"¹⁰⁸. It was also noted that Mr W was threatening to stab his sister.
- 8.10 Mr W's psychiatrist also documented that Mr W was currently due to appear in court and that he may receive a custodial sentence. It is not evident from the information available if the forensic assessment was completed.
- 8.11 Mr W was next assessed by a consultant psychiatrist at his home on 19 January 1994. It was noted that Mr W was, at the time, living with his girlfriend and her three-year-old daughter from a previous relationship and that she was pregnant. During this assessment Mr W disclosed that he had previously been referred to a psychiatrist due to "hearing voices [and] being violent"¹⁰⁹. Mr W also disclosed that from the age of 20 he had been using heroin, but was currently only using amphetamines, which he was injecting up to four or five times a day. Mr W also reported that he had not attended his previous psychiatric outpatient appointment, as he had been working.
- 8.12 It was noted that Mr W reported that he was very keen to enter an inpatient detox programme but that he did not want to be admitted to the programme until his girlfriend had had the baby. The consultant psychiatrist noted that "it was difficult to assess [Mr W's] motivation and certainly this man's background [was] not very encouraging"¹¹⁰. The psychiatrist concluded that "reluctantly [I am] prescribing a small dose of Chlorpromazine¹¹¹ ... [which] might help with the adverse effects of the amphetamines"¹¹².
- 8.13 The treatment plan agreed with Mr W and his girlfriend was that Mr W would contact his GP once the baby was born to obtain an inpatient detox admission. This does not appear to have occurred.
- 8.14 On 13 May 1994 Mr W was admitted to hospital having taken an overdose of 70 chlorpromazine tablets, one ounce of amphetamines and half a bottle of spirits. He denied any intention of suicide and reported that he had no

¹⁰⁸ Referral letter 27 January 1993

¹⁰⁹ Letter 19 January 1994

¹¹⁰ Letter 19 January 1994

¹¹¹ Chlorpromazine antipsychotic medication [Chlorpromazine](#)

¹¹² Letter 19 January 1994

memory of taking the overdose and believed that his girlfriend had given him the medication while he was asleep. Mr W subsequently discharged himself before tests were completed.

- 8.15 On 19 May 1994, following another home assessment, Mr W had a brief inpatient admission. He was discharged on 23 May 1994 “having come to the conclusion that drugs were responsible for all his problems. He left hospital not intending to use amphetamines again”¹¹³ and said that he was committed to engaging with community mental health services.
- 8.16 Mr W was next seen by a CMHT associate specialist doctor on 14 July 1994. The doctor noted that Mr W reported that he was continuing to be suspicious of his wife¹¹⁴, was taking amphetamines and was continuing to experience auditory and visual hallucinations.
- 8.17 After this appointment Mr W self-referred himself to a community drug service (4 August 1994). However, after attending his initial appointment (5 August 1994), where he was prescribed trifluoperazine¹¹⁵ 5mg and procyclidine¹¹⁶ 5mg, Mr W DNA’d all further appointments and was discharged from the service on 16 September 1994.
- 8.18 From 1999-2001 Mr W’s GP notes were documenting that Mr W was continually reporting that he was experiencing auditory hallucinations and anxiety attacks. The GP was regularly prescribing Mr W zopiclone¹¹⁷ and diazepam.¹¹⁸
- 8.19 Mr W’s next contact with community mental health services was in April 2004, when his GP again referred him to the CMHT. The referral noted that Mr W was “reasonably clear”¹¹⁹ of illegal drugs, but was experiencing anxiety and paranoid thoughts when he was in public. The referral also noted that he was being prescribed Stelazine 10mg (trifluoperazine)¹²⁰ and nitrazepam¹²¹.

¹¹³ Discharge letter 26 May 1994

¹¹⁴ She had previously been referred to as Mr W’s girlfriend

¹¹⁵ Trifluoperazine is an antipsychotic medicine in a group of drugs called phenothiazines [Trifluoperazine](#)

¹¹⁶ Procyclidine is used to relieve unwanted side effects caused by antipsychotic medicine [Procyclidine](#)

¹¹⁷ Zopiclone is a pharmaceutical non-benzodiazepine that is primarily used in the treatment of insomnia [Zopiclone](#)

¹¹⁸ Diazepam is used to treat anxiety disorders and alcohol-withdrawal symptoms [Diazepam](#)

¹¹⁹ Referral 23 April 2004

¹²⁰ Stelazine is the brand name for trifluoperazine, a high-potency antipsychotic medication in a class of drugs called phenothiazines. Antipsychotic medications are also known as neuroleptics or major tranquilisers. [Stelazine](#)

¹²¹ Nitrazepam is used to treat short-term sleeping problems [Nitrazepam](#)

8.20 After Mr W DNA'd several appointments, he was assessed by the CMHT on 12 and 14 October 2004. The assessments noted that Mr W was reporting that he had ceased taking illegal drugs, but was experiencing symptoms of social anxiety, which were presenting as breathlessness and palpitations when he had to leave his accommodation. Mr W also reported that he was experiencing auditory hallucinations in the form of several different non-command voices, both male and female, which occurred at periods of quiet and at night. It was documented that Mr W reported that he found these symptoms "annoying and difficult to cope with"¹²² and that he was also experiencing periods of low mood, although he was not at risk of self-harm or suicide. Mr W also disclosed that he had an extensive history of offences and custodial sentences, which he reported were "the results of his heroin addiction"¹²³.

8.21 Mr W reported that since he had been taking Stelazine (10 mg mane¹²⁴), there had been little benefit and his symptoms of anxiety and aggression had increased. The treatment plan agreed with Mr W was:

- To meet with the mental health worker on a fortnightly basis
- To provide Mr W with information about the Face to Face support service
- To provide Mr W with information about anxiety management at the next appointment
- To obtain Mr W's past psychiatric notes.

8.22 After Mr W failed to engage with the CMHT, he was discharged back to his GP.

8.23 Mr W next came to the attention of the CMHT on 14 March 2005, when it was noted that the reason he had not engaged any further with the CMHT was that he had commenced a prison sentence. A letter sent to the CMHT noted that while Mr W had been in prison, he had been under the care of the Mental Health In-reach team, who assessed that he had not presented with any psychotic symptoms or risks of self-harm but had undergone an opiate detoxification. On his release it was assessed that there were no mental health issues. The CMHT wrote to Mr W's GP, suggesting that as his previous symptoms were likely to have been due to his drug dependency, he should be referred to substance misuse services. He was subsequently discharged from the CMHT.

¹²² Patient records 12 October 2004

¹²³ Patient records 12 October 2004

¹²⁴ Mane -daily

9 Mr W's substance and alcohol misuse 1980-2013

- 9.1 Mr W disclosed in a post-incident assessment¹²⁵ that at the age of 13 he began solvent misuse, as he reported it “took me away from my day to day problems”¹²⁶. He also reported that he had discontinued his misuse of solvents after his father found out and had physically punished him.
- 9.2 Mr W reported that from the age of 16 he had started drinking alcohol, and by the time he was 18 he had begun to smoke cannabis in the company of friends. However, this quickly escalated to daily use for a number of years, although he reported that it had made him feel excessively paranoid and anxious, so he had stopped using it.
- 9.3 Mr W reported that during his incarceration in prison in 1990, he had been introduced, by other inmates, to smoking heroin and that he quickly became addicted and was taking it intravenously.
- 9.4 From the information available, it is evident that from 1994 Mr W had been sporadically under the care of a number of substance misuse services, which were being provided by either the NHS or the third sector, who were prescribing and managing his methadone prescriptions. His engagement was reported as being sporadic, and he was reporting that alongside his methadone programme, he was continuing to use other substances, including illegal drugs.
- 9.5 On 7 November 1993 Mr W's primary care notes documented that he was reporting that he had stopped using heroin, but was now injecting amphetamines on a daily basis.
- 9.6 At a GP appointment on 19 January 1994 it was noted that Mr W was also disclosing alcohol abuse and that he was now spending £60 a day on amphetamines.
- 9.7 On 8 June 1999 Mr W reported to his GP that he was again using heroin intravenously, but wished to reduce his drug use. The GP referred him back to a drug misuse agency.
- 9.8 Throughout 2000 Mr W's primary care records were indicating that he was on various methadone prescriptions, and he was now being supervised, daily and weekly, by a substance misuse agency. He also disclosed that he

¹²⁵ 15 April 2016

¹²⁶ Psychiatric report 12 April 2016

was using heroin on a regular basis. He was requesting that his GP prescribe both nitrazepam and diazepam.

- 9.9 On 27 October 2000 Mr W reported to his GP that he was waiting for an appointment to be assessed for a residential rehabilitation placement. It is unclear if this information was accurate or if the assessment took place.
- 9.10 On 23 April 2001 Mr W reported to his GP that he had disengaged from the substance misuse agency and that they had stopped his methadone prescription. He disclosed that he was now injecting up to 12 bags of heroin a day.
- 9.11 However, later that year (5 July 2001) it appears that Mr W had re-engaged with the substance misuse agency, as he reported to his GP that he did not feel the dose of methadone was sufficient, he was continuing to inject heroin daily and he was occasionally missing his collection of methadone from the pharmacist. At his next appointment with his GP (12 July 2001), Mr W reported that his methadone prescription had been increased to 50ml by the prescribing substance misuse agency.
- 9.12 On 25 October 2001 the GP noted that Mr W had been discharged from the substance misuse agency, as he had failed to attend his appointments.
- 9.13 In a drug screen that was carried out when Mr W was admitted to hospital with an abscess (12 September 2002), he tested positive for:
- Opiates
 - Benzodiazepines
 - Cannabis
 - Cocaine
 - Methadone
 - Amphetamines.
- 9.14 In June 2003 Mr W was sentenced to 12 months in prison for possession of heroin.
- 9.15 On 4 October 2005 Mr W's GP was informed that Mr W was being supported by LCFT's substance misuse service and was now being prescribed methadone 50ml.
- 9.16 Caring Solutions' investigation team were not provided with records from LCFT who were the substance misuse provider until 2007. On 24 May 2007

LCFT advised the GP that Mr W's care and methadone prescribing had been transferred to an independent sector provider.

- 9.17 Caring Solutions' investigation team were unable to access records from this provider, but letters were sent sporadically to Mr W's GP advising him that they were prescribing methadone to Mr W and also that he was regularly disengaging from their service.

10 Mr W's physical health and involvement of primary health care 2013-2014

- 10.1 In January 2013 Mr W presented himself to his GP with a swelling in the site of his previous DVT. However, he failed to attend a subsequent appointment (22 January 2013) at which the GP had intended to undertake a vascular Doppler ultrasound procedure¹²⁷ in order to check for a possible DVT.
- 10.2 On 14 February 2013 the GP noted that he had advised Mr W that he would only prescribe nitrazepam until his methadone programme had been established and he had engaged with the CMHT.
- 10.3 From this point to the offence in 2015, Mr W had only sporadic contact with his GP, when he required a Med 3 Sickness Certificate¹²⁸, a referral to the CMHT, or additional medication because he had either reportedly lost his prescriptions or had it stolen.
- 10.4 Mr W was last seen by his GP on 17 September 2014, when he was prescribed the analgesia naproxen (500mg) for ongoing shoulder and knee pain. At this appointment he was also issued with a 3 month Med 3 Sickness Certificate, which cited "mental health issues, drug dependency problems and knee pain" as being the reasons why he was unable to work.

Arising issues, comments and analysis

- 10.5 After Mr W's arrest in 2015, it was noted in a letter from a hospital's Department of Infectious Diseases that Mr W had been diagnosed with hepatitis C in 2012. We were unable to locate any evidence of this within his medical records. It was noted in his primary care notes that he received his first hepatitis B vaccination on 9 August 2010, when he was serving a custodial sentence. There were no records to indicate if any diagnostic tests were completed.

¹²⁷ [Doppler ultrasound](#)

¹²⁸ [Sickness Certificate](#)

11 Mr W's involvement with CGL July 2013- June 2015

Please refer to the chronology (located in appendix 2), which provides details of CGL's Inspire's involvement with Mr W. This section discusses the key issues that have been identified with regard to CGL's Inspire service's involvement in Mr W's care.

- 11.1 On 1 July 2013 the substance misuse service was awarded by Lancashire County Council to CGL. The local CGL service is known as Inspire. Mr W's first review was on 11 July 2013.
- 11.2 Mr W's treatment programme with Inspire was to involve a combination of pharmacological and psychosocial support. He was also given access to groups, one-to-one sessions with a key worker, medical reviews and a needle exchange programme.
- 11.3 On 27 November 2013 Mr W completed his My First Goal Map, in which he identified that his priority was to secure suitable accommodation for himself and his partner, improve his relationship with his partner, and become alcohol free. He agreed to work towards achieving these goals with the local housing officer and his key worker. He then failed to attend any further appointments until 11 February 2014, but was maintaining his collection of methadone from the community pharmacy.

Clinical reviews

- 11.4 Mr W attended a clinical review (11 February 2014). Following this review a comprehensive letter was sent to his GP, which documented that Mr W was reporting that he had stopped using intravenous drugs for two years and had last used crack cocaine six weeks ago.
- 11.5 It was noted that as Mr W had secured new accommodation, his care was to be transferred to another provider. It was also noted that Mr W requested to maintain his daily methadone collection.
- 11.6 During the review Mr W disclosed that he had two adult children and that one child, was seven years old. It was noted that no family services were involved.
- 11.7 Risks identified were of accidental overdosing. Mr W was provided with a two-week prescription, with daily collections Monday to Friday, to ensure that he maintained his methadone (80mg mane) during the transfer of services.

- 11.8 The GP was advised that Mr W “would benefit from a referral to BBV¹²⁹ Nurse and eventual referral to Liver Team”.¹³⁰ There was no indication that such a referral occurred.
- 11.9 Mr W’s care was transferred on 13 March 2014 to a different provider. He failed to engage with this new provider, missing his methadone collection during the transfer period. On 11 April 2014 Mr W again presented to CGL Inspire and a medical review was undertaken.
- 11.10 In a subsequent letter to Mr W’s GP (17 April 2014), it was documented that Mr W’s methadone had been stopped due to him missing collections and his house move, which had made it difficult for him to access the community pharmacy.
- 11.11 It was also documented that he disclosed that he had used heroin once and a “few diazepam at night”¹³¹. His drug screen tested positive for methadone, opiates and diazepam.
- 11.12 It was also noted that Mr W was “engaging well with groups and Intuitive Recovery and activities at Inspire”¹³². It is difficult to see where this information was obtained, as the evidence within the notes was that Mr W had both an extensive historical and a more recent pattern of non-engagement with Inspire.
- 11.13 The letter to the GP also documented that Mr W:
- “Denied any on-going involvement in violent or criminal offences.
 - No history of severe enduring mental illness or involvement with the secondary mental health services.
 - Client reports to have no children... Please let us know if this is correct and up to date.”¹³³
- 11.14 In our review of Mr W’s contact with his Inspire recovery coordinator between this review and the next review on 16 September 2014, it was documented (13 May 2014) that Mr W had disclosed that he had been using intravenous crack cocaine (13 May 2014). Mr W also disclosed that he was using crack cocaine, the hallucinogenic drug Lysergic Acid Diethylamide

¹²⁹ BBV Blood-borne virus

¹³⁰ 11 February 2014

¹³¹ 17 April 2014

¹³² Letter to Mr W’s GP 11 April 2014

¹³³ Letter to Mr W’s GP 11 April 2014

(LSD)¹³⁴, ecstasy, benzodiazepines, temazepam, and nitrazepam, which was either being prescribed to him or he was obtaining illegally. Mr W also disclosed that at times his drug use was costing as much as £200 per week and that he was often funding it through criminal activities.

- 11.15 On 23 June 2014 it was documented that Mr W reported that “he would like a referral for the mental health team, [stating that] he [was] hearing voices in the evening”¹³⁵.
- 11.16 During a meeting with his key worker (31 July 2014), Mr W reported that he was homeless and that his benefits had been suspended for the last six months.
- 11.17 On 11 September 2014 the community pharmacist informed Inspire that Mr W had failed to pick up his methadone on two occasions (9 and 10 September 2014).
- 11.18 At his next CGL Inspire clinical review, which was undertaken by a nurse practitioner on 16 September 2014, Mr W denied any illegal drug use; however, his drug screen tested positive for benzodiazepines, methadone and opiates. There were no comments in the letter to the GP (18 September 2014) regarding Mr W’s recent disclosures of using intravenous crack cocaine, the discrepancies between his disclosure and the drug test results, or the fact that he had missed some recent methadone collections.
- 11.19 There were also no comments in the letter about Mr W’s disclosures to his key worker that he was hearing voices or about his homelessness and benefit status. In fact, the letter documented that Mr W’s accommodation was “stable” and that his only risk was that of accidental overdosing, which was assessed as being “low”. Again it was noted that Mr W had no dependent children and no involvement with the judicial services.
- 11.20 From 16 October 2014 to the next review on 13 January 2015, Mr W was reporting to his key worker that he had been regularly using heroin. For example, on 12 November 2014 he reported that he had “used heroin 16 times in the last 28 days (smoked)”¹³⁶. Additionally, Inspire was informed by the community pharmacist that Mr W had missed seven methadone collections over this period.
- 11.21 Mr W’s next and final review before the incident was undertaken by the clinical lead on 13 January 2015. The letter to the GP noted that Mr W had

¹³⁴ [LSD](#)

¹³⁵ Inspire notes 23 June 2014

¹³⁶ Inspire notes 16 October 2014

disclosed that he was using one bag of heroin a day and crack cocaine “occasionally”¹³⁷. His drug screen tested positive for methadone, opiates and benzodiazepines.

- 11.22 It was noted that there was no feedback from the community pharmacist, despite it being clearly noted that they had been in contact with Inspire, during the preceding months, to report that Mr W had missed his methadone collection on seven occasions.
- 11.23 Again, the only risk being identified was the risk of accidental overdose, which was assessed as being “low”.
- 11.24 It was documented that Mr W had reported that he had three children, the youngest of whom was aged eight, and that he had supervised contact with this child. He was advised to keep his methadone away from the children, in a wooden box that had previously been provided to him. He was also advised “not to get intoxicated when supervising them”¹³⁸.
- 11.25 Under the mental health section it was noted that Mr W had “been seen by the psychiatric services briefly in the past and [Mr W] reported no major issues identified. Depression/psychosis. The client is on treatment under GP for depression.”
- 11.26 From this point Mr W was seen by his key worker, he was reporting that he was using a bag of heroin a day.
- 11.27 Due to failing to pick up three consecutive doses of methadone, his prescription was suspended from 26 February to 19 March 2015. It was only reinstated once Mr W had attended a review with the doctor. Mr W attended the scheduled appointment on 19 March 2015.
- 11.28 At a care plan review on 12 May 2015, Mr W reported that his barrier to stopping his substance misuse was that he “[liked] using heroin and drinking. Discussed detox and rehab [Mr W] declined.”¹³⁹
- 11.29 Mr W’s last contact with Inspire was on 17 June 2015, when he reported that his heroin consumption had increased to two bags a day. He had no fixed abode (NFA). He requested that his methadone be reduced from 25ml by 2ml a week. Mr W missed all further methadone collections until the incident.

