External Investigation into the Case of Ms A

Incident date: 10th October 2011

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- Mrs Sally Hodkin's family for taking the time to meet with the panel in what must have been very difficult circumstances
- Ms B for taking the time to meet with us
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- Ms A for agreeing to see two members of the External Independent Investigation Panel
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- Ms A's General Practitioner
- The Metropolitan Police
- The Independent Police Complaints Commission

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EXECUTIVE SUMMARY

Please note that this Executive Summary should not be read separately from the detail in the Main Report.

Introduction

Caring Solutions (UK) Ltd. was commissioned by NHS England (London) to undertake an Independent Investigation of the care and treatment provided to Ms A by Oxleas NHS Foundation Trust ('the Trust'). This is the report of the results of this investigation.
At the request of her family, Mrs Sally Hodkin has been named in this report.

1. Incident Description and Consequences

1. On 10 October 2011, the perpetrator Ms A went to a bus stop and attacked and stabbed a young woman, Ms B, in the hand. Ms B successfully fought off Ms A, who dropped the knife. Ms A then grabbed another knife from a butcher's shop situated near the attack and ran off. Ms A then, in a nearby memorial park, fatally stabbed Mrs Sally Hodkin with the knife. Mrs Sally Hodkin was pronounced dead at the scene.

2. Ms A was arrested and taken into custody and charged with the murder of Mrs Sally Hodkin and the attempted murder of Ms B, and transferred to a women's secure unit at Ealing Hospital where she remained until her trial. Ms A had a previous conviction for the manslaughter of her mother in 2006, after which she was detained under section 37/41 of the Mental Health Act (1983) (Appendix 1) and at the Bracton Centre, a Medium Secure Unit, Oxleas NHS Foundation Trust.

3. In the hours prior to these incidents, Ms A made a number of attempts to seek help. The police were called and took her to A&E at Queen Elizabeth Hospital (QEH) after she had refused to enter an ambulance. She spent time at A&E but was agitated and left the unit on a number of occasions whilst waiting to be seen. The A&E triage nurse referred her for psychiatric assessment and, whilst waiting for the mental health liaison nurse (MHLN), Ms A made further calls to the police and was 'shouting and screaming' in A&E. 1½ hours after her initial call to the police she was seen by the MHLN who was not informed of the police involvement. The electronic record system (RiO) could not be accessed at A&E, but the MHLN had previously identified that she had killed her mother and had been detained in Bracton Clinic. The MHLN left Ms A at A&E to write up his assessment. Again she became agitated, ran off and was brought back to A&E. An A&E nurse and a member of security staff escorted her to Oxleas House (OH). Ms A agreed to be admitted to the in-patient service. Ms A asked to wait in reception, rather than the day unit, whilst her admission was arranged. Staff agreed to this request as she was still in sight of staff. She left the OH twice and the second time did not return. She took a bus to Bexleyheath, bought a knife and went on to commit the offences.

4. On the 7 February 2013, at the Central Criminal Court, Old Bailey, a jury convicted Ms A of murder and attempted murder. Ms A was sentenced on 4 March 2013 to life imprisonment with a minimum tariff of 37 years.

2. Terms of Reference: Key Questions and Actions

Full Terms of Reference are contained in Appendix 2. The key questions the Panel were asked to address are:

1. Was the Trust's internal investigation adequate in terms of its findings, recommendations and action plan?
2. What progress has been made by the Trust in implementing the action plan from the internal investigation?
3. Were the families of both Ms A and Mrs Sally Hodkin involved as fully as is considered appropriate, in liaison with the police?
4. Develop a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident.
5. What were the mental health services provided to Ms A and were documents in place?
6. What are the admission processes and the security arrangements at Oxleas House for informal patients and are they adequate?
7. Were the assessments and care planning of Ms A appropriate and of good quality?
8. Was Ms A's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, and local operational policies?
9. Are there other matters of public interest which need to be considered?

3 Investigation type and process

1. This is an external, Level 3, Independent Investigation conducted by a Panel of three members. The Panel was chaired by an experienced senior nurse and nurse manager with previous experience of several investigations. The Chair was supported by two Panel members. These were an experienced senior social worker and mental health service manager with extensive experience of investigations; and a consultant forensic psychiatrist with experience as an Associate Medical Director and previous investigation experience.

2. The investigation included:
   - meetings with Ms A and her family, Ms B and Mrs Sally Hodkin's family;
   - interviews of relevant staff involved in the care and treatment of Ms A;
   - a review of relevant Trust strategies, policies and procedures and the Internal Investigation report;
   - information from other agencies, including the police and courts.

3. The Panel analysed the evidence collected in accordance with the National Patient Safety Agency's (NPSA) recommended practice and used their framework as a structure for this report.

4. The Panel carried out an audit of the internal investigation report and assessed the implementation of the action plan from the internal investigation recommendations. The Panel have commented on the quality of the report and the level of implementation of the action plan. The Panel ensured that their conclusions were based on facts and evidence and were not influenced by the outcome of the case.

5. The Panel are not police officers but they do see the role of the police officers as relevant to the circumstances of the case and their investigation. When police officers are exercising their powers under section 136 of the Mental Health Act they are making a decision in relation to the detention of a person who appears to be mentally disordered for the purpose of examination by a doctor/interview by an AMHP and the making by those professionals of any necessary arrangements for her treatment or care. For the conduct of future investigations consideration should be given as to how police expertise including possibly police membership (or indeed that of other agencies where the context requires) is brought into the process in light of this. The comments regarding the exercise by the Police of the section 136 power in this Report focus on the nexus between how the Police and health staff work together at an operational level when a decision is being taken to both exercise or not to exercise the s.136 power. Conduct of the police other than in relation to that issue forms part of the review carried out by the Independent Police Complaints Commission and does not form part of the Panel's investigation. The Panel acknowledges that it cannot duplicate the role of the IPCC.

4 Summary of Findings – Internal Investigation

1. The Independent Investigation Panel found that the panel for the internal investigation was formed quickly and consisted of people independent of the services involved in the care and treatment of Ms A, thereby adding objectivity to the process. The family of Mrs Sally Hodkin was involved in the investigation: Ms B was invited to contribute but declined. The Independent Panel found that the report was clear, and that conclusions and recommendations were based on the facts presented. There were some limitations to the internal investigation process: the Internal Panel did not involve the family of Ms A (although they were informed about the outcome of the internal investigation), nor interview the A&E Charge Nurse or Ms A's GP. There were appropriate systems for dissemination of the report and associated action plan.

2. The Internal Investigation Panel made a number of recommendations. These addressed:
   - care planning, care and risk assessments;
   - communications;
   - admission process from A&E to OH;

- review of Mental Health Liaison Operational Policy;
- compliance with absconding procedures;
- review of Security and Safety Policy and security arrangements at OH;
- location of the MHLN at A&E and remote access to RiO;
- consideration of disciplinary action;
- communication between Trust services and the Multi-Agency Public Protection Arrangements (MAPPA).

3. The Independent Panel commented that recommendations are not always SMART (simple, measurable, achievable, realistic and timetabled). Similarly, the action plan does not always have goals that could be audited. SMART recommendations and auditable goals mean that compliance can be tested.

4. The Independent Investigation Panel agreed with the issues raised by the Internal Panel, but concluded that there were additional areas of concern, and that some wording in the report was factually incorrect. The Independent Investigation Panel noted that some actions had not been fully implemented at the time of their investigation and recommended urgency in addressing these actions.

5 Summary of Findings – Care and Treatment of Ms A

5.1 Chronology

1980 Ms A was born. She had a younger brother and sister. Her parents separated when she was five. From age 11 her behaviour became difficult (truanting from school, bullying, violent outbursts) and she spent some time in the care of the local authority. At 15 she was cautioned by police for an assault on her mother and left home. She moved to London, where she was using illegal drugs. She took two overdoses and was seen by a consultant psychiatrist and by a clinical psychologist. She was sexually active from age 13 yrs (self-reported). At 17 years she presented to A&E, having heard voices, and threatening to kill herself and her mother. Her late teenage years were characterised by difficult relationships which failed (one partner was deported for drug dealing, her husband was refused entry back into the UK from Jamaica; another partner pressured her into having an abortion). She gave birth to two sons, one with her partner who was deported and one with her husband who insisted the son stay with him in Jamaica. Relationships were characterized by violence on both sides, misuse of illegal drugs and alcohol, and finally involvement with prostitution. The last relationship before the manslaughter of her mother was with a man she described as very controlling, who threatened to kill her if she did not terminate a pregnancy.

Ms A's mental health deteriorated from this time. She began believing that her partner and people more generally wanted to kill her, believing that she was Jesus, that she could see invisible people.

October 2005 Ms A's son was taken into care after her family informed Social Services and her GP that they were concerned about her mental state and inappropriate sexual behaviour towards her son. Ms A was convicted of criminal damage to a neighbour's house and police reported that she had threatened her neighbour with a knife. Ms A was examined by a psychiatrist who found no evidence of current mental illness.

November 2005 Ms A's brother and sister found their mother's body when they returned home in the early hours of the morning. Ms A was arrested on 21 November 2005 and was assessed as 'actively psychotic' at the police station. She was first moved to prison then transferred to the Bracton Centre Medium Secure Unit in February 2006. Initially she was assessed as unfit to plead in court; this was revised to her being fit to plead in August 2006.

October 2006 Ms A pleaded guilty to manslaughter on the grounds of diminished responsibility. A psychiatric report to the Court had concluded that an acute psychotic episode, coupled with emotionally unstable personality traits, had been present before and after the alleged offence. The psychiatrist recommended that Ms A would require a long period of time in a secure hospital environment for further treatment, risk assessment and long-term rehabilitation. Ms A was sentenced to be detained in psychiatric care under Section 37/41 of the Mental Health Act 1983 and returned to the Bracton Centre.

October 2006 to September 2009 Ms A was an in-patient at the Bracton Centre. During this time she was treated with anti-psychotic and mood stabilising medication. Concerns were raised about her disruptive, abusive and rude behaviour on the ward, her denial of any memory of the index offence, her fixation on making fast progress to discharge and her relationships with men in the Centre. She was allowed escorted leave from mid-2007 giving rise to concern about inappropriate behaviour in the community. In November 2007 she was asked to transfer temporarily to accommodation within the Centre for patients who can manage more independent living to free up a bed on her ward. She was resident there until her discharge from the Centre. Her behaviour continued to cause concern, including her relationship with a male patient, and mood instability when the medication dose was reduced. Following appropriate discharge meetings, she was conditionally discharged on 29 September 2009 to a housing association self-contained flat. A referral to the MAPPA was recommended but this was not followed up. She had expressed anxiety about moving to an environment where she would be alone at night but her care team considered that she did not need accommodation with 24 hour staffing cover. A contingency plan was agreed for her to access help urgently.

