



# **An independent investigation into the care and treatment of T, a mental health service user in Camden**

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

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# 1 Executive summary

- 1.1 Niche Health & Social Care Consulting Ltd was commissioned by NHS England in December 2015 to undertake an independent investigation into the care and treatment of T. T is a single man of Russian and Danish heritage. He was 44 when, on 9 May 2014, he committed the homicide that triggered this investigation. T had been treated by Camden and Islington NHS Foundation Trust and its predecessor bodies over a twenty year period for paranoid schizophrenia.<sup>1</sup>
- 1.2 In November 2014, T was found guilty of manslaughter on the grounds of diminished responsibility, and two counts of arson. The victim of the manslaughter was M, T's 67 year-old mother who was also his carer. T was detained under the Mental Health Act, indefinitely.
- 1.3 We begin this report by expressing our sincere condolences to T and to other members of M's family and friendship circle affected by the tragic events set out in this report.
- 1.4 This independent investigation follows the revised Serious Incident Framework (SIF) published by NHS England in March 2015, in particular Appendix A Regional Investigation Teams: Investigation of homicide by those in receipt of mental health care.<sup>2</sup> The aims of independent investigations are provided in pages 47-48 of the SIF. The SIF aims to ensure that mental health care-related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process will also identify areas where improvements to services might be required that could help prevent similar incidents occurring.
- 1.5 Our terms of reference are at Appendix A of this document and our approach is set out in section 3. The essence of our approach has been to establish if the homicide was predictable, if it was preventable and to identify learning from our analysis of it.<sup>3</sup>
- 1.6 When unwell, T would experience visual and auditory hallucinations including voices giving him instructions. He would also experience grandiose delusions with biblical, political and historical content and paranoid thinking about people in proximity to him. The Trust provided services to T from 1994 until his arrest on 9 May 2014. We view T's engagement with the Trust in three phases. In the first, between 1994 and 2002, T presented with many florid symptoms and multiple signs of risk to himself and others. He was admitted to acute inpatient mental health care on eleven occasions. In most of T's admissions, care and treatment was provided through the Mental Health Act.

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<sup>1</sup> For simplicity's sake, when we refer to 'the Trust' we refer to either the currently configured Trust or whichever predecessor body was in place at the relevant time.

<sup>2</sup> <https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incident-framework-upd2.pdf>

<sup>3</sup> Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'. 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.

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

Prevention 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. <http://www.dictionary.com/browse/preventable?s=ts>

Admissions ranged between one and four months in duration. T did not take anti-psychotic medication consistently when he was out of hospital.

- 1.7 Our view is that the Trust provided a good standard of mental health care to T between 1994 and 2002. The Trust was aware of the signs of relapse and risk and had a contingency plan that was activated when a similar pattern recurred. The evidence does not suggest that T was symptom-free at the time of each discharge but incidents of paranoid and hostile behaviour were controlled effectively by inpatient assessment and treatment.
- 1.8 The second phase of T's care by the Trust we identified was between 2003 and early 2014. In this time T was not admitted to Trust services and, in 2004, he stopped taking medication. T had an on/off engagement with the Trust's community services over the following decade. He was not seen by Trust staff to exhibit acute psychotic symptoms in this time. He was discharged from care on more than one occasion and the historic risk formulation based on the psychotic relapses that had led to serial hospitalisations was overshadowed. M sought input for T from the Trust's community services on occasion during this second phase but he was not admitted.
- 1.9 In our view, many aspects of the Trust's provision of care to T in this period were of a good standard. In particular, we commend the Trust for its decisions to provide care for T through the care programme approach.<sup>4</sup> However, the precise picture of the signs of relapse and management plan that was in place at the end of phase 1 of the Trust's engagement faded over the following decade. In addition, we feel that opportunities to assess the risks to M posed by T's mental health and his use of alcohol were not taken; nor were her needs as T's sole carer properly assessed.
- 1.10 The third and final phase of Trust care we identified was T's and M's presentations of 7 and 8 May 2014, shortly before the homicide. T was showing similar signs of relapse as had been noted prior to his admissions in the 1990s and early 2000s. Both T and M disclosed that he had threatened to harm M. On 7 May 2014, staff in the Trust's South Camden Rehabilitation and Recovery Team correctly judged that an admission was necessary. Although the full extent of risk and of T's psychosis were not discernible, they recorded disclosures of thoughts of harming M. They also noted the novel nature of the admission request. We commend their assessment of T that day and their risk management plan of admission. However, for systemic reasons we address in this report, the bed they requested was not made available. The failure of the Trust's bed management system that day to meet that identified need was the principal root cause of the homicide that occurred just over a day later.
- 1.11 On 8 May 2014, a second opportunity to admit T was available when he was assessed in M's home. In our view, the failure of the Trust's risk assessment and management process over the previous 10 years meant that the staff

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<sup>4</sup> The Care Programme Approach (CPA) is how services are assessed, planned, coordinated and reviewed for someone with mental health problems. A person under CPA will be allocated a named care coordinator (usually a nurse, social worker or occupational therapist) to manage their care plan. The care coordinator should ensure the CPA care plan is formally reviewed at least once a year. They should also ensure the care plan is recorded and that the person and relevant carers (both family and professional carers) are given copies. The CPA was introduced in 1991 and became mandatory in 1996.

undertaking the assessment were not in a position to assess or manage risk adequately. T was therefore not judged as in need of admission and no short term measures were put in place to mitigate the clear risks he posed. The outcome of this assessment – treatment in M's home - was, in our view, a second root cause of the homicide.

- 1.12 The main cause we identified of the Trust's failure to provide the bed on 7 May 2014 was a flawed bed management system. This system contained unwritten requirements that the staff seeking the bed did not fully understand. The system itself was under considerable pressure caused by a combination of an increase in demand for beds and a recent 30% reduction in the Trust's bed capacity. In addition, pressures on a reduced number of staff working in restructured and pressurised services played a part.
- 1.13 Shortly after the homicide, the Trust carried out an internal serious incident (SI) investigation into T's care. It concluded that the homicide was neither preventable nor predictable. No service delivery-related root cause was identified. Those were not our conclusions nor those of the Coroner or the Domestic Homicide Review (DHR) that followed. In our view, echoing the conclusions of the Coroner and the DHR, admission for T on 7 May 2014 would have prevented the homicide. Further, we found that the array of clinical and situational risk factors presented by T and M cohabiting on 8 May 2014, and the history, pointed to a likelihood of serious harm to M. The necessary short term risk management was not made available that day. We therefore conclude that the homicide was predictable.
- 1.14 In our investigation we have reviewed the Trust's SI report and action plan as well as the DHR and the available NHS and GP records relating to T. We interviewed staff from the Trust and met with T. A raft of recommendations was made by the SI panel, the Coroner and the DHR to the Trust to improve its services. We summarise the progress the Trust has made in implementing them.
- 1.15 We identified some areas for improved working that we address through the recommendations in paragraph 1.17.
- 1.16 We also identified good practice that included:
  - The continued support of T by the Trust's community teams within the care programme approach over the 12 year period after his last admission
  - The timely and appropriate response of the Trust's South Camden Rehabilitation and Recovery Team to T's and M's request that T be admitted on 7 May 2014
  - The robust and thorough measures implemented by the Trust since 2014 to ensure that its bed management process succeeds in its defining aim of providing a bed for every person who needs one.
- 1.17 We offer 12 recommendations in total, 10 recommendations to the Trust and two to NHS England. These are identified as they occur in the narrative of the report, but are grouped here

under priority for ease of reference. They have been given one of three levels of importance:

- Priority 1: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems/process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.
- Priority 2: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems/process objectives. The area of concern does not compromise the safety of patients, but identifies important improvements in the delivery of care required.
- Priority 3: the recommendation addresses areas that are not considered important to the achievement of systems/process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

**Priority 1 Recommendations**

**The recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems/process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised**

**Recommendation 2:**

The Trust's Rehabilitation and Recovery Division should implement measures to provide assurance that risk assessments meet the necessary quality standards. In particular, all risk assessments should flag known relapse signs and proven risk management strategies

**Recommendation 8:**

The role of the Crisis Team in assessing informal referrals should be clarified in policy given the principles in the concordat and the gatekeeping requirements. The aim should be to ensure a seamless and responsive assessment process for clients in acute crisis and clarity as to responsibilities where different service areas have involvement in the patient's care

**Recommendation 9:**

The Trust should review the measures taken by referrers to manage extended waits for beds in order to establish if any risks being taken can be better mitigated.

**Recommendation 10:**

The operational changes to the Trust's bed management system should be incorporated into the policy

**Recommendation 11:**

Given our concerns and the Coroner's, NHSE should refer this report to the Cavendish Square Group so that it may take forward learning from it with commissioners and providers in the capital.<sup>5</sup> In particular, NHSE should emphasise its concern that every patient who is identified by mental health services as requiring a mental health bed in London should be allocated a bed. And that all London mental health trusts should actively monitor their ability to provide beds when they are needed and be alive to the risks of workarounds developing when bed pressures exist

**Priority 2 Recommendations**

**The recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems/process objectives. The area of concern does not compromise the safety of patients, but identifies important improvements in the delivery of care required**

**Recommendation 3:**

The Trust should ensure that its systems are capable of identifying when its service users are not registered with a GP and ensuring that GP registration then occurs.



<b>Recommendation 4:</b> The Trust should ensure that when its policies require it to communicate with a patient's GP, that communication occurs.
<b>Recommendation 5:</b> It is recommended that NHS England ensure that people with a CPA care plan are not deregistered from their GP without contacting Adult Social Care and/or the Mental Health Trust first.
<b>Recommendation 6:</b> We recommend that the Trust's Rehabilitation and Recovery Division reviews its systems for ensuring that all care episodes are recorded in line with its record keeping standards.
<b>Recommendation 7:</b> The Trust should ensure that the role of alcohol and drug misuse in heightening risk is emphasised sufficiently in its risk assessment and management procedures.
<b><u>Priority 3 Recommendations</u></b> <b>The recommendation addresses areas that are not considered important to the achievement of systems/process objectives. The area of concern relates to minor improvements in relation to the quality of service provision</b>
<b>Recommendation 1:</b> Given the difficulties we have experienced obtaining the information we required during the investigation process, the Trust should implement a clear policy for ensuring that requests for information from independent investigations are met in a timely and efficient way.
<b>Recommendation 12:</b> The guidance for people undertaking SI investigations for the Trust should emphasise that investigators need to distinguish between evidence obtained from the contemporary records and evidence from subsequent statements, and when appropriate challenge staff about any discrepancy.

<sup>5</sup> The Cavendish Square Group is a chief executive-led collaboration of the 10 mental health trusts in London  
<http://www.cavendishsquaregroup.co.uk/>

## 2 The homicide

- 2.1 To recap briefly, T was admitted to hospital eleven times between 1994 and 2002 and treated for paranoid schizophrenia. Since 2003 he had been living independently with episodic input from community mental health services and no admissions. T did not take medication and was not seen by community services for extended periods.
- 2.2 T's only carer and social contact was M, his mother, aged 67 at the time of the homicide. Their relationship was intense and on occasion volatile. T would later disclose that he was physically abusive towards her when he was unwell. Alcohol use by T was also a risk factor. M was usually the first to notice deteriorations in her son's mental health. As well as acting as his carer and advocate, M could be critical of T.
- 2.3 Between 2013 and 2014, T was in occasional contact with the care co-ordinator who had been assigned to him in 2008. T experienced vivid delusions and hallucinations in the weeks preceding the homicide (April and May 2014). These included thoughts of killing and of suicide, religiosity and doubts about the identity of M. However, characteristically, he was guarded and vague about the content. T was drinking, at times heavily.
- 2.4 On 7 and 8 May 2014, M alerted the Trust to her son's deteriorating behaviour, self-care and his threatening behaviour towards her. T had been staying in M's flat for many weeks as he was afraid to stay in his own. T was assessed by mental health professionals, with M. He was actively psychotic, experiencing visual and auditory hallucinations and delusions. He was unable or unwilling to disclose the exact content. He disclosed vague thoughts of harming people including M. M said she felt at risk from him. For the first time in twenty years of T's mental health service contact, T and his mother asked for him to be admitted for an inpatient assessment. The staff who spoke to T and M on 7 May 2014 agreed and progressed the referral. But they were told that a bed was not available. An interim plan for Crisis Team care was put in place and the search for a bed was stopped.
- 2.5 On 8 May 2014, after a further assessment, the alternative plan for Crisis and Home Treatment Team care, initially in M's flat, was confirmed. T still wanted admission. He could not believe that the staff had not taken him to hospital. T would refer to overwhelming fears of an impending nuclear holocaust and of his soul being sucked into hell. He was also anxious about the significance of events in the Ukraine. He later said things felt "apocalyptic [...] I had to destroy and burn everything so the spirits couldn't see. I had to burn everything and maybe kill myself".<sup>6</sup> He would later disclose that after the assessment in M's flat he went out and drank eight cans of beer to ease his anxieties.

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<sup>6</sup> Psychiatric assessment, 27 July 2014

- 2.6 T's accounts of the events of the homicide varied.<sup>7</sup> It appears that on the morning of 9 May 2014, sometime after 04:00, T woke up. He felt that the three doses of olanzapine he had taken over the previous two days had "kicked in a bit" but he remained psychotic.<sup>8</sup> He did not take medication that morning. M was not up. He still believed that he needed to destroy his possessions by fire, starting with those in M's flat. If he failed in this he feared he would go to hell forever. If he succeeded he felt he would go to hell but not for as long. T went to a nearby 24 hour shop and bought two 12-pack boxes of firelighters and a bottle of olive oil. He then returned to M's flat.
- 2.7 On T's return to the flat M was up. She asked him why he was upset. In one account, T said she talked about the possibility of them both moving to Spain. T said that M was not listening and was "doing his head in". In another account he said M was shouting at him. He described M's tone of voice as "incredible". He would consistently state that he believed his soul would be saved, or spared, if he killed his mother but he had no plan to do so. T shouted back and M became silent, seeing how unwell he was.
- 2.8 The voice T heard was saying "flip out" which he took mean "Kill". Killing M had not been part of the immediate plan to burn his possessions but she had made him angry and he obeyed the voice. T in his own words "flipped out". They were both in the kitchen. T took a knife from a drawer and stabbed M with it. T also punched M. At around 05:00 a neighbour heard a loud prolonged scream lasting about 30 seconds. T stabbed M repeatedly in the neck and abdomen and kicked her when she was on the floor. A later assessment included:
- "Whilst he was attacking her he had thoughts of the apocalypse. He remembers stabbing her in the throat and finally in her heart. He said "I suppose I was trying to kill her. I felt she had been replaced by a holy spirit. It was cosmological."
- 2.9 After M had died T set four fires in her flat, he said in areas where his possessions were.<sup>9,10</sup> He would deny trying to burn M's body or trying to conceal the fact that he had killed her. Another neighbour heard the slam of the front door as T left the building at about 05:12. T then ran away, he would later say, knowing that he had done wrong.
- 2.10 Paramedics were called at 05:20 and arrived on the scene at 05:25. At this stage the fire brigade had been working on the fire for five minutes. It was reported that a couple with a baby and two others in the two flats above M's fled through a window and onto a roof to escape the blaze. They were

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<sup>7</sup> We rely to a large extent on the psychiatric assessment of 23 September 2014 where T provided more information than in earlier assessments.

<sup>8</sup> An anti-psychotic drug used to treat schizophrenia and acute manic episodes. T, who had not taken anti-psychotic drugs in ten years, had been provided with a short term, low dose, supply by the staff he saw the day before.

<sup>9</sup> The post mortem found no smoke in M's lungs so it was concluded that M had died before the fires were established.

<sup>10</sup> The psychiatric report of 21 May 2014 stated: "On examination of the crime scene there were four separate seats of fire discovered. These were located in an corner area of two separate bedrooms, by a table within the living room area nearby to where the deceased was discovered and which was also near to where a coffee table was located on which a large knife was discovered, and a fourth seat of fire, described as being the largest one, was located at the head of the stairs that led down to the basement area."

rescued by the fire brigade who also removed M's body from the ground floor flat. M was pronounced dead at the scene at 05:39. The post mortem would identify multiple stab wounds and blunt trauma injuries to the rear of the head. The cause of death was stab wounds to the neck and chest, shock and haemorrhage. A murder investigation was launched.

- 2.11 T spent the day wandering around Crouch End and Highgate Woods drinking. He heard voices telling him to set more fires. Just after 20:00 that evening he presented at the Royal Free Hospital with the aim of being detained by the police. He was arrested shortly afterwards.
- 2.12 On 3 November 2014, T pleaded guilty to manslaughter on the grounds of diminished responsibility, and two counts of arson.<sup>11</sup> The Court was satisfied that he was suffering from mental disorder within the meaning of the Mental Health Act 1983 and accepted his plea. T was ordered to be detained under sections 37/41 of the Mental Health Act, indefinitely.<sup>12</sup>
- 2.13 At the conclusion of the inquest into M's death, the Senior Coroner for inner north London gave a narrative ruling of unlawful killing. She had reservations about the robustness of the Trust's measures to prevent a repetition. She noted that admission had been agreed but no beds had been immediately available. Then, she noted, confusion had followed about the status of the bed request. She concluded that events could be repeated in London and elsewhere in the country.
- 2.14 In her Regulation 28 Prevention of Future Deaths report the Coroner told Camden and Islington Foundation Trust:

"It seemed to me from the evidence I heard that, when a need for good communication (for example between clinician and bed manager) has been identified, there has been a lack of precision in your trust about exactly what that means and how it needs to be actioned.

Rather than simply talking about the need for better communication, it is necessary to identify that information A must be delivered on every occasion, by person B, at time C, and using method D. Without this level of detail, staff are left with a vague concept and the communication is unlikely to achieve the desired result.

I appreciate that this does not give you much in the way of specifics to work on, but your organisation has already identified these. What I hope to do is to share with you what I perceive to be a recurring theme in your organisation that has been particularly highlighted by [M's] death."

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<sup>11</sup> As well as homicide, T was convicted on one count of arson with intent to endanger life, contrary to section 1 (2) and (3) of the Criminal Damage Act 1971 and one count of arson, being reckless as to whether life would be endangered, contrary to section 1 (2) and (3) of the Criminal Damage Act 1971.

<sup>12</sup> Section 37 is a hospital order that is an alternative to a prison sentence. The person is sent to hospital instead of prison. A crown court judge can add a section 41 restriction order to this, making the section a 37/41, if they think a person is high risk and they are concerned about public safety. The section 41 order places limits on both the person and the "Responsible Clinician" (i.e. the consultant psychiatrist in charge of the person's care). For example, the consultant needs to report on the subject's progress to the Secretary of State for Justice at the Home Office and needs permission from the Home Office before granting leave.

- 2.15 On 28 June 2015 the Trust's then Chief Executive replied, informing the Coroner of the steps the Trust had taken to make the action plans arising from its incident investigations more specific and robust.

### 3 Approach to the investigation

- 3.1 The basis of this independent investigation is set out in section 1. The investigation was carried out by Jon Wigmore for Niche, with expert advice provided by Dr Ian Davidson and Professor Liz Hughes. The investigation team will be referred to as “we” in this report. This report was peer reviewed by Carol Rooney, Head of Investigations, Niche.
- 3.2 T received services from Camden and Islington NHS Foundation Trust’s (the Trust’s) South Camden Rehabilitation and Recovery Team (the RRT) based at the Peckwater Centre, from its formation in 2012 until the homicide on 9 May 2014. Before 2012, T was a client of the community mental health team (CMHT) that was responsible for providing services to people with enduring mental health problems before the RRT was set up. On 8 May 2014, the eve of the homicide, his care was transferred to South Camden Crisis Resolution and Home Treatment Team (the Crisis Team).
- 3.3 We undertook recorded interviews with:
- RR1, (T’s Care Coordinator since 2008 - a Social Worker in the RRT)
  - RR2, (a Trainee Mental Health Worker in the RRT who dealt with T and M on 7 May 2014)
  - RR3, (the Clinical Team Manager in the RRT who assessed T and made an interim plan for medication and Crisis Team referral)
  - CP1, (T’s Consultant Psychiatrist 2002-2009 and Clinical Director of Rehabilitation and Recovery Division from 2010)
  - CP2, (T’s Consultant Psychiatrist 2013-2014)
  - BM1, (the Site Manager or Bed Manager, Highgate Mental Health Centre, who liaised with the RRT about a bed for T on 7 May 2014)
  - BM2, (Matron, Highgate Mental Health Centre, BM1’s manager)
  - CT1, (Mental Health Nurse, CRHT; the shift leader in the Crisis Team who spoke to T, M and RRT staff by telephone and supported the referral for a bed on 7 May 2014)
  - ACL, (Clinical Director for Acute Services from September 2014)
  - ADD, (Associate Director of the Acute Division from 2014)
  - MD, (Medical Director and Trust Deputy Chief Executive until September 2014; a member of the Trust’s SI panel who investigated and reported on this incident in 2014)
  - COO, (Chief Operating Officer 2014-present; the line manager for all the divisional directors who are the operational managers for divisions, and the clinical directors who are the lead clinicians in each of the five divisions in the Trust. Since July 2015, Deputy Chief Executive).

We interviewed on 19 and 20 May and 1 July 2016.

- 3.4 We were unable to establish contact with CT3, the Clinical Nurse Specialist who, with RR1, assessed T at M’s flat on 8 May 2014. We have therefore relied on his 2014 evidence to the police and the SI panel.

- 3.5 We had copies of police statements taken from RR1, RR2, RR3, BM1, CT1, CT2 and a Senior Staff Nurse in Accident and Emergency at the Royal Free Hospital who saw T when he presented there after the homicide. We also had police statements from:
- RR4, (Social Worker at the RRT who handled the initial telephone presentation)
  - RR5, (Locum Social Worker at the RRT)
  - CT2, (Mental Health Worker, CRHT)
  - CT3, (Mental Health Nurse, CRHT).

The police statements were dated between 12 and 23 May 2014.

- 3.6 The Trust provided us with summaries of the SI panel's interviews with RR1, BM1, CT3, CP2, ADD and CT4 (Interim Operational Services Manager, Crisis Teams). These interviews were undertaken between 29 July and 9 September 2014. We also had copies of documents related to the fact checking and dissemination of the SI report and the implementation of its recommendations.
- 3.7 We met with the Strategic Commissioner, Mental Health, for Camden services on 20 May 2016 and received from her a raft of documents illustrating the commissioner/provider dialogue over bed management and community service capacity.
- 3.8 In addition, on 19 May 2016, we met with T and discussed his impressions of his care as a RRT client in the years, months and days leading up to the tragic events of 9 May 2014. We met with T on 7 April 2017 to discuss the findings of the report and the recommendations made.
- 3.9 T told us that he was very unwell and had been drinking, and when unwell he has been very difficult to manage in the past. He said he feels that he and his mother he did everything they could to get him admitted to hospital in May 2014 because he knew he was very unwell, and even though he was hearing voices and seeing things, he knew he needed to be admitted. He hopes that future care providers will take him seriously if he becomes unwell in the future.
- 3.10 We are grateful to the Review Chair and the London Borough of Camden (commissioners of the Domestic Homicide Review (DHR) into M's death) for providing us with a copy of draft 7 of the overview report during our investigation. The final overview report of the DHR was published on 13 October 2016 as we completed this investigation.<sup>13</sup>
- 3.11 NHS England wrote to M's brother and nephew (T's uncle and cousin) in the USA to establish if they wished to be involved in the investigation and they responded positively. They did not have any direct involvement in the investigation and we did not receive any response to invitations to discuss the report. We have not been able to establish contact details for T's father who

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<sup>13</sup> <https://www.camden.gov.uk/ccm/content/policing-and-public-safety/domestic-violence/domestic-homicide-review.en>



lives in Spain and we have not therefore been able to involve him in the investigation.

- 3.12 We obtained T's clinical records from the Trust but these were initially incomplete. Delays occurred in the Trust's provision of information to us and it was not until 29 July 2016, over six months after this investigation started, that the Trust provided the final tranche of documents we had been requesting. NHS England therefore extended the deadline for the completion of this investigation from June to October 2016.

**Recommendation 1:** Given the difficulties we have experienced obtaining the information we required during the investigation process, the Trust should implement a clear policy for ensuring that requests for information from independent investigations are met in a timely and efficient way.

- 3.13 We were only able to obtain limited GP records for T who moved between practices and was de-registered in 2007.
- 3.14 We obtained T's clinical records from Barnet, Enfield and Haringey Mental Health NHS Trust where he has been cared for since his arrest on 9 May 2014.
- 3.15 A known weakness within mental health homicide investigations is that the situations faced by practitioners are inevitably simplified when reviewed with hindsight. An investigation cannot capture the logic of all decisions made in the unfolding events of a clinical encounter. Still less can it encompass the pressures and distractions of everyday mental health care in all its complexity. Throughout the investigation process we have been alive to the risk of hindsight and outcome bias colouring our analysis and conclusions.<sup>14</sup>

## Structure of the report

- 3.16 Section 4 provides background information about T and his family.
- 3.17 Section 5 outlines the care and treatment provided to T between 1994 and 2012. We have included a chronology of his care until 2012 at Appendix E.
- 3.18 Section 6 examines the issues arising from the care and treatment provided to T in the year and a half preceding the homicide. It includes our comments and analysis on matters relevant to our terms of reference.
- 3.19 Section 7 contains a summary of our findings under the headings provided in our Terms of Reference.