¹³⁷ Letter to GP 14 January 2015

¹³⁸ Letter to GP 14 January 2015

¹³⁹ Care plan review 12 May 2015

Arising issues, comments and analysis

11.30 In Caring Solutions' investigation team's review of the communication between Inspire and Mr W's GP, it was apparent that although they were more comprehensive than the previous prescribing agencies, there were some significant deficits in the information that was being documented.

11.31 This included a lack of accurate documentation regarding:

- Mr W's consistent lack of access to suitable housing and benefits. It was being noted that Mr W's accommodation was stable. This was despite him disclosing at nearly every appointment at Inspire that he was homeless and that for a period of at least six months his benefits had been suspended. He was reporting that his drug habit was costing approximately £200 a day, which should have led the key worker to consider whether Mr W was involved in criminal activities to fund this habit.
- The extent of Mr W's substance misuse
- There was no comment, either within the letter to the GP or within Inspire's notes, on the discrepancies between Mr W's disclosures regarding his illegal drug use and the results of the drug screens.
- Mr W's forensic history and an assessment of his current risks of reoffending.
- Mr W's historic and recent involvement with community mental health services and his potential complex mental health issues, which made him extremely vulnerable with regard to his continued and known substance misuse.

11.32 It was difficult to ascertain if these deficits were due to:

- A lack of a review of Inspire notes, including risks and a care plan being undertaken by the assessors.
- An over reliance on Mr W's self-reporting. From the information that was available to Caring Solutions' investigation team, it was clearly evident that Mr W was an unreliable self-historian, especially with regard to his drug use and extensive forensic background.

11.33 In interviews with Caring Solutions' lead investigator, CGL's senior and locality managers reported that there had been some issues with obtaining the patient records from the previous provider in terms of the compatibility of different agencies' electronic and paper records. Information provided by the

previous agency was limited therefore the full extent of Mr W's forensic history was not known.

12 CGL's risk assessments and management plans

12.1 Caring Solutions' investigation team were provided with one CGL risk assessment and management plan, dated 17 February 2015. The following risks were identified:

- Death, accidental overdose and harm to self.
- Contracting/transmission of BBV.
- Risks of violence to others. It was documented that Mr W "feels his mental health is a danger. Risk of violence and harm to others is not limited to intoxication and he is capable of violence when sober or intoxicated."¹⁴⁰ An action plan was identified with regard to what actions were required from Mr W. For example, he agreed not to carry weapons when he was attending Inspire. The plan also identified what actions staff would take if they felt threatened by Mr W, for example the use of panic alarms. However, there was no plan identified with regard to sharing information or informing other agencies, for example the CMHT, either if there was a decline in Mr W's mental health or to obtain further information.

12.2 Caring Solutions' investigation team identified a number of deficits within Inspire's risk management plan for Mr W:

- As the plan did not have a requirement for the assessor to score the level of each risk (i.e. low, medium or high), it was difficult to assess the level and severity of risk(s) being identified and the source of the information, for example self-disclosure or information from other agencies.
- Although there was a section where details of the identified risk(s) were to be documented and managed/reduced, it was blank. This was concerning given the disclosure within the risk management plan that Mr W considered himself a risk to others regardless of whether he was intoxicated.
- Despite the above-mentioned self-disclosure, in the letters to the GP following Mr W's reviews, the only risk that was being identified was that of an accidental overdose, which was assessed as being low.
- The risks to Mr W's mental health due to his known substance misuse and his lack of compliance with his methadone were not fully identified and/or considered in the risk management plan.

¹⁴⁰ Risk management plan 17 February 2015

- There was no identification of either the other agencies involved in Mr W's care or what role they could play in the mitigation and/or response to Mr W's risk(s).
- 12.3 It was difficult for Caring Solutions' investigation team to ascertain what triggered a review of Inspire's risk assessment and management plan for Mr W, as there were several occasions – for example, during the periods when his methadone had been suspended, or when the dosage of methadone had changed – when Mr W's situation significantly changed, which was very likely to have increased his risks both to himself and to others. Yet this did not appear to have triggered a revision of his risk assessment and management plan.

13 Changes to CGL's service provision

- 13.1 Since this incident CGL have implemented the following significant changes to their service both as a result of findings from their internal investigation, and as part of the wider organisational restructuring and changes introduced by the commissioning authority and NHS England:
- In addition to a clinical director and a director of nursing, CGL now employs consultant psychiatrists, whose role is to maintain clinical oversight, supervise clinical leads and hold clinics for patients. They also attend complex review meetings where patients who have been identified as having complex needs will be discussed. It was suggested to Caring Solutions' investigation team that if this had been in situ at the time Mr W was involved with the Inspire service, it is likely that he would have met the threshold of having complex needs, as he had a number of significant risk markers: homelessness, repeatedly missing methadone collections, mental health issues, failing to attend appointments and recent accidental and/or intentional overdosing.
 - Also, CGL's Data Lead and team leaders regularly audit CGL's electronic information system to extrapolate the complex cohort of patients and also red-flag patients with high or increased risk(s). Once identified, such patients will be discussed at the review meetings. It has been reported that this process is not "fool proof" and that further work is being carried out within the organisation.
 - CGL now utilise a tool called Assessment of Supervised Consumption Inventory (ASCI) to highlight the individual patients with complex risks and support needs.

- If a patient is not engaging with the service, their methadone prescribing is reviewed. It may be decided that they have to collect their prescriptions directly from the service as this enables more face to face contact. This also provides an opportunity to assess and manage the patient's risk(s).
- There is an organisation drive to promote greater professional curiosity and a shift in the culture within their support staff to encourage greater exploration of patients, including those who are not presenting with high risk markers.
- There is increased training for staff that focuses on improving practice, the delivery of interventions, identification and management of risk at both the assessment and at reviews.
- Risk assessments and reviews of risk management plans are now completed on a six-weekly basis, but will be reviewed earlier if any new risks become apparent or there is a change in the patient's risk markers or triggers.
- Patients who have been identified as having complex needs and/or very high risks will now be seen by the Enhanced Team, who manage a lower case load and therefore are able to provide more intensive contact and support to this cohort of patients. It is expected that part of the work of this team is to both develop and maintain greater contact with all other involved services so that a more comprehensive profile and support can be provided to this vulnerable and high-risk patient group.
- With regard to improving communication with patients, CGL use text messaging. If a patient is not responding, contact will be made via their community pharmacist.
- Following the incident CGL have implemented a more robust process to obtain a full medical history from the patient's GP, which includes requesting information about physical or mental health issues and/or the involvement of other services. If they fail to respond, attempts will then be made to make telephone contact with the GP.

13.2 All new patients are asked to sign a 'consent to obtain and share information' form. If they refuse, the patient will be discussed at a team meeting. Although there is clarity as to when a refusal to give consent to information sharing can be breached by CGL's staff in terms of safeguarding issues. However it was reported that if a patient's refusal to share information can be very problematic, as in cases where a patient, like Mr W, has high risk factors or complex mental health needs. This then results in

services working with their respective silos, basing their assessments on limited information and having to be reliant on self-disclosures.

- 13.3 CGL reported that if a patient is subject to a multi-agency care plan, for example MASH (Multi-Agency Safeguarding Hub), CGL would be invited to contribute, and they also would be able to access the information in multi-agency risk and care plans. They would be used to inform CGL's assessments.
- 13.4 CGL's senior and operational managers reported that when they do refer a patient to LCFT's mental health services, they do not always receive a response. Also unless a patient discloses their contact with other services, CGL will often be unaware of who is also involved and/or what treatment they may be receiving from other agencies. They also reported that they do not receive copies of any mental health services' correspondence to the GP. As a direct response to this incident they now automatically copy their correspondence to a patient's mental health services.
- 13.5 It was also reported that CGL routinely ask the patient about their forensic history but do not routinely seek to obtain information from the police and/or criminal justice services. Since Mr W's case, there have been individual cases where the offender manager will see their patients at the Inspire service base which facilitates informal information sharing about individual patients. There are some local information-sharing agreements in place with individual probation services which includes information sharing if a patient is on a probation order.
- 13.6 It was also reported by CGL's senior and operational managers that historically there were some inconsistencies with regard to when community pharmacists reported to CGL services when a patient missed one or two methadone collections. However since this incident the FP10 prescription now advises the dispensing pharmacist that they must inform the service if three consecutive doses are missed. This has resulted in front line staff now receiving prompt information from all community pharmacists about patients' compliance with their methadone collections.
- 13.7 CGL senior and operational manager agreed with Caring Solutions' investigation team that this case has highlighted the need to improve multi-agency working, information sharing, joint decision-making and effective identification of risk(s) so that a more coordinated support can be provided to patients such as Mr W. This urgently needs to be resolved at interagency senior level and formalised within a partnership agreement to ensure that it is a mandatory requirement for all agencies.

- 13.8 These issues will be discussed further within this report and there are a number of recommendations that concern improvement that need to be made by all sectors, including CGL, to strengthen multiagency working and to formalise shared care arrangements. Where CGL's involvement is identified, this will be highlighted in the respective recommendations.

14 Methadone prescribing

Caring Solutions' investigation team member Dr Richard Brown MRPharmS undertook the following review of the commissioning arrangement between Lancashire County Council and the community pharmacies, as part of the local Enhanced Service Contract. He also analysed Mr W's compliance with his methadone treatment from August 2014 to June 2015.

- 14.1 During the year prior to the incident, Mr W was part of a shared care programme to support his withdrawal from illicit substances.
- 14.2 Shared care¹⁴¹ is a term to describe a multi-agency approach to the care of a client across multiple organisations – such as general practitioners, pharmacists and community substance misuse services – who are jointly involved in methadone treatment in the community. In this case, the agencies that were involved in the shared care of Mr W were CGL Inspire, several local community pharmacists and his primary care service.

Lancashire County Council's commissioning and contract with community pharmacies

- 14.3 From April 2013 the commissioning of pharmacy-supervised methadone consumption services moved from Primary Care Trusts (PCT) to the Public Health Department of Lancashire County Council. Formal contracts between the LA and the pharmacies were mandated, and the County Council was accountable for the governance surrounding these contracts.
- 14.4 Lancashire County Council – via NHS Midlands and Lancashire Commissioning Support Unit (CSU) – was responsible for both issuing and monitoring the contract from 1 April 2014 to 31 March 2016.
- 14.5 A copy of the contract, which was in place at the time of the incident, was requested by Dr Brown from the LA. From the difficulties Dr Brown had in obtaining a copy of the contract. It was reported that the CSU were initially unable to provide a copy of the agreement with the local pharmacy. It took over a month to obtain a copy of the contract and covering letter.

¹⁴¹[DH Drug Misuse and Guidance Clinical Guidance 2017](#)

- 14.6 In our review of the contract, it was noted that it was in fact the GP's contract, not one for the pharmacists. Therefore, Dr Brown was unable to review or comment on the contract that was in place at the time of the incident for pharmacists involved in shared care in the locality.
- 14.7 Additionally it was noticed that the contract covered the period 1 April 2014 to 31 March 2016, and the covering letter was dated 24 October 2014, which was nearly seven months after the contract was supposed to have been activated. Additionally, the contract was not signed by the pharmacy until December 2015, and it was not signed by Lancashire County Council until February 2016, which was one month prior to the expiration of the contract. Both these signatures were after Ian Dollery's death. No satisfactory explanation was provided to Caring Solutions' investigation team.
- 14.8 The delays in both issuing and signing the contract are of concern to Caring Solutions' investigation team, as they appear to be indicating that at the time of the incident, Lancashire County Council was not performance-managing the contract with pharmacists – that is managing the monitoring and auditing both the quality of the services being provided and the improvements in patients' outcomes. We were informed that Lancashire County Council monitors the contract with GCL quarterly via formal contract management processes.
- 14.9 Dr Brown was also provided with a copy of Lancashire County Council's most recent contract for community pharmacists (1 April 2016 to 31 March 2017). He concluded that this contract provides greater clarity with regard to the community pharmacies' responsibilities for the monitoring of patients' methadone programmes and their communication with the prescribing agencies. It recommends the following:
- Once a patient's methadone consumption has been stabilised on a daily collection, they are then transferred from daily pickup of their methadone to weekly/twice weekly. The PP10 directs that the pharmacies should notify the prescriber when this change occurs
 - If a patient arrives to collect their methadone after having missed three consecutive doses in a seven day period their methadone should be withheld and they must be referred back to the prescriber.
- 14.10 Clearly these new requirements contractually require the community pharmacists to be in greater contact with the prescribing agency. This will ensure that there is a more comprehensive profile of the patient's compliance and treatment available to the prescribing agency. Therefore,

decisions regarding prescribing, dose regimes and risk assessments can be made by the prescribing agency with accurate information.

Mr W's compliance with his methadone collections

14.11 Every time a patient collects their methadone from a pharmacy, an entry is made into the Controlled Drug Register.¹⁴² Dr Brown reviewed the registers from the pharmacies that were dispensing Mr W's methadone for the period from 30 May 2014 to the date of the incident. The review ascertained the following:

- For each expected treatment point, was the dose(s) collected?
- Who was the prescriber?
- What was the dosage and quality dispensed?
- What was Mr W's recorded address?

14.12 By reviewing all the entries in the registers, the following information was obtained:

- Mr W was living in a fixed address until 15 August 2014, and from then until the incident, it was being recorded that he was No Fixed Abode.
- Mr W was required to present at the pharmacy daily Monday to Friday. On Friday he was also dispensed methadone for Saturday and Sunday. This regime continued until 21 January 2015 at which point Mr W moved to an alternate day pickup regime.
- Mr W's daily methadone dose was 30ml.
- From the information recorded, it is not possible to ascertain when Mr W was on daily dispensing if he was being supervised – that is, if Mr W was being observed by the dispensing pharmacist taking the methadone.

14.13 On 23 February 2015 Mr W's methadone prescriptions ceased as he had failed to collect five consecutive doses. It was reinstated on 19 March 2015, at which point he was moved back to daily pickup, with his Saturday and Sunday dose collected on Fridays as the dispensing pharmacist was closed over the weekends.

14.14 Just prior to the incident (11 June 2015), following a review at Inspire and at Mr W's request the pharmacy was informed that his methadone dosage was to be reduced to 25ml daily.

14.15 Mr W's last collection was on 17 June 2015, one day before the incident.

¹⁴² This is a legal requirement for the supply of Schedule 2 controlled drugs

Arising issues, commentary and analysis

- 14.16 Based on the review, it was noted that until 15 August 2014, while Mr W had a fixed residence, he only missed three collections out of a possible 56 (5.4% of doses missed).
- 14.17 From 18 August 2014 to the date of the incident, when Mr W had NFA, there were 186 collections, of which 56 were missed (30.1% of doses missed).
- 14.18 During September and October 2014, Mr W was regularly missing between one and two doses per week. There were only two weeks during this period when he collected a 100% of his methadone prescriptions.
- 14.19 It was noticeable that the period 27 October 2014 to 20 January 2015 was the most chaotic period, with Mr W failing to collect 50% of his methadone prescriptions.
- 14.20 It was during this period that Inspire changed Mr W's methadone collection to three times a week (Monday, Wednesday and Friday).
- 14.21 Following the reinstatement of treatment on 9 March 2015, Mr W's collection became comparatively more stable; however, 15% of doses were still missed.
- 14.22 During the week prior to the incident records indicate that Mr W collected his methadone on Monday, Tuesday and Wednesday, with no collection on the day of the incident (18 June 2015).
- 14.23 It was possible to observe that there was a distinct and regular pattern to the days that Mr W missed his collections:
- Single missed collections – 23 occasions
 - Two consecutive days missed collections – 14 occasions
 - Three consecutive days missed collections – 3 occasions
 - Mondays – 14 missed occasions
 - Tuesdays – 19 missed occasions
 - Wednesdays – 12 missed occasions
 - Thursdays – 14 missed occasions
 - Fridays – 1 missed (this included the collection for Saturday and Sunday).
- 14.24 Dr Brown concluded that the evidence indicates that when Mr W moved out of stable housing (18 August 2014), it appeared to have had a negative impact on his attendance, with his collection of methadone collection becoming sporadic. We now know that when he was homeless, Mr W led a

very chaotic lifestyle, sleeping rough, sofa surfing at friends and at times moving out of the area. (Refer also to Housing Section of this report which further discusses the risk of homelessness on people with substance misuse issues).

- 14.25 It is not possible to definitively conclude the reason why after 9 March 2015 Mr W was regularly missing his Monday to Thursday collections, but only missed one of his Friday collections. However, on Fridays he was collecting three days' worth of methadone, and we know that Mr W was fully aware that his contract with Inspire was that his methadone prescriptions would be stopped if he missed three consecutive days. Therefore, we can perhaps suggest that Mr W was ensuring that by collecting his Friday dosages he was avoiding the prescriptions being stopped. Also, on that day he had three days' worth of medication, and we know that he was often reporting that he was misusing and possibly selling methadone. This amount of methadone would have had both a greater street value and have greater effect if taken as one single dose.
- 14.26 If Mr W had been taking his methadone erratically, then he would have been potentially increasing his risk of accidental overdose due to a decrease in his opiate tolerance.
- 14.27 Additionally there appeared to be no consistency as to when the dispensing community pharmacists contacted Inspire to alert them to the fact that Mr W had failed to make his collections, or what triggered them to do this. At times this took place after one missed collection and on other occasions it was after three or four missed collections (refers to chronology).
- 14.28 If a more robust contract had been in situ at the time, which clearly outlined the pharmacists' responsibility for reporting missed collections to the dispensing agency, CGL Inspire would clearly have been able to react in a more timely manner in contacting Mr W and/or ceasing his methadone prescriptions. As it was, there was no single agency involved in Mr W's shared care that was undertaking an ongoing analysis of Mr W's methadone collections.
- 14.29 Community pharmacies use the web-based electronic system PharmOutcomes to record the delivery of services. Dr Brown suggests that it is entirely feasible to develop a facility within PharmOutcomes that immediately notifies a local authority and/or the prescribing agencies of any missed methadone collections by a patient. This requirement should be within the community pharmacists' contract and be implemented as a matter of urgency.

- 14.30 Dr Brown also recommends that Lancashire County Council should ensure that they are undertaking a robust governance process for both monitoring and evaluating the performances of all shared care agencies.
- 14.31 Additionally, we would suggest that regular shared care meetings should be convened by Lancashire County Council's Public Health Department, with representatives from prescribing agencies, primary and secondary services and community pharmacies. This would provide a regular forum to monitor and evaluate performance; resolve contractual issues; review the shared care provision; and monitor serious critical incidents, near misses and complaints relating to shared care services that are being investigated by the respective agencies.