September 2009 to October 2011 Ms A remained in the housing association flat under supervision from the forensic service. She re-established contact with her father and attempted to re-establish contact with her siblings. There were further reports of disruptive behaviour which Ms A denied. She was allowed two visits to Jamaica to see her family there. This included her husband alleging violent and aggressive behaviour,

which Ms A denied. In March 2011, her Supervising Psychiatrist told her to stop taking the mood stabilizing medication when she reported that her GP thought she might be pregnant. There were further difficulties reported in her relationships with men, including threatening texts from an ex-partner, and her reports of a miscarriage. In early October Ms A involved the police regarding an allegation (later withdrawn) of theft from her flat; receipt of threatening texts and fears she would be hurt. The events leading up to the attempted and actual homicides on 10 October followed.

5.2 Summary of Findings: Notable Practice, Care and Service Delivery Problems.

1. The Independent Investigation Panel identified the following two points of notable practice:

    1 The excellent process and contact records kept by the Bracton Centre clinical staff in relation to Ms A, both as an in-patient and a community patient.
    2 Shortly after the incident, the accommodation service did a comprehensive review of all the other clients of the service, in partnership with the Trust, to ensure there was no-one else at risk of relapse following the incident, and/or presenting a significant risk to themselves or others.

2. The Independent Investigation Panel identified the following service delivery problems in relation to the care and treatment of Ms A.

    1 Correspondence to the Ministry of Justice (MoJ) did not fully reflect Ms A's behaviour and presentation, and in one particular instance, the MoJ request to inform immediately if concerns arose during a trip to Jamaica, was not followed.
    2 Communication between the A&E Department and the MHLN did not ensure that important elements of Ms A's presentation were understood by all.
    3 The Admission Care Pathway and the Mental Health Liaison Policy differ on who escorts patients from A&E to OH.
    4 The care team did not provide full information on the referral form to MAPPA and, following Ms A's discharge there is no evidence they discussed MAPPA involvement.
    5 There is no document setting standards for those who will be in receipt of Section 117 after care who are being discharged and followed up by the forensic service

3. The Independent Investigation Panel identified the following care delivery problems in relation to the care and treatment of Ms A.

    1 There was a failure to gain a view of family members involved in specific situations with Ms A. The care team were too ready to accept Ms A's account of potentially worrying situations, and not enough weight was given to alternative accounts, or no attempt was made to get the views of family members involved.

2 Ms A's potential risk of violence to others in the community was not adequately considered by her care team, particularly on occasions when there were worrying reports about her behaviour, and/or stresses to which she was subject.

3 There was no overview of Ms A's presentation and changing level of risk when experiencing stresses which were identified in her care plan as associated with relapse. The care team responded on a reactive basis to issues as they occurred, and did not adequately consider the overall impact of these events on Ms A's mental state and behaviour, and her level of risk to others.

4 There was no communication with Ms A's employers. The Panel recognises that the team would have had to ask Ms A's permission to talk to her employers, and if refused, to have decided if they were justified in breaching her confidentiality. However the panel considers that these issues should have been discussed by the team. Ms A remained a conditionally discharged restricted patient.

5 There was telephone contact only on 6 October 2011 after Ms A missed her appointment. The panel considers that there should have been a review of Ms A before the weekend, when it was clear that she was subject to several significant stresses, had engaged in uncharacteristic behaviour and believed that she had miscarried, even though this was not true.

6 CPA reviews did not refer to all the key people who could have provided useful information regarding Ms A's behaviour and presentation.

7 Patients should feel closely supported in the community, and the care team can ensure that the patient's presenting behaviour is kept under closer scrutiny. The practice of placing conditionally discharged patients in low support accommodation should be reviewed.

6. Contributory factors

1. The National Patient Safety Agency (NPSA) determines that Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. The removal of the influence may not always prevent incident recurrence but will generally improve the safety of the care system; whereas the removal of causal factors or 'root causes' will be expected to prevent or significantly reduce the chances of reoccurrence. Root Cause Analysis (RCA) is a structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it with a permanent fix rather than continuing to deal with the symptoms on an ongoing basis.

2 The panel identified a number of contributory factors, which are presented under the following headings:

- Service user
- Involvement of family members and other stakeholders
- Clinical assessments

Factors related to the service user included:

- her diagnosis and treatment, ability to minimise symptoms and desire to make fast progress towards discharge;
- the time spent in the medium secure unit followed by conditional discharge to supported self-contained accommodation without 24 hour staffing;
- her wish to reduce medication which appeared to reduce her mood instability, and this being stopped because she thought she might be pregnant or wished to become so;
- problematic relationships with others, identified as a possible indicator of mental health deterioration;
- increase in stress factors, after her mood stabiliser had been stopped;
- increasing risk factors – reduced medication, unconfirmed beliefs about pregnancy and miscarriage, reported threatening/aggressive behaviour by her and threats to her from past boyfriends, 'offensive' response from her brother to her attempts to contact him;
- signs of agitation and distress when first seen by the police on 10 October 2011, lack of cooperation and again in A&E.

3. Factors related to involvement of family members and other stakeholders included:

- Ms A's sister and father felt they were not consulted and their views not considered by the care team, although they were in contact with her;
- missed opportunity for the care team to seek collateral information about Ms A's history and behaviour from her relatives;
- evidence of problematic interactions with other not adequately considered by the team
- no record of Social Services being invited to key meetings, nor clear evidence of which agencies were invited. Ms A's father was not invited and there was no contribution from her GP;
- no apparent consideration of contacting her employer
- inadequate response to her brother's telephone call to express concerns about her mental health.

4. Factors related to clinical assessments included:

- the decision to apply to the MoJ for conditional discharge on the basis of the responsible Clinician's (RC) recommendation rather than apply to the Mental Health Act Tribunal where her stage of readiness and mental health would have been tested by a judge, independent consultant psychiatrist and lay member;
- a referral form for MAPPA was completed but not sent on to the Coordinator; the referral did not present a complete picture of her previous conviction and aggressive behaviour and was not fully accurate regarding her relatives relationship with her;
- the Risk, Crisis and Contingency plans did not include all documented risk factors;

- two incidents in the community were not recorded in the documentation of a CPA review in December 2009;
- the appropriateness of her job was not considered and no consideration given to contacting her employer – this was a missed opportunity to learn about her relationships with colleagues and how she was managing the additional stress of work;
- the decision to place in her in supported accommodation which was not staffed 24 hours and where she would be alone at night although she was known to be nervous about this. 24 hour staffed accommodation would have provided more opportunity to observe her behaviour, particularly her relationships with men;
- reports which did not accurately reflect disruptive and aggressive behaviours described in the clinical notes;
- taking her version of events at face value without apparently conferring with others who could corroborate or otherwise her version. This included an alleged incident in Jamaica which if confirmed and shared with the MoJ, might have led to consideration of recall to the medium secure unit;
- inadequate response to reports of inappropriate behaviour on her part, which was not sufficiently explored with her;
- level of attention paid to the impact of her personality traits and volatile relationships with men;
- communications between one of her key workers in the supported accommodation and her CPN.

7. Root Causes/Causal factors

The NPSA determines a root cause as “a fundamental contributory factor which if removed will be expected to prevent or significantly reduce the chances of reoccurrence”. The Independent Investigation has concluded that there are two fundamental contributory or causal factors as follows:

1. The External Independent Investigation Panel is of the view that there was enough evidence for the police to place Ms A under section 136 of the MHA 1983 on one occasion in the small hours of the 10 October 2011, when she was observed by the Police (as stated in their statements) coming out of A&E for the second time. The PCs recognised that she had mental health problems and although she appeared to be willing to go to hospital, she did in fact leave A&E twice, the first time being escorted back to reception by the Police Officers, after they reassured her and the second time saying that she had only come out for a cigarette. When she came out of hospital a second time the Police had an opportunity to question her willingness to remain. Ms A had used the dedicated taxi phone on two occasions to call a mini-cab in the presence of the PC and had her call terminated by the PC on the second occasion. At this point the Panel felt it would have been reasonable for the PCs to conclude it was necessary to detain her under section 136 of the MHA. In their view, Ms A met both the criteria for section 136 set out in the Policing Mental Health

Standard Operating Procedure, February 2011, and the justification of compulsion for willing patients.

The panel accepts that section 136 of the Mental Health Act is an emergency power and that whether to use it is a judgement call. Given this set of circumstances some Police officers may have applied Section 136 of the Mental Health Act whilst others may not have. The Police Officers involved reached their decision in good faith and were satisfied that Ms A did not meet the relevant test. However, the Panel believes that Ms A could have been placed on a section 136 in light of her level of agitation and her demonstration of intention to leave the unit by twice attempting to arrange a taxi via the dedicated free taxi phone in the presence of the police officer. This was followed by Ms A's leaving of the A&E unit for a second time and it is the view of the Panel that the likelihood of her remaining to undergo voluntary admission had by now been placed in serious doubt. When leaving the QEH the police officers had felt that Ms A "had appeared fine, that she was a little nervous but ultimately was not happy with having to wait to be given her medication", the accompanying PC stated that "She genuinely seemed as though she wanted help". Both PC's stated that the Hospital was where she was repeatedly asking to be. They left the situation therefore feeling that she was nervous but presenting no threat and that she was in a place where she both wanted to be and would receive the support and care that she needed. The panel view is that throughout the period of her interaction with the emergency services Ms A was expressing the view that she wanted treatment and care.

Had Ms A been detained on Section 136 she would have been taken immediately to the locked Section 136 assessment unit within Oxleas House, being the designated safe place. Once there, the Trust standard is that the Duty Psychiatrist should assess the patient within 60 minutes. This assessment would have revealed that Ms A was a conditionally discharged restricted patient with a conviction for manslaughter; this would have allowed a much more considered assessment to take place, with Ms A detained throughout. The circumstances of this case highlight the need for a process by which the police and other emergency services are able to conduct, on arrival, an appropriate handover of the patient with appropriate health professionals regardless of the manner through which crisis mental health care is sought.

2. The MHLN had ascertained before going to A&E that she had killed her mother and was known to the Bracton Centre. However, he did not look at the care plan or crisis plan before going to assess her and was unable to access her electronic records whilst assessing her. He recorded her hearing voices, her request to be sectioned because she did not feel safe, that she had ceased taking all her medication and that she had used a strong form of cannabis. He was unaware that she had been taken to A&E by the police. Her contingency plan in part stated "there should be a low threshold for admission given the seriousness of the index offence...it is also known A was seen by a psychiatrist in the weeks before the offence and not thought to be psychiatrically unwell....this would appear Ms A can mask emerging symptoms of her illness".

The Panel does acknowledge that he accurately assessed Ms A as needing admission and accurately scored her high as a forensic risk, and that following a discussion with

the Duty Doctor at Oxleas House, her observation level was set at level 2 – which is to observe every 15 minutes.

2.1 Given what the nurse knew of the patient and his interview notes this does not seem to the panel an unreasonable judgement. Ms A did not show any signs of wanting to abscond to the nurse. However the panel do believe that had the nurse availed himself of the full information available then a different outcome may have resulted.

2.2 If the nurse had read the balance of paperwork that was not read, would it have made any difference to that assessment of presentation?