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<sup>14</sup> Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts are clear to the reviewers after the event. This colours judgments and assumptions about decisions made by 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)



- 3.20 Section 8 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified by the SI panel, the DHR and the Coroner.
- 3.21 Section 9 sets out our overall analysis and recommendations.
- 3.22 Appendix A sets out our terms of reference.
- 3.23 Appendix B describes the community services that cared for T.
- 3.24 Appendix C summarises our root cause analysis in a fish bone diagram.
- 3.25 Appendix D summarises the Trust's progress in implementing the SI report and DHR recommendations.
- 3.26 Appendix E contains a narrative chronology of T's care 1994-2012.

## 4 Background

### T's childhood and family background

- 4.1 T's father is Danish and has been retired, in Spain, for some time. He was a managing director in the food industry. He was 77 years old at the time of the homicide. T's father has a daughter from his first marriage who has always lived in Denmark. She and T have not kept in close contact.
- 4.2 T's mother, M, was born in Leningrad (now St Petersburg) in 1946 and was raised in Soviet Russia. M's twin brother and nephew both live in the USA.
- 4.3 Neither of T's parents were religious. T would tell the forensic psychiatrist who assessed him in 2000 that both his parents were "eccentric – both strong characters". He said his father was "too intense for me".
- 4.4 T was born in Copenhagen in 1970, moving to London in 1972 with his parents because of his father's work. The family seems to have been financially comfortable. There would be no other children. They initially lived in a flat in Golders Green before moving to a large house with a garden in Edgware in 1975.
- 4.5 M worked as a journalist with an expertise in Russian affairs and also obtained an income by renting three Russian properties. M reportedly travelled frequently to Spain and South Africa. She was described by neighbours as a "Russian eccentric ... a colourful, free-spirited, independent woman who was cared for and appreciated on her street and by friends across the world. She was caring, generous and full of life. She was part of the community ... She was very interested in alternative health approaches ..."<sup>15</sup>
- 4.6 T's parents fought a lot and separated around 1980. Around 1982 his parents divorced and T and M left the family home. M and her son went to live in Kentish Town. T had occasional contact with his father over the following 30 years.
- 4.7 M largely rejected conventional medicine but had frequent and often contentious dealings with primary and secondary health care professionals on her own and her son's behalf.<sup>16</sup> M thought her son was autistic and perhaps suffered from diet-related illness or allergy on top of an inherited disposition towards drug and alcohol abuse. She contested the basis and practice of psychiatry. M herself suffered increasingly from rheumatoid arthritis.
- 4.8 T was given a tenancy by the London Borough of Camden in 1998, coincidentally near the community mental health team (CMHT) team base. T told us that between 2001 and 2014 he been using his mother as a helper a lot. She lived in a ground floor flat not far away that she owned. T referred repeatedly to his mother's "1960s ideas". He said that she been using

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<sup>15</sup> DHR

<sup>16</sup> DHR

Chinese medicine and live leeches for her arthritis. T told us that she was “practically a Maoist” and been “driving him up the wall”. He disclosed that he was abusive to her when unwell.

- 4.9 The importance of M’s role as T’s sole carer and source of social and financial support cannot be overstated. Throughout the main community phase of T’s care (2003-2013) M regularly took T abroad. Destinations included Spain (where T and M would visit his father), Israel and South Africa. M also told mental health services if T was well or unwell and alerted them to signs of relapse that included hostility from T towards her.
- 4.10 T’s and M’s was a very complex, enmeshed relationship featuring high expressed emotion.<sup>17,18</sup> There were many supportive elements as well as negative, critical elements. Despite T’s statements over the years that he wanted more independence from M, when he felt stressed he would usually return to her.

## Training and employment

- 4.11 T attended a private school in Harrow until the age of 16 before moving to a state sector 6<sup>th</sup> form college in Mill Hill. He gained five GCSEs and, after a third year in 6<sup>th</sup> form college, three A-levels, in History, History of Art and Politics.<sup>19</sup> In 1989 he took up a place at Manchester University studying Soviet Studies but was asked to leave after two years because of poor attendance and underachievement. By his own account he was using drugs, particularly hallucinogens, heavily.
- 4.12 T then returned to London in 1992 and did some work in lighting for modelling agencies and magazines through M’s connections. He restarted university in London that year (a course in European Studies at North London University) but dropped out after a year. He attended a course in Copenhagen in 1993 for six months but, once again, was unable to complete it. He continued to use cannabis heavily. Aside from occasional casual work, T has never been in employment.<sup>20</sup>
- 4.13 T is interested in music (jazz in particular) and films. T formed few friendships and we have noted that he relied heavily on his mother for support and companionship.

## Substance misuse

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<sup>17</sup> ‘Enmeshed’ is a concept introduced by the family therapy pioneer Salvador Minuchin to describe families where individual members maintain little to no autonomy or personal boundaries. The roles among family members (e.g. rescuer, rescued) can be very rigid. Individuals in an enmeshed family may grow up not knowing how they really feel or what they want to do in their lives because they are encouraged to feel whatever a parent or other family member/s feel.

<sup>18</sup> Expressed Emotion (EE) is a way of understanding relationships between individuals with mental illness and their family members. High EE (defined as high levels of criticism, hostility and emotional over-involvement expressed by family members towards patients) has been shown to be a robust predictor of risk, poor outcomes for patients and increased distress and burden for carers. EE can be measured clinically using the Camberwell Family Interview where certain types of comment are counted and coded. It has been argued that cross-cultural differences exist in the levels of tolerance expressed by family members towards the person with schizophrenia. And that patients’ reactions to EE-type behaviour from their family members differ cross-culturally. High EE and an enmeshed family are both indicators of a risk of violence.

<http://bjp.rcpsych.org/content/181/6/466>

<sup>19</sup> Psychiatric assessment, 17 July 2014.

<sup>20</sup> Psychiatric assessment, 17 July 2014.

- 4.14 T attributes his mental illness to his heavy abuse of illicit drugs in the 1980s and early 1990s. He reportedly began smoking cannabis in the mid-1980s, from the age of 14.<sup>21</sup> He said his mother and her friends used to smoke it at home and he used it increasingly heavily from the age of 16.<sup>22</sup>
- 4.15 After he enrolled at Manchester University aged 19 in 1989, T said his substance misuse became substantial. He regularly attended raves, taking cocaine, LSD, ecstasy and ‘magic mushrooms’. LSD would give him auditory and visual hallucinations that he enjoyed but he would also feel paranoid and suffer panic attacks. Using cannabis, he reported, was a way of getting through the “come downs” that followed. However, T reported that cannabis caused paranoia.<sup>23</sup>
- 4.16 In the 1990s, T also reportedly used heroin (smoked), crack cocaine and benzodiazepines. However, by the early 1990s after T moved back to London, cannabis was his preferred drug. He said that he had stopped taking “class A party drugs” at around this time. T’s accounts of his drug use were not wholly consistent. T reportedly used an eighth of an ounce of cannabis “every couple of days” until 1999.<sup>24</sup> T reported that, in his view, most of his admissions had been drug-related. However, he also stated that he had stopped taking illicit drugs at the age of 24 (i.e. in 1994) and started drinking, replacing one with the other.<sup>25,26</sup> He could become aggressive when drunk, particularly towards M whose criticisms of his drinking and lifestyle would add to his agitation.
- 4.17 In 1996, T was discharged from hospital on the understanding that he would attend a six month residential alcohol detoxification programme in Denmark.
- 4.18 In December 2000 T disclosed taking morphine orally due to “pressure”. In the forensic assessment that followed a knife brandishing incident in April 2000, specific interventions aimed at his drug and alcohol misuse were recommended. T later attributed the knife incident to his use of morphine.
- 4.19 T associated his long spell without admissions (2003-2014) with his avoidance of drugs and alcohol, in the initial few years at least.<sup>27</sup> He told his GP in May 2001 that he had recently undertaken a substance misuse rehabilitation programme in South Africa at his parents’ insistence. At some point in the mid-2000s (T told us 2004) he began to drink again, on his own in pubs or in his flat. He told us he had wanted to see if drinking and staying well could be an option for him. He used alcohol to relieve stress, boredom and feelings of isolation. However, while his drinking was of concern to M, it rarely spilled over into behaviour that attracted the concern of the police. The notable exception was T’s arrest in 2007 for alcohol-related damage to property after a bout of whisky drinking. (The evidence we have points to beer

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<sup>21</sup> DHR

<sup>22</sup> Psychiatric assessment, 17 July 2014.

<sup>23</sup> Psychiatric report, 23 September 2014

<sup>24</sup> Discharge summary 6 July 2000

<sup>25</sup> Psychiatric assessment, 27 July 2014.

<sup>26</sup> Drug and alcohol report, 17 February 2015.

<sup>27</sup> Psychiatric assessment, 27 July 2014.

being T's usual alcoholic drink.) T's March 2008 attack on his mother in Cape Town was of concern to the CMHT but they were unable to obtain access to T in the weeks that followed to assess him.

- 4.20 T's accounts of his alcohol consumption varied considerably, from one to eight cans of lager three times a week to four to eight cans every day. Shortly before the homicide he told CT3 and RR1 that he was drinking four to five cans of 5% a.b.v. beer a day.<sup>28</sup> While in assessments T linked his past drug use with many of the negative events in his life, in particular his mental illness, there is little evidence of insight on his part as to the adverse effects of alcohol.
- 4.21 M repeatedly stated that T had a hereditary tendency to alcoholism and alcohol-related aggression. In 2010 M told the mental health services that T was a different person under the influence of alcohol which made him dangerous and unpredictable. She reported T's "heavy and reckless" drinking in the years before the 2014 presentation.
- 4.22 T reported after the homicide that he had increased his alcohol intake after going on holiday to Spain with his mother in 2013. At the same time his psychotic symptoms began to intensify but the evidence does not point to a simple cause and effect relationship.

## **Forensic & risk history**

- 4.23 In the early 1990s, T was charged twice with being drunk and disorderly<sup>29</sup>. There is a reference in one report of the riot police being called on two occasions, presumably due to T's behaviour, on one occasion at his mother's home and on another at a hospital ward.<sup>30</sup>
- 4.24 Most if not all of T's admissions between 1994 and 2002 were associated with threatening behaviour or disclosures by T that he might hurt another person.
- 4.25 On 26 April 1995, T reportedly threatened to stab his father with an 18 inch knife and told police officers that he had access to four other long bladed knives. He also threatened to kill himself.<sup>31</sup> In the Mental Health Act assessment which followed he was adjudged a danger to himself and his parents.
- 4.26 In August 1996 T smashed the windows of his mother's flat with a rubbish bin and chased her out of her home while he was naked. M described his speech content as strange and at times sexual. She thought he was drinking and taking drugs. He was admitted under Section 3 of the Mental Health Act.
- 4.27 On 18 April 2000, T attended an urgent outpatient appointment after concerns had been expressed by his CPN and M about his disengagement from

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<sup>28</sup> i.e. 5% alcohol by volume. This equates to 2.2 (440ml can) or 2.5 (500ml can) units per can.

<sup>29</sup> Discharge summary 26 November 2002.

<sup>30</sup> Discharge summary 26 November 2002.

<sup>31</sup> Risk assessment 29 January 2002.

services and mental state. T was agitated and expressed paranoid thoughts about the staff present. He paced around the room. Outside the room where the assessment was being conducted, T then threatened his sector consultant with a six-inch knife in response to her suggestion that he should attend hospital voluntarily. He said “Section me!” and “Call the police!” T later denied any attempt to harm or threaten her; he had, he said, just wanted to show her the knife. T later turned himself in to Shepherd’s Bush police station reporting what he had done. He was held on remand in Brixton prison for five days after which a hospital order was served for two months which he spent in the care of the Trust in the psychiatric intensive care unit at St Luke’s Hospital. T had bought the knife, he said, because he was paranoid that he was going to be attacked.<sup>32</sup>

- 4.28 The 18 April 2000 incident triggered a forensic assessment that occurred on 19 May 2000. It recommended a period of detention in locked conditions until T’s mental state had fully stabilised, with depot medication a consideration for the future. A specific intervention with regard to drug and alcohol misuse to prevent future relapse was also recommended.<sup>33</sup>
- 4.29 In May 2000, T reportedly threatened his father again with a knife although we have some doubts about the timing of the incident.<sup>34</sup>
- 4.30 In 2001, T told a psychiatrist during an assessment that he was sleeping with a knife. T disclosed a concern that if difficulties continued with a neighbour he might lose his temper and stab him.<sup>35</sup> He was admitted informally.
- 4.31 On 24 December 2001 T reportedly stated while unwell that he wanted to kill his mother.<sup>36</sup> He later disclosed that he would be violent, mainly towards his mother, when he was unwell because she “did my head in”.<sup>37</sup>
- 4.32 In September 2007, when drunk T smashed nine panes of glass with a hammer at Horse Guards Parade after he had been planning to protest outside the US Embassy about the Vietnam War. He told us he was very unwell at the time and had been drinking whisky. In 2008 he was found guilty of an offence against property and of failing to surrender to custody. T was fined and imprisoned for a day.
- 4.33 According to M and T, T assaulted M in March 2008 in Cape Town, under the influence of alcohol.

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<sup>32</sup> DHR

<sup>33</sup> Forensic assessment, 19 May 2000

<sup>34</sup> This report, repeated in various assessments, seems to originate in the discharge summary of T’s final, 2002, admission. However, it is probably incorrect as T was in police custody and then for two months in a secure mental health ward shortly after the 18 April 2000 knife incident.

<sup>35</sup> Risk assessment 29 January 2002.

<sup>36</sup> Psychiatric assessment, 21 May 2014.

<sup>37</sup> Psychiatric assessment, 23 September 2014.

## 5 Panel commentary on the care and treatment of T, 1994-2012

5.1 T's dealings with mental health services between 1994 and 2012 are summarised in the narrative chronology in Appendix E. Overall, we have identified three discernible phases:

- Phase 1: 1994-2002, serial inpatient admissions
- Phase 2: 2003-2014, on/off, low key community involvement
- Phase 3: 7 and 8 May 2014, the requests for admission.

### Phase 1: Serial inpatient admissions, 1994-2002

- 5.2 After his return to London in 1992-93, T's mental health began to deteriorate. He would later describe his episodes of mental health deterioration as "biblical and historical". He said: "I get biblical apocalypse and thoughts of going to hell". His heavy cannabis use continued. He began to experience grandiose delusions including that he was Jesus and his mother was Mary. As well as experiencing visual phenomena, T heard a voice that said "baby" and if he was thinking of something bad the voice "like an "old English gentleman" would say "Please do". When unwell, T believed that prophecies in the Book of Revelations would come to pass.<sup>38</sup> T felt increased paranoia about people near his busy flat in central London when unwell. If nervous or fearful of attack, he kept a hammer under his pillow or bed to defend himself.
- 5.3 T had eleven mental health hospital admissions between 1994 and 2002, eight of which were under the Mental Health Act. They typically lasted between a month and two months (the three informal admissions, all in 1997-1999, lasted three to four months). T's consistent diagnosis was paranoid schizophrenia that was occasionally associated with alcohol or drug taking. He would usually stop taking antipsychotic medication, from which he suffered extra-pyramidal side effects, shortly after discharge.<sup>39</sup>
- 5.4 In that period, using the records available, we can link only the 1996 admission to threats against M (see paragraphs 4.26 and E.7). The previous year T had reportedly threatened to stab his father. His 2002 admission was triggered by T's concerns that he might harm a neighbour.
- 5.5 T said that he never recovered fully and returned to how he had been before the onset of mental illness. When out of hospital he would become very preoccupied with Roman and Egyptian history as well as biblical studies.<sup>40</sup>
- 5.6 The notes of T's hospital admissions were not made available to this investigation and the records of his contact with community mental health services in this period are scant. Between admissions, T appears to have been generally reluctant to engage with community mental health services.

<sup>38</sup> Psychiatric assessment, 17 July 2014.

<sup>39</sup> Extra-pyramidal side effects of antipsychotic medication include tremor, slurred speech, akathisia (restlessness) and dystonia (involuntary muscle movements).

<sup>40</sup> Psychiatric assessment, 27 September 2014.



- 5.7 Our view, based on the limited records we have seen, is that the Trust's responses to T's relapses during this initial phase were of a good standard. In the assessments, T's signs of relapse were recognised and documented and credence was given to M's views. When necessary, T was sectioned, either before admission or when he refused to co-operate with treatment. After each episode T seems to have been well enough to manage relatively independently with reduced paranoia and hostility. Significantly, he did not harm anyone despite paranoid psychotic episodes aggravated at times by substance misuse.

## **Phase 2: Low key community care, 2003-2014**

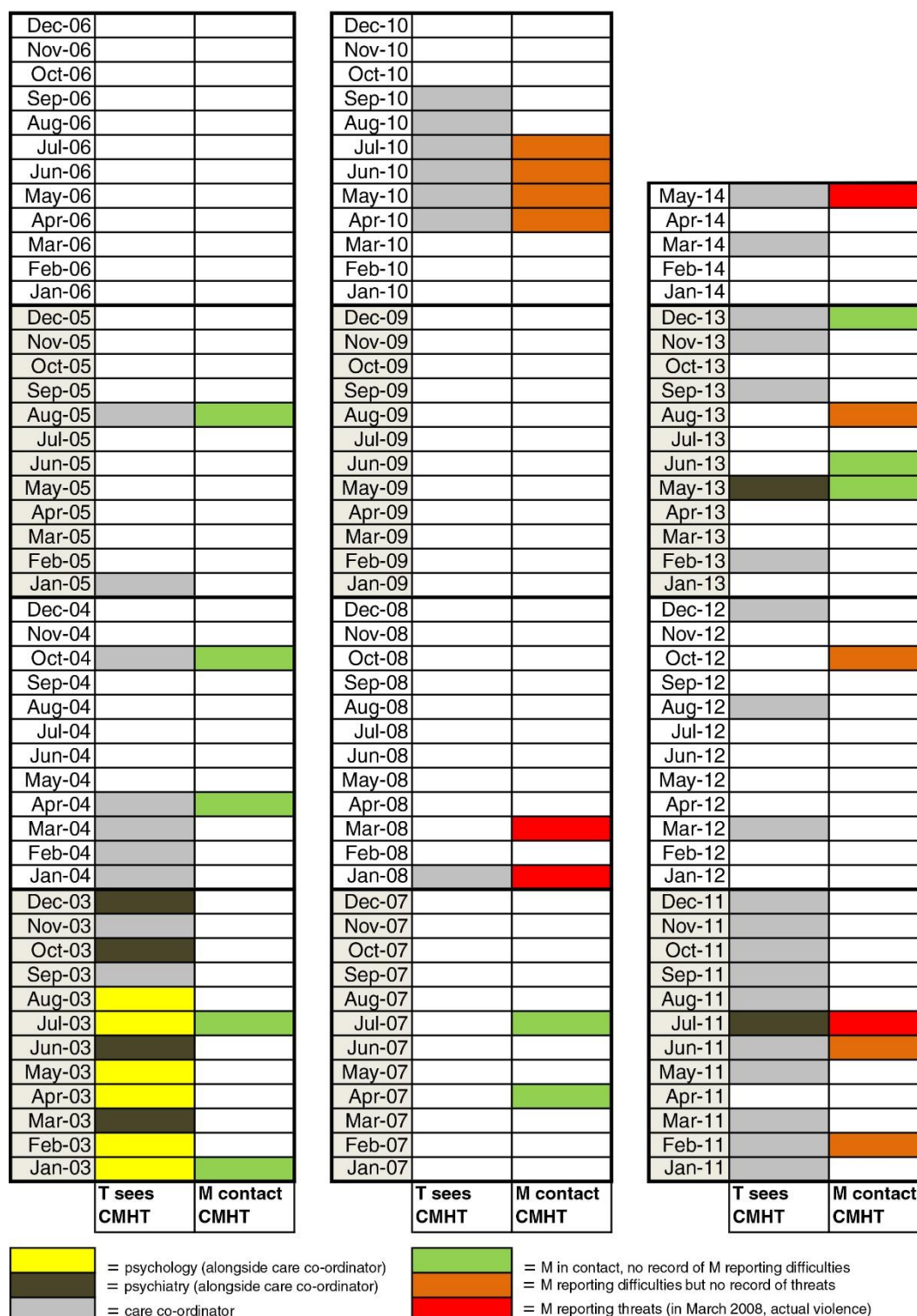
- 5.8 Figure 1 (overleaf) summarises T's and M's contacts with mental health services after T's final admission at the end of 2002. This illustrates a tailing off of contact after T's intense engagement following his 2002 admission where he was very focused on avoiding readmission. T told us that between 2003 and 2004 he had worked hard at staying well by taking regular exercise, avoiding drugs and alcohol and looking after himself. This is congruent with the records of this period that point to T taking medication (olanzapine 20mg and procyclidine 5mg per day<sup>41</sup>) and in 2003 engaging well in psychological therapy. The therapy aimed to assist T in taking part in mainstream activities, getting more independent from M and in preventing and managing relapse. At some point in 2004 T told us he started drinking alcohol again and shortly afterwards he stopped taking medication.
- 5.9 By 2005, T was a candidate for discharge from the care programme approach (CPA) but he retained a link with the CMHT as he felt he might need occasional housing and community support. However, that August he was discharged and he did not attend subsequent psychiatry appointments or see anyone from the CMHT in 2006 or 2007 despite efforts by his consultant psychiatrist CP1 and others to re-engage with him. Early in September 2007 T attacked a building on Horse Guards Parade with a hammer in the first recorded incidence of his leaving home with a weapon since the knife wielding episode of 2000. T told us that he was unwell and drunk at the time and had intended to protest against the Vietnam war.

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<sup>41</sup> A drug affecting a particular chemical system in the body (the cholinergic system) used in mental health alongside antipsychotic drugs for the treatment of extra pyramidal side effects.



**Figure 1: T's recorded contacts with community mental health services (face-to-face) and M's (face-to-face and by telephone), 2003-2014**



5.10 In January 2008, M reported threats from T to kill her and other bizarre behaviour to the CMHT – the first such report from her since 2002. T was seen and noted to be low in mood and off medication. He explained his hostility to M as a means of keeping her away from him. The CMHT were told

by M of the conviction and, in March 2008, of T assaulting M while drunk, in South Africa. T managed to avoid the CMHT's efforts at re-engaging with him (the team was at one point considering use of the Mental Health Act) and was not seen for the following two years.

- 5.11 Figure 1 illustrates that the CMHT and RRT were generally successful in seeing T in response to M's contacts.<sup>42</sup> In 2010, M's concern was T's mounting debts and RR1 re-engaged intensively with T and M in order to bring expert welfare rights advice in to resolve the situation. And in 2011 M's account that T had raised his arm to strike her was followed up (as was the Council's estates officer's report of flooding from his flat).
- 5.12 In the 11 years prior to the May 2014 presentation, there were two periods where M told the CMHT about threats of violence against her by T. These were never adequately investigated and as late as 2014 M's reports of domestic violence were described in T's risk assessment as 'unsubstantiated'. In addition, the intelligence about T's signs of relapse and historic risk of harm to others were not assimilated into the risk assessment and management plans after 2004. This would be significant on the second of the two assessments that we analyse within phase 3 of T's dealings with the Trust, his presentations of May 2014.
- 5.13 To contextualise those presentations, in the next section we set out in detail what can be discerned from the records of the RRT's dealings with T and M from 2013 until the eve of the homicide.

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<sup>42</sup> After 2012, the RRT took over from the CMHT – see Appendix B.

## 6 Panel commentary on the events preceding the homicide, 2013- 2014

- 6.1 In Appendix B we provide information about the two Trust services involved in T's care, 2013-2014. The most involved service was the South Camden Rehabilitation and Recovery Team (the RRT). The RRT had in 2012 taken over CMHT care for patients with bipolar affective disorder and schizophrenia, including T. The South Camden Crisis Team (the Crisis Team) was involved in the two days before the homicide. Its role were, first to 'gatekeep' referrals for inpatient beds, and second to provide community-based treatment to clients with acute mental illness. Information about gatekeeping is in Appendix B.<sup>43</sup>

### 2013

#### 12 February 2013: home visit

- 6.2 During a home visit, T told his care co-ordinator RR1 that he felt quite agitated. He voiced a long-standing complaint that his mother was over-involved and critical of him. He said M had mental health problems of her own that she chose to ignore and her friends in the press acted to protect her. However, he seemed to be coping well. RR1 noted that T's mental health seemed to deteriorate when his mother visited and domestic disputes occurred. Both T and M were noted to have rejected the idea of family therapy.

Panel comments: T felt stigmatised by his status as a mental health service user and adult dependent. A major focus of RR1's and his predecessors' work with T and M concerned T's stated wish to establish himself outside of his mother's ambit, as an independent adult. At times T discussed emigrating to achieve this. But his trips abroad were often with M and he always returned to his enmeshed relationship with her. In our view, T's relationship with M was rightly an area where RR1 and others attempted to assist by emphasising T's rights to privacy and autonomy. But they needed to take account of his mother's role as carer and the impact on her as well as any alternatives available to support his autonomy, in a constructive way. Paradoxically, the staff also relied on M to indicate when T was not managing.