15 Commissioning of substance misuse services

- 15.1 It has been recognised that patients with a dual diagnosis and who have complex needs often find it difficult to access and engage with treatment in part "due to the separation of mental health and substance misuse services which resulted in the respective services focusing only on one aspect of the patient's primary needs"¹⁴³. This results in a lack of coordinated services being available.
- 15.2 Historically substance misuse services were often provided within the NHS sector and therefore would have been using the same patient record system. However these services are now being commissioned by local authorities and providers are increasingly the third or independent sectors.
- 15.3 The contracts with such services now require that providers have to provide and be able to demonstrate far greater outcome-focused service provision.
- 15.4 They are also subject to regular recommissioning, and, as in Mr W's case, this can result in issues such as a lack of consistent information being provided and difficulties in the transfer of patients' information. In Mr W's case it was reported that there was a record summary provider by the outgoing provider. However due in part to the incompatibility of respective agencies' electronic record systems, significant information such as Mr W's extensive forensic history, was not transferred to CGL.
- 15.5 The substance misuse service in North Lancashire is to be recommissioned by Lancashire County Council, with a likely start date of July 2018. This investigation has highlighted that the commissioner needs to ensure that if a new provider of substance misuse services is commissioned the

¹⁴³ Mueser, K.T., Noordsy, D.L., Drake, R.E., Fox, L. (2003) Integrated Treatment for Dual Disorders: A Guide to Effective Practice, The Guildford Press

arrangements for the transfer of patients and their records must be embedded within the contract arrangements. This process also needs to be closely monitored by the commissioner to ensure that patients are not adversely affected by the recommissioning of services, that all information, including risk information, is transferred effectively in order to enable the provision of a seamless service and the safety of staff.

- 15.6 The recent governmental drug strategy advises that commissioners of services must ensure that the providers of services have:
- “A work force [that] is competent, well-led, appropriately supervised.
 - Services have [a] work force that is competent, motivated, well-led, appropriately supervised.
 - Assure themselves that services [provided] are safe and effective.
 - Support [the provider to] develop quality governance structures.”¹⁴⁴
- 15.7 It was reported to Caring Solutions’ investigation team by Lancashire County Council’s commissioner that Lancashire is a large and complex geographic with eight CCGs and three local authorities involved in the commissioning of substance misuse services. This has, at times, resulted in each commissioning authority appointing different organisations to provide its substance misuse services.
- 15.8 It was reported that due to competitiveness of the tendering process, such ideas can be commercially sensitive and therefore there is often reluctance for providers to share their visions of services. However Caring Solutions’ investigation team were informed that it is expected that once a provider has been commissioned they will fully participate in the redevelopment of services.
- 15.9 It was reported that CGL have already shared with the commissioners details of their innovative services in another area that has significantly improved all aspects of the care delivery and multi-agency working with this complex patient group.
- 15.10 A Five Year Forward View Strategy has been written by the Clinical Care Group (CCG) in consultation with all sectors within Lancashire. This has also been informed by stakeholder events involving the third and independent sectors, who are continually being encouraged to present their ideas for improvement in the delivery of services.

¹⁴⁴ [Drug Strategy](#)

15.11 During an interview with the CCG's Mental Health Commissioner he reported several further innovative services that have recently been or are in the process of being implemented within the Lancashire area:

- Everybody who presents at A&E with a mental health vulnerability, even if they have comorbidities of substance misuse or domestic violence, will be seen and have a risk assessment completed.
- A pilot in Pennine Lancashire for a vulnerable people service was launched on 1 July 2017. The service is aimed at looking at the group of people who are presenting at A&E and who historically have failed to engage with, or have lapsed in their engagement with, services. A referral to the appropriate service will occur, and this will be case coordinated until a safe transfer has been completed.
- Currently looking to develop a 'one care record' and a central telephone centre where other services, such as the police, are able to obtain information about a person's involvement in services.
- A reciprocal arrangement with the police to share information is currently in the process of being agreed. This is being undertaken with three chief inspectors who are also reviewing their mental health call-outs and current mental health coding to ensure compatibility with mental health services.
- An independent review was undertaken by the Royal College of Psychiatry and the Royal College of Emergency Medicine in November 2016. This review had made a number of recommendations for A&E departments with regard to the risk assessments of patients with mental health needs. It has been widely accepted that the recommendations from this review should be implemented within the whole of Lancashire's A&E departments.

Recommendation 1

Lancashire County Council, Local Pharmaceutical Council, NHS England and services involved in the provision of shared care services in the Lancashire area.

- The revised contract for the provision of substance misuse services should identify how patients' records are to be transferred to a new provider.
- Lancashire County Council should convene regular Shared Care meetings, with representation from prescribing agencies, primary and secondary health services and community pharmacies. These meetings should provide a forum

to:

- Monitor and evaluate performance of agencies against their Shared Care contracts.
 - Highlight and resolve any commissioning, contractual and agency concerns.
 - Review any serious incidents, near misses and complaints.
 - Oversee joint serious incident investigations.
- The Local Pharmaceutical Council, substance misuse services, NHS England should consider undertaking a review to ascertain the value of making an adjustment to the PharmOutcomes system so that it notifies all the involved shared care services when a supervised consumption patient has missed a single methadone collection. This review should take place within six months.

16 Mr W's contact with LCFT's community mental health services August 2010 - December 2013

- 16.1 In an assessment in 2010, Mr W reported¹⁴⁵ that in 2006 he had been assessed by the CMHT but had then received a custodial sentence.¹⁴⁶ On February 2010 a referral was made by Mr W's probation officer to the CMHT. At the time Mr W was subject to a 12-month Supervision Order for assault.
- 16.2 The referral reported that for the last four months, since Mr W had stopped using illegal drugs, his mental health symptoms had been increasing and he was now experiencing auditory hallucinations, anxiety and was in a heightened state of alertness. It was also documented that Mr W had reported that heroin and amphetamines had previously reduced his mental health symptoms. It was also noted that Mr W's GP was prescribing him nitrazepam¹⁴⁷.

¹⁴⁵ Documented in Mr W's patient records 24 February 2010

¹⁴⁶ There is no recorded custodial sentence between 2006 and 2010 in the information available to the investigators

¹⁴⁷ [Nitrazepam](#)

- 16.3 As part of the subsequent CMHT assessment (24 February 2010), a Health and Social Needs Assessment (H&SNA) and a safety profile were completed. They concluded that Mr W was at:
- Low risk for suicide, self-harm, social circumstances and treatment- and illness-related risk
 - High risk for harm to others and substance misuse.
- 16.4 The profile assessed that Mr W's risks were:
- Actual act or stated intent of harming others/aggression (historic and current)
 - Previous convictions for violence – historic
 - Intravenous drug use – historic
 - Drinking in excess of seven units a day – historic and current
 - Sharing injecting paraphernalia – historic and current
 - Epileptiform fits relating to alcohol/or benzodiazepine use – historic and current.
- 16.5 It was also assessed that Mr W did not pose any risk to children.
- 16.6 It was noted that Mr W was on a supervision order for Common Assault and that there were no incidents of domestic violence.
- 16.7 When we cross-reference this with Mr W's forensic history, we can see that in January 2010 Mr W had received a Community Order and a 12-month Supervision Requirement for the assault of a female with whom he was in an intimate relationship.
- 16.8 The assessment documented the contact details of Mr W's probation officer, but there is no indication that any contact was made in order to obtain information to inform the Safety Profile.
- 16.9 There was no detail documented within Mr W's safety profile of the drug agency that was managing his methadone programme.
- 16.10 It was also documented that Mr W "did not want [the assessor] to contact his GP to discuss his medication, particularly his Mirtazapine"¹⁴⁸.

¹⁴⁸ Mirtazapine antidepressant [Mirtazapine](#)

- 16.11 Following this assessment, Mr W was discharged back to the care of his GP. A referral was also made to the Single Point of Access (SPOA) in order to access support services to assist Mr W in managing his anxieties. It is unclear if this occurred.
- 16.12 There was no documentation of any further contact with community mental health services; however, Mr W was not administratively discharged until nearly a year later.
- 16.13 On 4 September 2012, while serving a custodial sentence, Mr W was referred for an Inreach psychiatric assessment. It was documented that Mr W was floridly psychotic and experiencing auditory and visual hallucinations. Mr W refused to be seen by a psychiatrist. It was also documented that his symptoms gradually lessened, and on his release from prison (7 December 2012), he was symptom and medication free and had refused any follow-up from community mental health services. He was discharged by a forensic Inreach Worker to his GP.
- 16.14 Three days after his release from prison (10 December 2012), Mr W presented himself to his GP with what was documented as multiple physical and mental health issues. The GP prescribed him nitrazepam 5mg and again referred him, via the Single Point of Access (SPOA) to the CMHT.
- 16.15 SPOA referred Mr W to the Complex Care and Treatment Team, but it was documented that they had been unable to contact Mr W by mobile phone, and an appointment letter was then sent to Mr W's mother's last known address (19 December 2012). A second letter was sent, again to Mr W's mother's address, cancelling the original appointment and rescheduling it for 4 January 2013.
- 16.16 After Mr W failed to attend this appointment, a letter was sent, again to his mother's address, stating that if he did not contact the service within 14 days, he would be discharged back to his GP. As Mr W did not respond, he was subsequently discharged from the CMHT.
- 16.17 On 28 January 2013 a GP again referred Mr W via SPOA, reporting that Mr W disclosed that he was hearing voices but "that they never told him to harm anyone"¹⁴⁹.
- 16.18 Mr W was seen on 12 February 2013 by a CMHT social worker who completed another H&SNA.

¹⁴⁹ GP referral 28 January 2013

- 16.19 During this assessment, Mr W reported that he had been experiencing auditory hallucinations for the last 20 to 30 years. He also reported some visual hallucinations as well as physical anxiety symptoms and stated that he became angry and irritable when his anxiety increased. He disclosed that he used illegal drugs to “manage his voices”¹⁵⁰. The assessment documented that Mr W had reported that he felt overwhelmed by the voices and that he believed that other people could read his thoughts.
- 16.20 Mr W disclosed the extent of his history of illegal drug use and reported that he was currently being seen by a substance misuse service, but he did not give his permission for CMHT to contact the service. Mr W also disclosed that he often bought medication to help him sleep. The assessor noted that Mr W smelt strongly of alcohol and admitted to having drunk prior to the assessment.
- 16.21 The H&SNA documented that Mr W had a history of DVT and that his mobility was limited.
- 16.22 It was also documented that Mr W had reported that he had three children, aged 25, 19 and 6, and that “he can have access [to them] if he wishes”¹⁵¹.
- 16.23 It was noted that Mr W had disclosed that he had recently been in prison for common assault (September 2011 to December 2012) and that he had been in prison “12 or 15 times but did not wish to divulge why”¹⁵².
- 16.24 It was also noted that Mr W was homeless and that his benefits has been stopped.
- 16.25 A safety profile was completed (12 February 2013), which documented the following risk factors:
- Substance misuse: intravenous drug use – historic
 - Drinking in excess of seven units per day – historic and current
 - Sharing injecting paraphernalia – historic
 - Epileptiform fits relating to alcohol/or benzodiazepine use – historic
 - Actual acts or stated intent of harming others – historic.

¹⁵⁰ H&SNA, p10

¹⁵¹ H&SNA, p9

¹⁵² H&SNA, p10

16.26 Under the forensic history section, it noted “12 months supervision order for common assault”.

16.27 The contact details of Mr W’s probation officer were documented, but there was no indication that the assessor asked Mr W’s permission to make contact with his probation officer or his substance misuse service.

16.28 Following this assessment, Mr W was discussed at the team’s case meeting and a care coordinator was appointed.

16.29 On 28 February 2013, the care coordinator requested a Police National Computer (PNC) database check, which reported that Mr W had 49 convictions and 100 offences. It was documented within the H&SNA that from 1990 to 2011, Mr W had:

- 6 offences against persons 1990-2011
- 47 theft and kindred offences 1986-2009
- 5 drug offences 1996-2003
- 4 firearm/shotgun/offensive weapons offences 1984-2001.

Having obtained this information, the care coordinator completed a Care Plan and a Crisis and Contingency Plan (4 April 2013), but did not revise the Safety Plan.

16.30 Mr W was reviewed by a consultant psychiatrist on 11 April 2013. In a letter to Mr W’s GP (16 April 2013), it was suggested that Mr W’s hallucinations were “probably a feature of his substance misuse ... He [was] aware that for a long time he was involved in doing wrong things but he [wanted] to give up that way of living.”¹⁵³

16.31 The letter also documented that Mr W had been diagnosed with:

- “Mental and Behavioural Disorder due to use of opioids.
- Possibility of Co-morbid Psychosis NOS¹⁵⁴.”

16.32 The consultant psychiatrist asked Mr W’s GP to prescribe mirtazapine (30mg). The intention was to arrange a further CPA review in July 2013.

¹⁵³ Letter to GP 16 April 2013

¹⁵⁴ NOS Not Otherwise Specified

- 16.33 On 10 May 2013 Mr W telephoned his care coordinator, reporting that he had left his bed and breakfast accommodation as his benefits had been stopped because he had been assessed as being fit to work. Later in the day the care coordinator was unable to contact Mr W as both his mobile number and that of his mother were unobtainable. The care coordinator contacted Mr W's Inspire recovery coordinator who provided a different mobile number. Mr W did not answer and there was no answerphone facility.
- 16.34 It was noted that the care coordinator made no further efforts to contact Mr W until a month later (10 June 2013), when again there was no response. Mr W contacted his care coordinator again on 12 June 2013, when he disclosed that he was homeless and was using heroin and crack cocaine. He was given an appointment for 2 July 2013.
- 16.35 Mr W DNA'd this appointment and a decision was made at the team's case management meeting (17 July 2013), at which the consultant psychiatrist was present, to discharge Mr W from the service.
- 16.36 In October 2013 Mr W's GP again referred him, via SPOA, to the CMHT, and an outpatient appointment letter was sent to Mr W via his mother's address.
- 16.37 Mr W attended the assessment appointment with the CMHT on 9 October 2013, and an H&SNA and a Safety profile were completed.
- 16.38 It was documented in the H&SNA that Mr W had requested that he wanted his care coordinator to "write a diagnosis of schizophrenia or psychotic disorder on [his benefit form]. The [care coordinator] advised that she would not agree to this as [she] had no evidence of this."¹⁵⁵
- 16.39 The H&SNA also documented that there were "risks to staff due to [Mr W's] long history of violent offences"¹⁵⁶, although there was no documentation of what action(s) staff should take to mitigate this potential risk, such as no lone working.
- 16.40 The safety profile assessed that Mr W was at risk of:
- Suicide, self-harm and self-neglect: assessed as being "low"
 - Harm to others and social circumstances: assessed as being "medium"

¹⁵⁵ H&SNA 9 October 2013

¹⁵⁶ H&SNA 9 October 2013 p9

- Substance misuse: assessed as being “high”

- 16.41 The safety profile also documented that Mr W “had a long forensic history” and listed a summary of his offences and the contact details of Mr W’s probation officer. There was no documented evidence that any contact was made with Mr W’s probation officer or the substance misuse agency or of whether Mr W was asked if he gave consent for contact to be made.
- 16.42 At the CMHT team case discussion (10 October 2013), it was agreed that Mr W would be offered a further appointment on 29 October 2013. Mr W did not attend this appointment.
- 16.43 At a further team case review (7 November 2013), it was agreed that they would try and engage Mr W with the High Intensity Team (HIT).¹⁵⁷ It was also agreed that a CPA meeting would be arranged and that Mr W’s drug agency would be invited to contribute. There is no record of such a meeting taking place.
- 16.44 On 13 December 2013 Mr W did not attend his HIT appointment, and following a case review on 16 January 2014, Mr W was discharged from the service.

17 Mr W’s contact with LCFT’s community mental health services August 2014 - September 2014

- 17.1 Mr W had no further contact with the CMHT until 4 August 2014, when he again presented himself to his GP, reporting that he was hearing voices. Mr W reported that he was not taking illegal drugs, had reduced his alcohol consumption and was taking his prescribed antidepressant.
- 17.2 Mr W’s GP referred him again to the CMHT. The referral noted that Mr W had disclosed that he was “imagining violence all the time and things going into his head and has been stabbing people”¹⁵⁸ and that his voices were “telling him to calm down”¹⁵⁹.
- 17.3 Mr W was seen on 7 August 2014, both an H&SNA and a safety profile were completed.
- 17.4 The H&SNA documented that Mr W had disclosed that he was:

¹⁵⁷ High Intensity Team provided assertive outreach support. Since this incident this service has been disbanded.

¹⁵⁸ Referral 4 August 2014 p1

¹⁵⁹ Referral 4 August 2014 p1

“experiencing day dreams on a daily basis where he sees scenarios of violence in his head ... he sometimes gets into arguments with people and gets into fights ... 7 weeks ago he broke his foot after kicking someone ... he volunteered that he was NOT remorseful about these incidents and was not concerned if he went back to prison.”¹⁶⁰

17.5 Mr W also disclosed in this assessment that his alcohol consumption had significantly increased, he had last taken crack cocaine in February 2013 and he had not been taking his Mirtazapine, although he had recommenced it after he had recently seen his GP.

17.6 It was documented that in a subsequent call by the assessor to Mr W's GP surgery, they reported that their records indicated that Mr W had been regularly collecting his repeat prescription since March 2014.

17.7 Mr W also described experiencing both auditory and visual hallucinations but denied having any suicidal thoughts. His mood was assessed as being “positive but aggressive ... low self-esteem”¹⁶¹.

17.8 Mr W again reported that since February 2014, his benefits had been suspended, as he had failed to attend a Department of Work medical appointment, and he was either stealing or foraging in skips for food.

17.9 Information that was documented in Mr W's H&SNA on 9 October 2013 regarding both historic incidents of domestic violence and his children being on the Child Protection Register in 1994 was also noted.

17.10 It was also documented that Mr W reported that he had

“never used weapons but [he had] a criminal record for stabbing using a weapon ... Has fantasised in the past about extreme violence towards others such as shooting and stabbing people (from the age 16) which he has acted upon in the form of stabbing his father on numerous occasions to the extent [his father] had to wear protective clothing, stabbed his previous wife.”¹⁶²

17.11 Details of Mr W's offences were also noted within the H&SNA. In the Formulation Section, it was noted that Mr W had

¹⁶⁰ H&SNA 10 August 2014 p2

¹⁶¹ H&SNA 10 August 2014, p34

¹⁶² H&SNA p11

“Failed to tell the truth about using weapons as he had stabbed, at least to our knowledge, 3 different people over the years”¹⁶³.

17.12 In the Staff Allocation Section, it was again noted that there was a “risk to staff potentially due to long history of violent offences”¹⁶⁴.

17.13 The safety profile assessed that Mr W’s risks were:

- Suicide, self-injury and neglect: assessed as being “low”
- Harm to others, and substances: assessed as being “medium”.

17.14 In the Safeguarding Section, it documented that Mr W was:

- “Deemed to pose a risk to children.
- Known Schedule One Offences.
- Significant allegations made of abuse or neglect of children/young people.
- Incidents of domestic violence.”¹⁶⁵

17.15 The management plan was to discuss the case at the team meeting with regard to Mr W’s possible “psychotic symptoms and a one off review by the consultant psychiatrist in order to clarify diagnosis”¹⁶⁶.

17.16 The consultant psychiatrist suggested that contact should be made with Mr W’s probation officer and the substance misuse service in order to obtain information about their current involvement with Mr W.