The balance of the paperwork available to the MHLN included the Care Plan and the Community Crisis Plan. These documents would have informed him that: she was stated to require a low threshold for admission; that she could mask the signs of her psychiatric illness; and emergency acute admission should be facilitated via home treatment team or via presentation at Oxleas House.

Given this additional information the panel believe that the correct level of observation should have been one to one constant observation.

2.3 If Ms A had been observed constantly by a nurse following her arrival at A&E, would her presentation have led to 1:1 observation?

An observer of Ms A following her arrival at the A&E department would have been witness to:

- Her arriving under police escort
- Her agitation and distressed behaviour
- Her leaving the department on several occasions
- Her attempting to phone for taxis to take her away
- Her threats to kill
- Shouting, disruptive and abusive language
- Phone calls to the police (999)
- Her fear of being in the unit
- Her wanting someone to be with her

Given this presentation the panel believe that it would have significantly have raised the risk profile for Ms A and that one to one observation levels would have been indicated.

2.4 If Ms A had been observed constantly and had the balance of her clinical notes read would this have changed the observation level?

Given the above the panel believe that the additional written information and observations of her behaviour following arrival at the A&E unit would have significantly raised the risk profile for Ms A and that one to one observation levels would have been indicated.

Whilst the External Independent Panel accept that this was a judgement made by the MHLN and the Duty Doctor, they judge the observation level to be inadequate given her forensic history and clinical presentation. Had Ms A's observation levels been set so that she was in eyesight at all times (as indicated by her forensic history and clinical presentation at that time) then this would have provided an opportunity to support Ms A and discourage her from leaving before being admitted to the in patient service.

Once Ms A was escorted to Oxleas House it would have become obvious to anyone observing her that Ms A was not settled, she asked to sit in a reception area where she could see staff and she pushed open the inner and outer doors of Oxleas house and then went back into the Unit, before absconding one minute later. Had Ms A been on eyesight observation there would have been, as described in the Trust Policy, an opportunity to engage with Ms A whilst continuing to clinically assess her. There would also have been an opportunity to persuade her from leaving Oxleas house by the observing staff member. This observation level assessment and the consequent poor follow up within Oxleas House, gave Ms A the opportunity to leave Oxleas House without challenge.

8. Lessons Learned

1. The Internal Investigation report identified a number of areas of concern with which the Independent Investigation Panel agreed and made some additional observations about the recommendations. The Independent Investigation Panel identified additional issues for concern, including two 'root causes' and a number of contributory factors.

2. Observations about specific Internal Investigation recommendations included the following:

   - Recommendation 9.1.1. should include taking into account all relevant risk information as well as relapse indicators.
   - The Internal Investigation recommended that, if known Bracton Centre patients attend at A&E, ring the Trust crisis line or contact the Bracton Centre, the 'On-call' Consultant or Specialist Registrar (SpR) should be contacted. However the Independent Investigation Panel considered that this would place a large responsibility on these staff, and recommended that the Trust consider providing a specialist on-call rota for the Forensic Service.
   - The Independent Investigation Panel noted that the Mental Health Liaison Service (MHLS) is now situated within the QEH A&E Department but felt that the environment was not conducive to calming an agitated patient, and that this should be addressed urgently.
   - The Trust should include reference to making full and accurate information available on referral and address the role of MAPPA following discharge from the Bracton Centre.
   - The statement inviting the Police to look at the issue of Section 136 of the Mental Health Act (1983). An action must be included that the Police and the Trust will work together to review the issue of Section 136, to ensure it is working in practice across the Police and the Trust.

3. Additional requirements following the External Independent Investigation process. A number of additional care and service delivery problems were identified by the Independent Investigation Panel. These included:

   - discharging conditionally discharged patients to low support accommodation which does not have 24 hour staffing;
   - when patients on a 'conditional discharge' gain employment, communication with the employer and assessing the appropriateness of the job;
   - the practice and approach sometimes taken by the RC in applying to the MoJ, rather than the patient seeking this through the Mental Health Act (MHA) Tribunal;
   - information sent to the MoJ did not fully reflect Ms A's behaviour and presentation;

- the Bracton Centre practice and culture in its communication with families and other stakeholders involved in the care of the patient, both during the CPA process, and during day to day management of care
- the Bracton Centre staff working practices in responding to a contact made to the clinic reporting concerning behaviour by a community forensic patient, as when Ms A's brother phoned the Bracton Centre to report his concerns;
- the Bracton Centre's decisions to support restricted patients who are on a conditional discharge to visit other countries without taking account of all the documented risks;
- the training on risk assessment and management and clinical observation for all the Mental Health Liaison Team, to ensure it is being accessed by all staff and mandatory training;
- communication between the A&E Department at QEH and the Mental Health Liaison Service, to ensure it remains effective.
- the walk undertaken by patients assessed by the MHLS as in need of admission who then have to walk from A&E to Oxleas House through a public area which may be busy and loud, with part of the walk being outdoors, creating the opportunity to abscond;
- the Admission Care Pathway and the Mental Health Liaison Policy currently differ as to who accompanies the patient from the A&E Department to Oxleas House;
- the 'Discharge from Hospital Policy' does not include standards when patients are discharged and followed up by the Bracton Centre;
- clinical supervision and clinical leadership at the Bracton Centre, the Mental Health Liaison Service, and at Oxleas House both require robust structures.

9. Recommendations

1. The recommendations and action plan of the Trusts internal investigation should be reviewed to take account of the External Independent Investigation Panel additional findings.

2. Actions developed from additional recommendations must be auditable to ensure compliance.

3. The Trust to ensure that the action plan continues to be monitored and its progress reported upwards via its governance reporting systems.

4. The Trust should ensure that all recommendations from Internal Investigations are SMART and auditable, leading to effective learning.

5. The Trust should ensure that all Policies identified within the report are updated to address the findings.

6. The Trust should ensure that all those involved or affected by a serious incident, have the opportunity to contribute to an investigation and to receive support.

7. The Trust should assure itself that leadership at both clinical and managerial level is effective.

8. The Trust should review the Practice of discharging conditionally discharged patients to low supported accommodation which does not have staffing over a 24 hour period.

9. The Trust should review the approach taken when patients on a 'conditional discharge' gain employment, in terms of communication with the employer and assessing the appropriateness of the job.

10. The Trust should satisfy itself that the practice and approach sometimes taken by an RC in applying to the MoJ, rather than the patient seeking this through the MHA Tribunal, is acceptable.

11. The Trust should review the Bracton Centres communication with the MoJ, as correspondence to the MoJ did not fully reflect Ms A's behaviour and presentation.

12. The Trust should review its practice and culture relating to communication with families and other stakeholders involved in the care of the patient, both during the CPA process, and during day to day management of care.

13. The Trust should ensure that robust processes are in place to support a clinical decision to allow patients who are on a conditional discharge to visit other countries.

14. The circumstances of this case highlight the need for a process by which the police and other emergency services are able to conduct, on arrival, an appropriate handover of the patient with appropriate health professionals regardless of the manner through which crisis mental health care is sought. The circumstances of the case also highlight the need for A&E departments and their Mental Health Trust partners to consider how the Mental Health Act powers are deployed in support of the crisis care pathway including the powers that may be enacted by the hospital alone.

15. The Trust to review the uptake of training relating to risk assessment and management, and clinical observation, for all Mental Health Liaison Team staff to ensure staff are up to date.

16. The Trust should ensure an auditable process is in place to monitor communication between the A&E Department and the Mental Health Liaison Service, so that it remains effective.

17. The Trust should review the route undertaken by acutely mentally unwell patients, who are admitted via the MHLS to Oxleas House.

18. The Trust must ensure that given the new commissioning arrangements for Forensic Services, no gap is allowed to develop for Service Users who are forensic inpatients, but then discharged to the care of a general team.

19. The Trust should review their Duty Dr on-call arrangements to consider the use of a specific Dr on-call rota for the Forensic services.

20. MAPPA should hold a central database for those patients on Level 1 MAPPA.

21. NHS England should ensure that the terms of reference guide the Panel to identify where it may become necessary to invite additional Panel members with specialist knowledge of other organisations such as Police or Housing.

MAIN REPORT

1. Incident Description

1. On the 10 October 2011, Ms A, the perpetrator, went to a bus stop and attacked and stabbed a young woman, Ms B, the surviving victim, in the hand. Ms B successfully fought off Ms A, who dropped the knife. Ms A then grabbed another knife from a butcher's shop situated near the attack and ran off. Ms A then, in a nearby memorial park, fatally stabbed Mrs Sally Hodkin with the knife. Mrs Sally Hodkin was pronounced dead at the scene.

2. Ms A was arrested and taken into custody and charged with the murder of Mrs Sally Hodkin and attempted murder of Ms B, and transferred to a women's secure unit at Ealing Hospital where she remained until her trial.

3. In the hours prior to these incidents, at 4.01am a mini cab firm contacted the Police to say that Ms A was crying in the back of their office, refusing to leave. At 4.15am two police constables (PCs) arrived, and Ms A informed them that she had mental health issues and needed medication.

4. It is documented that she was deemed to be agitated, but reasonably compliant in her behaviour. The police constables walked with her out of the office, and she appeared to them to have the self control and capacity to understand what was said to her. They decided to send her to hospital voluntarily, as they genuinely thought she was seeking help. She then refused to get into the ambulance, saying "I'm not getting in that box".

5. The PCs did not at any stage carry out a Police National Computer[1] (PNC) check which would have shown that Ms A had a conviction for manslaughter (in 2006 Ms A was convicted of manslaughter after stabbing and fatally injuring her mother. She was detained under section 37/41 of the Mental Health Act (1983) (Appendix 1[2]) and detained at the Bracton Centre, a Medium Secure Unit, Oxleas NHS Foundation Trust).

6. The Officers took Ms A to the A&E at Queen Elizabeth Hospital (QEH), they arrived at 4.29am, and helped her to book in. Ms A told the A&E receptionist that she needed to be seen by the mental health team. The officers explained to her that she had to remain there. There were at least 15 people waiting to be seen by the triage nurse at that time.

7. At 4:31 am, as the Officers were about to leave the car park, Ms A ran out to them. They reassured her, and ushered her back inside at 4:34 am. CCTV footage showed one Officer having a conversation with Ms A by the main entrance. During this time Ms A was seen to move around a lot and appeared to be agitated. Ms A then picked up the direct phone to the taxi company near one of the Officers and said she was going to call a cab. The Officer replied "you don't have any money". She then put the phone

[1] The Police National Computer (PNC) is a computer system used extensively by law enforcement organizations across the United Kingdom. It went live in 1974 and now consists of several databases, available 24 hours a day, giving access to information of national and local significance.
[2] All sections of the Mental Health Acts noted through the document have a fuller description in Appendix 1.

down and stood near the reception area away from him, once again returning to the direct phone for a taxi in his full view.

8 At 4:37 am both Officers left the hospital, only to be followed by Ms A again. She reassured the police she was only having a cigarette. Both officers waited for a few minutes and then left to attend to another call.