The DHR recorded numerous episodes where M presented to primary and secondary health services with somatic complaints, few of which on testing led to a diagnosis of illness. From 2010 she suffered increasingly from severe pain associated with rheumatoid arthritis. M's critical interactions with the health care staff she saw on her own behalf are described in the DHR overview report. They resemble some but far from all of her dealings with the mental health staff seeing her son.

<sup>43</sup> i.e. to assess the referral to confirm whether a safe and less restrictive option to admission was available. And to provide a single portal to Trust inpatient services. In line with national policy, all admissions to inpatient beds must be approved by a crisis team.

## 20 March 2013: risk assessment

### 6.3 T's risk assessment completed by RR1 stated:

"Risk event history: May 2000 2 month admission to St Luke's Hospital under section 3. Diagnosed as Paranoid Schizophrenia. He was on remand as he had threatened his consultant with a knife He presented paranoid and stated he was carrying a knife for his own protection. He had become non-compliant with olanzapine and was seen by the forensic psychiatrists.

Reports [of] domestic violence have been reported by [T's] mother, these are not substantiated and often occur where [T] feels intimidated by his mother. It is worth noting that [T] keeps a hammer under his bed.

Overall risk rating: Medium

#### Risk Formulation

Has very poor relationship with his mother who has difficulty accepting [T's] mental illness, her over involvement in [T's] life is very distressing for him. From teams knowledge of [T] it is felt that there is little need for [T's] mother to express the level of concern she does.

#### Risk Formulation

May 2000 2 month admission to St Luke's Hospital under section 3. Diagnosed as Paranoid Schizophrenia. He was on remand as he had threatened his consultant with a knife. He presented paranoid and stated he was carrying a knife for his own protection. He had become non-compliant with olanzapine and was seen by the forensic psychiatrists.

Reports of domestic violence have been reported by [T's] mother, these are not substantiated and often occur where [T] feels intimidated by his mother.

It is worth noting that [T] keeps a hammer under his bed".<sup>44</sup>

Panel comments: The risk assessment rightly referred to the two main risks evident in T's history, namely knife-related violence and domestic violence. However, it did not meet the standards provided in the Trust's Clinical Risk Assessment and Management Policy (July 2011) in the following regards.

First, the assessment did not address itself to the areas specified in policy, namely: 'How serious is the risk? Is the risk specific or general? How immediate is the risk? How volatile is the risk? What specific treatment and interventions can best reduce the risk? What plan of management is needed to reduce the risk?' The omission of the latter two points in particular, undermines the formulation as a risk management tool. The knife incident and threats to others were not represented as part of a clear pattern but rather as outlying incidents. Reference to the features of paranoid schizophrenia in T's presentation (e.g. proven ways of identifying

<sup>44</sup> This is a repetition of the earlier risk event history section.

and mitigating relapse) was absent from the formulation. This was surprising as T's past history of florid psychotic relapse was the only rationale for his receipt of CPA that we could identify.

Second, the policy stated: 'If the carer is at risk they should be seen separately so that the risk can be explored and actions agreed. [...] The carer should also be offered an assessment and should be assisted to develop a plan for meeting their own needs.' This clearly did not happen despite the document's reference to reports of domestic violence. Instead, the view that there was little need for M to express the concerns she did was offered. This was an unevidenced and pejorative opinion that would feed directly into decision-making the following year. The formulation, in our view, should have recognised M's role in identifying T's relapses.

Third, despite the documented links between T's risks and substance misuse, the requirement in 5.11 of the policy to cover substance misuse was not followed.

Fourth, there was no apparent involvement of the service user (T) in the formulation. This meant that no clear, collaborative risk management strategy was evident from the document despite T's ability in his latter admissions to recognise his own signs of relapse.

These deficits were particularly unfortunate given the good quality of the preceding (2002-2004) risk assessment (paragraph E.23) that identified relapse indicators including extreme paranoia about neighbours. It posited a low threshold for admission.

Unlike the 2002-2004 document, however, the 2013 formulation did refer to a potential risk to M. In section 7 we will consider the extent to which its references to M assisted Trust staff in dealing with the May 2014 presentations.

- 6.4 Given our findings about risk assessment, we fully endorse the DHR's recommendation that the Trust should 'review its approach to risk assessment and risk management, including the weight given to allegations of abuse and/or threats and the actions taken to address such allegations'.
- 6.5 While we were encouraged by evidence we were provided with that the Trust was monitoring the completion of risk assessments, this case illustrates the fact that the quality of the formulation rather than the existence of a plan is critical.

**Recommendation 2:** The Trust's Rehabilitation and Recovery Division should implement measures to provide assurance that risk assessments meet the necessary quality standards. In particular, all risk assessments should flag known relapse signs and proven risk management strategies.

## 9 May 2013: CPA meeting

- 6.6 T attended his CPA review meeting with M. RR1 and CP2, his consultant psychiatrist, were present (CP2 that day met T and M for the first time). CP2's notes of the meeting recorded that T felt anxious about things going on around him such as gangs of people in the street who might be going to commit serious crimes. T accepted this may have been slightly irrational. M said T often drank heavily when at home and she often found bottles scattered around the flat. T said he only drank small amounts occasionally. T was noted by CP2 to be splitting time between his own and his mother's flat.
- 6.7 CP2 summarised T's mental state as:
- "Good self care, normal eye contact, reactive affect, quiet voice with normal tone and form of speech. No mood symptoms. He described longstanding suspiciousness of other people, but was guarded when asked about this. He said that he thought his past psychotic symptoms were linked to substance misuse."
- 6.8 M told RR1 and CP2 that she thought T was autistic and had been since he was a child. She thought he needed psychological therapy. She felt sceptical about medical treatment and psychiatric diagnoses. She spoke about severe extra-pyramidal side effects when T had been treated with antipsychotic medication in the past. T expressed an interest in cognitive behavioural therapy (that he had engaged with in 1999 and 2003) and a plan for a referral for a psychological assessment was documented. CP2 noted that T was not seeing his GP.

Panel comments: The Trust's CPA policy stated that CPA should be reserved for service users with 'Severe mental disorder (including personality disorder) with high degree of clinical complexity'. Risks might include 'harm to others [...] relapse history requiring urgent response, self-neglect [...] and significant reliance on carers'. In our view the RRT's decision to maintain contact with T within CPA, given his history, was correct.

The Trust's CPA policy stated that a review should include: notification to the GP two weeks in advance of the meeting; an evaluation of the care plan; an updated risk assessment and management plan; a re-assessment of the need for mental health services; and a review of the service user's attitude to carer and family involvement. While some of these areas were covered, there is no evidence that an attempt to contact the GP was made before or after the meeting; and the care and risk assessment plans were not reviewed as a consequence of it.

This was the first CPA that T or M had attended in over a decade.<sup>45</sup> In our view, more active involvement of T and M in reviewing the care and risk

<sup>45</sup> It is the only community-based CPA we have any record of T or M attending.



management plans, and an exploration of their expectations of the RRT and CPA, should have been recorded.

In October 2012, RR1 had encouraged T to register with a GP. CP2 told us that in the CPA meeting he believed T was registered with a GP because he asked him about it and T “said he had an appointment or something coming up with the GP”. That is not wholly congruent with CP2’s contemporaneous note that T was not seeing his GP. CP2 thought he had dictated a clinic letter for the GP along the lines of his RiO entry but it could not be sent as it turned out T was not GP-registered.<sup>46</sup>

- 6.9 People with serious mental illness are prone to premature mortality and high morbidity. It is therefore essential that service users are registered with a GP. Given our concerns in this area, we make the following recommendations to the Trust and NHS England:

**Recommendation 3:** The Trust should ensure that its systems are capable of identifying when its service users are not registered with a GP and ensuring that GP registration then occurs.

**Recommendation 4:** The Trust should ensure that when its policies require it to communicate with a patient’s GP, that communication occurs.

**Recommendation 5:** It is recommended that NHS England ensure that people with a CPA care plan are not deregistered from their GP without contacting Adult Social Care and/or the Mental Health Trust first.

- 6.10 We also endorse the DHR recommendation to NHS England that commissioners of GP services should ensure that GP practices are not able to deregister patients who have a care plan without contact with the relevant Adult Social Care department and/or NHS Foundation Trust.

## **20 August 2013: contact with M**

- 6.11 Shortly after the CPA, T and M went to Spain. On 20 August 2013, M told RR1 that T was unwell, deteriorating, depressed and spending most of his time in bed doing very little.

## **9 September 2013: home visit**

- 6.12 RR1 visited T and found him slightly anxious but stable. He noted: “He seems to be OK with his mother”.
- 6.13 According to the DHR, T re-registered with a GP in September 2013 and was de-registered in January 2014. We have no evidence of an RRT role in this.

## **26 November 2013: home visit**

<sup>46</sup> RiO is a proprietary electronic patient record in use by the Trust between 2008 and 2015.

- 6.14 RR1 noted that T was stable but “felt the social stigma of his diagnosis”. RR1 tried to persuade T to consider daytime activities but T was, as he had always been, reluctant to consider changes to his established routine. T was positive about the option of psychology. He was noted to be spending half his time at his mother’s flat.

Panel comments: We commend RR1’s repeated efforts to encourage T to engage in social activities as a means of fostering an independent life where he did not rely on M.

## **10 December 2013: care plan**

- 6.15 The care plan completed by RR1 included:

### **“Presenting issue 1**

Interventions [T] is currently not on any medication.

His mental health is stable at the current time.

[RR1] to visit [T] once every two- four weeks to provide support and monitor mental health

### **Presenting issue 2**

Family/relationships/social network

Goal [T] has a difficult relationship with his mother. This has a direct impact on his mental state. His mother still finds it difficult to come to terms with his mental health. She finds the limitations it places on him frustrating and is often critical [of him].

Interventions [T] to contact [RR1] during times of stress.

[RR1] to offer support to [T’s] mother [T] feels his mother is over involved.

### **Presenting Issue 3**

Finances

Goal [T] to manage on benefits without becoming to in debt

Interventions Support from Welfare rights worker when required

### **Presenting Issue 4**

Other

Goal Referred for psychology assessment, with aim of providing coping mechanisms

### **Steps to prevent a crisis developing (Contingency plan):**

Attend A&E or GP

### **Crisis plan**



[T] or [T's] mother to contact South Camden R&R Care Co-ordinator or Red Team [number]  
Contact Crisis Team [number]  
Make urgent appointment to see Consultant or [Senior Registrar]”.

Panel comments: In our view, this contained reasonable provisions for a client not receiving active treatment presenting at the time with relatively low support needs and little wish to engage with mental health services (for example in the occupational sphere).

There is no evidence that T was referred for a psychological assessment although it had been part of the plan formulated in the CPA seven months earlier.

The plan to offer support to M was appropriate and in line with the Trust's CPA policy requirement for 'consideration and assessment of the carer's needs'. When we met RR1 he told us that his record keeping understated the frequency and depth of his contacts with M and T.

There was no evidence that T was involved in care planning as required by the CPA policy or sent a copy of the care plan.

The plan for T or M to contact the RRT or Crisis Team in the event of difficulties was wholly appropriate but not congruent with the contents of the risk assessment that suggested that M was a cause rather than a reporter of risk.

In our view, a care plan goal should have been to ensure that T was re-registered with a GP.

The care plan did not meet the Department of Health standard referred to in the Trust's CPA policy by setting out: 'Who the service user is most responsive to; How to contact that person; Previous strategies which have been successful in engaging the service user.'

- 6.16 Given our comments about care planning, we endorse the SI panel's recommendation about the implementation of NICE guidance CG178 and that care plans should be audited with a view to improving their adherence to the relevant standards, particularly those related to the involvement of service users and carers.

### **30 December 2013: T attended RRT**

- 6.17 RR1 spoke to M and noted that T was to attend the RRT team base that afternoon. T was now spending most of his time at M's flat. RR1 saw T and described him as consistent in his mental state. T said he felt safer at his mother's flat as his own accommodation was in too crowded an area. RR1 noted:

“[T] often misinterprets goings on in the street. In particular, a group of males can be heard in the flat below, he believes he is somehow at risk.”

- 6.18 T told us that his dealings with RR1 had been like “a little game”. He had been worried that RR1 might put him in hospital if he said too much about his thought processes. T said that most of his discussions with RR1 had been about his mum’s constant nagging. He hadn’t felt that very much had been offered by mental health services. In the months before he asked for hospital admission in May 2014 he had had no therapy and little help. He could not recall any decision about therapy being made at the CPA meeting in May 2013. He thought a psychological approach for him and his mother would have helped (he was undergoing psychological therapy in the secure unit when we saw him). He saw hospital as a last resort to be asked for only when he was “completely finished”.

Panel comments: T frequently described anxiety and fears about activity in the area where he lived. More severe paranoia related to people in the vicinity of his flat had also been, historically, a marker of relapse. T’s reports of feeling violent impulses towards neighbours had been why he had been admitted in 2001 and 2002.

In our view RR1, who knew that M could add to T’s stress, might have given some consideration to the possibility of a deterioration given M’s reports and T’s decision to spend so much time with M after their holiday in Spain.

The issue of where T lived, that had been considered at various stages over the previous years, might also have been looked at again given T’s avoidance of his own flat. T’s fears about people in his own neighbourhood increased his proximity to M, the person identified as over involved and potentially a recipient of domestic abuse in the risk assessment.

## 2014

- 6.19 No records exist of RRT contact with T or M until they presented to the team base at the Peckwater Centre on 7 May 2014.
- 6.20 In his police statement, RR1 described the following actual and attempted contacts with T in early 2014:
- 24 February 2014: T did not open the door to let RR1 into his flat for a standard appointment
  - 11 March 2014: RR1 saw T in his flat and he “appeared okay with no major concerns for his mental health”
  - 24 April 2014: RR1 stated: “I saw [T] at Peckwater centre as he was here for a blood test. I spoke to [M] on the phone, a short conversation. I said, “Hi, how are things going?” She seemed content – said “Things are going okay for [T].” [T] was staying with her for the time being. I said, “Is [T] in?” She said, “No. You can catch him as he’s going to the

GP at the same building as Peckwater.”<sup>47</sup> So I caught him here. I didn’t spend much time with him, he seemed fine. I reflected with him on what his Mum said, he said, “Yeah, things are okay.” It was unusual his mother seemed genuinely content. Usually she’s quite intense, but she wasn’t.’

Panel comments: When we spoke to RR1 he told us that he had worked in the RRT as an AMHP and acting manager with his own caseload, frequently covering for sickness and working until midnight. The pressure created by management duties on the Red Team also created a lot of work for RR1 at this time.

We are sympathetic to the pressure described by RR1 and note the findings of the CCG-commissioned review of the Trust’s crisis care services that pointed to a legacy of low morale and high vacancy levels following the 2012 service restructure. However, we agree with the authors of the SI report and the DHR that it was a lapse in practice on RR1’s part not to document all of his contacts with T.

- 6.21 Given our concerns about record keeping, we make the following recommendation:

**Recommendation 6:** We recommend that the Trust’s Rehabilitation and Recovery Division reviews its systems for ensuring that all care episodes are recorded in line with its record keeping standards.

### **April 2014: Risk assessment review**

- 6.22 We were provided with a risk assessment for T citing this date of formulation. It was otherwise identical to the 20 March 2013 document.

### **May 2014: M said she had attempted to contact the RRT**

- 6.23 M later told RR3 and CT2 that she had left voicemail messages on RR1’s telephone asking him to contact her in the first week of May due to her son’s deterioration. RR1 said that he had no record of attempted contact from M.

### **7 May 2014**

### **10:00: M, who was agitated, contacted the RRT repeatedly**

- 6.24 RR2, a student mental health worker, and RR4, a locum social worker, were on duty in the RRT’s ‘Red Team’.<sup>48</sup> Both took calls from M. RR4 noted on RiO:

<sup>47</sup> The evidence we have seen does not point to T being GP-registered in April 2014.

<sup>48</sup> The Red Team consisted of RRT staff members on a rota available to respond to requests for interventions for clients with lower support needs who did not have ready access to care co-ordination. See Appendix B for more information about the RRT.

“t/c from [T’s] mother [telephone number] sounding distressed and emotional saying she is in fear that her son will harm her as he is not well. She said he is asleep at the time of calling and she does not want to talk for long as she may wake him.

Advised that if she is afraid for her safety, she should contact police immediately, [M] demanded that mental health services come to the flat ‘now to speak to him and take him to hospital’.

[M] reports that [T] has been living with her and that he is not well. She said he is sleeping on the floor and smoking a lot. She said he is not washing himself or feeding himself. He has not harmed her but she is afraid that he might. It is not clear why she has this fear that he will harm her.

I repeated my advice to [M] about contacting emergency services if she is need of immediate assistance and advised her I will contact her with a plan of action after getting some background information about [T].”

- 6.25 Shortly after 10:00, RR2 had a similar conversation with M who said she could speak more freely as T had left the flat to buy cigarettes. RR2 found M forceful, “frantic”, repetitive, demanding and “overly dramatic”. M wanted T taken to hospital immediately and was frustrated with the arrangement for RR4 to call her back.

### **10:30: The RRT arranged an assessment for that afternoon**

- 6.26 RR4 spoke to M on the telephone who was angry that the RRT had not responded quickly enough, generally, and that morning in particular. RR4 who went on to speak with T recorded that:

“... recent risk assessment states that ‘from teams knowledge of [T] it is felt that there is little need for [T’s] mother to express the level of concern she does’. I asked to speak directly to [T] who has now woken up.

[T] who was in the same room came to the phone and asked straightaway if he could be admitted to hospital. He tells me in a calm and controlled manner that he needs to go to hospital as he is not well, is hearing voices and believes he may become aggressive towards his mum if he remains where he is. He is not clear about the connection between the voices and the thoughts of harming his mother. He says he is has heard the word ‘baby or something like that’. He sounds lucid and articulate. [T] says he does not want to go to his own flat. He is unable to identify any triggers to the symptoms he is describing. Not receptive to suggestions for how he might manage any symptoms. Sounds impatient and insistent about wanting to go into hospital.

Controlled manner, good concentration and logical thought processes incongruent to reports of his deteriorating mental state.

He agreed to come to The Peckwater Centre today at 1pm to meet with the Red Team for an urgent assessment and said he can make his own way there. I advised him to leave his mum's house now if he is concerned about the situation escalating whilst he remains.

Plan

Red Team Assessment booked today at 1pm with [RR2] and Manager."

- 6.27 In her police statement RR4 added that she had advised T that if he needed to go anywhere immediately to be safe he should attend A&E at one of the local acute trusts.<sup>49</sup> T, who had already agreed to attend the Peckwater Centre, asked if an ambulance could take him to A&E. RR4 said that if he could walk to the Peckwater Centre he could probably walk to A&E. RR4 was at a meeting that afternoon, hence the decision that it would be RR2 with a Red Team manager who would undertake the 13:00 assessment.

Panel comments: On 7 May 2014, uniquely, M was actively collaborating with T in trying to get T admitted through face-to-face contact with the RRT and Crisis Team. The RRT staff understood that the presentation was unusual. In our view the decision to assess T in the RRT base, with M, face-to-face that day, represented best practice.

RR4's conversation with T appears to be the first response to T's or M's requests for a bed that day where A&E attendance was suggested as an option. It should be remembered that T had presented to A&E in 1999, 2001 and 2002 with paranoia and had been admitted informally on each occasion. It is not clear to us why T did not attend A&E on this occasion. This was another uncharacteristic aspect of the presentation.

- 6.28 **Circa 12:00** (entered on the record at 12:22): RR5, the locum social worker leading the Red Team in the morning, received a call from M. M complained at the failure of the RRT to come out and see T immediately and asked for the Crisis Team's number. RR5 urged M to wait for the outcome of the Peckwater Centre assessment and undertook to arrange a home visit if T did not attend.

### **12:15: M involved the Crisis Team**

- 6.29 CT1, the shift leader on the Crisis Team, received a message to ring M. CT1 recorded (at 14:30):
- "T/c earlier from [T's] Mum [telephone number] who reports that he is not washing or eating. He told her this morning that he felt that he needed admitting, she says that this is very unusual. Reports that he is hearing voices and not taken medication for a long time. Sleeping on floor."
- 6.30 In her police statement CT1 said that the call with M had lasted about 35 minutes. M had said that it was unusual for T to request hospital. M had also

<sup>49</sup> University College London Hospital (UCLH) or the Whittington.

described T's history of carrying a knife and his current delusions about neighbours. While talking to CT1, M was on her way to the Peckwater Centre to attend the appointment.

### **12:50: Crisis Team liaised with the RRT and checked M and T**

- 6.31 CT1 rang the RRT and confirmed that T and M were going to attend the appointment. She offered Crisis Team support if it was needed. She then rang M back and confirmed that M was in the Peckwater Centre with T. CT1 spoke briefly to T to reassure him that the RRT would help.

### **c12:55: T assessed as needing an acute bed**

- 6.32 T and M were met by RR2 and RR5 in reception. T appeared dishevelled, distressed and flat in affect. M was visibly anxious. T was asked if M should attend the assessment and said no. M remained in the waiting area. RR2 and RR5 assessed T in an interview room.

- 6.33 RR2's notes of the interview (entered at 14:19) touched on apparent inconsistencies in T's presentation and the idea (similar to the risk assessment formulation) that M was responsible for T's symptoms:

"Spoken to [T] and his mother. He initially stated that he was not sure if he had voices and has since escalated to external voices and colours. He appears unwashed and nervous, hands shaking, nervous head jerks. He has not eaten for 4 days and has had disturbed sleep. His mother said he has been sleeping on the floor and breaking CDs.

Appears his mother seems to make him worse. He does not want to go to his flat or his mother's and seems to think hospital is the only option. The crisis team have filled out a gatekeeping form but there are no beds currently available in the trust."

Plan: To get a Doctor to prescribe Olanzapine. To confirm a bed for him".

- 6.34 In his police statement RR5 stated that T, who was dishevelled, had been unable to say what the voices were saying to him and had denied thoughts of harming others. He was fixed on getting into hospital and RR5 explained that the Crisis Team would have to be involved before this could be pursued.
- 6.35 In his police statement RR2 recalled that T had complained that his mother was "doing my head in" and disclosed that he could hit somebody. He had seemed to RR2 to be agreeing with whatever was put to him and seeking hospital as a way of getting away from his mother. T agreed to wait in the Peckwater Centre while a bed was sought.
- 6.36 T told us that while he had been staying in M's flat he had felt that the "energy had been really strong". He had been going into a park nearby for a cigarette and a cup of coffee. He had felt scared. He had also felt like jumping in front of a train. Sitting in M's flat he thought that he had to burn everything down

and go to Sweden. He thought he was going to hell. This was a very different feeling from anything he'd experienced in the previous ten years. He felt real panic. It was like the previous times when he had needed admission. He had seen lost spirit worlds on the computer and was trying to make connections between classical civilisations. T told us that his thoughts had "driven me mad". He had been hearing new spoken instructions at the time to start fires. But he was too preoccupied with his thoughts, embarrassed and scared to disclose his symptoms fully to the assessing staff. He had always felt the stigma of mental illness very strongly. He did not want to seem like the "village fool" or a "crazy idiot". T told us that he would have accepted treatment. He could not believe that the staff would not admit him.

- 6.37 RR2 recalled that M took a bit of convincing that the RRT was taking action but reluctantly agreed to wait while the Crisis Team was contacted. T left the building for a cigarette, agreeing to return by 14:00.

Panel comments: T's presentation featured sufficient signs of psychotic relapse (including reported hallucinations, poor self-care and an earlier suggestion of thoughts of harming his mother) to warrant inpatient assessment. The staff who spoke to T and M responded correctly to the same risk scenario that had repeatedly triggered admissions in the first phase of T's dealings with services. The fact that he was, unusually, requesting admission was also significant. In our view, given his presentation that day and the confirmatory evidence from M, the decision to admit T was correct. Up to this stage, the Trust's response to the presentation was exemplary.

A safeguarding alert would have been a reasonable response to a presentation featuring reports of threats to harm a 67 year old woman. However, we acknowledge that the staff assessing T did not know T or M and were working from a risk formulation that was far from conclusive in its references to evidence of a risk to M.

- 6.38 **13:20:** RR2 sent a message to the Crisis Team pager (the Crisis Team was in a meeting). M sent another message to the Crisis Team pager.

### **13:50: Gatekeeping: Crisis Team decide T should have a bed**

- 6.39 CT1 left a meeting to speak to RR2 and on the basis of her conversation with him, confirmed that the Crisis Team would gatekeep a bed. She noted (at 14:30):

"T/c from [RR2] saying the same [as M who she had spoken to earlier]. [T] reports that he is worried about hurting someone else, lashing out. Is visibly shaking and very anxious, though speaks calmly. He seems scared and is self medicating by drinking alcohol excessively. Reporting not eating or sleeping and requesting admission, though it seems there is possibly a difficult situation at home with his Mum. Visibly dirty and very poor self care.



## Plan

Gatekeeping to be completed for informal admission on basis of chaotic behaviour (drinking alcohol and often not at home), requesting admission which is extremely unusual for him, very poor self care. Not taken medication for a long period.”

Panel comments: The Trust’s Bed Management Policy stated:

### **‘How to arrange an admission**

When an inpatient admission is deemed necessary following assessment, the practitioner who carries out the initial assessment, whether it be a member of the Crisis Team or A&E Liaison staff, should contact the Duty Nurse at the Highgate Mental Health Centre to arrange an admission to hospital. The duty nurse will allocate the patient the most appropriate available bed, on an assessment or treatment ward ... Once a bed has been authorised the Duty Nurse must enter the patient on the virtual bed section on RiO.’