17.17 Mr W’s probation officer reported that they had not been involved since 2012. It was noted that when the care coordinator contacted CGL Inspire they reported that Mr W’s recovery worker was not working, but their records indicated that he was well known to them and in their experience Mr W’s mental health was more evident when he was not using misusing substances

17.18 A case discussion on 21 July 2014 agreed that Mr W would be reviewed in the outpatient clinic but that there needed to be further liaison with CGL.

¹⁶³ H&SNA p22

¹⁶⁴ H&SNA p24

¹⁶⁵ Safety profile7 July 2014 p3

¹⁶⁶ Safety profile7 July 2014 p3

Based on the information available, there is no indication that any further contact was made by the CMHT with CGL.

- 17.19 It was documented that when Mr W was informed by phone that he would be seen on 29 September 2014, he was unhappy about the length of time he would have to wait for this appointment as “he needed help now”¹⁶⁷. It was noted that he became verbally abusive and threatened to break a window.
- 17.20 Mr W agreed to be referred to a local support service, Help Direct. The referral alerted Help Direct that they should not visit Mr W at home “due to possible known risks to others”¹⁶⁸.
- 17.21 Mr W attended his appointment with the consultant psychiatrist and care coordinator on 29 September 2014.
- 17.22 Following this appointment, a summary letter was sent to Mr W’s GP, which noted that:
- “[Mr W’s] problems are mainly [related] to an inability to control his anger, constantly fantasising and having thoughts of violence which he feels he is prone to act on when he is under the influence of alcohol ... I did not find convincing evidence of hallucinations ... I explained to him that I needed to see him two or three times before one is able to establish a clear cut diagnosis ... He seems to be agreeable to this suggestion.”¹⁶⁹
- 17.23 The letter also advised Mr W’s GP that the management plan, with regard to allocating a care coordinator, was to be discussed at the team’s case discussion meeting and also that a CPA review would be convened in six weeks.
- 17.24 This was the last time Mr W was seen by the CMHT.
- 17.25 At a subsequent team case discussion meeting (16 October 2014), it was agreed that Mr W would be allocated two further reviews and a care coordinator, whose task it would be to obtain information from the involved CGL service on Mr W’s engagement and also his drug use. This did not occur.
- 17.26 On 10 November 2014 the care coordinator made telephone contact with Mr W to remind him of an appointment later that day, but Mr W failed to attend.

¹⁶⁷ Patient Contact Details 21 August 2014

¹⁶⁸ Patient Contact Details 21 August 2014

¹⁶⁹ Letter to GP 9 October 2014

17.27 In a letter to Mr W's GP, it was noted that Mr W would be offered a further appointment but that if he failed to attend he would be discharged from the service.

17.28 A Crisis and Contingency plan was completed on 12 January 2015. The only section completed documented that "currently [Mr W] is of NFA... [and that Mr W] was unwilling to work"¹⁷⁰.

17.29 As Mr W failed to attend a further appointment on 2 February 2015, a letter was sent to Mr W's GP by the consultant psychiatrist, but was not signed, advising him that Mr W had been discharged from the service due to non-engagement.

18 Arising issues, comments and analysis

The following sections of this report will review LCFT and CGLs' involvement with Mr W from 2013 until the incident.

Caring Solutions' investigation team will be referring and making reference to the relevant LCFT policies that were in situ at the time, NICE and the Royal College of Psychiatrists' guidances¹⁷¹ on the diagnosis, management and risk assessment of patients with dual diagnosis.

Caring Solutions' investigation team analysis will also reference the most recent governmental Department of Health (DH) Drug Strategy (2017)¹⁷², Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group: UK guidelines on clinical management (2017)¹⁷³, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness¹⁷⁴ and the Bradley Report¹⁷⁵.

Caring Solutions' investigation team will be considering the following:

- CMHT's diagnostic assessment of Mr W.
- Based on the known information, were the assessments undertaken by LCFT's practitioners reflective of Mr W's risks and support needs?

¹⁷⁰ Crisis and contingency plan 12 January 2015

¹⁷¹ [Rethinking Risk](#)

¹⁷² [Drug Strategy 2017](#)

¹⁷³ [DH Clinical Guidelines, Drug Misuse and Dependence](#)

¹⁷⁴ [National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Webpage](#)

¹⁷⁵ [The Bradley Report](#)

- The responses of the CMHT’s practitioners to Mr W’s consistent failure to engage.
- We will be considering if LCFT CMHT’s referral and treatment pathways were suitable to meet the needs of this particular difficult-to-engage patient group.

The following sections will also be addressing the following NHS England TOR:

- “Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the perpetrator’s first contact with services to the time of their offence.
- Review the appropriateness of the treatment of the perpetrator in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the perpetrator harming themselves or others.
- Examine the effectiveness of the perpetrator’s care plan including the involvement of the service user and their family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.”

LCFT’s assessment and diagnosis

- 18.1 In Caring Solutions’ comprehensive review of Mr W’s medical notes, it was very evident that since his first presentation, in the 1990s, to mental health services, Mr W was at times disclosing that he was experiencing psychotic symptoms. These included auditory and visual hallucinations, paranoid ideation, delusional beliefs, ideas of reference¹⁷⁶, and thought broadcasting¹⁷⁷, and at times it was observed that he was presenting with incongruent emotions¹⁷⁸.
- 18.2 Mr W was also disclosing that he was gaining some relief from his symptoms when using illicit substances and alcohol and that he experienced increased severity in his mental health symptoms during his very infrequent periods of abstinence.
- 18.3 There was only one occasion, in 1995, when Mr W was prescribed antipsychotic medication; the rest of the time he was being prescribed

¹⁷⁶ People talking about him

¹⁷⁷ Thought broadcasting is the belief that others can hear or are aware of an individual’s thoughts

¹⁷⁸ A person’s response does not match circumstances/situation

antidepressant medication. It is unclear, however, how compliant he was with any of his prescribed medications. Additionally, as has already been highlighted, Mr W's methadone collections were at best inconsistent.

18.4 Mr W's continual use of psychoactive substances, repeated inconsistencies in his self-reported accounts of his mental health symptoms, substance misuse, forensic history, current psychosocial situation and sporadic contact with both LCFT and substance misuse services all contributed significantly to the difficulties that the various clinicians had in confirming a definitive diagnosis. This also resulted in Mr W's risk assessments, treatment and care plans often being based on inaccurate information.

18.5 Clearly Mr W's presentation presented significant challenges to the involved clinicians in their assessments. Mr W also appeared to be largely treatment resistant and/or unwilling/unable to consistently engage with either the CMHT or substance misuse services. His contact with services was very sporadic, and he would disengage with them, usually after the initial assessment appointment. Therefore, there was no opportunity for either the clinicians or the care coordinators to undertake detailed longitudinal assessments that could have informed the various mental health formulations, risk assessments and treatment plans.

18.6 On Mr W's last assessment by the CMHT psychiatrist (20 September 2014), it was documented that the working diagnosis was:

- "Mental Behaviour Disorder due to [the] use of Opioids.
- Mental and Behavioural Disorder due to [the] misuse of alcohol.
- Possibility of Co-morbid psychosis NOS."¹⁷⁹

18.7 It was documented in a letter to Mr W's GP that Mr W had a:

"Long forensic history and tendency to be violent, it would appear that the main problems [were] related to [his] poor impulse control and anger. I did not find convincing evidence of hallucinations but [Mr W] did describe that when he was alone he thinks people are talking about him."¹⁸⁰

The psychiatrist also documented that he had explained to Mr W that he would need to attend two or three more appointments before a definitive diagnosis could be reached. Although it was documented that Mr W

¹⁷⁹ NOS refers to a diagnosis without specific or distinguishing features

¹⁸⁰ Letter to Mr W's GP 9 October 2014

“seemed agreeable to this suggestion”¹⁸¹, he failed to engage any further with the CMHT.

18.8 Following Mr W’s arrest (June 2015) there was ample opportunity for Mr W to be observed and assessed in a setting where he was free from illegal substances. He was observed responding to unseen stimuli and given the following mental health diagnoses:

- Paranoid Schizophrenia International Classification of Mental and Behavioural Disorders (ICD F20.0)
- Antisocial or Dissocial Personality Disorder (ICD F60.2).

18.9 Caring Solutions’ investigation team were able to access three psychiatric assessment reports that were prepared for Mr W’s trial, which all confirmed these diagnoses.

18.10 Caring Solutions’ investigation team have concluded that given Mr W’s sporadic contact with services, his conflicting disclosures and the limited information available to his psychiatrist prior to his index offence, it would have been difficult to have definitively given Mr W the diagnoses that were given after his arrest. However, based on the known information that was available, there was ample evidence to indicate that Mr W was consistently presenting with a differential diagnosis¹⁸² of Drug Precipitated Psychosis and Drug- and Alcohol Related Harm.

18.11 Additionally, in the review of Mr W’s records, it was very evident that from his early 20s Mr W was exhibiting traits of impulsivity, high negative emotionality and associated risk behaviours, including irresponsible, exploitative and antisocial behaviours; recklessness; and deceitfulness. Caring Solutions’ investigation term concluded that all of these were suggestive that Mr W met the diagnostic criteria for Severe Dissocial Personality Disorder.¹⁸³

18.12 Caring Solutions’ investigation team have concluded that if an extensive review of Mr W’s historical records had been undertaken during his involvement with CMHT, then a more comprehensive assessment of Mr W’s mental health presentation, risk and support needs could have been undertaken, which would have informed a diagnosis, his risk assessments and treatment plans.

¹⁸¹ Letter to Mr W’s GP 9 October 2014

¹⁸² Differential diagnosis: the process of weighing the probability of one disease versus that of other diseases possibly accounting for a patient’s illness

¹⁸³ [Severe Dissocial Personality Disorder](#)

19 Dual diagnosis

This section will review the assessment, care and treatment of Mr W in light of recent research and best practice guidelines for the assessment and management of patients with a dual diagnosis.

19.1 Dual diagnosis covers a broad spectrum of mental health and substance misuse problems that an individual might be concurrently experiencing. The nature of the relationship between these two conditions is complex – for example, the destabilising and detrimental effects that substances can have on a patient’s mental health or on the medication they are being prescribed for their mental health symptoms, as well as the possibility that a patient may be self-medicating with substances, and therefore their underlying mental health symptoms may be obscured or exacerbated.

19.2 Research indicated that 30-50% of people with severe mental illness have co-existing substance misuse problems and that over 70% of people in contact with substance misuse services have co-existing mental health problems.¹⁸⁴ The Department of Health states that this patient group present:

“Significant challenges to service providers due to the complexities of their physical, social, psychological and other issues associated with this condition ... [This] makes the detection, assessment, treatment and the provision of good quality care even more challenging.”¹⁸⁵

19.3 Although the term ‘dual diagnosis’ has been widely adopted, there has been some criticism that it implies just two distinct diagnoses, whereas it is recognised that patients, like Mr W, often have multiple diagnoses, which can also include interrelated risk factors and support needs.

19.4 As in Mr W’s situation, this patient group can also have a complex range of both associated physical health issues, often related to their drug abuse, and psychosocial needs, for example housing and financial/benefit situations that are often the result of their unstable life situation. Clearly at times Mr W was presenting and asking for help with many of these issues.

¹⁸⁴ Weaver, T., Charles, V., Madden, P., Renton, A. (2002) Co-morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC): A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations. Department of Health/National Treatment Agency, London

¹⁸⁵ DH 2004a, Care Services Improvement Partnership (CSIP) (2008) dual diagnosis is ‘everyone’s business’ (CSIP 2008)

19.5 It is recognised that a risk for patients with dual diagnosis is that “their co-existing problem(s) are often not detected or [are] overlooked”¹⁸⁶. This can result in them being misdiagnosed and/or receiving inappropriate treatment.

19.6 Research and recent governmental and NICE guidelines have consistently identified that it is

“everyone’s business to provide good quality services for people with mental health and substance misuse difficulties ... it should be central to modern mental health”¹⁸⁷.

19.7 Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide¹⁸⁸ identified that one of the biggest challenges facing front-line mental health services in their assessment and support of patients such as Mr W is:

“The complexity of [formulating a] diagnosis, care and treatment with service users who are at higher risk of relapse, readmission to hospital and suicide. One of the main difficulties is that there are a number of agencies involved in a person's care - mental health services and specialist rehabilitation services, organisations in the statutory and voluntary sector.”¹⁸⁹

19.8 It has been suggested that one of the fundamental issues is that:

- Substance misuse services often have limited expertise to work with people with more complex dual-diagnosis presentations and/or there is a general lack of attention given to a patient’s mental health issues.
- Secondary mental health services often lack the skills for supporting patients with a dual diagnosis and have limited knowledge and awareness of local substance misuse services.

These deficits can adversely affect the treatment outcomes for patients such as Mr W in both their engagement with the involved services and their recovery outcomes.

¹⁸⁶ Mueser, K.T., Noordsy, D.L., Drake, R.E., Fox, L. (2003) Integrated Treatment for Dual Disorders: A Guide to Effective Practice, The Guildford Press

¹⁸⁷ [National Institute for Mental Health: Dual Diagnosis, Themed Review Report 2006/7](#)

¹⁸⁸ [Mental health policy implementation guide: Dual diagnosis good practice guide](#)

¹⁸⁹ [Mental health policy implementation guide: Dual diagnosis good practice guide](#)

19.9 Caring Solutions' investigation team reviewed LCFT's Dual Diagnosis Partnership Protocol, which was and still is in place¹⁹⁰ states LCFT's commitment to delivering:

"The optimum level of care for these Service Users ... The application of a 3 stage approach will require all clinical staff to consider the Service User's needs at each step, ask pertinent questions of their own agency's capability to respond independently to the needs of this Service User group and ultimately promote integration of all key partners where necessary."¹⁹¹

19.10 The three stages that LCFT's practitioners are expected to apply in their assessment and support of patients with a dual diagnosis are:

"Stage 1: Screening/review of overall needs:

All relevant staff must undertake screening/review of the Service User in order to establish immediate risks and support needs. The key factors to be assessed at this stage are:

- Severity of mental ill-health to determine if this is mild – moderate or a severe & enduring condition.
- Substance use patterns: current use, dependence, perceptions & readiness/motivation to change.
- Housing & support network e.g. homelessness, engagement with supported housing, social networks.
- Risks: to self, to others, safeguarding, neglect and vulnerability in relation to all of the above.

Key Question: Can our service support the person's overall needs and manage associated risks? If the answer is NO move to stage 2.

Stage 2: Use of the Liaison Model

The clinical worker is then required to discuss the outcomes of screening/review with the team's liaison worker /supervisor. During this discussion consideration of the following options will take place:

- Consultation with another service re advice on treatment/support
- Offer of collaborative care with another service

¹⁹⁰ Protocol due to be reviewed October 2017

¹⁹¹ LCFT's Dual Diagnosis Partnership Protocol, p5

- Referral on to another service

The worker must then ask the following:

Key Question: Which service(s) can offer support in relation to the person’s needs? The locality-specific matrix of services will assist in making decisions about which service to contact based on matching the assessed needs to the ‘spectrum’ of mental health and substance use presented.

Stage 3: Treatment Models and care coordination

The clinical worker will subsequently ask the following question:

What type of care should be offered and who should coordinate this? LCFT promotes and supports the liaison model and considers it to be best practice for service users with mental health & substance misuse issues.”¹⁹²

19.11 The protocol reiterates that:

“At each juncture the worker needs to examine the case for working independently with the client, delivering services in conjunction with other services within the Trust and also how care may be delivered in collaboration from a range of external organisations”¹⁹³.

19.12 Caring Solutions’ investigation team were unable to find any documented evidence of, or references to, the implementation of any of these three stages by the CMHT practitioners who were involved in Mr W’s assessments and care.

19.13 The chronology of Mr W’s contact with LCFT’s CMHT indicates that there were missed opportunities for interagency communications:

- Telephone messages were left by both agencies, but they were not followed up.
- When contact was made with CGL with regard to Mr W’s contact details, there was no discussion about Mr W’s history, risks, support needs or the respective agencies’ treatment plans.
- On 16 October 2014 at a CMHT case discussion meeting, Mr W’s care coordinator was tasked to obtain information from CGL Inspire with regard to Mr W’s engagement and his drug use. This did not occur, partly because a decision was subsequently made to discharge him from the service.

¹⁹² LCFT’s Dual Diagnosis Partnership Protocol 2014, p7-8

¹⁹³ LCFT’s Dual Diagnosis Partnership Protocol 2014, p9

- The contact details of Mr W's probation officer were also noted several times within Mr W's notes, but no contact was made.
- 19.14 Additionally, correspondence from both Inspire and LCFT's CMHT was only being sent to Mr W's GP. The GP reported that although all correspondence is read, they do not have the capacity to go out of the surgery to locate a patient whom they have been informed is not attending appointments with secondary care services, nor do they see themselves as a conduit to pass on information to other involved services.
- 19.15 In interviews with Caring Solutions' investigation team, CGL's senior managers and the front-line staff reported that apart from potential safeguarding issues, they would only liaise with other involved agencies with the patient's consent. However since this incident prior to the commencement of a patient's methadone prescribing it is now mandatory for the patient to provide consent for information sharing with their GP and the dispensing pharmacist.
- 19.16 CMHT's practitioners who were interviewed also reported that they would not routinely share information: for example copy letters to other agencies, due to data protection and information governance. There was no evidence to indicate that either CMHT asked Mr W if information could be shared with the other involved services.
- 19.17 This lack of information sharing was of concern for a number of reasons:
- All agencies' risk assessments and care and treatment plans were being based on partial information provided solely by Mr W.
 - Staff from all involved agencies did not have sufficient knowledge of Mr W's risk profile to adequately protect themselves and to develop a safe working plan. However, we did note that on one occasion the CMHT advised an advisory support service that they should not lone work with Mr W, which indicates that there was awareness that Mr W posed some risk to support staff.
 - The CMHT were not advised of Mr W's erratic compliance with his methadone prescriptions and therefore were unable to assess the impact that this may have had on both his mental health and his engagement.
- 19.18 Clearly to facilitate and develop a culture of interagency information sharing, all agencies should be copying their correspondence to all involved services. Patients should be asked to give their consent for this to occur, and in the case of the CGL service, if the patient refuses, then consideration

should be given to the suitability and safety of the service provision to that patient.

19.19 Research and the various governmental drug guidances were, at the time of Mr W's care, and currently still are highlighting that identifying and supporting this patient group in their recovery is:

“Only achievable through partnerships across services particularly housing, employment and mental health services ... agreed pathways of care will enable collaborative care delivery by multiple agencies ... Coordinated multi-agency plans, collaboration and good communication between services are important to ensure patients do not fall between the gaps.”¹⁹⁴

19.20 Evidence is clearly indicating that in this case all the involved services were operating in isolation. There was no coordination of information, thus enabling Mr W to provide, at times, conflicting information about both his historic and his current situation without being challenged.

19.21 It was reported by CGL that both at the time and currently there is an absence of any substantive interagency protocols at both commissioner and senior level between CGL, LCFT and other organisations. This has resulted in practitioners often being reliant on local arrangements and relationships. Such arrangements are often lost when the new provider is commissioned or individual practitioners leave.