9. At 4.37 CCTV footage recorded Ms A entering the hospital by the main entrance by herself, and from this time onwards she is recorded as constantly moving around and appearing agitated. On her return to the A&E waiting area, Ms A asked the receptionist “how long am I going to be here”? and “is it going to take for me to kill someone, as I’ve done it before”.

10. At 4:45 am Ms A called the Bracton Centre. The statement by the staff member who answered the call reads as follows:

“A lady telephoned, very distressed with a muffled voice and talking very fast. She said she had a taxi waiting and if she passed the phone to him would I tell him that we would pay for the cab as she desperately needed to come back here. I said I wasn’t authorised to do that but would pass her to the relevant unit, which she said was Joydens. I passed the call straight through and 2 minutes later Joydens called back to reception and said the call I had put through needed to be passed to the Duty Doctor, then hung up. The phone to the caller was dead so I called the Unit Coordinator and he telephoned me back 5 minutes later saying it wasn’t the procedure to pass the calls to the Duty Doctor, he had spoken to Joydens and they didn’t manage to get her telephone number”.

11. At 4:53 am Ms A was seen by the triage nurse, she said she wanted to see a mental health person and go into hospital. She said everyone wanted to hurt her and she was hearing voices. The psychiatric team accepted her referral.

12. Whilst waiting to be seen in A&E Ms A called the Police several times, saying that she was dangerous and that she was very scared, and that her Psychiatrist had said that when she was like this she was very dangerous, and also that the last time she felt like this she killed someone.

13. Ms A also wanted the Police to take her into custody as she felt the hospital staff were not taking her seriously. The Police Communications Officer called the hospital directly, who said that they had the matter in hand.

14. The Charge Nurse of A&E reported that security came to him saying that there was a lady in the waiting area who was saying that she wanted to kill someone, and she was really distressed and shouting and screaming, and she was shaking and scratching her arms constantly. He called the Mental Health Liaison Nurse (MHLN) and asked him if he knew about the lady. The MHLN did know about her as he had had a referral from the

triage nurse. Both the A&E Charge Nurse and the MHLN were unaware of the circumstances preceding her arrival in A&E, and the fact that she had been brought there by police.

15. At 5:30 am Ms A was seen by the MHLN, who could not access her RiO (electronic) notes whilst assessing her in A&E as the RiO connection was not working properly, however he had looked at her RiO notes in Oxleas House (an acute psychiatric admission unit situated in the grounds of QEH), before he came to assess her.

16. The MHLN learned from this that she was known to the Bracton Centre and that she had killed her mother. He did not look at the care plan or community crisis plan before coming to assess her. He recorded that she told him that she had been feeling unwell and scared and paranoid.

17. Ms A reported that she had stopped taking both Sodium Valproate (mood stabiliser) and Quetiapine (anti-psychotic) for months. She talked about flashbacks of being abused as a child, and her concern that her children were being sexually abused in Jamaica. She also stated that she had used Skunk (a form of strong cannabis) recently. She appeared suspicious and wanted the assessment room door left open. The plan made by the MHLN was for Ms A to have an informal admission, and she was placed on level 2 (15 minute) observations while she waited to be escorted to Oxleas House.

18. Following a discussion with the duty psychiatrist (a GP trainee[3] who had just commenced this post as part of his rotation) the MHLN recorded the plan as: informal admission, with risks to self, harm to others and self neglect being marked "low", and substance misuse and forensic risk being marked "high" – the latter was said to be "based on the past". Ms A was placed on level 2 observations - stated within the s 'Safe and Therapeutic Observation Policy (2012)' as: 'patients on level two observations should be observed no less frequently than every fifteen minutes'.

19. The MHLN left the assessment room in A&E and went back to Oxleas House (several minutes' walk away) to type up his assessment. The Charge Nurse reported to the External Independent Investigation Panel that immediately after he left, Ms A came out of the assessment room and started shouting "when are they taking me to Oxleas, because I'm really unwell I need to be in Oxleas, you people don't understand". He further stated that she again ran off, and he and the security guard caught up with her, and together with the Triage Nurse, they got her back to A&E, from where she was then escorted, by a security guard and an A&E Nurse to Oxleas House.

20. Ms A was initially placed in the Mary Seacole Unit of Oxleas House whilst arrangements were made to admit her. Later Ms A asked if she could wait in the reception area. This was agreed to as she was deemed to be in sight of the night staff.

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[3] The duty Doctor was a GP trainee undertaking a placement within Oxleas House, under the usual rotation arrangements for trainee medical staff. His roles and responsibilities were those expected of a Junior Doctor in this post.

21. At 7.05 am Ms A suddenly pushed open the doors to the Unit to leave. She returned but left again at 7.06 am and this time she did not return. Ms A caught a bus to Bexleyheath, where she purchased a knife from a supermarket. Ms A then used the toilet in the supermarket to take the knife out of the wrapper, placing it in her bag.

21. Ms A then left the supermarket, and went to a bus stop where she attacked and attempted to stab Ms B. Ms B successfully fought off Ms A, who dropped the knife. Ms A then grabbed a knife from a butcher's shop situated near the attack, and ran off to a nearby memorial park, where she encountered and fatally stabbed Mrs Sally Hodkin with the knife. Mrs Sally Hodkin was pronounced dead at the scene.

22. On 7 February 2013, at the Central Criminal Court, Old Bailey, Ms A was convicted by the jury of murder and attempted murder. Ms A was sentenced on 4 March 2013 to life imprisonment with a minimum tariff of 37 years.

2. Pre-Investigation Risk Assessment

1. A risk rating[4] was carried out at the commencement of the Independent Investigation process using a framework which was first developed within the NHS Controls Assurance framework. Using this scoring system, risks can be allocated a score of between 1 and 25, with 1 reflecting negligible risk and 25 reflecting extreme risk. Table 1 sets out the framework.

2. The pre investigation risks were rated at 15. Ms A had killed her mother, using a knife. Given this history the potential likelihood of an incident occurring is set at 3 (possible), and the potential impact set at 5 (extremely high impact).

3. A post investigation Risk Assessment will be completed following the Independent Investigation process, to assess whether the risk score will change as a result of the Independent Investigation findings. This will take into account clinical and risk behaviour of Ms A during her time with the Mental Health Services.

Table 1 – NHS Controls Assurance Risk Scoring Methodology

Likelihood (the potential likelihood of the risk occurring)			**Impact** (the potential impact to individuals or the organisation of the risk
Almost	**5**	Multiplied by:	**5** Extremely
Likely	**4**		**4** Very High
Possible	**3**		**3** Medium
Unlikely	**2**		**2** Low
Rare	**1**		**1** Negligible

[4] NHS Controls Assurance Risk Scoring Methodology – NHS Litigation Authority 2008

3. Background and Context

1. Oxleas NHS Foundation Trust is an organisation that provides a wide range of integrated Mental Health Services. The Trust currently employs 3398 substantive staff equating to 2969 whole time equivalent posts. Their annual income is currently £204 million.

2. The Trust provides Mental Health Services to the London Boroughs of Bexley, Bromley and Greenwich, these include:

   - Mental Health Services for all age groups.
   - Learning Disability Services
   - Forensic Services
   - Psychology Services
   - Day Services
   - Support Groups

3. Within all Services there are a range of professionals – medical and nursing staff; social workers; occupational therapists; psychologists and support workers.

4 Terms of Reference

1. The terms of reference (Appendix 2) for the External Investigation set out the following:

4.1. Aim

1. The aim of the independent investigation is to evaluate the mental health care and treatment provided to Ms A, via the objectives set out in 4.2.

4.2. Objectives

1. A review of the Trust's internal investigation to assess the adequacy of its findings, recommendations and action plans
2. Reviewing the progress made by the Trust in implementing the action plan from the internal investigation
3. Involving the families of both Ms A and the victims as fully as is considered appropriate, in liaison with the police
4. A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident
5. An examination of the mental health services provided and a review of the relevant documents

6. An examination of admission processes and the security arrangements at Oxleas House for informal patients
7. The appropriateness and quality of assessments and care planning
8. The extent to which Ms A's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
9. Consider other such matters as the public interest may require
10. Complete an Independent Review report for presentation to NHS London within 26 weeks of commencing the investigation, and assist in the preparation of the report for publication

4.3. Key Questions and Actions

1. Was the Trust's internal investigation adequate in terms of its findings, recommendations and action plan?
2. What progress has been made by the Trust in implementing the action plan from the internal investigation?
3. Were the families of both Ms A and Mrs Sally Hodkin involved as fully as is considered appropriate, in liaison with the police?
4. Develop a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident.
5. What were the mental health services provided to Ms A and were documents in place?
6. What are the admission processes and the security arrangements at Oxleas House for informal patients and are they adequate?
7. Were the assessments and care planning of Ms A appropriate and of good quality?
8. Was A's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, and local operational policies?
9. Are there other matters of public interest which need to be considered?

4.4. Key Deliverables

1. The Independent Investigation Panel were required to deliver:

    1. a full Report;
    2. an Executive Summary;
    3. involvement of the Trust to consider findings and share recommendations;
    4. a presentation to NHS England (London);
    5. an up to date position on the Internal Investigation action plan;

4.5. Scope

1. The investigation will complete within 26 weeks of commencement

4.6. Investigation type and process

1. This is an External Independent Investigation conducted by a Panel of three members (section 4.9 details the panel members in terms of roles and experience).

2. At the outset of the Investigation the Panel met to agree their approach to the investigation in terms of data collection and analysis of that data.

3. A project plan was devised by the Chair of the Panel to ensure the Panel continued to operate within the terms of reference and the timeframe set out in section 4.2.

4. Approaches were agreed to ensure the development of findings based on fact and evidence. This included a review of Trust strategies, policies and procedures, information from other agencies, court statements, and Internal Investigation report. A list of documentation reviewed is set out in Appendix 4. This was triangulated by interviews with Trust staff, other agencies, Ms A and her family, Ms B and Mrs Sally Hodkin's family.

5. When this process was complete the Panel met to collectively review the evidence. Findings were developed against each element of the terms of reference. This process was underpinned by the application of the [5]Contributory Factors Classification framework.

6. The Panel, using the framework set by the [6]National Patient Safety Agency (NPSA) classified the findings into root or contributory causal factors.

7. The panel then developed the report following the [7]National Patient Safety Agency (NPSA) report writing framework.

8. An audit of the Internal Report using an audit tool that was originally developed in conjunction with a number of Mental Health Trusts in the North West of England, and subsequently developed further by Caring Solutions UK Ltd.

9. The findings from the audit tool were then brought together into a consolidated analysis of the Internal Report, from which a number of conclusions are drawn and recommendations made.

10. An audit of the Trust's action plan, using the Trust's evidence, (Appendix 3) was produced to address the recommendations made in the Internal Report, to assess if the action plan has captured all of its recommendations. The level of implementation was considered.