Different expectations and interpretations of the Crisis Team’s role in the referral of T were shared with us and we consider them in the next section. In the Trust’s 2014 Bed Management Policy, a Crisis Team-supported RRT referral for a bed was allowed in exceptional circumstances.

In our view it was in T’s best interests to be admitted without delay. Duplication of the assessment would have served no useful purpose. Our main question at this stage in the timeline is why the referral failed. Our view is that the root causes lay outside of the Crisis Team’s involvement which we commend as facilitative of admission.

In particular, we commend CT1 for her responsive approach to M’s telephone call to the Crisis Team, for following up with M and T, and the RRT, and for gatekeeping the referral for a bed. CT1 did not add any service- or policy-driven process stages to the delicate situation that the RRT was trying to manage. She understood and acted on the information provided by M correctly.

## **c13:50-55: The Bed Managers said “There are no beds”**

- 6.40 RR2 told RR3 and RR5 that the Crisis Team was supporting the bed request and he then rang the early shift bed manager at the Highgate Centre who said that no beds were available; nor was there a bed in the Crisis House.
- 6.41 RR5 also rang the bed management team to find out if a bed was available. The early shift bed manager again said that there was no bed but she undertook to get back to the RRT. She was unable to do so and handed the case over to BM1, the late shift bed manager.

## **14:00: Re-assessment by RRT, interim plan put in place**

- 6.42 RR5 handed over the Red Team shift to RR3 and introduced him to T and M who were in the waiting area. This was the first time RR3 had met T or M and he did not recall T having been discussed in a prior team meeting. RR3 asked T if he would take medication and T agreed. RR3 proceeded to assess T with M present. RR5 and RR2 were also there. RR3 noted (entered on the record at 15:03):

“...She ... said right when [I] asked [her] if her son is going to hurt her. I clarified with her before leaving that she keep herself safe and if she feels she is at risk she should call the emergency services and not let her son in the house, she said she will not be able to do that. I said that she will need to assess the risks, I have advised her that she must keep herself safe. I telephoned her to reiterate this and left a message.

Risks factors include: 44 years, male, not taking medication, no beds available, anxious, hearing voices and seeing different colours, reported that he was not sleeping and not eating.

Protective factors include: supported by his mother, agreed to take medication, prescription issued, referred to [Crisis Team], [Crisis Team] to contact mother and arrange an appointment for an assessment, they sought help.

Presenting complaints - Client wants to be admitted as he is hearing voices outside head. Anxious.

History of presenting complaints - sleeping on floor for some time now, not eating, not washing, not taking meds

#### Past Psychiatric History

DIAGNOSIS: PARANOID SCHIZOPHRENIA, said that he had not have an admission in 10 years, reviewed discharge summaries on Rio.

Taken from Rio; discharge summaries on clinical documents

#### PAST PSYCHIATRIC HISTORY:

[Summary of the 10 admissions 1994-2001 – see entries in paragraphs E.1-E.21]

[Detailed summary of personal history, family and medical history from RiO]

#### Forensic History

Taken from Rio; Clinical documents

[Summary of 1996 drunk and disorderly conviction and 2000 knife incidents]

Social - He has a flat but it would appear that he stays at his mother.

Drugs - He denied any drug use

Alcohol - He said that he had some alcohol last week or 2 ago but could not state how much or what; could not remember.

Allergies - He denied any allergies including drug allergies

Medication - He said that he was not on any medication

MSE

Appearance and Behaviour - Slightly unkempt, anxious, eye contact, restless.

Speech - Normal

Mood - Anxious

Thoughts - He would appear to be distracted in thoughts; he was not able to tolerate full interview.

Perception - He admitted to auditory hallucinations, outside his head, he made reference to voices telling him to kill but said that there was no one specific, he then said that at time the voices tell him to hurt his mother. He said that he was also experiencing visual hallucinations; seeing different colours; red.

Impression - 44 year old man with history of schizophrenia, have not taken medication for a long time, currently experiencing auditory and visual hallucinations. Would appear to be in relapse of symptoms.

Plan

I have referred to the [Crisis Team] who will contact client's mother today to arrange appointment for assessment

I have issued a prescription for olanzapine 5 mg [daily] 7/7 supplied

I have informed client's mother that she should contact emergency services if she feels she is at risk so he can be taken to A&E".

Panel comments: As T was asking for an admission, a Mental Health Act assessment was clearly not appropriate. T also indicated a willingness to take medication. Our view is that the olanzapine prescription was therefore reasonable. The fact that T had not taken anti-psychotic medication for a decade and had no GP meant that the low dose was appropriate. We emphasise, however, that T's presenting and overarching need was for admission rather than a low intensity community-based intervention.

RR3's assessment was documented to the standard provided in the Trust's Non Medical Prescribing Policy. RR3 demonstrated diligence in this area of his practice. We are not of the view that medication could have been

expected to exert a significant short term therapeutic effect, assuming – contrary to his previous history – that T took it.

RR3 reproduced significant history in the assessment from the RiO documentation available to him. Given the limited community documentation, most of this originated over a decade earlier. RR3's request for admission for T, that RR3 took forward, was congruent with the history of the 1994-2011 admissions RR3 reproduced in his assessment.

RR3 also noted what he could discern from T and M about the nature of the risk. This was vague given T's extreme difficulty -T told us caused by fear and embarrassment - in communicating his psychotic experiences. However, a risk to M was recorded and later communicated to BM1.

RR3's assessment spanned four and a half pages, most of which was information going back to the 1990s. 'Risk Factors' is the heading where colleagues might expect to see a distillation of all new risks. In our view, under the heading 'Risk Factors', RR3 might have usefully summarised everything disclosed by T and M that day related to T's risk of harm. The risk of violence, in particular, was not referred to in that section of the assessment.

We also have reservations about RR3's contingency plan that M should, herself, 'assess the risks' and lock her son out and/or call emergency services if she felt unsafe. In reality, T's continued residence in M's flat despite his threatening behaviour pointed to M's reluctance to take these steps. These clinical and situational factors together undoubtedly presented a novel and complex situation to manage. One obvious difficulty with the plan documented by RR3 was that the level of threatening behaviour from T commensurate with a 999 call and lock out would be expected to occur when T and M were together in the flat. Further, the plan did not mention the main risk management measure - obtaining a bed.

If there was any doubt that the suggestion to ring 999 was unfeasible, M appears to have spelled out to RR3 that she did not accept it.

We acknowledge that RR3 was in a very difficult position. He had never met M or T before and was working with a risk assessment that contained no pointers as to risk management, in particular where M's safety was concerned. He made the correct decision to obtain a bed but no clear route to the requested bed was open to him and no other way of separating T and M appears to have been available. His view, based on the presentation he saw, was that M's involvement was a protective factor. Nevertheless, he was aware of and reported the risk of harm to M.

- 6.43 **Circa 14:15:** After the assessment RR2 rang BM1, the late shift bed manager. RR2 recalled that BM1 told him there were five referrals waiting for bed allocations so there was probably no chance of a bed before the next day. RR2 made the following entry on RiO (at 16:34):

“There are still no beds today but [BM1] is aware of the referral from the crisis team. He will contact red team tomorrow to update on the situation.”

BM1 recalled in his police statement that he undertook to contact his manager, BM2, the matron, and ring back if anything became available.

RR2 told RR3 that there were still no beds.

### **Circa 14:20: Bed refused, prescription issued, T and M leave**

- 6.44 RR3 then rang BM1 who recalled RR3 telling him that a bed was needed and the risk was high as T had threatened to kill his mother.<sup>50</sup> RR3 told BM1 that the voices in T’s head were telling him to do it. BM1 again explained the bed situation and said that he would contact BM2 who was off-site. He told RR3 that it was unlikely a bed would be available before 17:00 and that if the risk was high the patient should be transferred to A&E where he could be assessed. If a bed was deemed necessary the senior on-call manager would be contacted with a view to securing a private bed if no other beds were available. BM1 explained that if a bed became available before 17:00 he would call RR3.
- 6.45 RR3 told T and M that they were trying to get a bed but he could not make any promises as there were no beds. He told them that Crisis Team support would be the next best option, explained what the Crisis Team could offer and confirmed that T would accept a prescription. T and M returned to the waiting area while RR3 reviewed the RiO records, wrote up his assessment and left messages with CP2 and the Crisis Team. RR3 explained the olanzapine prescription to T and, with him, found M on her way out of the building. RR3 suggested that she return to the consulting room. M refused. RR3 explained the plan to her (Crisis Team and olanzapine) and stated again that the emergency services should be called to take T to A&E if she felt at risk. M took the prescription and left with T.

Panel comments: There is no evidence that T and M were told before or during their Peckwater attendance that the Trust had liaison psychiatry services in the suites in the A&E departments at the three local acute hospitals, the Whittington, the Royal Free and University College Hospital. And that A&E would ensure the face-to-face pre-admission assessment M had sought for T. The CQC stated that, based on its inspection visit of 27-30 May 2014, “we saw these services working well”.<sup>51</sup>

A&E assessment was a significant route of access to Trust beds and the only route in the Bed Management Policy at the time with a target time (four hours to prevent the acute trust hosting the suite from breaching the A&E waiting target). The documentation suggests that it was suggested to M by

<sup>50</sup> RR3’s assessment had mentioned T referring to voices telling him to kill someone (unspecified and then retracted); and telling him to hurt his mother. RR3 did not recall T stating that he would kill his mother. After the homicide T stated that he did not have a plan to kill his mother.

<sup>51</sup> [http://www.cqc.org.uk/sites/default/files/taf\\_provider\\_camden\\_and\\_islington\\_nhs\\_foundation\\_trust\\_scheduled\\_20140805.pdf](http://www.cqc.org.uk/sites/default/files/taf_provider_camden_and_islington_nhs_foundation_trust_scheduled_20140805.pdf)  
We note that a 2016 CQC inspection was very critical of conditions in the suites.

the RRT as a crisis plan in the event that she felt unsafe rather than as a pragmatic way of getting T admitted. As we have noted, A&E had been T's route into inpatient services on previous admissions.

While the exact sequence and content of communications between the RRT and BM1 are not clear, BM1's undertaking to speak to the matron (BM2) was the first step towards finding a private bed.

### 15:04: Crisis Team assessment for home treatment arranged

- 6.46 RR3 rang a Crisis Team support worker, CT2, and outlined the plan. CT2 explained that the Crisis Team would undertake its own assessment for home treatment but there was no capacity for this to occur until the following morning. CT2 began ringing M to arrange the assessment but did not initially get through.

Panel comments: CT3 told the SI panel that the Crisis Team regarded a gatekeeping request, by definition, as a rejection of home treatment as an option. The gatekeeping function, from the Crisis Team's point of view, was a wholly discrete function from an assessment for home treatment.

CT1 told us that a same-day Crisis Team assessment for home treatment had been rare in 2014.<sup>52</sup> At the time there would usually be a single trained nurse on duty with two colleagues, typically a support worker (like CT2) and a social worker. The Crisis Team was not an emergency service and had no access to a place of safety other than A&E.

CT1 stated:

"At that time we still had to hold quite a few ... people [assessed as needing a bed] while they were waiting for a bed. They would remain in the community and we'd either try and see them or keep in touch by phone until that bed was available. That happened quite a bit because of the pressure around that time. ... each shift would just keep phoning to speak to the bed manager to find out what was happening with that bed and try and find out what the timescale was, so that you could then keep the service user updated as to what was happening. [...] It was just keep chasing the bed manager, to try and find out what the wait might be."

In T's case, it appears that the RRT as the assessing team 'owned' the bed request from the point of view of the Crisis Team. The Crisis Team did not therefore seek a bed for T. This fell to the RRT which would, shortly, close for the day. In effect, from the Crisis Team's point of view, the request for home treatment superseded the RRT's admission request.

CT3 told the SI panel that M had been told by CT2 that the Crisis Team did not do new assessments at home at night time. The Crisis Team undertook

<sup>52</sup> In this regard we will comment further on the Trust's 2015-16 performance dashboard which provided quarterly figures between 55.8% and 70.9% for Camden referrals seen within 24 hours of referral that year.

to assess such referrals within 24 hours. The following morning's arrangement was therefore in line with its service target. Between the time of the RRT referral and the next day's assessment for home treatment T would not be a Crisis Team client.

No one via the records nor any interviews gave us any adequate explanation as to why a person needing urgent admission due to relapse and high risk could be adequately and safely managed by once a day visits and low dose medication (especially given his known poor concordance with community treatment and that the only effective use of medication was during inpatient stays - most under the Mental Health Act).

In our experience, Crisis Teams as bed gatekeepers are often involved while a bed is sought. Once a bed search is started it is not called off unless the Crisis Team positively states that a bed is no longer required as some other plan has removed the need for inpatient admission.

Given our comments about gatekeeping, we endorse the SI panel's recommendation that the role of the Crisis Team in gatekeeping should be clarified in policy.

6.47 **15:30:** The referral form from the RRT to the Crisis Team for assessment was completed.

6.48 **Circa 15:30:** CT2 spoke to M and (at 16:00) recorded the fact that M had expressed frustration at the lack of response from the RRT in the previous week and the failure to get a bed. M explained that T was with her as he was too scared to stay in his own flat:

"Advised that when seen today at the Peckwater she had advised that [T] said he was having thought about wanting to hurt her however no plan or intent to act on these thoughts.

Advised her that if she was feeling unsafe then [T] should attend A&E and/or she should make contact with emergency services and he could be reviewed by the Mental Health Liaison Team however not amenable given the envisaged waiting times at A&E.

Acknowledged her frustration and advised that [the Crisis Team] were able to offer an assessment tomorrow morning. [M] advised that she is unable to accompany [T] to an office assessment as she is 68 years old and had rheumatoid arthritis and requested that we see him at home. Discussed and agreed with the team that we would offer home assessment between 10-12am at her address and I advised her that we would make contact with the Red Team/care coordinator and request that someone is available to attend.

Reported that she had already collected the prescription for olanzapine and had given [T] one of the 5mg tablets. She is also encouraging him to stay hydrated with water although his appetite is still a problem. I advised that



olanzapine does help with increasing appetite and he was only on an initial dose so that he could be monitored.

### Plan

Home assessment tomorrow morning between 10-12am at mum's address, [address]

Email sent to care coordinator and Red Team requesting that they attend assessment with CRT tomorrow morning".

6.49 In her police statement CT2 stated:

"I said [to M], "If you feel that you're in immediate harm, contact emergency services or [T] can be taken to A&E." I said, "He can be reviewed by Liaison Team in A&E." [M] said "To go to A&E you have to wait so long." She indicated to me that [T] couldn't wait in A&E."

### 15:30: The bed request for T was cancelled

6.50 BM1, who had been unable to speak to BM2 (who was in a meeting until about 16:00) told us:

"... if you don't have beds the wards are very busy [because they are at full capacity] so you're up and about [assisting ward staff. In 2014 the site manager/bed manager role had been] a very, very stressful job, you're up and about all the time. There were all the referrals that came through, I still remember there were about 10 referrals or something that day waiting for beds. I knew that [T's case] was a referral so it was on the system waiting, I was doing all the things and it dragged until 3.30. I didn't phone anybody; I said 'Let me check on the system'."

6.51 BM1 looked on RiO and saw RR3's record of his assessment of T that had been entered at 15:03. He assumed that a bed space was no longer required as T had been risk assessed and sent home. BM1 did not therefore discuss the likely need for a private bed for T with BM2. He terminated the search for a bed for T. This decision was not recorded and it was not discussed with the RRT.<sup>53</sup>

Panel comments: One of the RRT staff we spoke to told us:

"There seemed to be [in 2014] a culture in terms of, patients are admitted only if they are sectionable, that was the sort of unspoken criteria, the unspoken culture within the organisation, that they need to be sectionable."

We have also seen evidence that the Trust had been using private beds frequently in this time, including for informal patients.<sup>54</sup> We were told that the problem was that the RRT had not pushed the bed management team

<sup>53</sup> It is suggested in the SI report that the decision was made later. We were not provided with evidence for this, for example in the form of an electronic marker of BM1 accessing T's RiO notes. We set out our thinking about the sequence of events in paragraph 8.5 and the linked footnotes. We do not regard the factual anomaly as significant in terms of the overall root cause analysis because our conclusion is that the failure to provide the bed was a system failure not an individual failure.

<sup>54</sup> See Figure 3, paragraph 7.74.

hard enough for the bed. This was refuted by RR3 who told us that he had spelled out the risks attached to T's presentation to BM1. BM1 recalled that he had been alerted to a threat to kill but RR3 is clear that this was not what he had said.

A similar view to the 'insufficient pushing for a bed' position was that the 'no beds' message had been confused by the RRT with an outright refusal of the referral rather than a simple statement of the bed state at the time. Rather than keeping in close contact with the bed managers (i.e. pushing) the RRT made a new plan (the Crisis Team referral and medication) that did not involve pushing. This was seen by BM1 and in all likelihood the Crisis Team as an alternative plan to the referral for a bed rather than an adjunct to it.

The RRT staff we spoke to saw no contradiction in the request for Crisis Team input and their expectation that a bed was being still being pursued. They emphasised that they had assessed and recorded the risks correctly and that no statement was ever made or recorded that a bed was no longer needed; or that the bed search had been discontinued. The view that Crisis Team input often ran alongside a live bed search was echoed by CT1 and CP1 and is in line with our own expectations of how crisis teams usually work.

We endorse the SI panel's concerns and recommendations about the pressures on the staff who undertook bed management roles alongside site management duties in May 2014. The Trust was then still adjusting to the significant loss of capacity, including beds, that had followed its 2011/12 restructuring. Bed managers were fielding calls about staff not turning up, dealing with crises and servicing ECT and clozapine clinics. At interview we found BM1 to be a reflective and responsible practitioner.

Significantly, the crucial bed management function of linking an eligible referral with a bed did not occur here. The matron, BM2, who was available from 16:00, was not asked to obtain a private bed in line with Trust policy.

BM1 told the SI panel that he would have found a bed had T not been sent home, apparently with an alternative plan. Meanwhile, the RRT understood from BM1 that a bed would probably not become available during RRT working hours. The RRT staff may not therefore have seen any point in repeated telephone calls to the bed managers.

In our view, staff actions and/or inaction did not cause the failure of the Trust to provide the bed. The underlying cause was a flawed bed management system. An unwritten requirement to 'chase' a bed, i.e. to repeatedly re-refer a patient to the bed managers, is not a viable bed management system. The inherent fragility of this system was, sadly, exposed by the circumstances of this case.

It is inarguable that once a bed has been identified as needed then it should be made available unless there is a clear decision documented to the

contrary. If the system relies on who telephoned most then it is not a safe system, it is a flawed system. We consider the effectiveness of the bed management measures the Trust has implemented since this case in the next section.

### **18:18: RR3 checked that M and T were alright**

6.52 RR3 called M and confirmed arrangements for the following morning:

“I advised her that she should call emergency services if needed tonight and tomorrow before she sees the [Crisis Team], she enquired as to if there were psychiatrist at A&E and I said to her that there should be psychiatrist who will assess [T] if he presents.”

Panel comments: We commend RR3 for making contact with M at the end of his shift and for putting forward the option of attending A&E.

The impossibility of managing the risk to M effectively while T lived with her had been a factor in RR3’s plan for admission. RR3 clearly and correctly remained concerned at the risks after the end of his working day. Having made the admission and Crisis Team referrals, there was little more he could do than remind M that emergency services and A&E were available if need be. This was an inadequate risk management plan but our investigation has not identified any feasible or available alternative measures short of admission that would have reduced the main assessed risk – harm to M.

At this stage and in the earlier assessment the lack of reference to the main risk management measure identified – admission – was surprising to us.

## **8 May 2014**

### **09:20: Arrangements for RRT/Crisis Team home assessment**

6.53 CT3, the Crisis Team member assigned to the assessment, recalled in his police statement that he had telephoned RR1 and confirmed that he would undertake the assessment with him. He recalled that RR1 wanted the assessment to occur in the Peckwater Centre and would ring T and M to arrange this. RR1 was then to ring CT3 back to confirm arrangements. RR1 did not wholly corroborate CT3’s account of the day’s events.

6.54 In his police statement RR1 stated that RR5 had briefed him on the previous day’s events when he arrived at work that morning and he liaised with CT3 about attending.

6.55 **10:03:** CT3 received a message that T had tried to call. He rang RR1 who said he had spoken to M. CT3 then rang M who was “livid” and told him T

had, after speaking to RR1, left the flat. Although M stated the home visit was now pointless, CT3 insisted it would go ahead.

- 6.56 **10:30:** CT3 arrived at the Peckwater Centre and RR1 confirmed that T had returned to the flat. RR1 and CT3 spoke to M again and set off to undertake the assessment.

Panel comments: We do not know what briefing RR1 and CT3 received before the assessment. Nor do we know what was covered in the handover.

No one had been told the bed search was off at the time of the 8 May 2014 assessment. The last RRT entry from the day before about the bed request stated that an update about it would occur the next day and a bed was still being sought.

CT3's evidence to the SI panel was that the home treatment referral amounted to an RRT decision that a bed was not, after all, needed. Our initial reservation about the 8 May 2014 assessment as documented is that there is little evidence of co-ordination between the RRT and the Crisis Team about the assessed need for a bed, or of admission being considered.

- 6.57 **11:00:** M's cleaner later told the police about being at M's flat, in all likelihood just before the assessment. She said that T would usually be talkative while she was there but that morning he was completely silent. He would usually reply to her, talk to her and be friendly. She said that T had his hands down the front of his trousers which, again, wasn't normal for him. She said that T appeared very 'vacant' and that she felt unsafe.<sup>55</sup>

### **c11:00-11:55: The joint RRT/Crisis Team home assessment**

- 6.58 CT3's record of the assessment (added to RiO at 15:58) is as follows:

"Occasionally [T's] mother, [M] would come to the room to express her views forcefully about how unwell [T] is and why he can't go back to his own accommodation. Promised to speak with her alone (with [T's] consent) after speaking with [T].

[T] was lying on the bed face up. [T] observed to be sexually disinhibited, playing with his genitals as we spoke. [T's] mother later said he does the same even when speaking with her. [T] also smoked intermittently.

#### **[Presenting complaint]**

[T] was referred by the R&R team after presenting at team base ...with his mother, expressing that he was hearing voices and feeling paranoid. [T's] mother said [T] had also threatened to harm her.

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<sup>55</sup> Psychiatric report, 27 July 2014

### **[History of presenting complaint]**

[T] reported that he moved in with his mother about a month ago because he wasn't feeling well in his own accommodation. Earlier reported feeling paranoid about the place however did not repeat that during assessment. [T] said he finds the area too stressful and wants to move. "There are too many people there." Mother later added that too many drinking bars in the area fuels his alcohol intake and causes him to relapse.

[T] said he finds his mother interferes in his affairs too much but did not want to go back to his own accommodation either.

[T] was unable to give any clear picture of what had been happening prior to moving to his mother's place. [T's] responses were "nothing" and "not really".

[T] said he drinks 4/5 cans of beer (5% strength) daily and chain-smokes.

[T] said he has been hearing voices but couldn't say what the voices were saying. His responses were quite ambivalent. [T] said he was also seeing colours.

Several times, [T] asked if we were not going to take him to hospital. It was explained to him that he did not need to go to hospital.

[T] attributed his symptoms to his alcohol intake, and was ambivalent when asked if he had any mental illness. However there was query learning difficulty as during the assessment, there was no evidence that [T] was distracted by voices or any hallucinatory phenomenon though he appeared not to understand or fully take in everything, and would intermittently ask "so am I going into hospital?" Each time, [T] was told he didn't need to be in hospital.

[T] took his medication Olanzapine 5mg. [T's] mother said he had refused to take the medication however when we asked him to take it, he promptly took it. Mother insisted [T] only took it because we were present.

[T] hasn't taken any anti-psychotic medication for about 10yrs and has been out of hospital during the period. Mother later insisted she has been looking after [T] the whole time, which has kept him well. Described and showed pictures of exotic holidays with [T].

Mother suggested [T] has ... [an inherited] gene, which disposes him to alcoholism but added that [T] has low tolerance for alcohol and therefore is easily influenced by it though he doesn't drink more than 4/5 cans. Mother also alleged [T] may have autism spectrum disorder and said [that] he may have inherited that ...

[T] denies using any illicit drug but admitted to using alcohol

No recent forensic history

Mother alleges [T] had not bathed for days. Though [T's] fingernails' seemed dirty, there was no evidence of being malodorous. And he looked reasonably kempt.

## PLAN

[Crisis Team] to work with [T] for short-term intervention

[T] to be referred to [Camden Specialist Alcohol Treatment Service] if agreeable

Paired visit to supervise medication and assess risks and mental state

Dr to review Friday 09/05/14

[T] to see [RR1] at [Peckwater Centre] Thursday [that day] at 4pm

[RR1] to take [T] to visit his own accommodation next week."