19.22 CGL senior managers reported that they have been very keen to be part of an interagency Dual Diagnosis Protocol that provides a multi-agency 'wrap round' and rapid access service for patients, like Mr W, who have a dual diagnosis and who meet the threshold of having complex needs.

19.23 They also reported that one of the main difficulties they have experienced in trying to develop such a protocol with LCFT is convening meetings where individual service providers' senior managers and the commissioners of both mental health (Clinical Commissioning Groups) and substances misuse services are represented. They reported that to date, this level of participation has not been achieved.

19.24 CGL's senior managers suggested that if such a protocol was in situ, it would result in a multi-agency structure for:

- Undertaking shared assessments and reviews
- Developing multi-agency risk assessments and management plans

¹⁹⁴ [Drug Strategy 2017](#)

- Identifying a lead coordinator for each case
- Holding regular multidisciplinary meetings for all involved services to discuss particular patients who are classed as meeting the threshold of having complex needs. Such a meeting would also be a regular venue for resolving any interagency issues.

19.25 CGL's senior manager reported that they had been fundamental in developing such a protocol in another area and that they have discussed the issues and development of such a protocol in the locality with their commissioner, but as yet the difficulties of convening a joint strategy forum have yet to be resolved. Also, the LA's current recommissioning of substance misuse services has resulted in the impetus being lost.

19.26 LCFT's Serious Incident Report (SIR) identified that the lack of an interagency protocol was a contributory factor to this incident, and one of its recommendations was:

"The nature and extent of joint working between Substance Misuse Services and Mental Health Services should be jointly reviewed by LCFT and Substance Misuse Services for people with dual diagnoses of mental illness and substance misuse. This should include:

A review of the LCFT Dual Diagnosis Protocol in the light of changes to community Mental Health Services and Substance Misuse service providers and an information sharing agreement."¹⁹⁵

19.27 LCFT's most recent action plan relating to this recommendation states that as of March 2017, the following actions had been implemented:

- "Working group in place and reviewing the dual diagnosis protocol (this is being done Trust wide and includes Inspire).
- Dual Diagnosis to be part of the 'Promoting Health, Preventing Harm' work stream.
- Dual diagnosis practitioners are in post."¹⁹⁶

19.28 CGL's senior manager reported that they had not been involved in or consulted about the development of LCFT's dual-diagnosis protocol, nor have they observed, at a service level, any significant changes in LCFT's services.

¹⁹⁵ LCFT's Action Plan provided to Caring Solutions June 2017

¹⁹⁶ LCFT's Action Plan provided to Caring Solutions June 2017

- 19.29 Caring Solutions' investigation team is concerned that CGL does not appear to have been involved in the development of LCFT's protocol,
- 19.30 What this investigation has clearly highlighted is that providers of services to patients who have a dual diagnosis should not be developing protocols in isolation. For such a protocol to be effective in the delivery of a seamless services that meets the needs of this complex patient group all services including primary, secondary and third and private sector providers and the commissioners of all services, have to be involved and fully committed,
- 19.31 The latest governmental Drug Strategy (2017) highlights this, stating the need for:
- “improved collaboration between mental health and substance misuse services ... and that commissioners and providers provided a coordinated whole system approach to meet the complex needs of people who use drugs ... and that joint outcome measures need to be developed across all partnership services: for example mental health, drug treatment, housing and criminal justice services”¹⁹⁷.
- 19.32 Throughout the strategy it is reiterated that a patient's “recovery is only achievable through partnerships across all services”¹⁹⁸. Also, in order to achieve a whole system approach, the partnership arrangement needs to be agreed at a senior management and commissioner level.
- 19.33 The strategy suggests that “Health and Wellbeing Boards¹⁹⁹ are well placed to bring together a local system of care in order to deliver better outcomes”²⁰⁰ for this particular patient group.
- 19.34 The government strategy provides little in the way of how Health and Wellbeing Boards, providers and commissioners should be implementing its aims and objectives to improve services.
- 19.35 Clearly this case has highlighted that there are systemic issues within the provision of health and social care to individuals, such as Mr W, which need to be addressed at a wider strategic and commissioning level. These issues need to involve the development of a cross-sector protocol. Therefore, Caring Solutions' investigation team would recommend that the Health and

¹⁹⁷ [Drug Strategy](#)

¹⁹⁸ [Drug Strategy](#)

¹⁹⁹ Health and wellbeing boards are central to the government's vision of a more integrated approach to health and social care. Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health. [Health and Wellbeing Boards](#)

²⁰⁰ [Drug Strategy](#)

Wellbeing Board assumes responsibility for the coordination of a forum that includes:

- Lancashire LA's public health commissioners
- Mental health commissioners CCGs
- Senior managers from LCFT, third and independent substance misuse providers
- Housing providers
- Any other relevant services.

The Health and Wellbeing Board should utilise the findings of this investigation to convene a multi-agency forum where a coordinated dual-diagnosis strategy can be agreed and implemented to ensure that there is a coordinated and collaborative whole system integrated pathway to support individuals who use substances so that they have access to high-quality physical and mental healthcare, housing and employment.

19.36 At their six-month review, Caring Solutions will seek evidence of the progress that has been made in developing and implementing such a protocol and will ascertain if it has improved the service delivery to this vulnerable patient group.

Recommendation 2

Lancashire Health and Wellbeing Board, Lancashire County Council (Public Health), Lancashire Clinical Commissioning Groups, Lancashire Care NHS Foundation Trust and provider(s) of substance misuse, housing and judicial services.

Lancashire Health and Wellbeing Board should assume responsibility for the coordination of a forum to develop and implement a local dual-diagnosis protocol that provides:

- A coordinated and collaborative whole system integrated pathway to support individuals who misuse substances so that they have access to high-quality physical and mental healthcare, housing and employment.
- A senior strategic board that oversees and monitors the implementation of the dual-diagnosis protocol across all of the health and social care sectors.
- Clarity with regard to interagency information sharing and the management of

risk, shared care arrangements, including care coordination.

- Biannual meetings with representatives from all involved sectors with the aim of developing robust interagency relationships, to share lessons learned from serious incidents and to proactively identify and manage interagency issues.

20 LCFT's risk assessments

20.1 From February 2010, at every initial CMHT assessment appointment a Health and Social Needs Assessment (H&SNA) and a safety profile were completed. The last assessment was completed on 8 August 2014. Three Safety Profiles were completed.

20.2 In summary, Mr W's:

- Risk of suicide and self-harm was rated as low in all safety profiles.
- Risk of neglect was assessed as medium, apart from the 12 February safety profile, in which it was assessed as low.
- Risk of harm to others was assessed as medium, apart from one assessment (12 February 2013) in which this risk was not assessed.
- Risk of substance misuse was assessed as low on 12 February 2013, high on 8 October 2013 and medium on 8 August 2014.

20.3 In the "Risk History Details" and "How Risk is Managed" sections, the following entries were made:

- 12 February 2013: "has a number of prison sentences over the years, became quite defensive when talking about this said he has had custodial sentences for everything except rape and murder. Most recent sentence from September 2011 to December 2012. Did not want to discuss but said it was around domestic abuse."
- 8 October 2013: this section was not completed.
- 7 August 2014: Mr W "spoke about experiencing 'day dreams' on a daily basis where he sees scenarios of violence in his head. He has had these since he was aged 5 years but [they] are becoming more frequent ... he sometimes gets into arguments with people and gets into fights – 5 weeks ago someone spoke back to him and he cut his wrists – 7 weeks ago he broke his foot after kicking someone who did something to his ex-girlfriend ... He volunteered that he was not remorseful and was not concerned if he

went back to prison.” The section also documented the exact comments from the February 2013 safety profile with regard to Mr W’s forensic history.

20.4 In their review of the assessments undertaken Caring Solutions’ investigation team have highlighted a number of deficits in both the content and the Safety profile pro forma within all three of Mr W’s safety profiles. All the assessments failed to adequately identify or assess even based on the limited information available the full extent of Mr W’s possible future risks of harm to himself and others.

20.5 In all three safety profile the assessor noted in the “Risk History Obtained From” section that information was not obtained from any other sources apart from Mr W. The options identified within the pro forma were psychiatric and medical notes and police and other agencies. No effort appeared to have been made by the assessors to obtain information from other sources, despite LCFT’s Clinical Risk Policy directing that:

“Effective communication and sharing information within the mental health team, with other relevant practitioners (including General Practitioners) and between agencies is essential, and information sharing arrangements must be documented.”²⁰¹

In the opinion of Caring Solutions’ investigation team, in order to continue to effectively assess Mr W’s risk of relapse in his substance misuse and mental health symptoms as well as his potential risk of reoffending, it was essential that the assessors proactively sought the involvement of and obtained risk information from all services involved including CGL and Mr W’s GP.

20.6 Mr W’s GP was the conduit of all services’ involvement as he was the only agency who had a comprehensive picture, via agencies correspondence, of Mr W’s historic and current situation that could have been utilised to inform risk assessments and support planning. He also could have provided valuable information on Mr W’s ongoing vulnerable physical health.

20.7 LCFT’s Clinical Risk Policy at the time stated that the context of risk assessments is:

“The likelihood of an event happening with potentially beneficial or harmful outcomes for self and others” (Sainsbury Centre for Mental Health, 2000).

²⁰¹ LCFT Clinical Risk Management policy January 2012 p6

Risk assessment can, therefore, be described as a dynamic process based on an estimation of the likelihood and severity of particular adverse events occurring under particular circumstances within a specified period of time. It is the gathering of information about clinical presentation, risk behaviour and risk history, and an analysis of the potential outcomes of identified behaviour. The nature, frequency and severity of the risk behaviour must all be considered ... Current guidance (DH, 2007) emphasises the need for a structured and tiered approach: an initial risk screening assessment, followed by a more in-depth risk assessment where indicated, leading to a formulation, which provides the basis for the risk management plan – all of which should be firmly embedded within care planning processes.”²⁰²

20.8 The policy identifies that the function of the risk management plan is to:

“Provide a clear explanation of how specific risk behaviours arise in an individual given the presence and relevance of various conditions, which have been identified as risk factors. It should further indicate interventions or responses which are likely to reduce (or increase) the likelihood of the specific risk behaviour(s) occurring and consequently is the key to subsequent risk management planning. It includes predisposing, precipitating, perpetuating and protective factors.”²⁰³

20.9 However, LCFT’s safety profile pro forma is mainly a series of tick boxes where the assessor is required to tick the patient’s current and historic risk factors. It does not require the assessor to document a narrative about each risk identified or provide an opportunity for the assessor to analyse the potential outcomes of the identified risks.

20.10 Clearly Mr W’s known history presented with many of the risk factors for violence that were outlined within LCFT’s Clinical Risk Management Policy. These were:

- Demographics: male, lack of social support.
- Background history: childhood maltreatment, history of violence, first violent at young age, history of childhood conduct disorder.
- Clinical history: non-compliance with medication.
- Psychological and psychosocial factors: anger, impulsivity, suspiciousness, lack of insight.

²⁰² LCFT Clinical Risk Management Policy January 2012 p6-7

²⁰³ LCFT Clinical Risk Management Policy January 2012 p6

20.11 The Bradley Report, which was published in 2009, clearly highlighted that the co-existence of alcohol and substance misuse was a significant indicator of future significant risk of relapse and reoffending. Even based on the limited information available to the various assessors, we would have expected Mr W to have been identified as being at high and significant risk of relapse and reoffending and disengagement from secondary mental health services.

20.12 LCFT's policy also directs that one of the key standards of CPA is that:

"The assessment must include reference to risk, safeguarding ... A formal risk assessment must be completed and recorded at initial assessment. On-going risk assessment will be carried out for all Service Users and this will continue to inform the care planning process. Any new information gained which highlights any previously unidentified risk or escalation of known risk will result in a further formal risk assessment being documented ... to address their identified needs, who are involved in actions to meet those needs, their relapse signature and management of risk including contingency/crisis arrangements."²⁰⁴

20.13 Caring Solutions' investigation team noted that when the CMHT assessor did obtain detailed information about Mr W's forensic history but it did not trigger a review of his Safety Profile.

20.14 Additionally, LCFT's Care Planning Approach Policy:

"Emphasises the need for a focus on delivering person-centred mental health care and also repeats that crisis, contingency and risk management are an integral part of the assessment and planning processes."²⁰⁵

There was no evidence within Mr W's notes that risk management or crisis plans were completed.

20.15 The Royal College of Psychiatrists suggests that:

"The basis of all violence risk assessment is that past behaviour is the best guide to future behaviour. It follows that the most important part of risk assessment is a careful history of previous violent behaviour and the circumstances in which it occurred. On an individual level, a detailed understanding of the patient's mental state, life circumstances and thinking is a major contributor to the prevention of harm. ... A critical function is to stratify

²⁰⁴ LCFT Care Planning Approach Policy July 2013 p7

²⁰⁵ LCFT Care Planning Approach Policy July 2013 p5

people into a group (low, medium or high risk), which will help dictate the appropriate risk management strategy.”²⁰⁶

- 20.16 The Royal College of Psychiatrists reiterates the importance of longitudinal risk assessments being undertaken in order to assess a patient’s risk to other, which includes a combination of “statistical data with clinical information in a way that integrates historical variables, current crucial variables and contextual or environmental factors. Additionally, any concerns raised by families should be responded to, and, in principle, their concerns should also automatically trigger a more structured risk assessment.”²⁰⁷
- 20.17 The Royal College of Psychiatrists also suggests that if in an assessment of the patient there is concern regarding their risk of harm to others, it should “trigger a more structured risk assessment process, with the use of an assessment tool that is appropriate for the group, such as a HCR-20 assessment ...and avoiding the notion that one size fits all”²⁰⁸.
- 20.18 Caring Solutions’ investigation team were informed that in 2014 the CMHT team lost their dedicated substance misuse worker. It was also at this point that the High Intensity Team (HIT) was disbanded. The HIT had provided the assertive outreach service²⁰⁹, which managed a smaller caseload than the CMHT. These included patients with more complex treatment needs, who often had dual diagnosis and like Mr W were chaotic and difficult for services to engage with. Since this restructure, the CMHT have been expected to deliver this function within their existing caseload.
- 20.19 It was reported to Caring Solutions’ investigation team that since this incident, CMHT’s practitioners now have weekly meetings with LCFT’s forensic service, at which patients are discussed who have significant forensic histories. The CMHT will be supported by the forensic service in developing risk management plans and they will also, when required, undertake HCR-20 assessments.
- 20.20 LCFT have also introduced an enhanced risk assessment that can be utilised for patients who present with higher levels of risk.
- 20.21 Additionally, the CMHT deputy manager is the link person whose role it is to develop working relationships with external agencies and who is the point of

²⁰⁶ [Rethinking risk to others in mental health services, Royal College of Psychiatrists London 2016 p24](#)

²⁰⁷ [Rethinking risk to others in mental health services, Royal College of Psychiatrists London 2016 p24](#)

²⁰⁸ [Rethinking risk to others in mental health services, Royal College of Psychiatrists London p38](#)

²⁰⁹ [Assertive Outreach](#)

contact when there are particular concerns about a patient who has multiservice involvement

20.22 Caring Solution's investigation team was unable to test the robustness of the Enhanced Risk Assessment. Additionally CGL did not report that they were aware of the role of the CMHT deputy manager as the link person.

20.23 Caring Solutions' investigation team concluded in their review of Mr W's safety profile assessments that there were several significant deficits that significantly affected the accuracy of the assessments. These were:

- The assessor did not actively seek to obtain information from other agencies, nor did they ever challenge Mr W when he provided conflicting information, for example about his forensic history, contact with his children and recent substance misuse.
- No review of Mr W's psychiatric notes.
- The Safety Profiles that were completed failed to identify or consider the presence of several known significant and recognised key risk indicators. These were:
 - Poor compliance with his medication.
 - Ongoing homelessness and poverty.
 - Social exclusion.
 - History of offending behaviour against people and property.
 - Historic and ongoing substance misuse.
 - A known historic and recent history of disengagement with CMHT services.

20.24 Despite Mr W's limited disclosures, Caring Solutions' investigation team were of the opinion that the Safety Profiles that were completed failed to adequately identify and assess the extent of Mr W's possible future risks of harm to himself and others based on his historic and recent risks. The successive Safety Profiles did not provide any additional information, nor did they highlight the very high risk that based on his recent history, he would disengage with the CMHT service after the initial assessment. As a consequence, the CMHT failed to establish a relevant risk management and crisis plan, or identify the potential risks to others, including CMHT staff.

20.25 The assessors should have been alerted to Mr W's potential risks and, until such time as additional information was obtained both from other involved agencies and from a review of his psychiatrist's records, they should have been assessing that Mr W's risks were at the highest level. It was also noted

that most of the risk narratives appeared to have been cut and pasted from the previous assessment.

20.26 Caring Solutions' investigation team concluded that the current LCFT safety profile pro forma is inadequate for the following reasons:

- The tick boxes do not facilitate professional curiosity by prompting the assessor to ask further questions.
- There is no process embedded within the safety profile that highlights where there are deficits or insufficient information that directs when the assessor take further action(s), for example obtaining information from other service providers.
- There is no section that highlights when risk information has changed from the previous assessment(s) or documents when information is missing and what action is required.
- There are no indicators of when the risk information is such that it needs to be escalated to senior management for approval.
- There is no narrative section in each area of risk, both historic and recent, where the assessor is required to document the information on which they have made the assessment.
- There is no correlation between the information obtained within the H&SNA and the Safely Profile.
- There is no analysis or commentary section or overall assessment of risk.

20.27 Given the fundamental deficits identified within LCFT's current safety profile pro forma, Caring Solutions' investigation team recommends that a complete revision of this document is undertaken. The new assessment tool should :

- Require a narrative of all risk identified.
- Require the assessor to identify the contact details of all agencies involved and what action has been taken to obtain information.
- Highlight where there are deficits of information and what action(s) the assessor is going to take to obtain the information. Until such information is obtained and assessed, the patient's risk should be assessed as high.

- 20.28 Additionally where a significant historic risk has been identified, for example an index offence, that is not considered a current risk, there should be a section where this is documented. This will ensure that any significant historic risk information that may need to be considered in subsequent assessments is documented and accessible.
- 20.29 Based on the information obtained in the risk assessment, a risk management plan should be developed that clearly highlights who may be at risk and what action(s) needs to be taken to reduce or eliminate the potential risks – for example, a staff safe working action plan, or reporting a risk to the safeguarding team.
- 20.30 A “My Safety Plan”, which includes a risk management and crisis plan and is based on the information obtained during the risk assessment, should be developed by the assessor in collaboration with the patient and any involved family and/or carers.

21 LCFT’s care planning

- 21.1 From 4 March 2013 to 18 July 2013, three care plans were completed.
- 21.2 Caring Solutions’ investigation team reviewed Mr W’s care plans with reference to the LCFT Care Programme Approach Policy (July 2013) that was in place at the time. The policy emphasised that the:

“Two central components of the CPA are the role of the care co-ordinator who has overall responsibility for the coordination of the assessment and care planning processes in partnership with the Service User and Carer, and multidisciplinary team working ... Collaboration and communication about risk are vitally important components of good and safe practice.”²¹⁰

Despite this directive that care planning and subsequent reviews should be collaborative with both the patient and other involved practitioners, there was no evidence that the CGL or his GP were asked to contribute.