[5] The National Patient Safety Agency contributory factor classification system, based on the Vincent et al 1998 contributory factors framework (2009)

[6] Root Cause Analysis (RCA) is a structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it with a permanent fix rather than continuing to deal with the symptoms on an ongoing basis.

[7] National Patient Safety Agency (NPSA) guide to investigation report writing following a Root Cause Analysis of Patient Safety Incidents (2008)

11. A 50 page evidence trail was compiled from documentation, interviews, Internal Investigation statements, and Independent Investigation interview statements.

12. The [8]Salmon/Scott Principle was applied throughout the External investigation.

13. Given the outcome of Ms A's actions the Panel were very aware, during this process, of the potential [9]outcome bias. They ensured, during their time together that their decisions were based on fact and evidence, and not influenced by the known outcome.

14. The Panel are not police officers but they do see the role of the police officers as relevant to the circumstances of the case and their investigation. When police officers are exercising their powers under section 136 of the Mental Health Act they are making a decision in relation to the detention of a person who appears to be mentally disordered for the purpose of examination by a doctor/interview by an AMHP and the making by those professionals of any necessary arrangements for her treatment or care. For the conduct of future investigations consideration should be given as to how police expertise (or indeed that of other agencies where the context requires) is brought into the process in light of this. The comment regarding the exercise by the Police of the section 136 power in this Report focus on the nexus between how the Police and health staff work together at an operational level when a decision is being taken to both exercise or not to exercise the s.136 power. Conduct of the police other than in relation to that issue form part of the review cared out by the Independent Police Complaints Commission and does not form part of the Panel's investigation. The Panel acknowledges that it cannot duplicate the role of the IPCC.

4.7 Communication

1. The report will be presented to NHS England (London) for consideration and subsequent publication.

4.8 Investigation Commissioner

1. The Investigation has been commissioned by NHS England (London), in accordance with Department of Health Guidelines published by the Department of Health in circular

[8] There are six cardinal principles of fair procedure under the Tribunals and Inquiries Act 1921 devised by Lord Justice Salmon, who, in 1966, chaired a Royal Commission on Tribunals of Inquiry following dissatisfaction with procedural aspects of Lord Denning's inquiry into the Profumo affair.
[9] Outcome bias is the tendency to evaluate the quality of a decision based on the known outcome of that decision. If the result is good, we think the decision was good; if result is bad, we think that the decision was bad. Jakub Petrykawski

HSG (94) 27, “The discharge of mentally disordered people and their continuing care in the community”, and the updated paragraphs 33-6 issued in June 2005.

4.9 Independent Investigators

Panel member 1: Chair of the Panel

1. Pat Shirley is an RGN, RMN, DMS with significant knowledge of Mental Health Services and systems, having retired as an Executive Director of Nursing and Governance for a large Mental Health and Learning Disability Trust; a post which she held for 6 years.

2. Prior to that she has worked as a senior clinician and manager in both Inpatient and Community Mental Health settings. She has also taken part in several investigations, both as an individual investigator and as a panel member.

3. Since retiring Pat has completed four Independent Investigations into homicides by Mental Health Service Users; an 8 month fixed term part-time post as a Clinical Director for a Community NHS Service, to support its integration with a Mental Health Trust; two reviews of a NHS Trust Community Mental Health Service; a review of a patient death for a Mental Health Trust in London; two external investigations into staff grievances (1) sexual harassment (2) bullying and harassment.

Panel member 2:

1. Peter Green is a qualified psychiatric social worker and general manager with significant experience as a senior executive in local government, the National Health Service, the Mental Health Act Commission and latterly independent psychiatric hospital provision and consultancy.

2. Peter was the principal social worker at St. James’s University Teaching Hospital, Leeds and has worked in all three high security hospitals, as a senior practitioner at Rampton Hospital, working exclusively with women patients, the head of social work services at Broadmoor Hospital, and the Director of Rehabilitation and General Manager at Ashworth Hospital.

3. Peter has considerable expertise in the assessment of mentally disordered offenders and evaluation of service delivery. He has significantly aided the administration of two public inquiries, completed a thematic review for NHS London of 40 homicide cases committed by recipients of mental health services between 2002 and 2006, and has acted as the lead investigator for six independent investigations of homicide by patients in receipt of mental health services.

Panel member 3:

1. Dr Crystal Romilly is a Consultant Forensic Psychiatrist of 10 years' standing at the Shaftesbury Clinic Medium Secure Unit, which is part of South West London & St Georges' Mental Health NHS Trust. The first two years of her appointment was as In-reach Psychiatrist at HMP Wandsworth.

2. Since then she has worked with male and female medium secure patients, and community patients. She was acting Associate Medical Director of the Forensic Service in 2009. This is her second homicide inquiry. She did a degree in Economics at the LSE before studying Medicine as a graduate.

5. Level of investigation

1. The external Investigation is a level 3 Independent Investigation.

6. Involvement and support of Service User and Relatives, and Victim and Victim Relatives

1. Two members of the External Investigation Panel met with the family of Mrs Sally Hodkin on 8 July 2013 at an agreed location. The family raised questions which have been reflected in section 10.1 of the main report. The Chair of the External investigation Panel updated the family on the External Investigation panel process and timeline.

2. Two members of the Panel met with Ms B on 29 May 2013 at an NHS location. Ms B raised questions which have been reflected in section 10.1 of the main report. The Chair of the External investigation Panel updated Ms B on the External Investigation Panel process and timeline.

3. Ms A agreed to be interviewed and was interviewed at the Prison in which she is detained. The Consultant Psychiatrist on the External Independent Investigation led the interview. Ms A's father, brother, and sister, agreed to meet with the panel. Two members of the panel visited his father at his home. Ms A's brother and sister met with all three members of the panel at an agreed location.

7. Involvement and support provided to staff involved

1. Staff reported that following the incident they were very well supported. This included support for staff who attended the trial to give evidence.

8. Information and evidence gathered

1. Appendix 4 sets out the list of documentation used to gather evidence for the External Independent Investigation. A glossary of terms is set out in Appendix 6 of the main report. Other information was gathered by the following:

Face to face Interviews/Meetings

- 12 Oxleas NHS Foundation Trust staff interviews and 1 former staff member.
- 1 Oxleas NHS Foundation Trust Non Executive Director, also Chair of the Internal Investigation
- The Regional Director and the Support Worker for the organisation which managed the Supported Flats Scheme, where Ms A lived.
- Ms A's General Practitioner
- Ms A, Ms A's father, brother, and sister
- Ms A's current Psychiatric Nurse
- The A&E Charge Nurse, Queen Elizabeth Hospital
- Ms B, The surviving victim
- Mr C, the husband, and two adult sons of Mrs Sally Hodkin, the deceased victim

Telephone interviews

- Both the Group Operations Director and the Head of Operations, for Mental Health and Learning Disability Services for the organisation which managed the Supported Flats Scheme.
- The Multi-Agency Protection Public Arrangements[10] (MAPPA) Mental Health Advisor and Assistant Chief Officer for PD Strategy Implementation, London Probation Trust concerning current consultation on how mental health is integrated more fully to the MAPPA process.

Contact and discussion via the telephone

- The investigator for the Independent Police Complaints Commission Independent Investigation. Please Note: The External Independent Investigation Panel invited, but were unable to meet with the two Police officers who took Ms A to A&E due to a potential conflict as the Inquest into Mrs Sally Hodkin's death had not taken place at the time of the External Investigation. The Police, however, did helpfully provide statements from the two PCs involved.

Contact with the Ministry of Justice

- The External Independent Investigation Panel deliberated on the involvement of the Ministry of Justice within the investigation process, however, felt that on

[10] MAPPA – Multi Agency Public Protection Arrangements – Criminal Justice and Courts Service Act 2000

balance there was little they could add to the process, given that, in relation to Ms A, their instructions to the Bracton Centre had been clearly defined.

9. Findings – the Internal Investigation

9.1 Was the Trust's internal investigation adequate in terms of its findings, recommendations and action plan?

1. There were three main headings to the Internal Investigation's Terms of Reference, as follows:

    - *To investigate the circumstances which led to the decision to recommend Ms A's conditional discharge under section 41 of the Mental Health Act in 2009*
    - *To investigate the multi-agency care and treatment of Ms A from her conditional discharge in 2009 to the incidents on 10 October 2011*
    - *To investigate the care and treatment provided in the 72 hours prior to the incidents on 10 October 2011*

2. In relation to report presentation the External independent Investigation Panel notes:

    a. The internal report is clear, readable with a chronology which provides a sufficient overview.

    b. There is a logical connection between the facts which are set out.

    c. Clarity of roles, responsibilities, and boundaries between agencies and teams, was examined and recommendations made with regard to this.

    d. There are recommendations in the action plan to ensure learning.

3. In relation to the contents of the report, the external investigations finds the following:

    a. The internal investigation did not sufficiently address the Bracton Centre's lack of communication with Ms A's father which is relevant as he was in contact with her, was her Nearest Relative under the Mental Health Act, and could have provided additional information about her behaviour when she was in the community.

    b. The internal investigation does not address the Bracton Centre's relationship with the father, sister and brother. It is not clear if they were ever considered vulnerable by the Bracton Centre and/or by the Internal Investigation Panel. During the interview with Ms A's father, he stated that Ms A contacted him whilst she was going out with a man (also a former Bracton patient) who had said to her "your dad loves you, my Dad didn't love me, therefore I am going to kill your father". However the internal report does state that the relationship with her brother and sister should have been a relapse indicator.

c. While Ms A was in the community, she was twice given permission by the Ministry of Justice[11] (MoJ) to go to Jamaica to visit her sons. On the first occasion, her return was held up by the volcanic ash incident, and on the second by her mother-in-law's death. The internal investigation did not explore the reports by Ms A's husband of concerning behaviour during the first trip, nor make enquiries about the mother-in-law's death during her second visit. The External Independent Investigation will address this in section 10.5 of this report.

d. Ms A was conditionally discharged from the Bracton Centre on 29 September 2009. Prior to the Responsible Clinician's (RC)[12] application to the MoJ for a conditional discharge, Ms A had applied to the First Tier Tribunal for a review of her detention. Ms A withdrew the application in favour of her RC (Consultant Psychiatrist) applying to the Ministry of Justice. This process is not examined by the internal investigation. This is examined in section 10.5.

e. The content of the referral to MAPPA (though never sent off) was examined by the Internal Investigation and was deemed in their report to be set at an appropriate level. Discussion of the failure to forward the clinical team's referral for MAPPA consideration, implications of not doing so, and the current practice is considered in section 10.5

f. It is noted within the internal report that Ms A did not disclose her forensic history to her workplace. However this has not been developed as a finding. The Independent Investigation Panel considers whether the Bracton team should have made contact with the employer, bearing in mind that Ms A was a conditionally discharged restricted patient, and had there been communication with her workplace, it could have provided an insight into her behaviour whilst at work and under pressure. This is addressed in section 10.3

g. Police involvement was examined, and a comment is made inviting the Police to look at the issue of Section 136 of the Mental Health Act (1983). There is no action or recommendation which directs the Trust and the Police to work together to address this at a Borough level.

h. There is no evidence that training for the Mental Health Liaison Team based at QEH/Oxleas House was examined, in relation to risk assessment and management, and clinical observation.

i. It is documented in the Trust's Internal Investigation action plan as recommendation 9.1, that "there were gaps in the management of A following

[11] Restricted patients are mentally disordered offenders who are detained in hospital for treatment and who are subject to special controls by the Ministry of Justice due to the level of risk they pose. These controls include permission for community leave, transfer to another hospital, discharge and recall to hospital. The Mental Health Casework Section takes these decisions on behalf of the Justice Secretary.