- 6.59 In their police statements RR1 and CT3 stated that in the initial part of the assessment they had spoken to T in a bedroom where he had been lying on the bed, fully clothed. M was nearby on her computer. T had asked that the door should be left open. M could therefore hear and react to what was said.
- 6.60 RR1 had led the initial assessment. CT3 recalled RR1 asking T, "Is it the same issues with M?" and T replying "Yes". Despite probing, T would not elaborate on why he did not wish to return to his own flat beyond saying it was unsafe. He remained vague about the content of the voices and his delusions. M reacted angrily to RR1's suggestion that T should return to his flat – she said he should be in hospital.
- 6.61 RR1 left the bedroom and spoke to M who reiterated that T should be in hospital. She expressed concerns about T's drinking, the fact that he was touching his genitals (and had been doing so when talking to her) and his poor self-care. She said he should live away from the area of his flat and move to a more suburban area with green spaces. M showed RR1 pictures on her telephone of her holiday with T in [Spain] at her ex-husband's (T's father's) apartment.
- 6.62 CT3 joined RR1 and M. T also joined them. The discussion centred on M's holiday pictures. No hostility from T towards M was detected. M discussed her own theories as to the root cause of T's problems – alcohol and autism.
- 6.63 CT3 and RR1 asked T if he had taken his medication that day. M said he had refused to take it. T insisted that he had not refused. T agreed to take it in their presence. He returned with the box with two tablets missing. CT3 assumed this meant that T had recently taken one, and one the day before. The staff did not see T swallow a tablet. CT3 also outlined that T would be referred to the alcohol service. T seemed "ambivalent" about this. CT3 judged that T's clear commitment to taking medication meant that hospitalisation was not necessary.

- 6.64 RR1 spoke to T one-to-one about playing with his genitals while CT3 encouraged M to give T space. T told RR1 he was doing it because he felt anxious and he undertook to stop and to drink less. RR1 had never seen T behave like this before. RR1 tried to persuade T to return to his flat and offered to take him there. Meanwhile CT3 arranged for a psychiatrist to see T the following morning. At M's insistence this was to occur in her home rather than in the Crisis Team base.
- 6.65 RR1 asked T to attend the Peckwater Centre at 16:00 that day and T agreed. RR1 hoped to start working towards getting T to return to his own flat. T confirmed he would leave his mother's flat if M annoyed him and M was again given the advice to summon the emergency services if she felt threatened or unsafe. Both T and M seemed calm at the point that the staff left. Neither staff member observed any signs of difficulties between them and M's anxiety appeared to have abated considerably.
- 6.66 T told us that during the assessment he was lying in the bedroom looking at the lamp, hallucinating. The voices were telling him he had to kill his mum and burn the place down. He could remember asking twice if he could be admitted to hospital. He had been concealing his symptoms at the time because he felt like an idiot. He found his symptoms embarrassing. T said he could not understand why the staff had not sectioned him based on what they could see. With hindsight T said that he should have hit one of the staff as this would have ensured that they sectioned him. T repeatedly told us:

"I can't believe how nuts I was, I can't believe they didn't put me in hospital".

- 6.67 Later that day CT3 updated the risk assessment, adding that:

Risk Formulation 1: [T] denies any active thoughts of [self harm] or harm to others

Risk Formulation 2: [T] denies any active thoughts or [self harm] or harm to others. [sic]

[...]

Risk Formulation 3: Historical evidence documented. However during current assessment, no evidence found. [T] denies any active thoughts of [self harm] or harm to others. Admitted gets angry with mother at times but said he will go out to calm down when he felt that way

[...]

#### Risk Summary

[T] denies any active thoughts of [self harm] or harm to others  
44yo gentleman using alcohol (4/5 cans of beer daily, 5%) to manage adjustment issues. Lives independently yet heavily dependent on 68yo mother, by spending large amount of time at her accommodation. Mother



heavily involved in his daily routines and what he eats and what treatment he needs - a pseudo-dependency arrangement.

Query relapse of psychotic symptoms. Some evidence of mental health/learning difficulty issues. Mother alleges [T] has threatened [her] when he is drunk [T] admits threatening his mother sometimes but says it is because his mother does not leave him alone. Mother informed to contact emergency services if she felt unsafe at home with [T].

Encouraged mother to recognise [T] as an adult and give him some space if he doesn't want to take her advice".

Panel comments: The benefit of hindsight can introduce unfairness into any investigation. Hindsight bias occurs when people in our position who know the outcome overestimate its predictability or obviousness, compared to the estimates of those who must guess it without advance knowledge. With this at the forefront of our minds, we express the following views about this assessment.

Firstly, we echo and amplify the comments of the SI panel who found that there had been 'little exploration of the antecedents which had led to the contacting of services the previous day', in particular the thoughts of harming M. We consider that more attention might have been given to the disparity between the two days' presentations. Had more weight been given to the previous day's disclosures, the unworkable plan to continue to manage the risks to M while T co-habited with her might have been re-considered.

The previous day's events were novel in T's and M's relationship. There are no records of them ever presenting to mental health services together and asking for admission for T before. T usually avoided M when he was unwell. Nor was T known to have ever based himself in his mother's flat, or to have co-habited with anyone before, while relapsing. This was T's first frankly psychotic presentation to mental health services in over 11 years and his (and M's) first acceptance of a prescription for anti-psychotic medication in a decade. The unusual features of the presentation had rung alarm bells in the minds of the staff who had seen T and M the day before.

The right questions about harm, symptoms and alcohol were asked. In the risk assessment T's denial of thoughts of harm was set out four times. But T's capacity to answer questions was not considered sufficiently. His inability to say anything meaningful, the contrary evidence of the day before and T's historic presentations were not given sufficient weight. Undue significance was given to T's uncertain concordance with a low dose antipsychotic that, historically, had required weeks not days to exert a therapeutic effect.

We were surprised at the suggestion in CT3's assessment record that T might have a learning disability or 'adjustment issues'. This called into question the extent of the communication between the two assessors and

the presumption that T had capacity. T's presentation and history pointed clearly in a different well-established direction, psychotic relapse. Of note was T's uncharacteristic sexual disinhibition in the presence of his mother that the cleaner and RR1 had never seen before. Despite this and other signs, the assessors felt T had sufficient capacity to understand and answer questions about his thinking. His repeated "nothing" and "not really" answers to questions were interpreted as capacious denials of thoughts of harming people.

Alcohol was also part of a complex assessment picture. It is possible that some of T's confused behaviour was attributed to alcohol rather than psychosis. T and M agreed that T would threaten M under its influence. CT3 was sufficiently concerned to recommend a specialist service referral. T's disclosure of consuming four to five cans of 5% a.b.v. beer a day would not have been reassuring in risk management terms. This was another contra-indication to home assessment and treatment.

We have reservations about the conduct of the assessment, as recorded. The negative responses the assessors gave when T repeatedly requested admission during the assessment suggest that admission had been ruled out as an option from the outset or at best before the assessment was complete. That was not, however, the assessors' later account and may therefore reflect the way the assessment was recorded.

We also give weight to the assessors' interpretation of what they saw that morning. M did not appear at risk from T who seemed to be accepting treatment in the flat. Psychiatric assessment was to occur the next day, before the weekend. T seemed amenable to further contact with RR1 later that day and undertook to leave the flat if M was provocative. No clear record of T harming M existed and delusions about M had not been recorded as a feature of T's psychotic process for many years. The risk assessment pointed towards M over-reporting T's relapses and raising concerns needlessly. T had, as far as the RRT knew, largely remained well without anti-psychotics for a decade and was now apparently taking them. In fact T had no known forensic history or clear history of harming people. The 2000 knife incident was the only well-documented incident involving a weapon available to the staff. However, the fact that actual harm to others had previously been avoided by admission to hospital and effective treatment did not diminish the level of risk.

Given this, we agree with the SI panel that the homicide could not have been predicted to occur the following morning. However, we do not share the SI panel's definition of predictability as being an estimate of the exact time when an adverse event will occur. In our view, despite the reassuring factors, it was highly predictable that T would harm someone given his psychotic state, his use of alcohol, his history, the access to weapons and his largely unsupervised proximity to another person (M).

We think that a robust risk assessment formulation would have pointed the assessors more clearly to these factors. It had been reports of such a

presentation in 2008 that had prompted the CMHT to consider admitting T. And thoughts of harming people in his immediate vicinity had contributed to earlier decisions to admit him.

T had little history of accepting mental health treatment in the community (the only known episode had followed the 2002 admission). T had always needed admission to reduce his symptoms. Voluntary admission had often been followed by use of the Mental Health Act. He was known to have recently threatened his mother. In our view, a risk assessment formulation that gave full account to what was known of T when he was unwell would have called the plan to manage risk in M's home into question and raised again the need for admission.

In our view it was predictable that if T had access to other people in the condition in which he presented on 8 May 2014, he was likely to harm someone. The steps taken to reduce that risk were insufficient. We therefore consider that on 8 May 2014 a second opportunity to prevent the homicide was missed.

While we do not think that the exact timing of the homicide could have been predicted, we are of the view that harm to M while T cohabited with her was predictable.

Given our findings, we endorse the DHR recommendation that the Trust 'should review its approach to crisis treatment and seek to avoid putting in place treatment plans at the home address of someone who has made allegations of abuse against the service user or who has reported threats or fears of violence.' In addition we make a further recommendation.

**Recommendation 7:** The Trust should ensure that the role of alcohol and drug misuse in heightening risk is emphasised sufficiently in its risk assessment and management procedures.

- 6.68 That afternoon RR3 handed over his intervention and prescription to the Crisis Team doctor. No reference was made in any documentation to a request for a bed being "live" although the RRT staff told the SI investigation that they thought a bed was being pursued by the Crisis Team alongside home treatment.

Panel comments: We found this view impossible to reconcile with the clearly documented refusals of T's requests for admission that occurred during the assessment.

- 6.69 T did not attend the 16:00 meeting with RR1 at the Peckwater Centre and was not followed up again that day. He would report that, consumed with thoughts of avoiding apocalypse and hell, and a voice telling him to "flip out", he drank eight cans of beer and purchased fire lighters with the intention of destroying his possessions.

Panel comments: RR1 had reasonably surmised that T and M cohabiting presented a range of difficulties and the 16:00 meeting was intended as a first step towards supporting T to return home. T's attendance at it, or not, would be a marker of the extent to which his relapse was manageable in the community.

We agree with the SI panel that RR1 should have followed up T's non-appearance given the events of the preceding 36 hours. We would also expect that a crisis and home treatment team would have capacity to undertake a second home visit in a day in the event that a patient failed to attend an agreed appointment.

## **9 May 2014**

- 6.70 The tragic events of the homicide, that most likely occurred between 04:00 and 05:00, are set out in section 2 of this report.

## 7 Arising issues, comment and analysis

- 7.1 In this section we address our specific and core terms of reference with reference to our findings in this investigation. We also identify further areas for recommendation where they have not emerged from the narrative in the previous section.

### **The Trust's responses to the relationship between T and M**

- 7.2 From the outset of her recorded involvement in T's care (in 1996), M was opposed to the psychiatric approach. She disputed the diagnosis of paranoid schizophrenia, arguing that T had inherited autistic and alcoholic traits. M felt that antipsychotic medication was harmful to T and at times she discouraged him from taking it. She believed in alternative remedies including herbal and homeopathic products as well as dietary supplements. She thought that T's relapses were alcohol and/or drug driven.
- 7.3 Despite her reservations, M sought psychiatric input for T when he showed signs of not coping. From the records available to us, it appears that M, who was T's nearest relative under the Mental Health Act, was involved in getting T admitted in 1996, 2000 and 2002. In 2008, after M had reported aggression and violence from T, efforts were made to assess him again with a view to admission. Further reports from M of T exhibiting signs of relapse occurred in 2010, 2011, 2012 and August 2013 after she had returned from a holiday in Spain with T.
- 7.4 M was T's only known social or family contact. He was dependent on her for practical and financial help. She was a key point of contact for the CMHT over the years when efforts were made to re-engage with T. As Figure 1 illustrates, M expressed no concerns about T's behaviour in many of her contacts with the CMHT.
- 7.5 There is no reference in any of the assessments of T prior to 2014 of him disclosing psychotic thoughts of harming his mother. Friction between T and M was, however, a recurring theme in the clinical documents from 1996 onwards. This could relate to T's feeling that M was overbearing and controlling, particularly in her visits to his flat where she could be scathing about his hygiene standards and lifestyle. Another source of tension appears to have been M's role as an informant to mental health services when T was showing signs of relapse.
- 7.6 The professionals working with T usually described M as overinvolved in her son's life. M was at times depicted as undermining T's treatment and recovery. At various points over the years T discussed his wish to live more independently of M. T also told us that discussing his relationship with M with his care co-ordinator was a tactic for not discussing his mental health. In March 2003, the psychologist who was embarking on a second programme of appointments with T reported that:

'[T] still reports quite an 'intense' relationship with his mother characterised by 'high expressed emotion' behaviours. He states that his mother becomes very worried about him and tends to frequently visit him to check that he is safe. Likewise, he tends to spend quite a lot of time at his mother's flat. He feels quite overpowered by his mother's level of concern at times. He has a goal of trying to become more independent from his mother.'

- 7.7 RR1, who took over T's case five years after that assessment, stated that he did not see M as a difficult person but as someone who loved her son and was suffering. He told us:

'I never saw [M] being physical with [T]. When [M] was verbal with [T], he would be quite quiet and demure. He would try and challenge her but not in an aggressive way. She wouldn't back down, she was very determined. Once I asked her to leave [T's] flat with me, so I could talk to her outside about her behaviour. She came to the office with me; it was a very difficult conversation. I was saying [T] was an adult. She needed to respect what he wants. She was initially angry in general about [T] not being normal. I said, "He'll never be what you want him to be." She acknowledged this. To me it felt like she was devastated as [T] was unable to fulfil her expectations of an adult. We considered family therapy for them, both to help with this, but both of them (more her) didn't want it.'

- 7.8 After the homicide, T expressed having held feelings of anger towards M and feeling that she had been holding him back. In one assessment he disclosed that he had been violent towards her when unwell. He added, however much he had tried to get away, "I always ended up back with mum". In the period prior to the homicide T said he "blamed her for everything, the whole madness, but I did not tell her".<sup>56</sup>

- 7.9 Guidance published by the National Institute for Clinical Excellence (NICE) in 2002 and 2009 stated that services caring for people with psychotic illnesses should:

'Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings'.<sup>57</sup>

- 7.10 Although the SI report stated that M had repeatedly declined a carer's assessment, we found little evidence that one had been offered over the 12 year span of her son's dealings with community mental health services. The December 2013 care plan referred explicitly to support being made available to M but the only records we have related to this after that date are of M complaining that her May 2014 calls had not been returned.

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<sup>56</sup> Psychiatric assessment, 27 September 2014.

<sup>57</sup> National Institute for Health and Clinical Excellence (2002) Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care [CG1] replaced in 2009 by National Institute for Health and Clinical Excellence (2009) Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care [CG82]. The Trust recognised in 2015 that it needed to improve access to family interventions, the basis of which are set out in this document from another London trust: <http://www.slam.nhs.uk/media/243417/Family%20intervention%20in%20psychosis%20Oct%202013.pdf>

- 7.11 M suffered increasingly from rheumatoid arthritis and her ability to care for T was reducing. In May 2010, M complained that she was being let down as a carer by the CMHT. We think that repeated offers of a carer's assessment should have been made and documented in line with section 10 of the Trust's CPA Policy. We therefore endorse the SI panel's and DHR's recommendations about improving the profile of carers' assessments. We also underline the DHR recommendation that all carers should be reminded of their right to a carer assessment shortly before a CPA.
- 7.12 There are some references in the records of both T and M rejecting the suggestion of family therapy but this does not appear to have been explored in depth with either person. RR1, when he spoke to us, thought that T and M had been referred for psychology input after the 2013 CPA meeting but there is no record of this. When we met T he had no recollection of therapy being offered in 2013.
- 7.13 With hindsight, we think it is likely that M habitually under-stated T's threatening behaviour rather than exaggerated it (which was the essence of the Trust's 2013/2014 risk formulation). Her anxiety about T being aware of her disclosures to the RRT is evident in the records of her telephone calls on the morning of 7 May 2014. After the homicide T disclosed that he had been violent towards M when he had been unwell because she "did my head in". M's opposition to the medical model of mental illness and psychiatric care may have also affected her willingness to expose her son to admission.
- 7.14 While M was entitled to carer support and access to family interventions if she would accept them, our view is that the main priority in the CMHT/RRT's work with her should have been risk assessment, i.e. an exploration of M's reports of domestic abuse and violence from T. It is of concern to us that these reports were noted to be 'unsubstantiated' in the 2013/2014 risk assessment after mental health service contact spanning two decades.

## **Risk assessment and management**

- 7.15 We did not consider that the risk assessment and management plan available to the staff who assessed T and M in May 2014 met the standards provided in Trust policy. Most of the fields on the document were empty, including those asking for evidence of risk of harm to self and to others. The reader, of the paper document at least, was required to navigate four pages of empty fields and prompts before reaching the formulation, such as it is (paragraph 6.3).
- 7.16 We noted that Trust policy required that the following six questions should be addressed:
- 'How serious is the risk?
  - Is the risk specific or general?
  - How immediate is the risk?
  - How volatile is the risk?
  - What specific treatment and interventions can best reduce the risk?



- What plan of management is needed to reduce the risk?’

These key questions were not touched on in the risk assessment. These were significant omissions, that in our view undermined the usefulness of the formulation.

7.17 The Trust’s Risk Assessment policy also stated:

- ‘If the carer is at risk they should be seen separately so that the risk can be explored and actions agreed.’

7.18 In T’s case it is significant that the most specific account of his violence towards M was the 2008 assault on her in South Africa when he was drunk. RR1 told us that he had frequently seen M one-to-one but there is no indication in the risk assessment or notes that an opportunity was taken to explore the domestic violence reported by her, even though domestic violence was mentioned in the plan. Nor did any account by T of his behaviour towards M inform the risk assessment although his relationship with M was frequently the subject of meetings with RR1.

7.19 Further, the risk assessment was not aligned with care planning or CPA in timing or in content. Where the 10 December 2013 care plan stated that M should contact the RRT in the event of a crisis, the 3 April 2014 risk assessment stated that there was ‘little need for [T’s] mother to express the level of concern she does’. Of additional concern to us, the document provided no relapse indicators. In this regard we contrast the 2002-2004 risk assessment plan (paragraph E.23) with its specific list of relapse indicators with the 2013/14 document.

7.20 Risk assessments should not in our view be linear, i.e. a list of past events. They should enable pattern recognition in order to assist practitioners in managing scenarios safely where a cluster of known risks occur together. In this case the known risks were drinking, high expressed emotion, paranoid schizophrenia, psychotic relapse, a history of using a knife, thoughts of harming people and constant exposure to M.

7.21 The formulation available in May 2014 presented a vague picture which downplayed the risks to M and also to staff. It is therefore to the credit of the RRT staff who saw T and M on 7 May 2014 that they identified a risk pattern within the relapse. Up to and including this stage, the RRT’s Red Team system worked extremely well. Many of these risks had been predicted in the 2002/2004 risk assessment that had posited a low threshold for admission. But we emphasise that the poor risk formulation available to the staff who referred T for admission on 7 May 2014 had little or no part in the system failure that led to the bed not being made available.

7.22 Turning to 8 May 2014, we note first that the risk management plan had not been revisited on 7 May 2014 when it was clear that a bed would not be made available that day. We have noted that the risk management strategy identified in that day’s assessment – admission – was not referred to.

- 7.23 Of relevance to the circumstances of this case, the policy stated that a post-incident risk assessment should include:
- ‘Details of trigger factors e.g. use of (and access to) supplies of alcohol or drugs, events such as contact with relatives ...
  - ‘Details of situational factors e.g. is the person living with vulnerable others or people whom the person has threatened before? ...’
- 7.24 In our view, a succinct summary of risk covering the areas above, linked to the live plan for admission, would have been of assistance to the assessing staff on 8 May 2014. It would also have ensured that the RRT’s admission plan was available to other service areas.
- 7.25 It is clear from CT3’s evidence to the SI panel and police that on 8 May 2014 he was influenced by the premise of the risk assessment, that M was prone to expressions of unjustified anxiety. When he revised the risk assessment document after his assessment, the previous formulation remained intact. CT3 described T’s and M’s relationship as a ‘pseudo-dependency arrangement’. Unfortunately we did not have an opportunity to explore the meaning of that statement with CT3. In our view T’s dependence on M was based on well-established concrete factors, namely his lack of alternative sources of social, practical and financial support. We were also surprised by CT3’s suggestion in his assessment that T might have a learning disability, particularly as the assessment was conducted jointly with RR1 who had known T for eight years and knew that he did not have a learning disability.
- 7.26 Commendably, CT3 did record the outcome of his risk assessment that day. In it he noted that T admitted to a history of threatening his mother when drunk. We agree with the SI panel that it could not be predicted that T would kill M the morning after that assessment. But we have questioned the basis of any plan aimed at reducing the risk to M that included T co-habiting with her. We have referred to T’s known alcohol use and related domestic abuse and the significant question mark about his capacity to deny thoughts of harm.
- 7.27 In our view, the deficiencies in the risk assessment process as a whole prior to May 2014 were reflected in the formulation available to staff on 8 May 2014. Neither of the staff assessing T had seen him unwell before and detailed information about his earlier presentations was not seemingly available to them. A closer review of M’s dealings with the Trust over the years would have shown that she was a reasonably reliable informant of her son being unwell. The risk assessment suggested the opposite. Information about established relapse indicators and historical risks was not presented clearly. The historical role of admissions as the only way of reducing symptoms and risk was not mentioned.
- 7.28 It is possible that the Trust’s risk assessment proforma in use at the time might be more navigable electronically than as a paper document. In our investigation we were concerned that the printout contained too many inapplicable prompts and fields (as well as, as we have noted, many sections

that should have been completed and were not). Important information including the date of the assessment, relapse indicators and the involvement of the carer and patient in risk management were either not provided for or were hard to discern quickly from the document.

- 7.29 Our view is that the incorrect and incomplete risk formulation fed into the assessment 8 May 2014. We consider it likely that the inadequacy of the formulation impeded the staff's ability to reassess risk that day. We regard the inadequate formulation as a root cause of the decision not to take short term steps to reduce the known risks. Those risks should not have been assuaged by what was seen in the 8 May 2014 assessment.

## **Safeguarding**

- 7.30 We do not dispute the Trust's SI panel finding that safeguarding procedures might have been implemented prior to the 2014 presentation. M's March 2008 report that T had been violent towards her was the best documented incident. Equally, we understand why staff may not have considered that M was then a vulnerable adult as defined in the relevant Government guidance.<sup>58</sup> And we agree with the SI panel's observation that T as well as M might have been a candidate for a safeguarding alert at various points. It should be remembered that in May 2014 M was increasingly frail and suffering constant pain from rheumatoid arthritis.
- 7.31 However, to state that safeguarding procedures should have been invoked seems to us to run a risk of putting the cart before the horse. The precursor process to safeguarding should have been robust, evidence-based risk assessment. We found scant evidence of this after 2004. Risk assessment should have included practical information about managing mental illness relapse and the careful exploration and recording of M's accounts of being abused by T.
- 7.32 Clearly the priority during the May 2014 presentation was immediate management of a volatile situation. We would expect that M would have been confused and frustrated by safeguarding procedures being invoked when she simply sought admission for her clearly unwell son. Admission for T was the only short term way to keep M safe, in our view. We understand why, in the absence of a risk assessment that met a reasonable standard, safeguarding was not considered in May 2014.

## **The effectiveness of the service user's care plan including the involvement of the service user and the family**

- 7.33 The only recent community-based care plan for T we saw was dated 10 December 2013 and we have commented on it in the previous section. In

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<sup>58</sup> 'No Secrets, Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse'. 'No Secrets' referred to this 1997 definition of a vulnerable adult: a person: "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/194272/No\\_secrets\\_guidance\\_on\\_developing\\_and\\_implementing\\_multi-agency\\_policies\\_and\\_procedures\\_to\\_protect\\_vulnerable\\_adults\\_from\\_abuse.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets_guidance_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf)

summary, while we had some reservations, we considered it broadly appropriate for a client with apparently low support needs. We commended its provision to provide M with support. While it was not clear if T or M had been directly involved in its formulation, it appeared to reflect T's preferred arm's length relationship with mental health services and it provided a reasonable crisis plan.

- 7.34 We recognise that balancing M's involvement with T's own wish for more independence and privacy was no easy matter for RR1 and we commend his efforts to get the balance right. His empathy and feeling for her as a carer was very evident to us when we met him. In our view, had M accepted it, a carer's assessment would have contributed to the therapeutic goal for T of building clearer boundaries into the son/mother relationship.