- 21.3 All three care plans were minimal in their content and actions to be taken, partially due to Mr W’s sporadic contact with the CMHT, although the plan dated 4 March 2013 did identify that a support worker from the HIT would “work with [Mr W] on his housing issues”²¹¹.

²¹⁰ LCFT Care Planning Approach Policy July 2013 p5 & 9

²¹¹ Care plan 4 March 2013

- 21.4 The action arising from Mr W's last care plan dated 18 July 2013 was that he was to be discharged back to his GP due to "his poor engagement with mental health services"²¹².
- 21.5 It was very evident that Mr W's interaction with both CGL Inspire and the CMHT was generally precipitated by him wanting practical support with his benefits or housing or help to get his methadone prescription reinstated. He consistently failed to engage in any recovery or harm-reduction support with either agency.
- 21.6 When Mr W did make direct contact with the CMHT to ask for help, there was often a delay in an appointment being given to him. For example, on 2 June 2013 he contacted his care coordinator, reporting that he was homeless and using heroin and crack cocaine. Mr W was given an appointment for 2 July 2013. He expressed his frustration at the delay by threatening violence, and he failed to attend the appointment.
- 21.7 It was unusual for Mr W to be disclosing how chaotic and high risk his life was, and this was, therefore, a rare opportunity, which was missed, for the CMHT to act promptly and maybe to have engaged with him. However, he was asked to wait a month to be seen at which point he had disengaged.
- 21.8 Additionally, every time Mr W was referred to the CMHT, a comprehensive assessment was undertaken at the initial appointment, but he then usually failed to engage in any further appointments.
- 21.9 Although it is appreciated that an assessment needs to be undertaken to identify any changes in a patient's needs and risks, this is a very time consuming process. For someone like Mr W, whose lifestyle is so transient and whom it is difficult to engage with, Caring Solutions investigation team would suggest that the criteria of an initial appointment should be to engage the patient quickly and to ascertain their immediate needs. Caring Solutions' team would suggest that as part of a new risk assessment process LCFT should introduce a support needs and risk screen that is completed at the initial appointment. Such a screen could both identify the immediate needs and risks and allow time for the assessor to begin to engage with the patient.
- 21.10 The CMHT also needs to be considering how suitable their service is for a patient with Mr W's presentation, who is living in the chaotic world of homelessness, substance misuse and poverty, and who is funding his lifestyle through criminality and survival crimes.²¹³ Clearly the HIT would

²¹² Care plan 18 June 2013

²¹³ Stealing for self-preservation e.g. food

have had capacity to have been more responsive, but this service is no longer available with the current CMHT structure.

Lancashire Care NHS Foundation Trust

Recommendation 3

Lancashire Care NHS Foundation Trust.

Lancashire Care NHS Foundation Trust should consider developing a new risk assessment tool that includes both a risks management and crisis plans which involves both the patient and all other involved agencies.

22 Safeguarding and Multi-Agency Safeguarding Hub (MASH)²¹⁴

- 22.1 In our review of Mr W's CMHT records, there was a notification from 6 September 1994 that a Child Protection meeting had been convened, as there were concerns regarding Mr W's 6-month-old daughter, who had been injured during an incident of domestic violence. The outcome of this meeting was not documented, nor was there any reference made to this historical incident within his more recent contact with the CMHT. A review of Mr W's LCFT notes would have highlighted this historic issue.
- 22.2 In an H&SNA on 9 October 2013, the section "Child Protection Issues" documented the dates of birth of Mr W's two youngest children and the fact that both children were on the Child Protection Register due to the mother's inability "to protect her children and risks to the children from domestic violence"²¹⁵. There was no further detail documented and no details as to where this information was obtained.
- 22.3 In the "Safeguarding Children" section, the following was documented:
- "Deemed that [Mr W] did not pose a risk to children.
 - Significant allegations made against [Mr W] of abuse or neglect involving children/young people.
 - Incidents of domestic violence."

²¹⁴ [MASH](#)

²¹⁵ Safety profile8 October 2013

22.4 Despite this information being documented, there was no indication that any further action was taken or that further information was sought about either Mr W's risk of domestic violence or his risk to his children.

22.5 At subsequent assessments with both the CMHT and CGL Inspire, Mr W provided conflicting information about his children and his access to them. This was not highlighted or challenged, and no action was taken, such as seeking advice from LCFT's safeguarding team or reporting concerns to the local Multi-Agency Safeguarding Hub (MASH).²¹⁶

22.6 LCFT's safeguarding policy identifies that:

"The support and protection of children cannot be achieved by a single agency. Every Service has to play its part and all staff must have placed upon them the clear expectation that their primary responsibility is to the child and his or her family." (Lord Laming 2003)²¹⁷

It directs that all staff must be

"Alert to the potential indicators of abuse or neglect for children and adults at risk and know how to act on those concerns in line with local guidance"²¹⁸.

22.7 This lack of response or further inquiry is of great concern, as potential safeguarding issues regarding Mr W's youngest child, whom he disclosed during one review at CGL Inspire that he had access to, may have been overlooked.

22.8 If there had at the time been a culture within both secondary and third sectors of information sharing, then information could have been shared and in the light of the combined knowledge of Mr W's history of domestic violence and of previous child protect issues consideration then could have been given as to whether this should have been referred to the local Multi-Agency Safeguarding Hub (MASH)²¹⁹.

22.9 MASH would have been able to compile intelligence from a wider range of sources about Mr W's history and his previous involvement with children and vulnerable adults' services and the police.

²¹⁶ The primary purpose of Multi-Agency Safeguarding Hub (MASH) is to improve the timeliness and quality of information sharing and decision-making between agencies when a referral is made to the police and/or Local Authority due to concerns about the welfare of an adult or child. The aim is to reduce potential risk of harm to children, young people and adults and to ensure appropriate and coordinated services are offered. This could either be through prompt progression to a safeguarding assessment by the Local Authority or referral to support services. [MASH](#)

²¹⁷ LCFT Safeguarding and Protecting Children and Adults Policy 2015 p3

²¹⁸ LCFT Safeguarding and Protecting Children and Adults Policy 2015 p13

²¹⁹ Multi-Agency Safeguarding Hub (MASH) The primary purpose of Lancashire, Blackpool and Blackburn with Darwen's Multi-Agency Safeguarding Hub (MASH) is to improve the timeliness and quality of information sharing and decision-making between agencies when a referral is made to the police and/or Local Authority due to concerns about the welfare of an adult or child. The aim is to reduce potential risk of harm to children, young people and adults and to ensure appropriate and coordinated services are offered. This could either be through prompt progression to a safeguarding assessment by the Local Authority or referral to support services. [Local MASH](#)

22.10 MASH would also have facilitated information sharing and enabled both CGL Inspire and the CMHT to develop a more comprehensive picture of Mr W's forensic history and his recent contact with the police in relation to the incidents of suspected domestic violence. It would have highlighted to all involved agencies any potential risk(s) to his youngest child. A multi-agency risk management plan could then have been developed. As it was, all involved agencies were working in isolation and assessing Mr W's risks to himself and others on at best partial information.

23 Housing

23.1 It appears that from the point Mr W was released (7 December 2013) from his last prison sentence, he was No Fixed Abode (NFA).

23.2 Mr W was also reporting at various assessments with both CMHT and CGL Inspire that he was homeless, either rough sleeping or "sofa surfing"²²⁰ with friends and family.

23.3 There was only one occasion, on 27 February 2013, when a CMHT support worker contacted a local housing charity in order to make an appointment for Mr W. It was noted that Mr W was known to the charity, and they reportedly said that "there would have to be a significant change in [Mr W's] behaviour and presentation [for him] to be considered for housing"²²¹ by them.

23.4 In a letter (11 April 2013) to Mr W's GP, the CMHT consultant psychiatrist reported that Mr W was:

"Homeless as his mum would not have him [staying with her] as [she] was finding it difficult for him to be at home ... Because of his past history he is now considered unhousable"²²².

23.5 On 10 May 2013 Mr W contacted his care coordinator to inform her that he had to leave his B&B accommodation, as his benefits had been stopped as they had assessed that he was "fit to work". He had given his mobile to a friend in exchange for sleeping on his sofa.

23.6 On 11 February 2014, during a medical review with CGL Inspire, Mr W reported that he had been homeless for the last two years but had just obtained accommodation. However, by 13 May 2014 he was reporting that

²²⁰ H&SNA p11

²²¹ CMHT notes 27 February 2013

²²² Letter to GP 16 April 2013

he was homeless having separated from his girlfriend and was again sofa surfing.

- 23.7 On 31 June 2014 Mr W reported to his key worker that his benefits had been stopped for six months, and therefore he was unable to seek accommodation. The key worker documented that when Mr W was asked how he was living with no money, he “asked me not to bother asking and stated that [he was] surviving well enough”²²³. He reported that he would not apply for Jobseeker’s Allowance as he did not want to look for work.
- 23.8 In two of the Safety Profiles (8 October 2013 and 7 August 2014) undertaken with Mr W, he identified that he was both historically and currently at risk of “pressure of eviction/repossession/homelessness/poor living circumstances”.
- 23.9 Mr W’s care coordinator reported to Caring Solutions’ investigation team that she remembered that on one occasion, Mr W disclosed to her that he was feeling very low about his lack of secure accommodation. He was often reporting that he had to sell or give his mobile phone to his friends in return for them letting him stay on their sofa. This was identified as one of the reasons why he often failed to attend his appointments, as services were unable to make contact with Mr W on the various mobile phone numbers that he gave them.
- 23.10 Also, correspondence was repeatedly being sent to his mother’s house, despite him reporting to both the CMHT and CGL that he was estranged from her. Again this was cited as a reason why he was often missing his scheduled appointments.

Arising issues, comments and analysis

- 23.11 Clearly Mr W was known to local housing providers, as on 27 February 2013, when a CMHT support worker contacted a local housing charity in order to make an appointment for Mr W, it was documented that the provider reported that “there would have to be a significant change in [Mr W’s] behaviour and presentation [for him] to be considered for housing”²²⁴. There was no evidence of any further support offered to Mr W to secure affordable accommodation.
- 23.12 Caring Solutions’ investigation team were provided details of local supported housing services and an agency that provided assistance bonds for deposits for accommodation.

²²³ Inspire notes 31 July 2014

²²⁴ CMHT notes 27 February 2013

23.13 It was reported by his care coordinator that Mr W had disclosed that his lack of affordable accommodation was, in part, preventing his recovery, as he was associating with his peers who were taking illegal substances and it was difficult to abstain in their company.

23.14 The correlation between inadequate housing, unstable tenancies, homelessness and mental health is well recognised. It is reported that people who are homeless have 40-50 times higher rates of mental health problems than the general population and that they are one of the most disadvantaged and excluded groups in our society.²²⁵

23.15 It is suggested in the Department of Health's strategy 'No health without mental health'²²⁶ that securing and maintaining appropriate housing is identified as a particular issue for people with mental ill-health. The strategy notes that "poor housing conditions and unstable tenancies can exacerbate mental health problems while periods of illness can in turn lead to tenancy breakdown"²²⁷.

23.16 Research²²⁸ also indicates that individuals who have inadequate housing or experience homelessness often fail to receive the appropriate care and treatment for their mental health conditions for a number of reasons:

- "Poor collaboration and gaps in provision between housing and health services;
- Failure to join up health, social care and housing support services, and disagreements between agencies over financial and clinical responsibility; and
- Failure to recognise behavioural and conduct problems such as self-harm, self-neglect, tenancy issues such as substance misuse and anti-social behaviour"²²⁹.

23.17 The Social Exclusion Unit report Reducing Re-offending by Ex-prisoners (2002)²³⁰ firmly established that housing was one of the nine links between offending, reoffending and other wider factors that influence offending behaviours.

²²⁵ [DH](#)

²²⁶ [DH](#)

²²⁷ National Housing Federation [National Housing Federation](#)

²²⁸ St Mungo's, "Down and Out? Mental health and street homelessness", 2009 [St Mungo's](#)

²²⁹ St Mungo's, "Down and Out? Mental health and street homelessness", 2009 [St Mungo's](#)

²³⁰ Bradley Report April 2009 p5 [Bradley Report](#)

- 23.18 During the interview with the CMHT manager she reported that the role of care coordinators was to provide the social care support. She also reported that within the CMHT staff who act as care coordinators are both social care and nursing staff, and that the former tend to look more holistically at needs. For example, they will work more proactively than the nursing staff to help a patient to access support for housing.
- 23.19 On a practical note, with regard to the difficulties the CMHT had in making contact with Mr W due to his lack of a postal address, Caring Solutions' investigation team would suggest that this could have been resolved by making arrangements to use the pharmacy where Mr W was collecting his methadone prescriptions, as this was a place that it was known that he was regularly visiting. This was also a venue where his care coordinator could have arranged to meet with him.
- 23.20 Caring Solutions' investigation team would suggest that housing must be considered a priority focus for all the CMHT care coordinators, strenuous efforts must be made to support patients, like Mr W, to secure affordable and secure housing.
- 23.21 Additionally Caring Solutions' investigation team would strongly suggest that no patient, regardless of their housing history, should be considered "unhousable" as there are specialised support housing services that are very successful in supporting and managing patients with Mr W's presentation. But again this requires an interagency collaborate approach where information sharing is the central tenet.

24 LCFT internal investigation (SIR) and action plan

- 24.1 LCFT's internal post-incident review (SIR) was approved by the Network and Medical Directors on 23 December 2012.
- 24.2 The lead investigator was LCFT's Head of Investigations and Learning at Lancashire Care. The investigation team included Mr W's Consultant Psychiatrist, two care coordinators who had been involved in Mr W's care and the Deputy Manager from CGL Inspire.
- 24.3 The investigation concluded that "the root cause of the incident was an acute episode of paranoid psychosis brought on by what police described as a three day drugs binge ... A second root cause is that none of the Service User's associates who had witnessed and were concerned about his behaviour sought help for the Service User or raised the alarm."²³¹

²³¹ LCFT's SIR p3

24.4 The ToR were to:

- Establish the facts, i.e. what happened (effect), to whom, when, where, how and why (root causes and contributory factors)
- Establish whether failings occurred in care or treatment (care and service delivery problems)
- Look for improvements rather than apportion blame
- Establish how recurrence may be eliminated or reduced
- Formulate recommendations and an action plan
- Provide a report and record of the investigation process and outcome
- Provide a means of sharing learning from the incident.

24.5 The SIR made seven recommendations:

- “The lead CCG commissioner should agree with the local authority lead commissioners an information sharing protocol for the purposes of Serious Incident investigations which covers Substance Misuse Service providers and other non-statutory services. Consideration should be given as to whether this should be a mandatory contractual requirement. This should include access to clinical records, policies and procedures and access to staff to interview.
- A system should be put in place to ensure that when a PNC check is requested and identifies significant risks to staff or the public, these risks should be shared with all agencies involved in the care of the individual, a multi-agency risk assessment and formulation must be undertaken and the Multi-Agency Safeguarding Hub (MASH) should be alerted.
- Whilst it is beyond the remit of LCFT the managers of Inspire should, in the light of this report, review whether their current risk assessment procedure – which relies solely on Service User self-disclosure – provides sufficient safeguards to protect their staff and the public from high risk individuals or allows them to identify such individuals. Their standard Clinical Review letter should be amended to include harm to others in the risk domains.
- The nature and extent of joint working between Substance Misuse Services and Mental Health Services should be jointly reviewed by LCFT and Substance Misuse Services for people with dual diagnoses of mental illness and substance misuse. This should include:

A review of the LCFT Dual Diagnosis Protocol in the light of changes to community Mental Health Services and Substance Misuse service providers and an information sharing agreement.

- The Adult Mental Health Network must clarify how it can meet the needs of people who are difficult to engage and/or have chaotic and high-risk lifestyles, in particular people with a dual diagnosis of mental illness and substance misuse both in terms of service provision and discharge procedures.
- It is recommended that the AMH Network [Adult Mental Health Network] utilises the Safer Mental Health Services Toolkit (which forms part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness) to benchmark their services against and develop a robust action plan as there are a number of domains with particular relevance to the issues identified in this investigation.
- The Network must assure itself that all appropriate staff have received the Enhanced Risk Assessment training and that its implementation is evidenced in the clinical records.”²³²

24.6 The Medical Director informed Caring Solutions’ investigation team that he initially had not been satisfied with the original action plan, as it was not Specific, Measurable, Attainable, Relevant and Timely (SMART) enough. The action plan was subsequently revised.

24.7 LCFT’s last action plan identified the following progress:

- “Review the Dual Diagnosis Partnership Protocol

Action: Working group in place and reviewing the dual-diagnosis protocol (this is being done Trust wide and includes Inspire).

Dual Diagnosis to be part of the “Promoting Health, Preventing Harm” work stream.

Dual-diagnosis practitioners are in post.

- The information-sharing section of the protocol currently focuses on and uses the phrase “need to know”

Action: This phrase must be removed from the document and it must instead provide guidance in more detail on the sharing of risk-related information.

²³² SIR p34

It must include principles from the Data Protection Act and the recently updated Good Medical Practice to support intelligent decision-making with regard to information sharing.

- Ensure that information relating to PNC checks is specifically mentioned within the Dual Diagnosis Protocol.

Action: This will be included in the protocol as part of the review.

- Ensure that the Dual Diagnosis Partnership Protocol includes a specific section on expected Standards of Risk Assessment in patients with a Dual Diagnosis and links this to the sharing of that information

Action: This will be included in the protocol as part of the review.

- Protocol for PNC checks.
- The systems of communication to be used between the Trust Security Management Specialist and clinical teams to ensure that they are still in keeping with Trust systems and with Good Medical Practice.

Action: Protocol has been updated and is being utilised as part of the audit.

- Ensure the Protocol includes clear instructions to clinical staff to update the electronic clinical record (ECR) with new PNC check information, and advice on the sharing of PNC information with other organisations
- Conduct an audit to evidence that all relevant PNC check information is always placed in the electronic clinical record in the next Trust Audit Cycle

Action to be included in 2017/18 audit cycle.

Dip sample (10 cases from each ward) to ensure information is always placed on the electronic clinical record.

- Ensure that the Standard Operating Procedures (SOPs) of all teams includes a section mirroring the instruction to update the electronic clinical record with new PNC Check information

Action: This is to be included in all relevant community SOPs; there is also an appendix, which is the PNC Check Request Form. The Security Manager for the Trust also sends an email asking that when PNC checks are returned, staff are to ensure that all PNC are added to the ECR.

Develop a poster to be displayed in all communal clinical work areas, which outlines the importance of updating the electronic clinical record with PNC check information and which provides guidance on information sharing.

- The nature and extent of joint working between Substance Misuse Services and Mental Health Services should be jointly reviewed. This should include a review of the LCFT's Dual Diagnosis Protocol in the light of changes to information sharing for community Mental Health Services and Substance Misuse service providers.
- The Adult Mental Health Network must clarify how it can meet the needs of people who are difficult to engage and/or have chaotic and high-risk lifestyles, in particular people with a dual diagnosis of mental illness and substance misuse, both in terms of service provision and discharge procedures.