[12] A Responsible Clinician is the Approved Clinician who has been given overall responsibility for a patient's case. Approved Clinicians who are allocated as Responsible Clinicians will undertake the majority of the function previously performed by Responsible Medical Officer (RMOs), which ended on the 2 November 2008.

her presenting in crisis", however the Internal Investigation does not raise as findings, or recommend reviews of clinical supervision and clinical leadership.

j. A robust anti-absconding policy was in place and procedure was followed in that the Duty Psychiatrist called the Police.

k. The report does not include all contributory factors. This is addressed in section 11 of this report.

l. The report does not sufficiently address the root causes of the incident. This is addressed in section 12.

m. Each recommendation within the Internal Investigation Report is underpinned by supporting evidence; however not all recommendations are SMART[13]. Recommendation 10.1.1 of the action plan (set out in Appendix 3) is an example of this:

> "The medical director to be asked to consider whether any patient presenting in Accident & Emergency in crisis with possible psychotic symptoms always should be discussed with the on call consultant/specialist registrar as to whether admission is appropriate".

n. The action plan does not have auditable goals set against each recommendation. This makes the action difficult to measure in terms of effective completion.

4. In relation to the process of the Internal Investigation, the External Independent Investigation finds the following:

a. The membership of the internal investigation panel had its first meeting on 21 October 2011, having confirmed terms of reference on the 19 October 2011. An Independent Consultant Forensic Psychiatrist, an elected Trust Governor and a Non executive Director were part of the panel, which added objectivity to the process.

b. On 24 October the Internal Investigation panel visited Oxleas House to ascertain where Ms A waited, in relation to the layout of the building, and the position of the external doors. They also spent time reviewing the doors - which would normally have been locked, but which Ms A managed to force open. It is noted that the doors were in place to manage people coming into Oxleas House, and were not intended to prevent people from leaving the building.

c. The final version of the report was signed off on Friday 5 of December, and the full report was presented to Oxleas NHS Foundation Trust Board in January

[13] Specific Measurable Realistic and Time Bound - *Management Review* by George T. Dorn

2012, with the action plan, developed from the recommendations, going to the full Board in February 2012.

d. It is positive that the investigation was completed within two months of its commencement; however one interviewee felt they did not have an opportunity to review the report in draft form.

e. The Housing Association accommodation service felt they were not initially as involved with the Internal Investigation process as they would have wished. They also felt there was little mention of them in the report. The Group Operations Director of the Housing Association wrote to the Chief Operating Officer of the Trust to express her concern in relation to their involvement in the internal review.

f. The Trust Chief Executive and Chair of the panel met with Mrs Sally Hodkin's family on 4 November2011 and on 16 December 2011. The latter being convened to discuss the internal investigation findings with the family. The Panel responded to their questions within the report.

g. The surviving victim Ms B did not wish to be involved at the time of the internal investigation.

h. The family of Ms A was not contacted at the time of the incident. Ms A's father found out about the incident from the television news. The Chair of the Internal Investigation felt that a stronger attempt could have been made to include them in the investigation process.

i. The A&E Charge Nurse was not interviewed as part of the internal investigation. This was a missed opportunity given that he and his team were involved when Ms A presented at A&E, before she was assessed by the Mental Health Liaison Nurse, and when she was awaiting transfer to Oxleas House.

j. The GPs who saw Ms A were not interviewed as part of the internal investigation, and yet they had information in relation to Ms A's stress factors, including negative pregnancy tests, which could have usefully fed into Ms A's management and relapse indicators. The GP practice was not made aware what the identified relapse indicators were.

k. The Trust's RiO health records were examined. The Internal Investigation was provided with a GP encounter report. One month's documentation from Ms A's supported accommodation was examined.

l. One notable practice was that shortly after the incident, the supported accommodation did a comprehensive investigation of all their other clients, in partnership with Oxleas Trust, to ensure there was no-one else at risk of relapse following the incident, and/or presenting a significant risk to themselves or others.

Conclusion to Section 9.1

1. The Panel for the Internal Investigation was formed quickly and included an Independent Consultant Forensic Psychiatrist, and elected Trust Governor and a Non-Executive Director. This added objectivity to the process.

2. The presentation of the report is clear with a logical connection between the facts set out.

3. Clarity of roles, responsibilities, and boundaries between agencies and teams, was examined and recommendations made with regard to this.

4. There are recommendations in the action plan to ensure learning.

5. There are several areas of poor communication which have not been sufficiently addressed, both within Ms A's clinical care, and as part of the process of the internal investigation – see table 2.

6. Risk assessment and management were addressed in part throughout the report, however there are gaps in exploring detail such as when Ms A visited Jamaica, her relationship with a male Bracton Centre patient, and relationships with men in the community.

7. A recommendation should have been developed for the Trust and the Police to review together the use of Section 136 of the Mental Health Act (1983)– see table 3

8. There is no evidence that training for the Mental Health Liaison Team was examined in relation to risk assessment, management and clinical observation.

9. The Internal Investigation findings stated that "there were gaps in the clinical management of Ms A in relation to risk assessment". However the internal investigation does not raise this as a finding, or recommend reviewing the effectiveness of clinical leadership and clinical supervision – see table 4.

10. The report does not include all contributory factors, or sufficiently address the root causes of the incident – this is addressed in sections 11 and 12.

11. Each recommendation within the Internal Investigation report is underpinned by supporting evidence; however not all recommendations are SMART – see table 5.

12. The action plan does not have auditable goals set against each recommendation. This makes the action difficult to measure in terms of effective completion – see table 6.

13. The Trust's Board had a presentation of the Report at their January 2012 Board meeting, indicating a tight timetable for implementation of agreed actions.

14. The Chief Executive and Panel chair met with the family to share the findings of the investigation. The Panel also responded to their questions in the internal report.

15. The surviving victim Ms B did not wish to be involved at the time of the internal investigation.

16. The family of Ms A was not contacted by the Internal Investigation Panel. The External independent Investigation Panel support the Internal Panel Chair's view that more effort could have been made to include them in the investigation process – see table 7.

17. Key people were not interviewed, namely the Charge Nurse for QEH A&E, and Ms A's General Practitioner. This opportunity to examine their firsthand experience of Ms A was missed.

18. One notable practice is that shortly after the incident, the accommodation service did a comprehensive review of all the other clients of the service, in partnership with Oxleas Trust, to ensure there was no-one else at risk of relapse following the incident, and/or presenting a significant risk to themselves or others.– see table 8.

Table 2: Section 9.1 – Service Delivery Problems

Service Delivery Problem
Trust Internal Investigations must ensure that they address communication with all key stakeholders. The Internal Investigation Panel did not fully review the communication with the family, and the Supported Accommodation staff.

Table 3: Section 9.1 – Service Delivery Problems

Service Delivery Problem
The circumstances of this case highlight the need for a process by which the police and other emergency services are able to conduct, on arrival, an appropriate handover of the patient with appropriate health professionals regardless of the manner through which crisis mental health care is sought.

Table 4: Section 9.1 – Service Delivery Problems

Table 4: Section 9.1 – Service Delivery Problems

Service Delivery Problem
Internal Investigations should recommend a review of clinical supervision and clinical leadership, when the Trust action plan makes recommendations in relation to the clinical management of a patient. There were some gaps in the clinical management of Ms A, and the internal investigation should have recommended a review of clinical leadership and management.

Table 5: Section 9.1 – Service Delivery Problems

Service Delivery Problem
Investigation reports should develop recommendations and actions which are clear, concise and SMART, with auditable goals. Each recommendation within the report is underpinned by supporting evidence; however, not all recommendations are SMART.

Table 6: Section 9.1 – Service Delivery Problems

Service Delivery Problem
There are no auditable goals set against each action in the action plan. The action plan does not have auditable goals set against each recommendation. This makes the action difficult to measure in terms of effective completion.

Table 7: Section 9.1 – Service Delivery Problems

Service Delivery Problem
Internal Investigations must demonstrate that they have tried to involve the families of both victims and perpetrator. Ms A's father and her siblings were not involved as part of the investigation process.

Table 8: Section 9.1 – Notable Practice

Shortly after the incident the accommodation service did a comprehensive investigation of their other clients in partnership with Oxleas Trust, with regard to risk assessment and management.

9.2 What progress has been made by the Trust in implementing the action plan from the internal investigation?

1. Staff were identified to implement specific areas within the action plan (Appendix 3). Evidence against each recommendation and action was supplied to the Independent Investigation Panel.

2. The monitoring of high level incidents is carried out by the Trust Board and the Trust's Patient Safety Group (PSG). Each Service Directorate also has a PSG where action plans are developed and monitored at a detailed level. Progress is reported to the Trust PSG and ultimately, for high level incidents, to the Trust Board.

3. The External Independent Investigation Panel was able to find evidence of progress against each recommendation and the panel was assured the action plan had been discussed and updated.

4. The measurement framework applied to Ms A's action plan is that applied by the National Health Service Litigation Authority (NHSLA)[14] which uses a set of risk management standards within Healthcare Organisations. These are set at 3 levels and the principle applied to each level can be applied to the action plan progress, as follows:

   - Level 1 Policy: evidence has been described and documented
   - Level 2 Practice: evidence has been described and documented and is in use
   - Level 3 Performance: evidence has been described, documented and is working across the whole organization.

5. Recommendation 9.1.4 states that 'the on call consultant/specialist registrar must immediately be contacted for advice following any out of hours contact to an Oxleas service by a patient known to have been discharged from the Bracton Centre. This will include patients who phone the Trust Urgent Advice line, who are assessed by the Mental Health Assessment & Liaison team in Accident & Emergency or who contact the Bracton Centre'. The External Independent Investigation Panel considers this action to place a large responsibility on these staff and would request the Trust to consider providing a specific on-call rota for the Forensic Service separate from main stream Mental Health.

6. The action from recommendation 9.2.2 was immediately addressed, and all other actions followed up within a short time frame.

7. The Mental Health Liaison Service is now situated within Queen Elizabeth Hospital (recommendation 10.1.3).

   The assessment room is still within A&E, but at the time of the Independent Investigation Panel's visit to A&E, the room decor was poor and furniture which had been ordered had not yet arrived, making the environment not conducive to calming down a patient in an agitated state.