### **Care planning and support in relation to substance misuse**

- 7.35 In paragraphs 4.14 to 4.22 we summarise T's history of drug and alcohol use. While illicit drug use was implicated in many of his relapses of the 1990s, T said he had stopped all drug use by the late 1990s. This was not wholly consistent with other statements T made about his drug use. In 1996 and 2001 T reported attending residential detoxification programmes abroad at his parents' insistence.
- 7.36 The suggestion of referral for drug and alcohol-related relapse prevention work had been made by the forensic psychiatrist who saw T after the 2000 knife incident. However, the role of drugs and alcohol in the incident itself was not clearly established.
- 7.37 The 2000 risk assessment noted that T had 'previously been threatening when psychotic and intoxicated with alcohol' but the implication here and elsewhere was that alcohol was an adjunct to T's relapse risks rather than a relapse trigger. Alcohol use was not referred to in the documents we have seen relating to T's 2001 and 2002 admissions. Nor was it referred to in the comprehensive risk assessment document of January 2002 (that was reviewed on 10 December 2003 and 24 November 2004 – paragraph E.23). Avoiding alcohol, however, was a therapeutic goal of T's in his 2003 psychology engagement. He told us he had started drinking again in 2004.
- 7.38 Although M would report her anxieties about the effect of alcohol on T over the following six years, the professionals do not appear to have been overly concerned about T's drinking. M did not raise concerns about drinking in the 2013 CPA and there is no evidence that T ever wanted to change his drinking habits. We cannot therefore see that a referral to an alcohol or drug service prior to the events of May 2014 was feasible.
- 7.39 We have noted that T's presentation and disclosure of heavy alcohol intake during the 8 May 2014 assessment prompted CT3 to include the suggestion of a referral to the specialist alcohol treatment service in his plan. This was a sensible suggestion in our view. We have flagged our concern, however, that

the contributory risks posed by T's use of alcohol were not reflected in the short term in the Crisis Team plan.

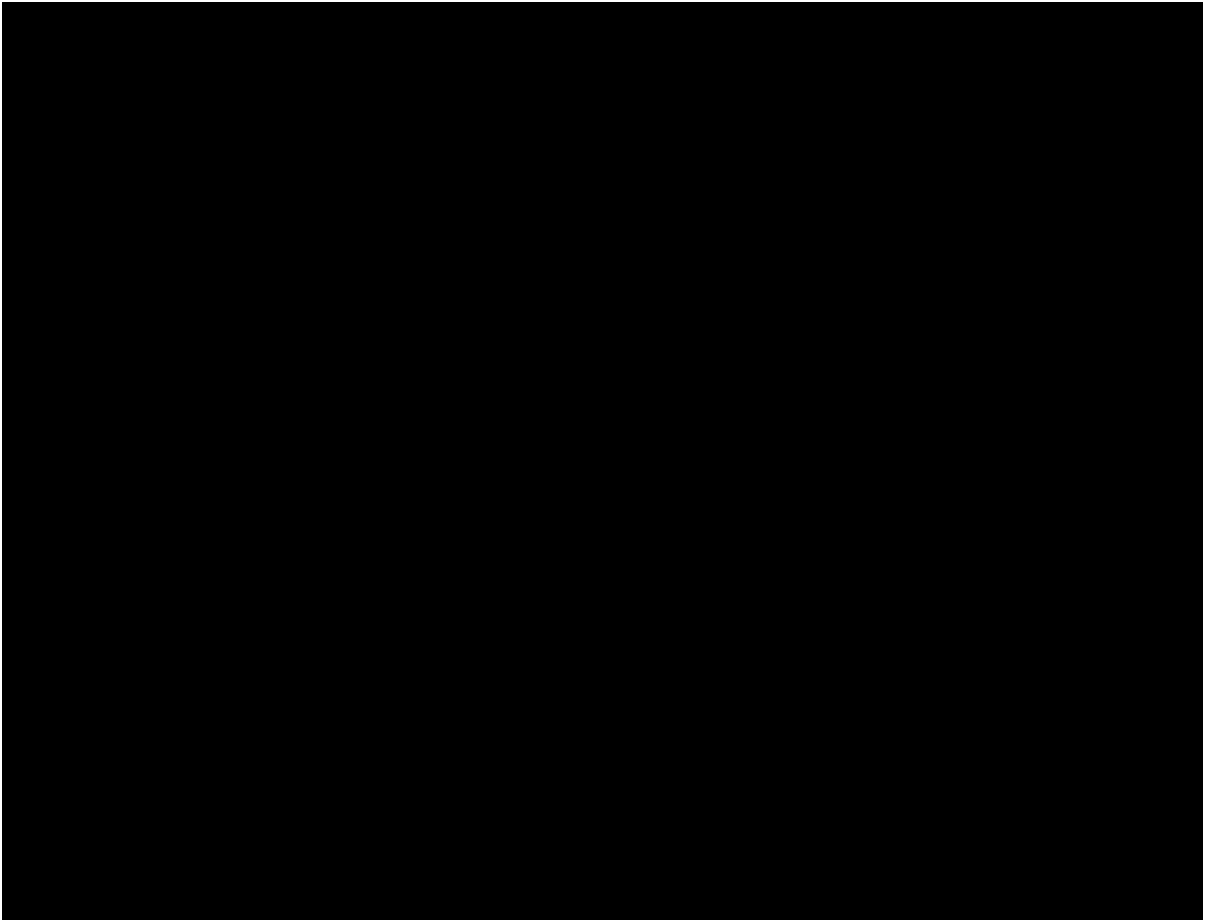
- 7.40 The documents we have seen do not include a definitive formulation of the inter-relation between T's mental health and his use of alcohol. T was reported not to suffer any alcohol withdrawal symptoms during the detention that immediately followed the homicide. We do not think that T was addicted to alcohol or had sufficient insight into its effects on him to make it a feasible target for therapeutic input during his involvement with the RRT.

## **Internal escalation processes for admission when there is no capacity to admit**

### **The system in 2014**

- 7.41 In line with national policy, the escalation scenario envisaged by the Trust's Bed Management policy in 2014 required the involvement of the Crisis Team in 'gatekeeping', as it does today (see Appendix B). The two forms of gatekeeping that existed in policy in 2014 are set out in Figure 2 overleaf (both assume Crisis Team support for an informal admission).
- 7.42 In this case the Crisis Team decided that the exceptional circumstance requirement was met. This meant that face-to-face Crisis Team assessment was not necessary and scenario 2 unfolded where the RRT not the Crisis Team would liaise with the bed managers. In our view this was a sensible decision. It relied, however, on a shared understanding between the RRT and the bed managers as to what was required and when. We have commented on the inadequacy of the Trust's 2014 bed management system where people had to be re-referred repeatedly to get a bed. This included a lack of systems for ensuring that a 'no bed' message was understood by the RRT and the bed managers in the same way.
- 7.43 The next stage in Trust policy was that the bed manager/duty nurse should be informed that a bed was required by the referrer. The bed manager would check that the referral was for the Trust and supported by the Crisis Team. If so they would complete a referral form. The bed manager would then, with regard to the presentation and other referrals on the 'pending list', and in liaison with ward managers, attempt to link the patient with a bed.
- 7.44 If no bed was available, the policy in 2014 allowed the bed manager to tell the referrer "We don't have any beds". The referrer would be told that the bed manager was working on it and to bring the patient to A&E if necessary in the meantime. No time limits existed for escalation where beds could not be sourced from within the Trust's stock and no formal process of grading referrals existed. A 'pending referrals' list available to the bed managers only was maintained. This consisted of a list of referrals where a bed had yet to be identified. The bed manager, we were told, would expect the referrer to keep in touch with them with regular telephone calls.

**Figure 2: The two approaches to Crisis Team gatekeeping in 2014**

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- 7.45 In policy, all voluntary referrals should have been considered for crisis house admission. RR2's evidence was that he was informed by BM1 that there were no crisis house beds available on 7 May 2014.
- 7.46 The Trust's 2014 policy emphasised that a private bed was to be used in situations of 'extreme emergency'. No guidelines existed stating what such an emergency consisted of, how it was to be assessed or who was to assess it. As found by the SI investigation, the next stage would be that the bed manager would escalate the bed request to the matron (BM2) who would seek authorisation for a private bed. Authority to admit to a private bed in daytime hours came from the Chief Operating Officer or his nominated deputy, in practice a divisional director. Out-of-hours, authority was provided by the director on-call.
- 7.47 In this case, as we have covered, the referral was cancelled before a discussion with BM2 occurred.
- 7.48 The RRT was told by BM1 that a bed during the day was unlikely; and if a bed was still needed at the end of the day T should be taken to A&E. Had T attended A&E in one of the three acute trusts where the Trust provided liaison psychiatry services, the liaison team would have assessed him and (assuming they and the Crisis Team agreed with admission) contacted the director on call (directly or through a matron, depending on the time) to gain access to a



private bed. In this scenario the Trust had formal agreements with the acute providers to expedite a bed allocation.<sup>59</sup>

### The system in 2016

- 7.49 The Trust made a number of changes to the escalation process after May 2014, not all related to this incident. Firstly, the Crisis Team is now required in policy to assess all informal referrals for admission face-to-face. Where admission is judged necessary, the Crisis Team must also involve the most senior doctor on duty.
- 7.50 In the scenario of T's presentation to the RRT, this would involve a qualified Crisis Team staff member attending the Peckwater Centre and re-assessing T after the initial assessment by the RRT. We put it to the Associate Director of the Acute Division from 2014 (the ADD) that this was adding an unnecessary process stage and she assured us that duplication would not occur in practice.<sup>60</sup> The ADD emphasised that the policy would not stand in the way of Crisis Team staff exercising professional judgment. She told us that where there was no value in re-assessing a patient, the Crisis Team would record its reasons for supporting the referral without its own assessment. However, the Crisis Team would endeavour to see each person who was referred informally for a bed face-to-face. In this circumstance our understanding was that it would still fall to the referrer – which could again be the RRT - to liaise with the bed manager, in the first instance at least.
- 7.51 In our view Crisis Team contact with the bed managers in the 2014 referral for the bed would have left no room for the uncertainty which led to the bed request being cancelled. We also gained the impression from several witnesses that Crisis Team staff were more familiar and comfortable with liaising with the bed managers than RRT staff. We can therefore see the benefits of Crisis Team liaison with bed managers in cases the Crisis Team has gate-kept remotely.<sup>61</sup>
- 7.52 Given the disparity between policy and practice we make the following recommendation:

**Recommendation 8:** The role of the Crisis Team in assessing informal referrals should be clarified in policy given the principles in the concordat and the gatekeeping requirements. The aim should be to ensure a seamless and responsive assessment process for clients in acute crisis and clarity as to responsibilities where different service areas have involvement in the patient's care.<sup>62</sup>

<sup>59</sup> The aim was to avoid where possible breaches of the acute trusts' four hour national A&E waiting time target.

<sup>60</sup> She explained that this additional Crisis Team involvement had been introduced as part of a process separate from this case to ensure that all informal referrals met the admission criteria.

<sup>61</sup> In this regard we also note that the Trust is committed, through 3.3 of the Camden and Islington Crisis Care Concordat Local Action Plan, to ensure that when people need urgent help they are only assessed once.

<http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/02/Camden-and-Islington-CCC-action-plan-for-submission-Final.pdf>

<sup>62</sup> See paragraph 7.77 for further information about the Crisis Care Concordat.



- 7.53 We emphasise that we do not regard the Crisis Team's arms-length involvement on 7 May 2014 as a root cause of the failure of the bed request. The root cause was the fragility of the Trust's bed allocation system.
- 7.54 The next area in the informal admission pathway where practice has changed is in the handling of bed requests by bed managers. Bed managers no longer tell referrers "There is no bed available". They now say "We'll get back to you when we have identified a time and location for the bed".
- 7.55 The pending list now consists of all referred people RAG-rated against bed availability.<sup>63</sup> People for whom a bed has been identified will be graded green (this applies to all people admitted under the Mental Health Act as a bed is identified prior to the assessment). People who the Trust can link with an expected bed vacancy are graded amber. People graded red have no bed linked to them. The pending list is constantly updated by the bed management team and circulated through the divisional director tier to Chief Operating Officer level twice a day.
- 7.56 T's 7 May 2014 referral would now be graded red. The COO told us that in a comparable case, the referral had been escalated to him while the patient waited in the Peckwater Centre. As the Peckwater Centre was to close at 17:00, the referral was prioritised over another from a patient in a medical bed. When the patient in the Peckwater Centre was linked with that bed their status became green on the pending list.
- 7.57 The COO told us that in T's case on 7 May 2014, informal admissions of other referred people had occurred that day, in some cases of people who had staff pushing harder for the bed but were in safer circumstances than T. We have found that a system that required re-referrals for beds was flawed.
- 7.58 We were told that, if T refused to wait in the Peckwater Centre today, efforts would be made to maintain contact with him while a bed was sought. Responsibility for co-ordinating the support for the service user, while a bed is being organised, lies with the referrer. This does not mean that the referrer must provide the support. It is a coordination role. This might include as a last resort encouraging a person to attend A&E. People are now occasionally asked to attend the Highgate Mental Health Centre (that houses most of the Trust's acute beds) out-of-hours until a bed can be identified. Discussions were underway with the CCGs about equipping the Highgate Mental Health Centre with an assessment suite at the time of this investigation.
- 7.59 Going back to the scenario where T and M returned to M's flat, under the current system the bed request would remain red and the fact that T was not in a place of safety would mean that his case would be prioritised within the list of other red cases. We were assured that under the current system T would have received a bed on the day of the referral.

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<sup>63</sup> RAG (red, amber, green) ratings denote levels of urgency and/or risk in NHS grading systems.

- 7.60 These changes to the pathway and to the visibility of the pending list have been supported by enhanced staffing in the Trust's bed management function. In addition, the bed managers now provide hourly updates to the referrer.
- 7.61 We accept the Trust's assurance that these changes to its Bed Management Policy and practice would significantly reduce the likelihood of a recurrence of the events of 7 May 2014. In this regard we highlight the fact that close contact is prescribed between referrer and bed manager. This seems to us to reduce the likelihood of misunderstandings arising over the status of referrals. It also improves the bed managers' ability to allocate with reference to up-to-date information about the status of people on the pending list, particularly those who will not be in a place of safety.
- 7.62 Secondly, decision-making about referrals has high-level visibility in the Trust. The Trust's commitment to find a bed for every patient that needs one is clearly owned, operationally, at COO level. Decision-making about allocation is transparent internally. This is reinforced by the fact that referrers are not told that a bed is not available. This statement imported an implication in the case of the RRT's referral of T that it fell to the referrer to take action.
- 7.63 We welcome the bed management improvements that the Trust has implemented since 2014. These measures seem to us to exceed the recommendations within the SI report where the failure to provide a bed was not seen as a root cause. We note the evidence that these changes are effective, for example the CCGs' quarterly key performance indicator (KPI) report (quarter 4, 2015-16) that enumerated all 30 incidences of referrals that became delayed admissions falling into the 'red' category and confirmed that a bed had been sourced in every case.
- 7.64 Given the circumstances of this case we recommend that the Trust is alert to the possibility of risky workarounds being developed where a bed is not immediately available. In line with the Coroner's recommendation, we also feel that all the bed management initiatives and communication lines should be incorporated explicitly into policy to ensure consistency and understanding of roles and responsibilities:

**Recommendation 9:** The Trust should review the measures taken by referrers to manage extended waits for beds in order to establish if any risks being taken can be better mitigated.

**Recommendation 10:** The operational changes to the Trust's bed management system should be incorporated into the policy

### **External escalation processes to commissioners in relation to bed capacity and agreed plans for mitigating risks**

- 7.65 After a consultation in 2011, the Trust responded to a funding cut in the order of 20% by closing 31% of its beds (102).<sup>64</sup> This left 152 adult acute admission

<sup>64</sup> Compared to a national average of a 7% reduction.

[http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/mental-health-under-pressure-nov15\\_0.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf)

and treatment beds plus 12 in the psychiatric intensive care unit. At the time of the consultation two thirds of the beds earmarked for closure were empty. However, demand for beds over the following two years, in 2014 particularly, would surge.

7.66 At the same time in 2012 all Trust services were reorganised. We were told:

“... every single person apart from the chief executive went at risk, a substantial number of people were downgraded, a substantial number of people [were] made redundant, and in many cases they were people who had been here a very long time and knew their caseloads very well. The model was reorganised from sectors and geographies to care pathways, the amount of management was taken out, it was all to hit a financial goal that was all about funding the acute sector. [...] The consequences of that have gradually settled over the years, but you can imagine the impact of [sudden change on] that scale, because that is changing almost every single bit of architecture in place in one go, which is quite a thing to do.”

7.67 Maudsley International suggested that community staffing levels were reduced by approximately 11% (excluding catering and administration).<sup>65</sup> And that the reorganisation resulted in a cash saving of about 18%.<sup>66</sup>

7.68 The impact of that increased demand was summarised in a Trust report for the commissioners in December 2014:

“For the past year the Trust has experienced significant and sustained pressure on inpatient beds which has resulted in a very difficult operating environment with occupancy rates consistently above 100%, patients being treated in private sector beds across London, internal ward moves for non-clinical reasons with associated quality and system impacts. In addition the Trust has spent to date £3.1m with an out turn projected at £4.5m in placing people outside the Trust.”<sup>67</sup>

7.69 The immediate source of this pressure was increased demand from referrals of people described as in crisis, particularly since 2012 (more than doubling from 200/month in 2012 to almost 500/month in October 2014). All entry points to Trust services faced increased pressure from all referral sources. Inpatient episodes increased by 10.2% between 2011/12 and 2014/15.<sup>68</sup>

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<sup>65</sup> A health consultancy commissioned by Islington CCG in 2015 to analyse the Trust's crisis care pathway. Maudsley International stated: ‘... the HSJ stated that between 2011 and 2014 the Trust has lost the second highest proportion of beds (19.1%) and the highest proportion of nurses (18%) out of 57 MHS mental health providers. These changes were felt by the Trust and other commissioning stakeholders to be right at the time they were made. Since these changes were made, the Trust has experienced increased demand for acute care and in [overseas visitors].’

<sup>66</sup> The King's Fund estimated that 40% of mental health trusts had reduced income in 2013/14 and 2014/15. High bed occupancy and community teams unable to provide sufficient support were also reported.

<sup>67</sup> [http://www.kingsfund.org.uk/sites/files/kf/field/publication\\_file/mental-health-under-pressure-nov15\\_0.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/publication_file/mental-health-under-pressure-nov15_0.pdf)

<sup>68</sup> A Review of Camden & Islington Foundation Trust Acute and Crisis Care Pathway, CIFT, December 2014

<sup>68</sup> Contributory factors were thought by Trust staff to include:

- Greater awareness of mental ill health
- The recession; high deprivation correlating with first episode psychosis

7.70 Of particular relevance to this case, the Trust noted:

‘This increase is likely to not reflect ‘true need’ due to the system constraints, despite the fact that bed managers always act on the basis of clinician decision, there may be an unconscious raise in clinical thresholds for admission’.

7.71 In September 2013, pressure and demand on acute beds impacting on quality of care, and resulting in increased clinical risk for service users who were experiencing delays to admission were added to the Trust’s risk register along with significant financial overspend.

7.72 In January 2014, six crisis house beds were added to the provision available to the Trust. However, Figure 3 (overleaf) illustrates the increasing use of acute beds from outside the Trust in the months preceding and following the homicide. (The bed usage above the purple line represents the beds purchased by the Trust from private sector providers.)

7.73 Camden Clinical Commissioning Group (the CCG) had been established in April 2013 under the changes to NHS commissioning enshrined in the Health and Social Care Act 2012. It commissioned through block contract arrangements with the Trust (i.e. services were bought and managed on the basis of activity rather than outcomes).

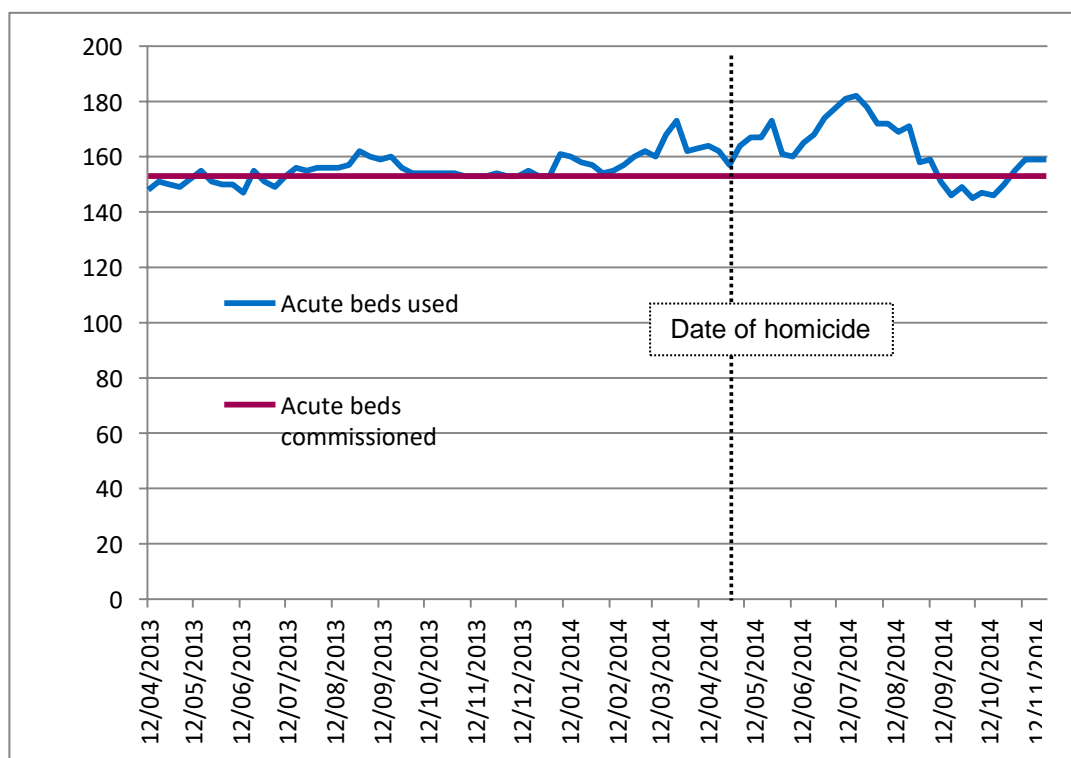
7.74 We were informed in the investigation that both the CCG and Islington CCG (we refer to them collectively as the CCGs or commissioners) had worked closely with the Trust from their inception to understand and resolve increasing bed pressures. Although bed pressure in the mental health sector was subject to national press coverage a local dialogue on this was not reflected in the documents we have seen until late 2014.<sup>69</sup> For example, the CCG’s report of its comprehensive review of Camden’s mental health provision in 2013 did not refer to bed pressures.<sup>70</sup>

**Figure 3: Acute beds used versus acute beds commissioned, April 2013-November 2014** (taken and adapted from the Trust’s document ‘A Review of Camden & Islington Foundation Trust Acute and Crisis Care Pathway’, December 2014)

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- Increased overseas visitors’ use of Trust beds (many students and young people moving to the areas served by the Trust with high numbers of people not known to the Trust being sectioned and occupying 40-50% of beds)
  - Pressure on beds from non-local patients
  - Population growth (8.2% in the over-20 population in 5 years)
  - Greater use of “legal highs”
  - More accessible and responsive Trust services

<sup>69</sup> For example in this December 2013 BBC report <http://www.bbc.co.uk/news/health-25331644>

<sup>70</sup> <http://www.camdenccg.nhs.uk/Downloads/ccg-public/about-us/mental-health-review-report-2014.pdf> It did, however, flag inpatient and crisis service use as a reason for the high spend and identify a need for investment in community and primary care capacity.



7.75 In its February 2014 mental health mandate, that had been formulated with close reference to the outputs of the 2013 review, the CCG noted that:

‘Camden continues to report some of the highest mental health needs in the country despite year-on-year having the second highest spending in the UK’.

7.76 Again, bed pressures and the commissioning of community based mental health services for people with long term serious mental illness were not directly addressed.<sup>71</sup>

7.77 In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. The Concordat focused on four main areas:

- ‘Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.’<sup>72</sup>

<sup>71</sup> <http://www.camdenccg.nhs.uk/Downloads/ccg-public/about-us/camden-ccg-mental-health-programme-mandate.pdf>

<sup>72</sup> <http://www.crisiscareconcordat.org.uk/about/>

- 7.78 The Camden and Islington plan led by the CCGs was developed with the Trust and other partners in autumn 2014 and submitted to the national Concordat website in February 2015. This included closer monitoring by the CCGs of the performance of the Trust's crisis services; the commissioning of an enhanced liaison service at A&E sites; a commitment to ensure that A&E is only used as a mental health crisis service as a last resort; and a commitment to ensure that people in crisis are only assessed once.<sup>73</sup>
- 7.79 In September 2014 the CCG informed the Borough's Health and Adult Social Care Scrutiny Committee of the move from the block contract to payment by activity. Increased bed pressure was reported by the CCG (with possible explanations including demographic change, community service changes and bed reduction). The following CCG view of Trust performance, given the higher than average level of the mental health spend, was provided:
- 'The stark picture is that Camden is much more expensive than other areas with comparable levels of need. Whilst there are some mitigating factors, we can and should be able to run services in a more cost effective way and improve outcomes for our customers.'<sup>74</sup>
- 7.80 The CCG's involvement in the scrutiny of care delivery included senior staff from both CCGs participating in a cluster review into 19 serious incidents (17 fatalities) involving patients in contact with Trust services between November 2013 and May 2014.<sup>75</sup>
- 7.81 In a paper produced in December 2014, the Trust summarised the work it had undertaken with its commissioners in understanding the increased demand.<sup>76</sup> It also highlighted the measures it was applying to address the problems arising from it. It highlighted benchmarking data that showed that it had a slightly higher than average number of commissioned acute inpatient beds per 100,000 core weighted population; and was significantly under-commissioned in the provision of crisis / home treatment teams. The four key remedial measures identified were:
- "Additional staffing within the crisis teams [...] to meet the requirements of carrying out home treatment at the desired level with a swift response to referrals. ...
  - Implementation of the proposal to create a crisis and home treatment team for older people which projects an impact of a reduced requirement of 8 beds. ...