Action: Review the Standard Operating Procedures for all community teams to ensure that all patients discharged from the service are discussed with the team consultant before the discharge takes place. This discussion must be regarded in terms of clinical importance as a "discharge CPA meeting" and be documented in the patient record.

A training programme for all community-based qualified staff members is to be developed by the Network and the Training Academy.

Conduct an audit to evidence that all patients discharged from community teams are discussed with the consultant and that the discharge is managed and documented in the electronic clinical record. .

- It is recommended that the AMH Network uses the Safer Mental Health Services Toolkit (which forms part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness) to benchmark their services against and develop a robust action plan, as there are a number of domains with particular relevance to the issues identified in this investigation.

Action: Conduct an audit of community mental health services using the Safer Mental Health Services Toolkit to inform future service development as part of the Trust Audit Programme.

Analyse previous benchmarking of services against the Safer Mental Health Services Toolkit.

- The Network must assure itself that all appropriate staff have received training in the Enhanced Clinical Risk Tool and that its implementation is evidenced in the clinical records.

Action: Actions from the MIAA Audit of the Enhanced Risk Assessment Tool are to be developed.”²³³

24.8 All actions have been identified as having been completed by March 2017 or have been part of the 2017/18 audit cycles.

24.9 Caring Solutions’ investigation team concluded that based on the evidence that was available, LCFT’s SIR has satisfied the key lines of enquiry, and their recommendations and the revised action plan were mostly appropriate. However one area that was not addressed within SIR was the significant deficits that Caring Solution’s investigation team have highlighted within LCFT’s risk assessment process. Additionally during interviews with Caring Solutions’ investigation team, CGL Inspire’s senior manager and the CMHT’s front-line staff appeared not to have been familiar with the changes that have been documented within LCFT’s action plan. In the case of CGL, they reported that they had not been involved in discussions with LCFT about their Dual Diagnosis Policy.

25 CGL’s post-incident report

25.1 After the incident, CGL Inspire’s project manager completed a Management Investigation Report (7 September 2015), which included a comprehensive chronology of the service’s involvement with Mr W.

25.2 The report concluded the following four points:

- “Partnership working with CMHT is not strong.
- Staff do not always evidence when they have attempted to link clients into a wider network of services.
- When clients miss the 1st and/or 2nd pick up of their prescribed medication at the Pharmacy, staff do not always follow this up by contacting the client, particularly where this is a pattern.
- A change to prescribing from supervised consumption to 3x weekly pickup was not supported by evidence [that] it was appropriate, given the client’s recent engagement history.”²³⁴

25.3 Based on these findings, the following actions were identified:

²³³ LCFT Action plan July 2017

²³⁴ Change, Grow, Live CGL Management Investigation Report 7 September 2015

- “Set up a formal joint review process for individuals that are engaged with both Inspire and the CMHT.
- Assertive linkages of clients into wider health and social care organisations, evidenced in file/case notes.
- ALL missed pickups to be followed up to check client’s welfare and patterns of missing one or two days to be reviewed with client and clinician.
- Changes to prescribing regimen to be supported by evidence/rationale.”²³⁵

25.4 An action plan was provided to Caring Solutions’ investigation team, which identified the actions associated with each area. Staff had been allocated to each action, but there were no dates for the completion of each action.

25.5 CGL’s senior manager reported to Caring Solutions’ investigation team that, they had not completed a full post-incident root cause analysis investigation, in part due to the fact that they had not been alerted by the police to the seriousness of the incident until some time had passed. It was agreed that this was an error and that CGL should have commissioned a full investigation. It was reported that CGL did not share the findings of their internal report with LCFT.

25.6 LCFT’s SIR report noted that:

“The investigation encountered significant obstacles accessing detailed clinical information from Inspire. Much of what is included in the report was gleaned from letters contained in the GP notes from Inspire clinical reviews. The investigation was eventually provided with an incomplete report.”

CGL senior managers reported in their interview with Caring Solutions’ investigation team that they did not think that this statement accurately reflected what had occurred and the difficulties they had in responding to LCFT’s investigator’s request. They reported that CGL was always willing to be involved in investigations being completed by other providers. However, in this case LCFT had wanted CGL to share Mr W’s full records very shortly after the incident had occurred and before the police had contacted them. Mr W was, at this point, not considered fit to be interviewed. Therefore, CGL could not seek his agreement, as they are required to process such a request, via their own internal information governance structure, for his notes to be released. What they did do was provide a verbal summary of information to LCFT at the one meeting the manager attended.

²³⁵ Change, Grow, Live CGL Management Investigation Report

25.7 CGL's senior manager reported that they had not been given the right to comment on the issues highlighted about their involvement within LCFT's SIR before it went to the CCG.

Arising issues, comments and analysis

25.8 As part of the investigation, Caring Solutions' investigation team reviewed the Recovery orientated substance misuse treatment services in North Lancashire service specification (2012-2013). It was noted that although it considers both internal and external governance requirements, it did not make any direct reference to the expectation that providers should work in partnership with other involved sectors when a serious incident occurs. In fact, it provided little direction as to what actions are expected to be undertaken following a serious incident.

25.9 Caring Solutions' lead investigator met with the commissioner of substance misuse services in North Lancashire, who was in the process of developing the next service specification for the upcoming retendering process. She highlighted the deficits in the previous specification and made several suggestions as to what should be included within the new specification in order to ensure that following a serious incident:

- Services are expected to undertake an investigation.
- Where practical undertake a joint investigation.

25.10 Public Health England's latest guidance, better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers²³⁶, also highlighted that this is an issue that needs to be addressed within LA's service specifications and that providers' internal governance processes identify serious incident reporting and investigations specifically across mental health and substance misuse services.

26 Previous investigations

The ToR for this case asked that Caring Solutions' investigation team

“Consider and report on any recurrent features/findings and recommendations of previous independent investigations.”

26.1 Caring Solution's investigation team accessed an independent homicide report from 2010 where the perpetrator was, at the time of the incident, in

²³⁶ [Better care for people with co-occurring mental health and alcohol/drug user conditions](#)

receipt of LCFT's community mental health services-Early Intervention Service (EIP)²³⁷. The victim was known to the perpetrator.

26.2 The similarities to Mr W's case was that the patient (Mr G) had been diagnosed with drug induced psychosis and that it was consistently difficult for services to engage with Mr G in either therapeutic or in his care management.

26.3 This report's recommendations include :

- Improving LCFT's incident policy and procedure
- Developing and auditing "audit community mental health teams to ensure that any potential safeguarding issues are flagged up and discussed, and that specialist safeguarding advice is sought when needed"²³⁸.
- LCFT should "audit to ensure that: "police criminal checks are made in line with the joint information sharing protocol between the trust and Lancashire Constabulary; and the information is recorded in the clinical records and details included in the service users risk profile"²³⁹.

26.4 A further independent homicide report²⁴⁰ was commissioned by the responsible strategic health authority, NHS England North, in 2012. The perpetrator (Mr F) was, at the time of the incident, under the care of LCFT's complex and crisis care team. The victim was known to the perpetrator.

26.5 Mr F had a mental health diagnosis of paranoid schizophrenia.

26.6 The report noted that "excessive drug use was a consistent feature of his presentation that preceded deterioration in his mental health"²⁴¹.

26.7 The report concluded that Mr F was never referred to a "drug worker for assessment and management. Throughout [Mr F's] engagement with trust services there was clearly a disconnect between addiction and mental health services"²⁴².

26.8 However since the incident the report noted that "a specialised practitioner has a dual diagnosis role in the team. The specialised practitioner can work

²³⁷ [Independent investigation into the care and treatment of Mr G: November 2014](#)

²³⁸ [Independent investigation into the care and treatment of Mr G: November 2014](#) p9

²³⁹ [Independent investigation into the care and treatment of Mr G: November 2014](#) p8

²⁴⁰ [Independent investigation into the care and treatment of Mr F: December 2013](#)

²⁴¹ [Independent investigation into the care and treatment of Mr F: December 2013](#) p11

²⁴² [Independent investigation into the care and treatment of Mr F: December 2013](#) p13

with the care coordinator and the service user to discuss the best approach – including therapeutic interventions and/or education about the impact of substance misuse on mental health”²⁴³.

26.9 This report also made reference to the introduction of a new risk assessment within LCFT and recommended that “the trust should report on the implementation of their new risk assessment process and on the roll out of training to the board. The trust plans to commission an external review of the quality of the new process. These findings should be reported to the board for any necessary action”²⁴⁴.

26.10 Since both these incidents occurred the substances misuse service is no longer is provided by LCFT and has been outsourced to the independent sector. This was the case when Mr W came to the attention of mental health services in 2013.

26.11 Caring Solutions also recently undertook an investigation into a homicide case involving another LCFT patient. This report was published in September 2017.²⁴⁵ The victim was known to the perpetrator.

26.12 The report’s recommendations included improving :

- Information sharing, both internally and also with external agencies.
- The identification of risk and the risk assessment process, both in terms of content and also the proformas being utilised.
- Identifying and reporting concerns about possible safeguarding issues.

26.13 Clearly there are a number of concerning similarities and deficits within these historical reports and this case, with regard to risk assessment and risks management and information sharing with other agencies. All of which is indicating that LCFT has not yet introduced robust enough processes to resolve these issues and improve practice. This is why they have again been identified within this report’s recommendations as requiring remedial action to be taken by LCFT and the other involved agencies.

²⁴³ [Independent investigation into the care and treatment of Mr F: December 2013](#) p13

²⁴⁴ [Independent investigation into the care and treatment of Mr F: December 2013](#) p13

²⁴⁵ [Independent investigation into the care and treatment of Mr S: September 2017](#)

27 Post incident support provided to the families

The ToR asked Caring Solutions' investigation team:

“To review how the Trust provides aftercare and support to families affected by homicide or other serious incidents and to identify any learning opportunities.”

Ian Dollery family

- 27.1 It was reported to Caring Solutions' investigation team by the police senior investigating officer (SIO) that post-incident the family of Ian Dollery were introduced to several Family Liaison Officers (FLOs), the Victim Support charity and the Support after Murder and Manslaughter (SAMM) charity. The SIO also met with LCFT to discuss what bereavement support could be provided to the family.
- 27.2 The author of LCFT's SIR reported that initially there had been a delay in contacting the family, as the police had advised that as the case was still being investigated, contact should not be made, as it might prejudice the criminal investigation.
- 27.3 The author of the SIR reported that he had meetings or email or telephone contact with the wife of Ian Dollery on four occasions (11 August 2015, 13 August 2015, 1 October 2015 and 6 October 2015), Initially to express condolences to the family, to explain the serious incident investigation process and to provide updates on the investigation.
- 27.4 Ian Dollery's wife was provided with a copy of the SIR and met with both the senior managers and the lead investigator to discuss the findings of the report.
- 27.5 Caring Solutions' investigation team were satisfied that LCFT met its Duty of Candour²⁴⁶ in relation to the involvement of the Dollery families in post-incident investigations. However, it would be helpful to the Dollery family to receive the most recent action plan from LCFT and also regular progress reports until all actions have been completed.
- 27.6 It was reported to the Caring Solutions' investigation team that LCFT had initially offered all the members of the Dollery family support from the local CMHT, as bereavement counselling could not be provided until at least six weeks after a death.
- 27.7 The author of the SIR reported that he remained very concerned about the families' wellbeing so he made direct contact with LCFT's specialist trauma

²⁴⁶ [Duty of Candour](#)

service. The psychologist made contact with the family to offer support, but due to the logistics of attending the family was unable to take up this support.

- 27.8 Ian's Dollery's wife initially received counselling that was funded by Ian Dollery's employer and then by Victim Support. LCFT then took over the funding and the contract is currently open-ended. The author of the SIR reported that he does maintain regular contact with the counsellor and when this support ends it will be in agreement with Ian Dollery's wife and the counsellor.
- 27.9 Additionally, the author of the SIR, the Director of Nursing and Quality, and the Medical Director have met with Ian Dollery's wife and one of her daughters as it was recognised that their experiences of the support provided by LCFT post incident had been unsatisfactory. It was also felt that their experiences needed to be captured so that LCFT and the other involved agencies could learn from this incident with regard to supporting families after a serious incident. Currently, the Associate Director of Quality Improvement and Experience is meeting with members of the Dollery family in order to capture their story and experiences in a format that is meaningful to them.
- 27.10 Caring Solutions' investigation team met with Ian Dollery's wife and the daughter who had witnessed the incident to discuss their experiences of the support that they had been offered by LCFT, which can be summarised as follows:
- Ian Dollery's wife reported that she had been referred to a number of different services, but after the initial assessments, she had been informed that she either did not meet their criteria or that she was too vulnerable to undertake trauma therapy. She reported that she could not understand how she did not meet the criteria or was considered too vulnerable
 - Ian Dollery's wife reported that the local CMHT were unable to provide her with support due to a conflict of interest as they were the service who had supported Mr W.
 - Ian Dollery's wife reported that she had stopped seeing one of the therapists, as she was told that her notes could be admissible in court.
 - She also reported that she had Cognitive Behavioural Therapy (CBT) at her GP surgery, which appeared to have been provided by Improving Access to Psychological Therapies. She was unclear who referred her but she stopped the therapy as she felt that it was not helpful.

- Ian Dollery's wife reported that she had found the author of LCFT's SIR to be approachable and helpful.
- Ian Dollery's daughter reported that the support provided by Victim Support which had been very helpful and was flexible as to when they saw her so that it could be fitted around her university studies.
- Both Ian Dollery's wife and daughter both questioned why LCFT could not immediately provide post-incident bereavement counselling, as they felt that they had needed support directly after the incident.

27.11 Both Ian Dollery's wife and her daughter reported that what they wanted was for someone from LCFT to say, "Sorry, what can we do to help?"²⁴⁷

27.12 Both also reported that they had since the incident experienced some physical health issues. They suggested that in cases like this, it would be helpful if there was someone who would talk to and support families with physical health issues.

27.13 Also, that as Ian Dollery's other children did not live in LCFT's locality, there was no support provided to them to access support in their area.

Mr W's family

27.14 It was reported that LCFT's SIR investigation team had not made any contact with Mr W's family, including his older children, either post-incident or during the SIR investigation.

27.15 Caring Solutions' investigation team would suggest that this was a missed opportunity to provide support to this family, who clearly have also been deeply affected by the incident and may have been in need of support from LCFT's services. They could also have provided valuable insights into Mr W's care and treatment from LCFT's services that could have further informed the SIR.

²⁴⁷ Interview 15 June 2017

28 Predictability²⁴⁸ and preventability²⁴⁹

28.1 Throughout the course of this investigation, we have remained mindful of one of the requirements of NHS England's ToR was Caring Solutions' investigation team should consider if the incident that resulted in the death of Ian Dollery was predictable or preventable.

28.2 While analysing the evidence we have obtained, we have borne in mind the following definition of a homicide that is judged to have been predictable, which is one where "the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it"²⁵⁰.

Predictability

28.3 This report has clearly identified that Mr W had seven of the nine links between offending and reoffending behaviours that were highlighted within the Social Exclusion Unit report²⁵¹. These links were:

- Poor education
- Lack of employment
- Historic and current drug and alcohol misuse
- Mental and physical health issues
- A lack of self-control
- Institutionalisation and poor life skills
- Lack of access to affordable housing.

28.4 Mr W was throughout his adult life living in the chaotic world of homelessness, substance misuse, poverty and he was often funding his lifestyle through criminality and survival crimes. He also had a very long and significant forensic history of serious crimes against property and persons – both strangers and also in his relationships. His engagement with both substance misuse and mental health services was sporadic.

²⁴⁸ [Predictability](#) is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.

²⁴⁹ [Preventability](#) – to prevent means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.

²⁵⁰ Munro, E., Rumgay, J., "Role of risk assessment in reducing homicides by people with mental illness". The British Journal of Psychiatry (2000), 176: 116-120 [Munro](#)

²⁵¹ Bradley Report April 2009 p5 [Bradley Report](#)

- 28.5 Additionally in the months leading up to this incident, Mr W was self-reporting that he was continuing to use illegal substances, and it was unclear how compliant he was with his methadone programme.
- 28.6 Mr W was consistently failing to engage with either a recovery programme provided by CGL service Inspire or CMHT services.
- 28.7 Clearly all these factors do indicate that Mr W was at high risk both to himself and, based on his forensic history, to others.
- 28.8 Based on the analysis of the evidence presented, Caring Solutions' investigation team have concluded that it was highly predictable that Mr W would offend again at some point, either to fund his very extensive substance misuse and as a result of his unstable mental health. Additionally given Mr W's history it was predictable that he would be involved in violence towards others.
- 28.9 However, what was not predicable was that Ian Dollery was going to be his victim. Tragically, and clearly of little comfort to his family, Ian Dollery just happened that evening to be in his garage at the time when Mr W was walking past.

Preventability

- 28.10 In Caring Solutions' consideration of the preventability of this incident, the following two questions have been asked :
- Based on the information that was known, were Mr W's risk factors and support needs being adequately assessed and addressed by the involved agencies?
 - Additionally, based on the information that was known at the time, was the incident on 18 June 2015 preventable?
- 28.11 A preventable incident is one for which there are three essential ingredients present: the knowledge, legal means and opportunity to stop an incident from occurring.
- 28.12 Caring Solutions' investigation team have considered the following:
- If a more interagency information approach had been adopted, would this have facilitated information about Mr W's forensic and mental health history and current presentations could have been shared?

- Additionally would this have enabled a more multi-agency and therefore a more comprehensive, profile of Mr W's presenting risks and support needs to have been developed?
- If Mr W had been provided with a more definite and, it now transpires, a more accurate mental health diagnosis, would this have facilitated his engagement with mental health services and prevented the incident?
- If Mr W had been provided with a more definite and, it now transpires, a more accurate mental health diagnosis, would this have facilitated his engagement with mental health services and prevented the incident?

28.13 Given Mr W's history, his lifestyle, his ambivalence and resistance in his engagement with services and treatment regimens, Caring Solutions' investigation team have concluded that even if there had been an assertive outreach service available and that there had been greater information sharing it is unlikely that Mr W would have engaged in a recovery or harm reduction programme with either CGL Inspire or the CMHT.

28.14 Given the longevity of Mr W's drug misuse and his unwillingness to engage with a drug rehabilitation programme, there was no indication that he ever intended or was able to significantly reduce his drug misuse or comply with a methadone programme.

28.15 Caring Solutions' investigation team has been very mindful of Ian Dollery's family's understandable concern as to why, given Mr W's history, he was allowed to remain unsupervised in the community. They reported that if he had been supervised and closely monitored then this incident would not have occurred.

28.16 In response Caring Solutions' investigation team have concluded that even if a more accurate mental health diagnosis and/or more comprehensive multi-agency assessments had been undertaken of Mr W's risks to himself and others, he had never met the criteria for detention under the Mental Health Act 1983. Therefore could not have been sectioned in a hospital environment or supervised in the community.

28.17 Additionally, as he had not committed any crimes since 5 December 2011, therefore he could not have been incarcerated or supervised in the community via a probation order. Caring Solutions' investigation team have concluded that the involved practitioners did not have the means available to them to prevent the incident occurring.