8. Whilst the Mental Health Liaison Operational Policy has been revised to include recommendation 9.2.2 of the action plan, two interviewees confirmed to the Independent Investigation panel non-compliance with this recommendation. The recommendation states "where practicable, the mental health assessment and liaison nurse should remain with the patient and transfer the patient, accompanied by the security guard from Accident and Emergency, directly onto the ward".

[14] The National Health Service Litigation Authority has developed a risk assessment framework underpinned by a range of NHSLA standards and assessments. Most Healthcare organisations are regularly assessed against these risk management standards

9. The action for Recommendation 9.1.2 refers to an Operational Policy in relation to the Bracton Centre; however there is no specific Operational Policy for the Bracton Centre. The Forensic Service Directorate have Working Practice Manuals which have been developed for each specific Forensic Service. One of the protocols developed within the Working Practice Manual for the Bracton Centre is the Role of the Unit Coordinator. This has been updated to include recommendation 9.1.2. Their role will be to ensure that when a former patient of the Bracton Centre contacts the Centre in crisis, they record the contact immediately in the patient's RiO record notes, and alert the Mental Health Liaison Service as to the nature of the contact.

10. Recommendation 9.2.2 is clearly stated in the text of the Operational Policy for the Mental Health Liaison Service. It is not described accurately in appendices 5 & 6 of the Operational Policy which sets out the care pathway and admission process following a Mental Health Liaison assessment with a decision to admit.

11. The Deputy Chief Executive, Medical Director and Trust Clinical Patient Safety lead have visited services, given presentations and discussed the action plan with staff in the visited services. The Chief Executive has also met face to face with each Crisis and Home Treatment Team.

Conclusion to Section 9.2

The conclusion to section 9.2 is as follows:

1. All actions and recommendations are being worked through, using the NHSLA framework, to comply with either level 1, 2 or level 3. Some actions were taken either immediately or shortly after the incident.

2. There is a clear process for developing, monitoring and reporting the progress of an action plan that develops from a serious incident, extending from Service Directorate level to the Trust Board.

3. There is evidence of non-compliance with recommendation 9.2.2 which the Trust must address – see table 9

Table 9: Section 9.2 – Care Delivery Problems

Care Delivery Problem
There is evidence of non-compliance with the Operational Policy for the Mental Health Liaison Service The action plan states that where possible the mental health assessment and liaison nurse should remain with the patient following a decision to admit, and transfer the patient to a ward within Oxleas House. This was said not to be happening by 2 interviewees.

9.3 Were the families of both Ms A and Mrs Sally Hodkin involved as fully as is considered appropriate in liaison with the police?

This section will cover the involvement of the families of Mrs Sally Hodkin, and Ms A, following the tragic incident, in relation to the Internal Investigation.

Mrs Sally Hodkin's family

1. Following the tragic incident, the Trust Chief Executive and Internal Investigation Panel Chair, met with the family on 4 November 2011 and again on 16 December 2011 at a place of the family's choosing. They went through the terms of reference for the Internal Investigation and the family asked for a number of issues to be addressed, these are as follows:

   - Confirmation of whether two Consultant Psychiatrists recommended Ms A's conditional discharge, and their names. The Internal Investigation response was to explain that only one recommendation was required to request that the Ministry of Justice considers a patient for conditional discharge.
   - Why was Ms A not transferred to prison in 2009, once her mental health had improved to the position where she could be conditionally discharged? The Internal Investigation response was that following Ms A's index offence, her case on a finding of guilt was disposed of by the Court using section 37/41 of the Mental Health Act 1983.
   - Were Ms A's drug screenings during her period of conditional discharge always negative, and did tests include non class A drugs? The Internal Investigation Trust response was that Ms A was subject to random drug screening including screening for non class A drugs such as cannabis, and all screening results were negative.
   - Had Ms A coped well with her employment, and had she shown any signs of difficulty? The Internal Investigation response was that the Bracton care team had not had direct contact with her employer. Ms A had not raised any concerns that were known about by the care team.

2. The Internal Investigation Panel met the family again on 16 December 2011 to go through the report, and also to address the questions raised by the family. The family received a copy of the report following this meeting.

Ms B – surviving victim

1. An offer was made by the Internal Panel to meet with Ms B and her family, but this was not taken up at the time of writing their report.

2. The Chief Executive, the Chair of the Internal Investigation Panel and the Patient Safety lead met with Ms B at her request on 13 March 2012, after the trial. Ms B has seen a copy of the Internal Investigation report.

Ms A's family

1. The family of Ms A was not invited to contribute to the Internal Investigation. The Internal Investigation Panel discussed this, and felt that there would not be a lot of benefit to the process given that Ms A did not have a close relationship with her family.

2. During his interview with the External Independent Investigation Panel, the Chair of the Internal Investigation reflected that he would want to revisit whether the Panel should have made a strong attempt to get Ms A's family linked in to the investigation.

3. The External Independent investigation Panel found that Ms A did have a relationship with her father, and in fact he had stayed in her flat several times and Ms A had stayed with him. Her father and his Russian wife had also spent time with her in Greenwich. Ms A reported a good relationship with her stepmother. Despite some contact being turbulent, their relationship survived, albeit on a tentative basis. It is unfortunate that Ms A's father found out about the incident from the television news. He had not been contacted by the Trust, though they had his number, or the Police, at the time of hearing the news.

10 Findings – the Independent Investigation

10.1 Were the families of both Ms A and Mrs Sally Hodkin involved as fully as is considered appropriate in liaison with the police?

This section will cover the involvement of the families of Mrs Sally Hodkin, and Ms A, following the tragic incident, in relation to the Independent Investigation.

Mrs Sally Hodkin's Family

1. Two members of the External Investigation Panel met with the family on 8 July 2013 at an agreed location. The family raised the following questions which will be addressed within the report, as follows:

    - What was the Greenwich Crisis Line – did she use it and what is it? The Panel was able to answer this shortly after the meeting, that it is the number for the Greenwich Home Treatment Team and the Mental Health Liaison Team in Accident and Emergency at QEH.

    - Why were the RiO notes not available in A&E?

    - What training is given to staff that access RiO?

    - There were several questions relating to MAPPA, - why did the Police not check Ms A's MAPPA status, and concerning the use of MAPPA by the Trust, and the MAPPA level which applied to Ms A?.

    - What was the understanding of staff in relation to the front doors at Oxleas House? Was it to keep people in? The Panel was able to say at the meeting, that the door was not there to keep people in, as it is a public seating area.

    - The Ministry of Justice – do they just rubber stamp requests for discharge with conditions?

    - Was her clinical diagnosis right – this was challenged in Court?

    - Were the local Police involved when she was released?

    - Why were there no random visits done to her home?

    - Her employer was not aware of her history – should they have been made aware?

    - How suitable was it for Ms A to have a job as a telephone sales person when she was subjected to constant rejection on the telephone?

- The Facebook message from her brother, and the Social Worker's comment "don't worry about it we can talk about it later" – is this ok?

- What is the cut off point for someone who has a mental illness, is on conditional discharge, and unwell in the community – when are they recalled?

2. The Independent Investigation Panel sent the family a copy of the high level notes made at the meeting and received their response.

Meeting with Ms B

1. Two members of the Panel met with Ms B on 29 May 2013 at an NHS location. Ms B had the following questions for the panel which will be addressed within the report:

    - Was Ms A "deranged" – she seemed very angry when she attacked her, and very aware of what she was doing?

    - Only one doctor was necessary to sign off Ms A to say that she is okay – how is this doctor informed?

    - Oxleas reports describes Ms A as a model patient – was she misdiagnosed? – how did she recover so quickly?

    - Why was there no condition about her not contacting her family?

    - How was the drug testing effective if Ms A knew it was going to be done? – the last one was carried out in the August before the incident

    - During the trial, the prosecution said that Ms A had not come to terms with killing her mother – had she accepted responsibility for killing her mother?

2. The Independent Investigation Panel sent Ms B a copy of the high level notes made at the meeting.

Ms A's family

1. The External Independent Panel met with Ms A's father on 9 July 2013 at his home, and with Ms A's brother and sister on 19 August 2013 at a location of their choice.

2. Ms A's father offered the following observations in relation to her care:

    - When Ms A was discharged, Mr A felt it was all a bit of a mess. "It seemed like there was no coordination". The Social Worker never called him once, although they knew that he was in touch with her – he felt that they should have called him to get his views.

- The father came to the UK for his daughter's first trial, and went to see her at the Bracton Centre – he met with the Psychiatrist and also kept in touch with the Social Worker whilst she was in the Bracton. This was at his instigation.

- He saw Ms A from time to time while she was an inpatient at the Bracton Centre as she was there for 3 years. Towards the end of her stay she was allowed out with him.

- When Ms A applied for a First Tier Tribunal, her lawyer asked him to write a letter on her behalf which he did. Ms A decided not to go ahead with her appeal, having been persuaded by her clinical team to wait, as they had decided conditional discharge agreed by the MoJ would be a positive endorsement of her progress.

- He felt it would have been better if she had gone to 24 hour supported accommodation following her discharge from the Bracton Centre.

- He stated that he met with her employer after the event; the employer said that he did not know why they were not informed of her previous history.

- The father explained that he found out Ms A had carried out the incident from the television. Later he got a call from the Police. At no time did the Bracton Centre contact him.

- He thought that the people who were supervising his daughter were following her, rather than leading her. There was always a heightened sense of anxiety around her, and when he heard of the incident on 10 October 2011, he wondered if his daughter was responsible.

- He knew that when Ms A was thought to be pregnant she was taken off a mood stabiliser, and not put back on it subsequently. He wondered if this was a problem.

- He feels there were so many instances along the way before that day when she could have been stopped, and that she needed someone to make sure she was taking her medication.

Ms A's brother and sister

1. Ms A's brother and sister offered these observations:

    - Both first learned about the incident when their father called them.

- No one from the Trust attempted to contact them when the Internal Investigation was in progress.

- Her sister stated that Ms A's Social Worker did not take any history from the family, and that she was only able to speak with her by getting her telephone number from her father. The sister also informed the Panel that "both she and their mother almost anticipated she would be killed by A".

- Ms A's sister stated that when Ms A was in the Bracton Centre, it was the calmest they had ever seen her; she wanted Ms A to stay in the Centre but felt she wasn't listened to by the staff. She explained that whilst their mother was the first person that Ms A had killed, it was not the first episode of violence towards her mother. She further stated that she spoke to the Social Worker and said that Ms A would do the same to someone else.

- Her sister attended a few meetings with Ms A, the Associate Specialist in Psychiatry, and the Social Worker, towards the end of her sister's time at the Bracton Centre, but when she realised that the team was not going to change their minds about her discharge, she stopped attending.

- Her sister also stated that she had felt safe seeing Ms A at the Bracton Centre, but wouldn't have felt safe seeing her in the community. The Care Team seem to have viewed the sessions as family therapy when really she wanted to find out more about what the team's plans were regarding her sister.

- Both feel that the conditional discharge was not talked through with them, and said that there was no contact from the Bracton Centre to say that Ms A was being conditionally discharged.