<sup>73</sup> <http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/02/Camden-and-Islington-CCC-action-plan-for-submission-Final.pdf>

<sup>74</sup> <http://democracy.camden.gov.uk/documents/g5266/Public%20reports%20pack%2016th-Sep-2014%2018.30%20Health%20and%20Adult%20Social%20Care%20Scrutiny%20Committee.pdf?T=10>

<sup>75</sup> These included: included: the homicide we report on in this document; seven definite or likely suicides; five possible suicides; two attempted suicides; four probable deaths from accident or natural causes.

[http://www.candi.nhs.uk/sites/default/files/Documents/Serious%20Incident%20Thematic%20Review%20Report\\_0.pdf](http://www.candi.nhs.uk/sites/default/files/Documents/Serious%20Incident%20Thematic%20Review%20Report_0.pdf). In half of the cases there were deficiencies in assessing, recording or addressing risks. The existence of a 'cluster' was not established.

<sup>76</sup> Suggested reasons included: increased overseas visitors' use of Trust beds (many students and young people moving to the areas served by the Trust with high numbers of people not known to the Trust being sectioned and occupying 40-50% of beds); pressure on beds from non-local patients; population growth (8.2% in the over-20 population in 5 years); greater use of "legal highs"; and more accessible and responsive Trust services.



- Additional inpatient bed capacity to ensure that the average level of activity can be accommodated within the funded bed base. This requires an additional 27 beds. However, with the implementation of the Crisis Home Treatment Team for Older People this would be projected to be 19 beds. Income from projected overseas visitors would equate to funding for 11 beds worth.
- Support to reduce the numbers of patients requiring low secure/forensic patients in inpatient beds.”

- 7.82 When we met with stakeholders, we were told that, historically, there had not been a consensus between commissioners and the Trust about what constituted objective relevant data. The Trust told us that the implications of being bottom in the country for its commissioned community resource compared to weighted population had been the subject of a ‘year long conversation’ with the CCGs.
- 7.83 The CCG commissioned UCL Partners to analyse the Camden Crisis Care Pathway with reference to commissioning guidelines and with an emphasis on improving crisis services.<sup>77</sup> A draft report summarising potential findings and recommendations was issued in May 2015. In August 2015, Islington CCG commissioned Maudsley International to carry out a further review to examine the available evidence, and to produce a report to help the CCGs and the Trust to develop more effective care pathways supporting the use of acute inpatient beds and crisis care in the future.
- 7.84 Maudsley International’s report recommended more work to develop a ‘vision for mental health services’ shared by commissioners and providers. The Trust’s development of a clinical strategy was suggested as a vehicle for building this. Greater openness and a joint communications strategy was recommended along with a detailed analysis of acute demand and its impact on capacity ‘across the whole system’.
- 7.85 Both reviews highlighted problems and solutions of relevance to this case and informed the sector transformation plan and the Trust’s revised clinical strategy. In particular, they pointed to a need for consensus between the Trust and the CCGs that capacity in the community rather than bed capacity needed building. Work is underway to address what providers and commissioners agree is a historic imbalance.
- 7.86 Meanwhile, bed pressure in the capital has not eased and we were provided with evidence in this investigation of close and regular liaison between the Trust and the CCGs, including through the occupancy risk share agreement. Islington CCG manages the risks of pressure/demand exceeding the commissioned bed base in the following ways:
- ‘Additional beds are now available as part of a risk share agreement with [the] Trust
  - Risk share arrangement includes monthly meeting with [the Trust] to monitor bed occupancy, identify issues and solve problems

<sup>77</sup> A specialist health research consultancy.



- The National Crisis Concordat has led to a local action plan to enhance admission avoidance capability
- Future controls Independent external review of acute bed capacity commissioned by CCG now complete. Action plan is being developed'.<sup>78</sup>

## **The Trust's engagement with other mental health providers in bed escalation**

7.87 We found some evidence that the Trust was engaging with other providers given the acute bed pressures in London, for example from 2013 through the London Leadership Group.<sup>79</sup> In January 2014 the CCG commissioned a further eight crisis house beds for the Trust.

7.88 On 18 July 2014 the Trust's then Chief Executive wrote the following to NHS England:

'This morning my Chief Operating Officer told me that yet again there were no mental health beds in London in either the NHS or private sector, fortunately through the day we have managed to find a couple to accommodate our admissions. However, the pressure on acute MH beds has been continuing for over a year with some peaks and troughs, but it has not gone away. During this time no one appears to have taken a serious look at what is happening, nor even collect basic data. The bed pressures have been across many Trusts with at least two opening a number of previously closed (6) wards, and even with that additional capacity, we still find ourselves in such a position.

'Understanding how many MH beds are required is an art rather than a science, as we have continually innovated to successfully reduce bed usage over many years. For this reason commissioners often approach this issue with the view that the systems are not being managed efficiently. There will obviously be some truth in this. However, our data suggests that there are other factors beyond system management that are happening. 44% of our inpatient admissions are from people who have never been admitted to MH beds before, most of whom are not known to the Trust services at all, this figure has risen significantly in the past couple of years. We believe as a central London Trust the balance of factors which affect us maybe different to others (we have 20 overseas visitors in beds). The Trusts [average length of stay], delayed discharges and readmission rates are good and significantly better than a few years ago, yet we have been in a position of continuous 'overspill' now for over 4 months, despite opening additional crisis beds earlier this year.

'With wards above acceptable capacity levels the system becomes less efficient and quality is affected through moves between providers and wards. I

<sup>78</sup> From Islington CCG's Governing Body Business Meeting of 11 May 2016, <http://www.islingtonccg.nhs.uk/Downloads/CCG/BoardPapers/20160511/Governing%20Body%20Agenda%20and%20Papers%2011052016.pdf>

<sup>79</sup> <http://www.candi.nhs.uk/sites/default/files/Documents/bod-public-28-11-13-pack-for-website.pdf>

could not envisage a situation where all the acute beds in London were full and there was not even an investigation into the situation nor a plan of action, so much for parity of esteem!

'We have recently established a MH leadership group consisting of 3 local authority Directors of adult social care, 3 CCG accountable officers and 3 MH CEO's to facilitate joint strategic approach to London wide issues. We met last week and bed numbers was an area of concern and debate; we agreed it would be part of our work programme this year, however upon reflection it will be some time before this work is scoped and begun and from my position it feels as though the situation has again become urgent. I appreciate that NHSE (London) does not commission acute mental health beds, however you are responsible for oversight of the CCG's and it seems to me that a co-ordinated approach is required. I know all the MH Trusts would be keen to support such an endeavour and commissioners, I am sure, would welcome the wider perspective to help review their local situation. I would be grateful to discuss how we can get some rapid traction on this unacceptable situation.'<sup>80</sup>

- 7.89 Given its heavy use of private beds and temporary ward closures, from 17 July 2015 until 1 April 2016 the Trust obtained access to 16 acute beds through a contract with East London NHS Foundation Trust. Meanwhile in May 2015 it re-opened Tredgold Ward, formerly a rehabilitation ward, as an acute admissions ward, adding 12 beds to its own acute provision. The Trust has not used any private beds since entering into the contract with East London NHS Foundation Trust and regards its current acute inpatient capacity as sufficient.
- 7.90 We approached the Cavendish Square Group<sup>81</sup> in March 2016 and London mental health trusts directly, as well as the Trust, to find out more about pan-London initiatives related to our terms of reference. Although we heard about local good practice we did not find evidence that mental health providers were working closely together to find joint solutions to the shared problems arising from matching rising demand with relatively static bed capacity.

**Recommendation 11:** Given our concerns and the Coroner's, NHSE should refer this report to the Cavendish Square Group so that it may take forward learning from it with commissioners and providers in the capital. In particular, NHSE should emphasise its concern that every patient who is identified by mental health services as requiring a mental health bed in London should be allocated a bed. And that all London mental health trusts should actively monitor their ability to provide beds when they are needed and be alive to the risks of workarounds developing when bed pressures exist.

<sup>80</sup> <http://www.communitycare.co.uk/2014/11/28/deaths-linked-mental-health-beds-crisis-cuts-leave-little-slack-system/>

<sup>81</sup> A chief executive-led collaboration of the 10 mental health trusts in London <http://www.cavendishsquaregroup.co.uk/>

## 8 Serious Incident investigation and Domestic Homicide Review

### The SI investigation and report

- 8.1 A Grade 2 SI investigation was established on 16 June 2014 under the chairmanship of ER, an external reviewer with extensive experience of undertaking root cause analysis as an independent consultant.<sup>82</sup> The appointment of ER met the requirement of the Trust's Management of Serious Incidents Policy (that we refer to as the Incidents Policy). The Incidents Policy required Grade 2 SI panels to be chaired by an independent individual from outside the Trust. The panel was also comprised of the Trust's then Medical Director (MD) and an interim director.
- 8.2 The terms of reference (ToR) of the SI investigation gave the panel considerable latitude to examine antecedent incidents and service responses, and, critically, the standard of care in the months, weeks and days before the homicide.<sup>83</sup>
- 8.3 The investigation began on 16 June 2014 and was due to be completed by 30 September 2014 (60 working days later). The SI report was finalised and circulated on 11 December 2014. The SI panel referred to difficulties obtaining information from the Trust, difficulties that we have also encountered.
- 8.4 In Appendix D we set out the Trust's progress in implementing the recommendations of the SI report and the DHR.
- 8.5 Some factual inaccuracies emerged through our review of the SI report, including:
- The RRT was referred to incorrectly as the North Camden RRT
  - The number of prior admissions was stated as 10 (11 is correct)
  - The Red Team was stated as providing a service to clients RAG-graded as 'red' when it was a duty service aimed at clients with lesser support needs

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<sup>82</sup> The Incident Policy stated: 'Incidents which are graded as 2 include the apparent suicide of a service user in 24 hour services, the alleged homicide by a person in contact with mental health services and "never events".' (Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.)

<sup>83</sup> 1. 'The aim of the investigation was to review the mental health care provided to [T] including:

- T's risk assessment, risk management plan and care plan.
  - The multidisciplinary integrated working of teams across the Trust's care pathways, considering interaction and communication issues of relevance to T's care.
  - That issues concerning safeguarding were actively considered and Trust policy followed.
2. To examine the events leading up to the incident on 9<sup>th</sup> May 2014 and the way in which staff responded.
3. To ensure that any family members are kept fully informed, involved and supported.
4. To review whether:
- ☐ Existing local and national policies and procedures were followed.
  - ☐ Clinical standards were met.
5. To consider any other factors raised by the incident that are relevant.
6. To provide a confidential report by the 30<sup>th</sup> September 2014, making recommendations to minimise the risk of a similar incident happening and / or to improve standards and practice.'

- The timeline of 7 May 2014 appears to conflate RiO entry timings with event timings.<sup>84</sup> This meant that, for example, BM1 is stated to have cancelled the bed request a minute after telling RR2 that the request was live.<sup>85</sup>
- RR2 is described as a nurse (he was a Trainee Mental Health Worker).

8.6 Other factual assertions in the SI report did not appear to be supported by contemporaneous evidence but that may be because we were looking at a different document set. These included:

- That M was repeatedly offered and declined a carer's assessment
- That M and T were informed on 7 May 2014 that they could wait for a bed in A&E (A&E was suggested by the RRT as a contingency plan should M feel in danger of harm, not as an established route to admission).

8.7 We have more substantive concerns about the SI report's apparent conflation of statements with contemporaneous records. Every person who gave a statement to the police and to the SI panel had hindsight bias. Some of the statements given to the SI panel bear little relation to what was recorded in the notes. The SI did not distinguish between contemporaneous and hindsight-biased evidence and referred to the stated evidence as if it was reflected in the records. In addition, anomalies between the records and the hindsight-based evidence (like the Crisis Team's suggestion of 8 May 2014 that T had an adjustment disorder and learning disability) were not apparently explored by the SI panel.

8.8 CP2's account to the SI panel of his May 2013 CPA formulation bears little relation to what he wrote at the time although it is presented as such. For example CP2's 2013 note of the assessment (paragraphs 6.6-6.8) did not refer to psychosis except in the historical context. In contrast, his evidence to the panel referred to 'continuous psychotic symptoms' with possible paranoid delusions that T was concealing. It was the latter, hindsight-based assessment, that was presented in the SI report as the 2013 formulation.

**Recommendation 12:** The guidance for people undertaking SI investigations for the Trust should emphasise that investigators need to distinguish between evidence obtained from the contemporary records and evidence from subsequent statements, and when appropriate challenge staff about any discrepancy.

## Involvement of staff, patient and family members

8.9 As required by the Incidents Policy, an effort was made to speak to T during the investigation. However, this was not possible given the view of his consultant psychiatrist about the impact on his mental health in the period

<sup>84</sup> The SI report in Appendix 5 provides cautionary words about this but our view is that the SI panel should have presented a likely, balance of probabilities, timeline for the crucial sequence of events on 7 and 8 May 2014.

<sup>85</sup> As well as being inherently implausible, this was contrary to BM1's evidence to the SI panel.

preceding the trial. We have seen evidence that in December 2014 Trust staff liaised with T's consultant in the secure mental health unit where T was detained about the circulation of the SI report to family members. T who was not then in contact with family members asked that he should receive a copy of the SI report which the Trust sent to his consultant in March 2015.

- 8.10 The evidence obtained, in our view, enabled the panel to analyse the key aspects of the ToR, namely the handling of the presentations of 7 and 8 May 2014, in the context of T's and M's dealings with the Trust over the previous twenty years.<sup>86</sup>
- 8.11 In line with the Incidents Policy, a 'Learning the Lessons Workshop' with relevant staff occurred on 25 September 2014. On 19 November 2014 queries from the DHR panel were addressed with staff. The SI Panel's queries about the sequence of events were put to staff. And on 8 and 9 January 2015, meetings to share the final report (dated 8 December 2015) with involved staff members occurred. Arrangements for supporting staff as the inquest date approached were also raised. On 30 June 2015 a Cross Divisional Bed Management Workshop was held by the Trust to discuss revisions to the Bed Management Policy with particular reference to the SI report. Concluding, we are satisfied that the SI investigation met the requirements of the Trust's Incident Policy in its involvement of the staff and T.

### **Root cause analysis**

- 8.12 The SI investigation stated that it was not possible to establish a root cause for the incident. The panel concluded:
- '[...] that nothing in [T's] presentation during his contacts with mental health professionals and services was predictive of the homicide, and that the homicide would not have been prevented even if these weaknesses had not occurred.'
- 8.13 The SI panel considered this conclusion carefully alongside T's and M's reports shortly before the homicide that T had thoughts of harming others.
- 8.14 The Medical Director (MD) told us that the assessments of 7 and 8 May 2014 had not, in the SI panel's view, clearly established that T had homicidal thoughts. The risks in his presentation on those days had not seemed to the staff particularly different to those that had manifested over the previous 12 years. She noted that it had later been established that T had experienced considerably more psychotic symptoms than he had disclosed before the homicide.
- 8.15 We agree that a clear picture of the extent of T's psychosis did not emerge. In fact although the evidence suggests that T had experienced relapses over the previous 12 years, no community-based assessment in that time or before

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<sup>86</sup> See for example paragraph 3.6.

had ever elicited very much in this regard. Admission was the only proven vehicle for assessment and treatment.

- 8.16 As was observed by staff at the time, however, T's and M's presentation on 7 May in particular was novel. T had not asked for admission since November 2002. The RRT staff on 7 May 2014 were not aware of a precedent for T and M requesting admission together and we could not find one. Uniquely again, T and M were cohabiting at the time of the presentation because T felt too paranoid to live in his flat. Disclosures that T thought he might harm M were not unheard-of but were rare.<sup>87</sup> None of the prior reports of T's relapses had come close to linking psychotic thought with a risk to M. Any questions in the staff's minds about the risks inherent in T's presentation reinforced the case for inpatient assessment.
- 8.17 At interview, RR3 did not, MD told us, persuade the SI panel that his admission plan had been based on a thorough mental state assessment. It had seemed to the SI panel that the bed referral had been based to a significant extent on RR3's 'gut feeling'.
- 8.18 Our first observation is that RR3 inherited the plan to admit from RR5, an AMHP. RR5 did not elicit clear thoughts of harming others from his face-to-face interview with T or a consistent account of his symptoms. None of the professionals did in the two days preceding the homicide. RR5 was sufficiently concerned to make a plan for admission which RR3 confirmed through his own assessment. Second, we judge that the documentary evidence available to the SI panel supporting the admission decision should have outweighed the ability of staff to justify their actions afterwards. Third, we would give weight to the 'gut instinct' of practitioners like RR3 and RR5 with many years' experience of assessments and mental health service delivery.
- 8.19 MD told us that the SI panel had felt that an informal admission on 7 May 2014 would not have meant that T would have received inpatient care and treatment as there was no guarantee that he would remain on a ward. MD also referred to the bed pressures and emphasis on least restrictive treatment. She contrasted the high threshold for admission and continued inpatient care in 2014 with the position in T's pre-2003 admissions, before the Trust had home treatment and acute bed pressures. MD also acknowledged that the SI panel had been of necessity speculating and an inpatient-based assessment may have addressed the full extent of T's psychotic processes and led to inpatient treatment over a longer period.
- 8.20 MD told us that in their deliberations the SI panel referred to the outcome of post-homicide assessments of T. They felt M featured in a lot of the psychotic processes. M's proximity to T appeared to be a precipitant. The SI panel judged it likely that T would, away from M, settle and be discharged back into community-based Crisis Team care quite quickly.

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<sup>87</sup> Such thoughts had been disclosed by T in an earlier presentation (2001, which triggered voluntary admission followed by sectioning). And M had disclosed an assault by T in 2008 and hostility from him in 2010 and 2011.



- 8.21 As MD acknowledged at interview, the SI panel's brief admission construction speculates that the entire extent of T's psychosis would not be assessed in hospital. That is a plausible construction. But we have no reason to doubt that even if he had remained guarded, T would have received adequate assessment and treatment from the Trust in a 2014 admission. This had occurred on the eleven previous occasions where admission had prevented an escalation of T's paranoid and hostile behaviour.
- 8.22 Our conclusion is simply that T's May 2014 presentation and the available history supported the RRT's view that admission was indicated. There was scant evidence in the previous decade of T being effectively engaged in community treatment. The last admissions of 2001 and 2002 had been voluntary but were converted to sections. Those admissions had lasted about a month. Both had been apparently effective with the latter being followed by a prolonged and unique episode of community mental health service engagement.
- 8.23 We have reservations about the short admission construction. It appears to us that there were two key ingredients to the risk to M. The first arose from T's presentation. The second arose from T's residence in M's flat. This made community-based risk management impossible while T was acutely unwell. Admission was the only short term intervention that could remove the risk attached to the constant proximity of T and M. In the short term, obviously, M would be safe if T was in hospital.
- 8.24 We find it unlikely that T would be admitted with thoughts of harming his mother and then soon afterwards be discharged by the Trust into his mother's home while actively psychotic. Re-establishing T in his own flat was an emerging therapeutic goal immediately before the homicide and we are sure it would be a marker of recovery and part of the discharge plan.
- 8.25 We agree with the SI panel that consideration of the post-homicide assessments is relevant. Our reading of them did not point to proximity to M being central to T's psychotic processes, either as a trigger or in terms of M being an instrumental figure in his delusional thinking. We are sure that T would have presented as acutely unwell if he was away from M as he had always done before.
- 8.26 In any event, we remain of the firm view that admission was indicated by the presentation of May 2014 and by the history. We do not accept that T would be, 24 hours after admission, returned to M's flat while psychotic. It follows from this that the failure of the Trust to admit T was a root cause of the homicide. We were not persuaded by the SI panel's contrary view that seemed to us to underplay the ability of the Trust's services to assess T adequately in an admission and work with him appropriately post-discharge. Our formulation is similar to that reached by the Coroner and the DHR after the SI investigation had concluded.
- 8.27 We consider next the SI panel's conclusion that 'nothing was predictive of the homicide'. We understand the point made by CP1 at interview that it was



reasonable to be reassured by the low key interactions between T and M on 8 May 2014. And that there were reasons to think that the plan to manage T in the community was viable. However, we have reservations about the blanket statement ‘nothing was predictive of the homicide’.

8.28 We have found that a homicide in the early hours of 9 May 2014 could not have been predicted. But we have noted other factors that were predictive of a serious imminent risk to M from T. We conclude that it was highly predictable that in the mental state T was in, with access to alcohol and weapons, and constant proximity to M, he would cause harm. The immediate risk factors were not mitigated in the plans made at the time. We therefore conclude that the homicide was predictable.

8.29 The SI report concluded:

‘Patient factors were the greatest contributory factor to this incident. [T] proved exceptionally problematic to assess and was often evasive concerning his symptoms and the problems he was having.

For example, he varied his story of hearing voices and the content of them several times over the 7th and 8th May and in particular gave different responses to whether the voices were telling him to harm anyone (generally or specifically). His reasons for not wanting to continue to live in his own flat were also difficult to assess, as was whether something specifically had occurred which made him fearful of returning or things were part of some delusional beliefs.’

8.30 We agree that a clear and consistent picture of T’s presentation and risks was not available in the community-based assessments. It never had been. Doubts justifiably existed about the extent of the presenting risks as they usually do. We reiterate that the nature of those risks and doubts lowered rather than raised the threshold for inpatient assessment.

8.31 The SI report continued:

‘[T] and [M] also provided different views on [T’s] drinking. [T] admitted to drinking 4/5 cans of 5% lager a day and did not see this as a problem, whereas [M] insisted that [T] had a low tolerance for alcohol and this was sufficient to make him inebriated. It was whilst under the influence of alcohol that the concerns of domestic abuse were at their highest.’

8.32 Again, we have reservations about the suggestion that the lack of consistent information in the community assessments was a contraindication to assessment in hospital. T appeared to lack capacity generally during the 8 May 2014 assessment to the extent that CT3 wondered if he had a learning disability. Evidence of T’s alcohol use was evident that day. If intoxication appeared to overlay T’s presentation, admission was the only way to undertake a baseline assessment.

8.33 The SI report concluded:

‘The relationship between [T] and [M] appears to have been at the core of the risk regarding [T]. There had been a long standing complex and variable relationship between mother and son (at times [T] would have no contact with [M] and complain about her intrusion in his life only to move back in to live with her a short time later). Both had consistently refused family therapy. The problematic relationship was well known, there were reports of domestic violence which were never proven and the final assessment on the 8th May 2014 indicated that this was a pattern which had been seen many times previously over the lengthy contact with services.’

- 8.34 We have referred to the features of the 8 May 2014 presentation that were novel. T had a relapse history of violent paranoid thoughts towards people in his vicinity. M, with whom he had a high EE relationship, was now in his vicinity nearly all of the time. Whatever the underlying dynamics were of the relationship, we are of the firm view that T and M needed to be apart while T was actively psychotic; and that admission was the only mechanism available to staff that could achieve this.

#### **The SI panel’s review of the risk management and care plans**

- 8.35 The SI panel started its review of risk assessment with comments on the Trust’s policy. No mention was made of the risk assessment document available to the staff on 7 and 8 May 2014 or to the updated version that followed the 8 May 2014 assessment. In our view this was a glaring omission. We have expressed our view that the risk assessment was a poor formulation that failed to capture the intelligence about T’s relapse indicators and management distilled from previous admissions. We do not consider that the SI report met the ToR to determine if practice met relevant policies and standards in this area.
- 8.36 The SI panel seemed to conclude that the objectives of the risk assessment policy had been met solely by RR1’s involvement. In our view, this construction did not engage sufficiently with the key issue of whether RR1’s risk formulation – in writing and/or in person – met the required standard.
- 8.37 The SI panel referred to the December 2013 care plan’s accessibility only. Again, our view is that a qualitative assessment of the care plan was necessary if the ToR were to be fulfilled.

#### **The SI panel’s review of multidisciplinary working**

- 8.38 In our view, the SI panel made pertinent points about the way that the RRT, the Crisis Team and the bed managers had interacted. In particular we endorse the conclusion that ‘there was confusion over the meaning of no beds being available’. We also agree with the SI panel’s conclusion that there were different understandings of the meaning of the Crisis Team referral. But in our view, these areas of confusion – markers of a flawed bed management process - were contributors to the root cause of the homicide, the failure to admit T.

- 8.39 The SI panel alluded to different understandings of the Crisis Team's 'gatekeeping' role. However, it was not clear to us what the SI panel considered were the consequences of, and remedy for, this. We note that the Trust has now implemented a change to its bed management policy whereby all referrals for informal admission must be assessed directly by the Crisis Team but that gatekeeping in practice may proceed today as it did in May 2014.
- 8.40 The SI panel commended the joint RRT assessment. While the evidence available to us cast some doubt on the soundness of the arrangements, we agree that the involvement of RR1 was good practice.