28.18 Therefore Caring Solutions' investigation team have concluded that this incident was not preventable.

29 Concluding comments

- 29.1 This investigation has highlighted considerable deficits in the multi-agency involvement with Mr W. Services were providing only reactive support, and there was no longitudinal assessment being undertaken of Mr W's risks or support needs. All services were operating in their respective service 'silos'. This meant that information regarding his potential risk both to himself and others was not shared, fragmented support was being offered to Mr W, and there was a failure to engage him in any effective long-term treatment plan.
- 29.2 Although there were many incidents where Mr W was known to have been the perpetrator of violence and public order offences, he was also a very vulnerable adult whose chaotic lifestyle was contributing to both his vulnerability and his risks to himself and others. It was also very evident that at the time of the incident, Mr W had no significant protective factors, and due to his substance misuse and social situation, such as a consistent lack of secure and affordable housing being available to him therefore Mr W had little access to opportunities that would have helped him to build a more productive and fulfilled life.
- 29.3 Caring Solutions' investigation team would suggest that this case has highlighted that LCFT's current CMHT pathway does not have the resources to manage this type of patient. Therefore consideration needs to be given by both the commissioners and LCFT to developing a service that can be more responsive to the needs of this complex and transient patient group. Such a service needs to be able to both provide the appropriate support and being able to identify and assess on an ongoing basis when a patient's risk(s) may be escalating to such a level that a serious incident may occur.
- 29.4 In conclusion Caring Solutions' team are aware that some of the findings of this report may be difficult for the Dollery family to accept, as they may appear to be absolving Mr W for the killing of their loved one. This is absolutely not the case, and their grief and the life changes that the entire family have experienced since that night cannot be overlooked. However, it is the hope of Caring Solutions' investigation team that the findings and recommendations within this report will provide Ian Dollery's family with at least some answers to their questions and concerns.

30 Recommendations

Recommendation 1

Lancashire County Council, the Local Pharmaceutical Council, NHS England and services involved in the provision of shared care services in the Lancashire area.

- The revised contract for the provision of substance misuse services should identify how patients' records are to be transferred to a new provider.
- Lancashire County Council should convene regular Shared Care meetings, with representation from prescribing agencies, primary and secondary health services and community pharmacies. These meetings should provide a forum to:
 - Monitor and evaluate performance of agencies against their Shared Care contracts.
 - Highlight and resolve any commissioning, contractual and agency concerns.
 - Review any serious incidents, near misses and complaints.
 - Oversee joint serious incident investigations.
- The Local Pharmaceutical Council, substance misuse services, NHS England should consider undertaking a review to ascertain the value of making an adjustment to the PharmOutcomes system so that it notifies all the involved shared care services when a supervised consumption patient has missed a single methadone collection. This review should take place within six months.

Recommendation 2

Lancashire Health and Wellbeing Board, Lancashire County Council (Public Health), Lancashire Clinical Commissioning Groups, Lancashire Care NHS Foundation Trust and provider(s) of substance misuse, housing and judicial services.

Lancashire Health and Wellbeing Board should assume responsibility for the coordination of a forum to develop and implement a local dual-diagnosis protocol that provides:

- A coordinated and collaborative whole system integrated pathway to support individuals who misuse substances so that they have access to high-quality

physical and mental healthcare, housing and employment.

- A senior strategic board that oversees and monitors the implementation of the dual-diagnosis protocol across all of the health and social care sectors.
- Clarity with regard to interagency information sharing and the management of risk, shared care arrangements, including care coordination.
- Biannual meetings with representatives from all involved sectors with the aim of developing robust interagency relationships, to share lessons learned from serious incidents and to proactively identify and manage interagency issues.

Recommendation 3

Lancashire Care NHS Foundation Trust.

Lancashire Care NHS Foundation Trust should consider developing a new risk assessment tool that includes both a risks management and crisis plans which involves both the patient and all other involved agencies.

Appendix 1 Terms of reference

The individual terms of reference for independent investigation 2015/21744 were set by NHS England with input from Blackburn with Darwen, East Lancashire, and Fylde and Wyre CCGs. These terms of reference will be developed further in collaboration with the offeror and family members.

NHS England and the investigators will provide all affected families with a comprehensive explanation of the independent investigation and how it will be conducted; ensuring families have the opportunity to be involved in the investigation process.

Core Terms of Reference

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the perpetrator's first contact with services to the time of their offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the perpetrator in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the perpetrator harming themselves or others.
- Examine the effectiveness of the perpetrator's care plan including the involvement of the service user and their family.
- Involve all affected families, as appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to NHS England that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.
- Undertake an assurance follow up review 6/12 months after the report has been published, to assure that the report's recommendations have been fully implemented and produce a short report that may be made public.

Supplemental to Core Terms of Reference

- To review how the Trust provides aftercare and support to families affected by homicide or other serious incidents and to identify any learning opportunities.

- Consider and report on any recurrent features/findings and recommendations of previous independent investigations.
- Provide a written report to NHS England North that includes a section that details the learning in a format that can be shared widely and outcome focussed measurable recommendations.
- Support NHS commissioners to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.
- Undertake an assurance follow up review 6/12 months after the report has been published, on the implementation of the Trust's action plans in conjunction with the CCG and Trust and feedback the outcome of the assessment to NHS England, North in a short report that may be made public.

Appendix 2 Chronology

Chronology from 28 January 2013 to 22 June 2015. Please note details of Mr W's history prior to 2013 is located within the narrative of this report.

Date	Source	Event	Comments
28/1/2013	CMHT	Mr W's GP re-referred Mr W to CMHT, noting that Mr W had moved addresses and that he was again reporting that he was hearing voices but that "they never told him to harm anyone".	
12/2/2013	CMHT	Health and Social Needs Assessment (H&SNA) conducted by a social worker. Mr W reported that he was homeless and that his benefits had been stopped. Safety profile completed. Care Coordinator was appointed from the High Intensity Team (HIT).	
26/2/2013	CMHT	Failed attempt by the Care Coordinator to contact Mr W by mobile and landline. Mr W later phoned care coordinator to inform her that he was homeless and had no money.	
27/2/2013	CMHT	Mr W was seen by a support worker who: Contacted Department for Work and Pensions regarding Mr W's benefits. Set up a meeting with a housing charity, who reported that they would have to see a significant change in Mr W's behaviour and presentation to consider him for housing.	
28/2/2013	CMHT	Care coordinator requested a Police National Computer (PNC) database check. Information shared with drug service that was managing Mr W's methadone programme.	
4/3/2013	CMHT	Care Coordinator completed Care Plan and Crisis and contingency plan.	No risk assessment undertaken.
11/4/2013	CMHT	Mr W was reviewed by a consultant psychiatrist and prescribed mirtazapine ²⁵² (30mg daily).	Mr W reported that he was rough sleeping.
10/5/2013	CMHT	Mr W contacted his care coordinator to inform her that he had to leave his B&B accommodation, as his benefits had stopped because they had assessed that he was "fit to work". Care coordinator unable to contact Mr W later in the day as numbers for Mr W and his mother unobtainable. Care coordinator contacted Mr W's drug worker for new mobile number. No answer and no answerphone	No documented notes of any discussion with Mr W's drug worker re Mr W.

²⁵² [Mirtazapine](#)

		facility.	
10/6/2013	CMHT	Care coordinator unsuccessfully attempted to contact Mr W.	
12/6/2013	CMHT	Mr W contacted care coordinator, reporting that he was homeless and was sofa surfing, and that he was using heroin and crack cocaine. He was given an appointment for 2 July 2013.	
1/7/2013	CMHT and Inspire	Substance misuse service charged to agency 1.	
2/7/2013	CMHT	Mr W DNA'd appointment. Attempts made to contact Mr W via his and his mother's mobile phone. Both numbers were unobtainable.	
11/7/2013	Inspire	Mr W attended appointment. Noted that he was under influence of alcohol. Key worker tried to contact CMHT; left message.	Attempt made to contact CMHT.
16/7/2013	CMHT	Care coordinator tried unsuccessfully to make telephone contact with Mr W.	
18/7/2013	CMHT	Care coordinator made two calls to drug services, left messages but no response. Mr W was then discharged from the service.	CMHT tried to contact Inspire.
25/7/2013	Inspire	Mr W DNA'd appointment. Telephone contact made with Mr W; he agreed to attend appointment on 5 August.	
5/8/2013	Inspire	Mr W DNA'd appointment.	
8/8/2013	Inspire	Unscheduled contact with Mr W, who reported that he was OK. Appointment given for 12 August.	
12/8/2013	Inspire	Mr W DNA'd appointment.	
20/9/2013	CMHT	Mr W's GP referred Mr W to CMHT via SPOA. A letter was sent to Mr W's mother's address.	
23/9/2013	CMHT	Appointment letter sent to Mr W's mother.	
29/9/2013	Inspire	Letter sent to Mr W offering appointment on 2 October 2013.	
2/10/2013	Inspire	Mr W DNA'd appointment.	
10/10/2013	CMHT	A case discussion occurred where it was agreed that Mr W would be offered a further appointment on 29 October 2013.	
29/10/2013	CMHT	Mr W DNA'd appointment.	
7/11/2013	CMHT	Case review: decision made to assign Mr W to HIT. Also, a CPA review would be convened and Inspire invited.	CPA review did not occur.
13/11/2013	CMHT	Mr W DNA'd appointment.	
26/11/2013	Inspire	Telephone contact with Mr W: he reported that he had not received letter from Inspire as he was no longer living at the address. NFA	

		therefore to contact him by phone.	
27/11/2013	Inspire	Mr W attended and completed his first recovery plan and map.	
6/12/2013	Inspire	Pharmacy reported that Mr W had failed to collect two methadone prescriptions.	
15/1/2014	Inspire	Wrote to Mr W offering him an appointment on 21 January 2014.	
16/1/2014	CMHT	Case review: decision made to discharge Mr W back to GP.	
21/1/2014	Inspire	Mr W DNA'd appointment.	
24/1/2014	Inspire	Letter sent to Mr W offering an appointment on 28 January 2014.	
28/1/2014	Inspire	Mr W DNA'd appointment.	
11/2/2014	Inspire	Mr W attended medical review. At time Mr W was being prescribed methadone 80mg.	Letter sent to GP.
10/4/2014	Inspire	Mr W's care was transferred to new Inspire service. Mr W reported that he was drug free. Assessment maps completed. Risk assessment and management plan completed.	
11/4/2014	Inspire	Medical review: reviewed Mr W's recovery plan and map.	Letter to GP.
9/5/2014	Inspire	Telephone contact with pharmacist, who reported Mr W, had not collected his methadone prescription in over a week. Telephone contact made with Mr W, who agreed to attend appointment on 13 May 2014.	Mr W reported that he had not received letter as he had moved.
13/5/2014	Inspire	Reviewed Mr W's recovery plan and map. Reported that he was again NFA and was again sofa surfing, and his benefits had ceased. He denied any illegal drug use.	
23/5/2014	Inspire	Informed that Mr W had not collected his methadone since 16 May 2014.	
27/5/2014	Inspire	Team review of Mr W. Noted that Mr W's drugs screen was positive for methadone, opiates and benzodiazepines. Agreed to place Mr W on a supervised methadone regime Monday-Saturday. Mr W attended clinical review: methadone restarted at 30mg.	

11/6/2014	Inspire	Mr W DNA'd appointment, despite two telephone calls with him that day to remind him of the appointment.	
23/6/2014	Inspire	Mr W reported that he had been crack and heroin free for the last 28 days. He was drinking three to four cans of strong lager most days but denied that he had any issues with alcohol. He reported that he would like to be drug free. Reviewed Mr W's recovery plan and map. Mr W reported that he was hearing voices and would like a referral to CMHT. Mr W was offered a workshop but he refused.	
24/6/2014	Inspire	Telephone contact with Mr W to confirm next appointment on 26 June 2014.	
26/6/2014	Inspire	Mr W DNA'd appointment. Unable to make contact with Mr W by phone.	
21/7/2014	Inspire	Mr W attended but reported that he was not well and left. Appointment letter sent.	
28/7/2014	Inspire	Mr W's key worker contacted pharmacist and requested that they pass on a date to Mr W for his appointment on 31 July 2014.	
31/7/2014	Inspire	Mr W attended appointment, reporting that he was homeless and his benefits had been stopped. Reviewed Mr W's recovery plan and map.	
4/8/2014	GP and CMHT notes	Mr W presented himself to GP reporting increasing in voices and symptoms. GP referred Mr W to CMHT.	
7/8/2014	CMHT notes	H&SNA and safety profile were completed.	
21/8/2014	CMHT notes	Case discussion where it was decided that Mr W would be seen in outpatients' clinic and that there would be further liaison with Inspire. Contact was made with Mr W by phone to inform him of his appointment.	
26/8/2014	Inspire notes	The medical review was cancelled by Inspire. A letter was sent to Mr W offering him another appointment on 16 September 2014.	
11/9/2014	Inspire notes	Pharmacist reported that Mr W had failed to collect his methadone on 9 and 10 September 2014.	
16/9/2014	Inspire notes	Medical review: methadone Mix 1 mg/1 Risk: accidental overdose prevention and harm reduction discussed.	Letter sent to GP.
17/9/2014	Primary care notes	Mr W seen by his GP: prescribed naproxen for pain relief for an ongoing shoulder injury. Mental health review undertaken: issued	Naproxen: nonsteroidal anti-inflammatory drug (NSAID) used to relieve symptoms of arthritis

		prescription for mirtazapine 30mg. .	and moderate pain. Mirtazapine: antidepressant used to treat major depressive disorder. This was the last time Mr W was seen by GP
29/9/2014	CMHT notes	Mr W seen by consultant psychiatrist and care coordinator.	
1/10/2014	Inspire notes	Inspire informed that Mr W missed his methadone pickup from pharmacy.	
8/10/2014	CMHT	H&SNA and safety profile completed.	
16/10/2014	CMHT	Case discussion meeting.	
10/11/2014	CMHT	Mr W DNA'd appointment.	
12/11/2014	Inspire notes	Care plan session with key worker Mr W reviewed recovery plan.	
19/11/2014	Inspire notes	Inspire informed that Mr W missed his methadone pickup from pharmacy on 18 November 2014. T/C to Mr W who reported that he had missed his pickup as he was moving.	
25/11/2014	Inspire notes	Inspire informed that Mr W missed his methadone pickup from pharmacy on 24 November 2014.	
26/11/2014	Inspire notes	Inspire informed that Mr W missed his methadone pickup from pharmacy on 25 November 2014.	
4/12/2014	Inspire notes	Inspire informed that Mr W missed his methadone pickup from pharmacy on 4 December 2014.	
5/12/2014	Inspire notes	Inspire informed that Mr W missed his methadone pickup from pharmacy on 3 December 2014.	
2/1/2015	CMHT	Care Coordinator completed a Crisis and Contingency plan.	
8/1/2015	Inspire notes	Mr W attended review.	
12/1/2015	CMHT notes	Crisis and contingency plan and care plan completed.	
13/1/2015	Inspire and CMHT notes	Inspire: medical review. CMHT: Mr W DNA'd appointment with HIT.	Last correspondence to GP.
15/1/2015	Inspire notes	Inspire informed that Mr W missed his methadone pickup from pharmacy on 14 January 2015.	
2/2/2015	CMHT notes	Mr W DNA'd appointment and was discharged from the service.	
17/2/2015	Inspire notes	Care plan sessions with key worker. Substance Use Risk Assessment was completed.	
26/2/2015	Inspire notes	Inspire informed that Mr W had missed three consecutive methadone pickups from pharmacy. Discussed with medic, who advised putting the prescription on hold. The prescription "can be released tomorrow if Mr W attends the centre and tests positive for methadone".	
27/2/2015	Inspire notes	Mr W attended centre (unscheduled), asking for a prescription. Centre closed. Recovery coordinator unable to test as lone working.	

		Unable to release Mr W's prescription.	
2/3/2015	Inspire notes	Inspire informed that Mr W had missed his methadone pickups from pharmacy since 20 February 2015.	Methadone suspended.
3/3/2015	Inspire notes	Failed telephone contact with Mr W.	
4/3/2015	Inspire notes	Mr W attended centre (unscheduled): it was explained to Mr W that as he had not picked up his methadone since 20/2/15, he needed to have a doctor's review before he could go back onto a script. No available clinic until 19/3/15.	
10/3/2015	Inspire notes	Mr W DNA'd his review appointment.	
16/3/2015	Inspire notes	Mr W attended centre (unscheduled): appointment given on 19/3/2015 for medical review.	
17/3/2015	Inspire notes	Mr W attended needle exchange: 1ml BD Micro-Fines 5 2ml syringes 5 Filters 5 Needle Ends – Short Blue 5 Vitamin C 5.	
19/3/2015	Inspire notes	Mr W attended medical review: methadone restarted, 25ml supervised. Mr W attended naloxone training.	
23/3/2015	Inspire notes	Care plan review: Mr W agreed to attend motivation group.	
25/3/2015	Inspire notes	Mr W attended group. No risk identified. Concerns none.	Mr W failed to attend any further groups.
15/4/2015	Inspire notes	Mr W DNA'd group.	
20/4/2015	Inspire notes	Failed telephone contact with Mr W. 15:10: Mr W came into the centre (unscheduled) and agreed to attend next group and care plan review on 12/5/2015.	
21/4/2015	Inspire notes	Mr W attended the centre and asked to use the telephone. Noted that Mr W was homeless.	
29/4/2015	Inspire notes	Mr W DNA'd MET group session.	
11/5/2015	Inspire notes	Mr W phoned key worker appointment made for 12 May 2015.	
12/5/2015	Inspire notes	Recovery care plan reviewed: substance barrier as "he likes using heroin and drinking". Discussed detox and rehab – Mr W declined. Mr W agreed one-to-one work in order to deliver foundations: care plan completed.	
14/5/2015	Inspire notes	Inspire informed by fax that Mr W missed his methadone pickup from pharmacy on 7 May 2015.	
27/5/2015	Inspire notes	Inspire informed by fax that Mr W missed his methadone pickup from pharmacy on 20 May 2015.	
4/6/2015	Inspire notes	Inspire informed by fax that Mr W missed his methadone pickups from pharmacy on 1 and 2 June 2015.	
5/6/2015	Inspire notes	Mr W DNA'd healthcare appointment. Failed telephone contact. Inspire informed by fax that Mr W missed his methadone pickup from pharmacy on 4 June 2015.	

8/6/2015	Inspire notes	T/C contact with Mr W: agreed appointment on 11/6/2015.	
11/6/2015	Inspire notes	Meeting with key worker.	Last contact with Mr W.
17/6/2015	Inspire notes	Mr W's last collection of methadone.	
19/6/2015	Inspire notes	Inspire informed by fax that Mr W missed his methadone pickup from pharmacy on 18 June 2015. Failed T/C to Mr W: left a voicemail message.	
22/6/2015	Inspire notes	Inspire informed by fax that Mr W missed his methadone pickup from pharmacy on 19 June 2015. Mr W also failed to pick up his weekend prescription. Inspire were informed by police that Mr W had been arrested.	Mr W had been arrested on 18 June 2015.