**Conclusion: the adequacy of the SI investigation's findings, recommendations and action plan**

- 8.41 Our conclusion is that the SI report fell some way short of the necessary standard. We highlight the lack of root causes identified in a case where a homicide was committed in the community shortly after a clear failure to implement a decision to admit. We did not find sufficient evidence to support the SI panel's thesis that this presentation was a continuation of an established pattern. We found all of the SI panel's rationales for the presentation being insufficient to meet the threshold for inpatient assessment, unconvincing.
- 8.42 The risk assessment formulation feeding into decision-making was not subject to the necessary level of analysis although it fell considerably short of the Trust's own standards. We were not persuaded by the SI panel's reasoning about patient factors either. Overall, we found the conclusion that 'nothing' in T's presentation was predictive of the homicide relied too heavily on a narrow construction of predictability, i.e. a construction that required the time of the homicide as well as the likelihood of it to be predictable. This formulation did not deal convincingly with the fact that the person identified at risk from T a day and a half earlier was killed by him.
- 8.43 The SI report also reached conclusions about the failure of the referral for a bed and recommendations that we endorse. In particular, we welcome the SI report's recommendation that the Bed Management Policy should be reviewed to ensure clarity; and the recommendation to implement carers' assessments.

**The Domestic Homicide Review**

- 8.44 We considered the depth of evidence obtained in the DHR, and its presentation and analysis, to be exemplary. We concur with its overarching conclusion that M's death was preventable given the Trust's failure to admit T following both its assessments.
- 8.45 The DHR's recommendations for the Trust flowed logically from its conclusions. In particular we underline those concerning:

- the weight given to allegations of abuse in risk formulations
- the venue in which risk of harm is managed
- the routine offer of a carer's assessment before a CPA.

## 9 Overall analysis and recommendations

### Was the homicide preventable?

9.1 In our consideration of this question we have noted that on 7 May 2014:

- T was correctly assessed by the RRT (supported by the Crisis Team) as presenting risks to M associated with psychotic relapse, aggravated by alcohol use and enhanced by their cohabitation. T and M disclosed that T had threatened to harm M
- Those risks, and the need for admission, were underlined by T's history which was available to the RRT and reproduced in its assessment
- A bed was correctly identified as being needed and was requested
- The bed request failed
- It is unlikely that T would have been returned to cohabit with M after inpatient assessment and treatment; and that he would have presented the same high level risks to her
- A consequence of the failure of the bed request was that T continued to cohabit with M while actively psychotic and using alcohol
- T's homicide of M was therefore preventable by admission on 7 May 2014.

9.2 Turning to the 8 May 2014 assessment we noted that:

- Insufficient historic risk data was available to the assessment
- Insufficient risk information about T's more recent domestic violence to M was available to the assessment
- A proximal factor was that the previous day's risk assessment and management plan was not adequately recorded nor given sufficient weight
- Consequently, contrary to the findings of the assessment, the fact that T's and M's presentations of 7 and 8 May 2014 were novel in many ways was not understood or acted on.

9.3 Our view is that the factors above reduced the effectiveness of the assessment. Had a risk formulation of the requisite standard been in place, a decision to admit T would have been made on 8 May 2014. This reinforces our view that the homicide was preventable.

### Was the homicide predictable?

9.4 In our analysis, we have adopted a broader definition of predictability than that applied in the Trust's SI investigation which narrowed the predictive time frame down to the night of the homicide. We agree with the SI panel that a homicide that night was not predictable.

- 9.5 Drawing from a definition provided by Iodem, in our view a homicide is predictable if:

*'Bearing in mind the known history, there was evidence from the perpetrator's words or actions that should have alerted professionals that there was a real risk of significant violence, even if the presenting evidence had been un-noticed or misunderstood at the time it occurred.'*<sup>88</sup>

- 9.6 We have given weight in our analysis in paragraph 6.67 to the protective factors identified in the 8 May 2014 assessment. We acknowledge that staff who know that follow up is imminent will quite reasonably focus on the likelihood of harm in the immediate interval before that follow up, in this case the 24 hour period before the assessment scheduled for the following morning. And it is, as CP1 reminded us, not uncommon for people to disclose thoughts and hallucinations urging them to hurt and kill people.
- 9.7 In our view, a reasonable risk assessment on 8 May 2014 would have called the protective factors the assessors identified into serious question. The recent and longer term history should have pointed to a probability of T causing significant harm to a person in close proximity to him. M and T had stated M was at risk. M could not escape from T and, apparently, would not leave him. Theirs was known to be a high EE relationship. T was drinking and could not answer questions.
- 9.8 Very little, if any, reliable evidence was elicited on 8 May 2014 to negate the risk assessment of the day before. The fact that M appeared calmer did not mean that she was safer. The known risk of violence to M could not be mitigated to any meaningful extent by home treatment as T would be near to M for very long periods of time, unsupervised. We conclude that there was sufficient evidence to alert the professionals to the real risk that T would commit significant violence. We therefore conclude that the homicide was predictable.

## **Root causes of the incident**

### **Root cause 1: The failure of the Trust's systems on 7 May 2014 to provide T with an inpatient bed**

- 9.9 We have no doubt that the failure of the referral of T for an inpatient bed on 7 May 2014 was the root cause of the homicide. In the short term, the requested admission would have prevented T from killing M in the early hours of 9 May 2014. Had he been subject to a fuller assessment and more active treatment than was possible in the community, we think that the medium term risks arising from his mental state would also have been reduced.

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<sup>88</sup> 'Independent investigation into the care and treatment of Mr X', July 2016, Iodem, pp18-19  
<https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/09/mr-x-july-2016.pdf>

9.10 Why was the bed request cancelled on 7 May 2014? The Trust's December 2014 analysis suggested that bed pressures had impacted on staff by effecting 'an unconscious raise in clinical thresholds for admission'. The CCG-commissioned research noted that the percentage of admissions under the Mental Health Act had increased by 10%, 2014-2015. We were told by RRT staff that it had been, and remained, difficult due to a culture in the Trust, to get informal patients admitted. Our view is that decision-making in this case was affected by staff expectations and the undue pressure on bed managers in particular to manage the build-up of referrals on their pending lists. In this regard we note the RRT's attempt to address T's acute needs with a patched together community package rather than push the bed managers to escalate the referral.

9.11 We emphasise our view that individual staff decision-making was only significant in the failure of the bed request because the overall system of bed allocation was flawed. In some ways, these flaws were masked when the Crisis Team was dealing direct with the bed managers. In our view the following communication and task factors applied to the bed management process when the RRT was requesting the bed:

- The lack of clear written guidelines about how to get a bed when the Trust's stock was full, leading to an ad hoc bed allocation system based on unwritten rules. It seemed to us that these rules were understood differently by the Acute Services staff who operated within them more than their Rehabilitation and Recovery colleagues
- The unwritten rules included:
  - The implications of the statement "There are no beds". For the Crisis Team this was a signal for more not less contact with the bed managers, in other words for a referral to be "pushed"
  - The RRT, in contrast, understood it to mean the referral had failed, at least in the short term, meaning that sustained contact with the bed managers was unlikely to be fruitful.
- No dedicated mechanism existed for ensuring that the referrer and bed manager had a shared understanding of the status of the referral. In the absence of such a mechanism, the referrer's RiO entry was used as a proxy for a status update resulting in the disposal of the bed request.
- Looked at another way, T going home with M increased the risk factors considerably and should have increased the priority of the bed request. Instead it had a perverse impact, reducing the priority to the extent that the referral was cancelled.
- This was able to happen because the pathways overseen by the Crisis Team (home treatment and gatekeeping, i.e. mediating acute admission) were seen by some staff as entirely discrete and by others as complementary. RRT staff in particular regarded concurrent home treatment and bed referral as a natural, if not an ideal, way of managing risk when an admission was delayed. Acute staff were more likely to see the two functions as, by definition, incompatible. (As an



aside, it seemed to us that a weakness of the Crisis Team perspective was that the assessment for home treatment did not seem to include an assessment for admission.)

- 9.12 We have considered the impact of the requirement in current Trust policy that all informal referrals are subject to face-to-face Crisis Team assessments. While this will reduce the likelihood of communication and task-related error, it also imports a further process stage to the assessment of RRT clients who have presented to that service. We were pleased to note that there is flexibility to depart from policy. That said, workarounds bring their own risks.
- 9.13 However, overall we were impressed with the raft of decision-making aids and task design measures introduced by the Trust to ensure that referral status is understood in the same way by all parties and has high visibility throughout the management structure.
- 9.14 Our view of contributory factors is similar to that of the Trust's and CCGs' that draw from the findings of the health consultancies who have recently analysed the Trust's crisis care pathway in depth. It is not for us to reproduce their conclusions or recommendations in detail. In summary, the radical reduction in the Trust's bed capacity of 2012 placed greater pressure on its community services that were also undergoing restructuring and staffing reductions. As staff were trying to make this structure work, a steady increase in demand occurred. We have seen persuasive evidence that demographic changes in Trust's catchment area, and other factors specific to that area of the capital, contributed to disproportionate demand for the Trust's crisis services.<sup>89</sup>
- 9.15 This scenario is very familiar indeed to mental health analysts. In February 2016 the Royal College of Psychiatrists' 'Old Problems, New Solutions' review of acute psychiatric care in England stated:
- 'Reductions in bed numbers appear in some areas to have been accompanied by attrition in services in the community, although it is difficult to identify precise numbers. Anecdotally, part of the recent increases in pressure on inpatient services is seen as coming from cuts in community services and changes in the way these services operate with, for example, Community Psychiatric Nurses carrying very large caseloads and Crisis Resolution and Home Treatment (CRHT) teams only having time for assessment and not for providing community-based treatment.'<sup>90</sup>
- 9.16 An outcome of these organisational and external changes was the pressure on acute beds illustrated in Figure 3 (paragraph 7.74). We have noted that by late 2014 the CCGs and the Trust were in dialogue about how to relieve bed pressures in a systemic way. The consensus position we heard about the root cause of bed pressure is summed up in this quotation from the Maudsley International review:

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<sup>89</sup> For example the Trust reported in 2014 that 'The percentage of people who are "new to the mental health system" who require admission has increased and is now more than 40% of occupied beds and on some days has reached 50%.'

<sup>90</sup> [http://www.rcpsych.ac.uk/pdf/Old\\_Problems\\_New\\_Solutions\\_CAAPC\\_Report\\_England.pdf](http://www.rcpsych.ac.uk/pdf/Old_Problems_New_Solutions_CAAPC_Report_England.pdf)



‘The effectiveness and efficiency of acute inpatient services is invariably contingent on the effectiveness and efficiency of all the wider service components in the mental health provider system, as well as the service model, management and resourcing of acute inpatient services. Patient flow through acute inpatient beds is a whole system issue that can only be effectively managed by a whole system response to bed management. In this respect the acute and crisis care pathways need to be viewed within the context of the operation of the wider system.’

- 9.17 This and other analyses of the acute pathway have furnished the Trust and its commissioners with a raft of recommendations aimed at building a shared understanding of problems and solutions. These are based on improved metrics and systems for managing the acute bed resource; and increased investment in community-based capacity.

### **Root cause 2: The decision not to admit T on 8 May 2014**

- 9.18 In our view, given the predictability of harm arising from T’s presentation and living arrangements, the failure to mitigate risk by admitting him on 8 May 2014 was a second root cause of the homicide.

- 9.19 We have noted the inadequacies in the Trust’s risk formulation in 2014 compared to the detailed enumeration of relapse indicators and risk management measures in the 2002-2004 document. We consider that these deficiencies contributed to the decision not to admit T on 8 May 2014.

- 9.20 CP1, who had been T’s psychiatrist 2002-2009, and had since led the Rehabilitation and Recovery Division, told us that it was possible that some attenuation had occurred. In other words, the awareness of the risks associated with T when he was unwell had faded over the long period where he had not presented as unwell. CP1 told us:

‘But that’s a natural psychological process and the risk assessment is about making sure that there’s documented counteractive framework to that psychological process.’

- 9.21 CP1 provided us with an encouraging picture of the rigour with which risk assessments are now formulated and audited within his area. We have seen evidence of regular audit and scorecard reporting of compliance across all the Trust’s divisions. However, in previous sections we highlighted the significant qualitative departures from the risk assessment policy in this case. We cannot be certain what the structural and proximal root causes of this were. In the absence of concrete evidence, our view is that staffing pressures reduced the quality and quantity of managerial supervision available to RRT staff, particularly those filling multiple roles. This meant that the quality of risk assessment formulations was not subject to sufficient managerial scrutiny and support and practice development also suffered.

- 9.22 We learned that the RRT’s Red Team provided an ad hoc duty service for low

support clients receiving little or no care coordination. In our view, T resembled, by virtue of his long standing uneventful presentation, a Red Team client. This service worked very well indeed in many aspects of its handling of T's and M's 7 May 2014 presentation. But the documentation of T's care, in particular the risk assessment, was predicated on a static presentation with low level mental illness symptoms.

- 9.23 We saw from RR3's assessment that the historic relapse risks, that we assume were the basis of T's continued CPA, were available to the RRT. But that was only part of the picture. We also found more recent evidence of domestic violence and abuse that should have triggered a proactive risk management strategy of gathering more information from M.
- 9.24 We were concerned by the low intensity of home treatment interventions available through the Crisis Team in 2014. This meant that a full assessment of T on 7 May or a second visit on 8 May 2014 were not options for a person assessed as needing intensive input. We were repeatedly assured that the Crisis Team always saw people within its 24 hour target. However, we have seen evidence in the form of the CCGs' quarterly KPI report (quarter 4, 2015-16) that the percentage of Camden Crisis Team referrals seen within a day varied between 70.9% and 57.0% in 2015/16 with the underlying trend being a reduction in the percentage seen within a day.<sup>91</sup> We welcome the Trust's analysis of these figures and the related actions it is taking.

## Recommendations

- 9.25 We offer 12 recommendations in total, 10 recommendations to the Trust and two to NHS England. These have been identified as they occur in the narrative of the report, but are grouped here under priority for ease of reference. They have been given one of three levels of importance:
- Priority 1: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems/process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.
  - Priority 2: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems/process objectives. The area of concern does not compromise the safety of patients, but identifies important improvements in the delivery of care required.
  - Priority 3: the recommendation addresses areas that are not considered important to the achievement of systems/process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

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<sup>91</sup> The Trust noted: 'A team audit is currently being completed to identify reasons for not seeing clients within one day of referral. Reasons for delay will include patients requesting delays in assessments, patients [not attending] or cancelling, resourcing issues in the team. For context the 4 hour audit has identified in Q3 that 29.4% patients requested a delay in the assessment date and 18% in Q4'.

**Priority 1 Recommendations**

**The recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems/process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised**

**Recommendation 2:**

The Trust's Rehabilitation and Recovery Division should implement measures to provide assurance that risk assessments meet the necessary quality standards. In particular, all risk assessments should flag known relapse signs and proven risk management strategies

**Recommendation 8:**

The role of the Crisis Team in assessing informal referrals should be clarified in policy given the principles in the concordat and the gatekeeping requirements. The aim should be to ensure a seamless and responsive assessment process for clients in acute crisis and clarity as to responsibilities where different service areas have involvement in the patient's care

**Recommendation 9:**

The Trust should review the measures taken by referrers to manage extended waits for beds in order to establish if any risks being taken can be better mitigated.

**Recommendation 10:**

The operational changes to the Trust's bed management system should be incorporated into the policy

**Recommendation 11:**

Given our concerns and the Coroner's, NHSE should refer this report to the Cavendish Square Group so that it may take forward learning from it with commissioners and providers in the capital.<sup>92</sup> In particular, NHSE should emphasise its concern that every patient who is identified by mental health services as requiring a mental health bed in London should be allocated a bed. And that all London mental health trusts should actively monitor their ability to provide beds when they are needed and be alive to the risks of workarounds developing when bed pressures exist

**Priority 2 Recommendations**

**The recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems/process objectives. The area of concern does not compromise the safety of patients, but identifies important improvements in the delivery of care required**

**Recommendation 3:**

The Trust should ensure that its systems are capable of identifying when its service users are not registered with a GP and ensuring that GP registration then occurs.

<b>Recommendation 4:</b> The Trust should ensure that when its policies require it to communicate with a patient's GP, that communication occurs.
<b>Recommendation 5:</b> It is recommended that NHS England ensure that people with a CPA care plan are not deregistered from their GP without contacting Adult Social Care and/or the Mental Health Trust first.
<b>Recommendation 6:</b> We recommend that the Trust's Rehabilitation and Recovery Division reviews its systems for ensuring that all care episodes are recorded in line with its record keeping standards.
<b>Recommendation 7:</b> The Trust should ensure that the role of alcohol and drug misuse in heightening risk is emphasised sufficiently in its risk assessment and management procedures.
<b><u>Priority 3 Recommendations</u></b> <b>The recommendation addresses areas that are not considered important to the achievement of systems/process objectives. The area of concern relates to minor improvements in relation to the quality of service provision</b>
<b>Recommendation 1:</b> Given the difficulties we have experienced obtaining the information we required during the investigation process, the Trust should implement a clear policy for ensuring that requests for information from independent investigations are met in a timely and efficient way.
<b>Recommendation 12:</b> The guidance for people undertaking SI investigations for the Trust should emphasise that investigators need to distinguish between evidence obtained from the contemporary records and evidence from subsequent statements, and when appropriate challenge staff about any discrepancy.

<sup>92</sup> The Cavendish Square Group is a chief executive-led collaboration of the 10 mental health trusts in London  
<http://www.cavendishsquaregroup.co.uk/>

## Appendix A – Terms of reference

### Core Terms of Reference

#### Purpose of Investigation

To identify whether there were any gaps or deficiencies in the care and treatment that the service user received which could have been predicted or prevented the incident from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring. Specifically,

- 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 findings if relevant from any additional report such as Domestic Homicide Review (DHR) and the Trusts progress in implementing any recommendations
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user'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 service users 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 service users harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered 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 the Investigation Team that includes measurable and sustainable recommendations.

- Assist NHS England in undertaking a post investigation evaluation.

### **Specific Terms of Reference**

- To explore the co-dependency between mother and son and to understand if this impacted on care with consideration of T's Mother's needs as a carer.
- To understand if the risks posed by T were fully understood and managed in relation to safeguarding his Mother.
- To explore care planning and support in relation to substance misuse.
- To explore the effectiveness of the internal escalation processes for admission when there is no capacity to admit.
- To explore the Trust's external escalation processes to commissioners in relation to bed capacity and agreed plans for mitigating risks.
- To explore the Trust's engagement with other mental health providers in bed escalation.

### **Outputs**

- A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care
- A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome
- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed)
- Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference
- Independent panel to involve police (including Family Liaison Officers) within the review process
- At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation
- A concise and easy to follow presentation for families
- A final presentation of the investigation to NHS England, Clinical Commissioning Groups, provider Board and to staff involved in the incident as required

- We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public
- We will require monthly updates and where required, these to be shared with families



## Appendix B –Trust services involved in T's care

T received services from the Camden and Islington Foundation Trust and its predecessor bodies between 1994 and 2014.

Between 1994 and 2002 T was admitted through the Trust to NHS-funded private hospitals and to St Luke's hospital in Muswell Hill, Haringey, where the Trust provided acute inpatient care until 2009. In this time, and until 2014, T had episodic contacts with the Trust's community mental health teams (CMHTs).

### South Camden Rehabilitation and Recovery Team

After some discharges, re-referrals and transfers of care, by 2002 T received services from the CMHT based at the Peckwater Resource Centre. In 2012, after a reconfiguration of community services, T became a client of South Camden Rehabilitation and Recovery Team (the RRT) which was based at the Peckwater Resource Centre. The RRT cared for patients with schizophrenia and bipolar affective disorder from the three CMHTs which had previously covered the area. Over this period T had continuity of care co-ordination from RR1 who was allocated his case in 2008.

The RRT, which was GP-aligned, had a caseload of between 700-800 patients and two full time consultant psychiatrists.

At interview RR3 told us that all the RRT staff were on a rota to work morning and afternoon shifts as the 'Red Team'. The Red Team provided ad hoc support to people at the lower end of the spectrum of support needs, who would not usually require intense care co-ordination. RR1 told us that the Red Team caseload was about 300 people who were not allocated to care co-ordinators. Although the Red Team was providing services to relatively stable clients, it was the function of the RRT that was the most accessible to users and carers in the event of a crisis. There would be a manager and two staff allocated to each Red Team shift. The Red Team became the First Intervention Team and then the New Referrals and Review Team.

### South Camden Crisis Resolution and Home Treatment Team

The South Camden Crisis Resolution and Home Treatment Team (the Crisis Team) provides services for residents in the southerly part of Camden, from age 18 upwards experiencing mental health difficulties, who are in crisis and acutely unwell. It aims to work with the client to avoid hospital admission and two of its priority categories are people presenting as a risk and people being considered for hospital admission. The Crisis Team aims relevant to this case are:

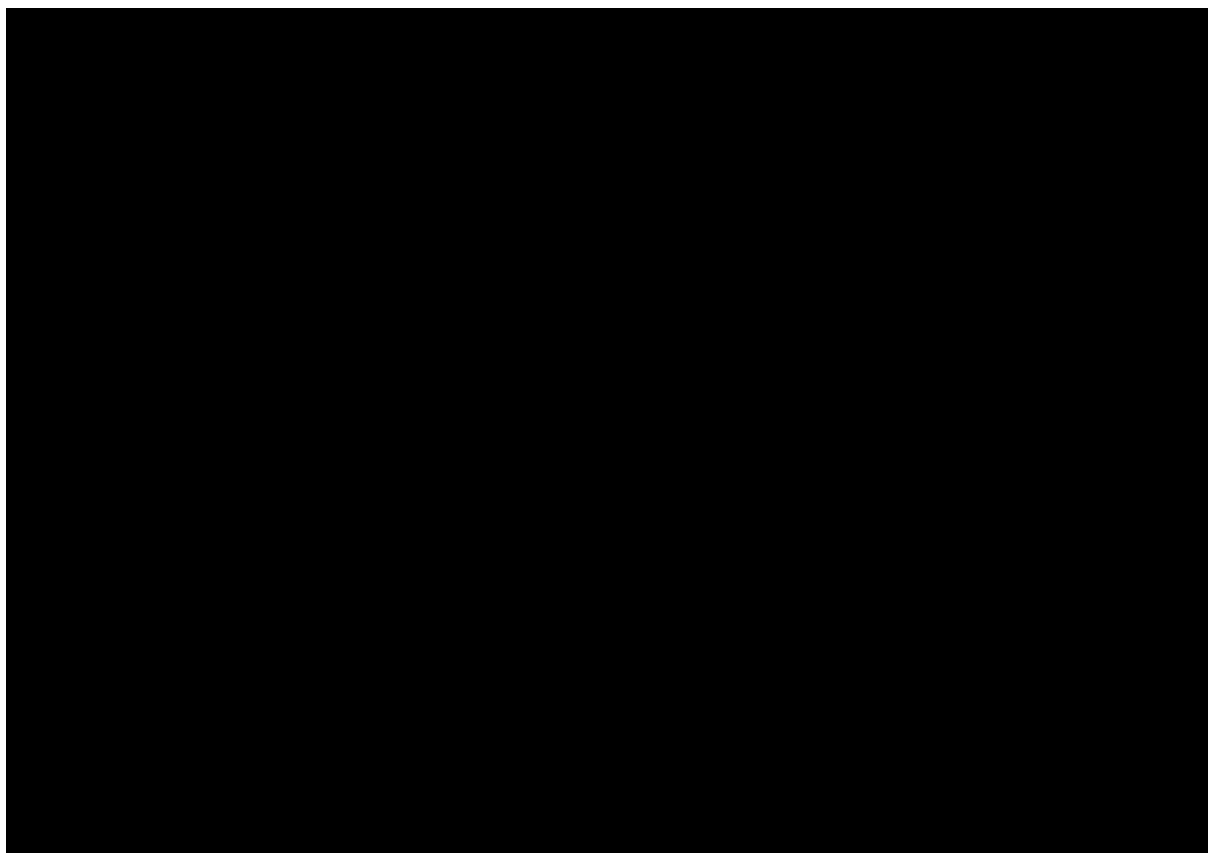
- 'To assess clients at A & E within one hour of referral'.
- 'To gatekeep all admissions to acute inpatient beds as per the guidance outlined in CQUIN'
- 'To provide home treatment to clients'.

## Gatekeeping

In 2014 and now, all requests for informal admission to the Trust's acute beds are referred to the Crisis Team which 'gatekeeps' the referral i.e. assesses whether or not admission is appropriate and provides a single point of entry to Trust acute beds. As well as home treatment, outcomes of Crisis Team assessments relevant to this case include:

- '[Admission to] Crisis House a six bedded unit where a client can stay overnight for a maximum of a fortnight'.
- 'Admitted to assessment ward'
- 'Referred for a Mental Health Act assessment'
- 'Admit to treatment ward'
- 'Safeguarding alert raised'
- 'Authorise and gatekeep all admissions to inpatient wards'.

The following diagram (from appendix 4 of the Trust's Bed Management Policy applicable in May 2014) sets out the gatekeeping process:



## Assessment and home treatment

The Crisis Team aims to see a client in 24 hours. CT1 told us that it had been rare for a client to be seen on the day of the referral. She said that in 2014 the Crisis Team during the day usually had one nurse on shift with a social worker and a support worker but the numbers of staff were increased if a shift was expected to be

busy. The Crisis Team would not undertake a community visit after 19:00. At night after 21:00 a single team member worked, holding a pager.

The Crisis Team would work closely with the care co-ordinator, if the client had one. CT1 told us that clients could receive two Crisis Team visits per day, occasionally three. ADD emphasised that twice daily visits were frequent and there had not been any capacity-related reason at the time precluding a second Crisis Team visit on 8 May 2014.





























