- Their observation of Ms A was that she was "very smart at reading people", and if you gave her enough time she would "become the person you wanted her to be". Both felt that she was very good at working the system and people.

- When Ms A contacted her brother via the social networking site shortly before the incident saying that she was missing mum, he contacted the Bracton Centre as he was very concerned. He and Ms A had not been in communication since she killed their mother. He reported that the Bracton Centre told him that if he was concerned, he should phone the Police. Subsequently he was so concerned after the significant publicity surrounding his sister's killing of Mrs Sally Hodkin that he has since changed his name by deed poll.

- Her sister spoke about Ms A's husband (now living in Jamaica), saying "Whilst he spoke slowly you could understand him. He always cared about her (Ms A) and if he told you things about her, you would believe him" (this will be addressed in section 10.5.)

- Ms A's brother and sister have been very severely affected both by Ms A's original index offence of killing their mother, and the subsequent homicide, and have sought counselling and support.

Conclusion to Section 10.1:

1. The family of Mrs Sally Hodkin, and the surviving victim, were given an opportunity to contribute to the Internal Investigation and were offered support from the Trust.

2. The family of Ms A was not given an opportunity to contribute to the Internal Investigation. This was a missed opportunity by the Internal Investigation to ascertain their views, which if taken up, may have led to more detailed exploration of the clinical team's communication with significant others, and its possible implications for the risk assessment and management of Ms A.

3. The family of Ms A was not offered support from the Trust following this incident, although they have been very severely affected by what has happened.

4. There was a missed opportunity by the Bracton Centre Care Team to seek collateral information about Ms A's history and behaviour from family members. This will be addressed in section 10.5.

10.2 Develop a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident

1. The chronology is set out as Appendix 5 of this report. It informs the panel's findings in terms of care and service delivery problems. It addresses Ms A's early life up to and including:

   - Sentencing Remarks by the Recorder of London in the Central Criminal Court (4 March 2013)

   - March 2013. IPCC Commissioner's Report made available: 'Investigation into the police contact with Ms A prior to her fatally stabbing Mrs Sally Hodkin. (4 March 2013)

   - A daily newspaper article was published in which Ms A's brother's account was given of how he was referred to as 'It' by his sister. (16 March 2013)

10.3 What were the mental health services provided to Ms A and were documents in place?

This section covers three distinct Mental Health services within the Trust and makes reference to the Section 136 suite at Oxleas House. The services are:

10.3.1 The Bracton Centre – Forensic Inpatient Service and Forensic Community Team
10.3.2 The Mental Health Liaison Service at QEH, Woolwich
10.3.3 Oxleas House, acute psychiatric admissions unit, on the same site as QEH, Woolwich

10.3.1 <u>The Bracton Centre Forensic Inpatient Service and Community Follow up</u>

1. The Bracton Centre (Campus) provides a range of specialist forensic mental health services for people aged 18 and over, living in the Boroughs of Bromley, Bexley, Greenwich, and Lewisham, and other Boroughs when requested. The centre offers assessment, treatment and rehabilitation, and has the following units providing 24 hour services:

   - **Danson Clinic:** A 17 bed unit within a medium secure setting which provides rehabilitation services for male service users with longer term needs, from the above Boroughs.
   - **Burgess Clinic and Crofton clinic:** 16 bed units within a medium secure setting for assessment and treatment of male service users.
   - **Heath Clinic:** A 16 bed low secure unit for women with challenging behaviour.
   - **Joydens Unit:** A specialist medium secure service for 13 women.
   - **Birchwood pre-discharge service:** These are cottages within the Bracton campus which enables 12 people to be cared for in self-contained accommodation.

2. There is a range of clinicians who work within the Bracton Centre, and as part of the Forensic Community Team. These include Psychiatrists from Consultant level downwards, Psychologists, Occupational Therapists, Social Workers, and Nursing staff.

3. Whilst the chronology (Appendix 5) sets out in detail Ms A's presentation during her time in the Bracton Centre, some key highlights are noted in this section.

   a. Following the fatal stabbing of her mother on 4 November 2005, and Ms A's subsequent remand into custody, Ms A was assessed by the prison in-reach psychiatry team who recorded that no evidence of mental illness was found.

b. The Consultant Forensic Psychiatrist who assessed Ms A on behalf of the Bracton Clinic (on 13 December 2005) that there was some evidence that Ms A was "suffering from a mental illness as evidenced by her over-valued or delusional ideas in relation to her ex-boyfriend and family members, and the apparent deterioration in her social and occupational functioning in the weeks leading up to the alleged index offence" (in November 2005). He felt she would benefit from a period of assessment in medium security.

c. Ms A had a further psychiatric assessment on 8 December 2005, and was transferred from prison to the Bracton Centre on 14 February 2006, under Section 48/49* of the Mental Health Act 1983. *Section 48/49 MHA 1983 is the Section used to transfer remanded/unconvicted and unsentenced prisoners to psychiatric hospital.

d. The internal inquiry described Ms A's diagnosis as "schizophrenia with a prominent mood component, complicated by emotionally unstable personality traits and a history of substance misuse", which is the formulation given by the Bracton Associate Specialist in a report for the solicitors in May 2006. At other times in her records, the diagnosis is variously given as paranoid schizophrenia with a prominent mood component, and schizoaffective disorder.

e. The External Independent Panel understands that the clinical team's working diagnosis of Ms A lay between Paranoid Schizophrenia with a strong mood component and Schizoaffective disorder, and that she was not diagnosed with a personality disorder.

f. As part of her detailed assessment within the Bracton Centre, Ms A was assessed by a Clinical Psychologist and on 19 July 2006 a report, using the [15]Millon Clinical Multiaxial Inventory, suggested that Ms A 'is trying to present herself in a good light and may be minimising any psychological difficulties'. The report went on further to state that "this type of profile highlights a need for attention and conspicuousness and describes people who tend to be 'vivacious histrionic' individuals who believe they are special and may view themselves as being special". From the clinical personality patterns, A obtained significantly elevated scores on the histrionic and narcissistic scales, and a slightly elevated score on the compulsive scale. This pattern may describe people who often exaggerate their own abilities, constructing rationalisations to inflate their own self-worth, and belittling others who refuse to enhance the image they try to project. The Clinical Psychologist wrote further that "individuals with this profile tend to make good first impressions because they are able to express their feelings. These individuals are often perceived to be friendly and helpful. Furthermore individuals with histrionic and narcissistic elements have been found to have good coping skills although they are bored easily and lack self-definition when they are alone".

[15] This is a self report instrument used for clinical assessment and diagnostic screening of individuals who evidence problematic emotional and interpersonal problems. It assesses the extent to which the individual has problematic personality styles

g. A mental state examination conducted by a Forensic Psychiatrist preparing a report for the Crown Prosecution Service after she fatally stabbed her mother, indicated that “it is likely that when psychiatrists assessed her in the past.... she was able to hide her symptoms for the duration of the assessment interviews”, and concluded that “an acute psychotic episode of schizophrenia was present” and that she also had some “emotionally unstable personality traits”. In conclusion, she recommended that Ms A would require a long period of time in a secure hospital environment for further treatment, risk assessment, and long-term rehabilitation.

h. On 23 October 2006 Ms A appeared at Lewes Crown Court and pleaded guilty to Manslaughter on the grounds of diminished responsibility. Ms A was sentenced under Section 37/41 of the Mental Health Act 1983 and returned to the Bracton Centre. The Section 41 restriction order was without limit of time.

i. The Annual Statutory Report covering the time period April 2007 to March 2008 noted: “She is currently denying any memory of the index offence, having monthly visits from her son who was in care and is soon to move to Jamaica to live with his brother and stepfather. There is no contact from her siblings and her father is currently living in Cyprus, remains in contact and is the main support from outside the hospital. Recently her brother in law was shot dead and she was unable to attend the funeral. She was asked to leave the AA meeting as she was disruptive, believing she will soon be released as she is well and ‘high functioning’, has little insight to the offence and therefore the duration of her treatment and is fixated on making fast progress to discharge”.

j. On 24 May 2007 a letter was sent from the Bracton Centre to the Mental Health Unit (MHU), Ministry of Justice (MoJ), clarifying their escorted leave request. “Generally we have been very satisfied with Ms A’s progress since October 2006 and particularly during the last four months when not only has she remained very settled in her mental state but has also been demonstrating a striking co-operation and willingness to participate in all treatment and rehabilitation”.

k. The letter further stated “She has been fully compliant with all prescribed medication which has remained unchanged. It proved to be effective treatment and helped Ms A to reach her current level of stability. In conclusion, our multidisciplinary team are very satisfied with her progress, compliance and motivation to remain well. At the present time we are less concerned about her faking progress, but instead we see true change”. This does not reflect the demanding behaviour of Ms A as seen in her chronology.

l. By July 2007 Ms A had been given escorted leave. On 10 July 2007 there was a [16]Care Programme Approach (CPA) meeting, at which it was stated that "Her narcissistic, attacking, defensive presentation has gradually developed. Her powerful pushing attempts to persuade that she is doing exceptionally well keep her in denial. She is not appropriate in public when on leave – very critical, bullying, making others feel uncomfortable. There is remaining denial in relation to her index offence, loss of mother. Her mental state changed around the time of her child's court case which decided her son will be allowed to live with his father (in Jamaica)".

m. In November 2007 Ms A was asked if she would move temporarily to the Cottage – a unit within the Bracton Centre for more independent living - for a trial period. It is recorded that this was done as an emergency as a patient in the cottage needed to be moved back to Joydens Unit. If successful she would be able to move permanently. The External Independent Panel is concerned about the appropriateness of this decision, given that A was still exhibiting confrontational and difficult to manage behaviour.

n. On 16 November 2007 Ms A was commenced on Sodium Valproate, a mood stabiliser. By January 2008 there was no change in Ms A's mental state and her Sodium Valproate was increased in strength.

o. On 12 February 2008 there was another CPA Meeting. Ms A wanted to get in touch with her brother and was keen to hear about her brother via her father. She had completed three periods of leave with her father which went well.

p. The Annual Statutory Report 2007 - 2008 stated "There has been improvement in her mood stability since Sodium Valproate was added to her treatment. Her insight as well as her ability to relate to members of staff and to other patients is improving. Being a high profile patient her case is very sensitive and complicated. Faced with the issues of the index offence does create a high level of anxiety in everyone, including the general public. Ms A's traumatic experience would require years of therapy and support. We are aware of her history of disguising and dissimulating symptoms of her mental illness".

q. In November 2008 it was noted that "There were some concerns in relation to changes in her mental state during the last few days. Increased impatience, more argumentative, critical of others, less tolerant, mood instability. This may relate to her recent change in medication – reduction of Sodium Valproate by 100mgs last week".

r. The Social Circumstances Report dated 15 January 2009 prepared for a First Tier Tribunal, noted that Ms A was nervous about moving to an environment

[16] DoH Guidance; Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach 1999

where she would be alone at night but that she had good self care and was very compliant with medication and treatment, and was prepared to be open with the team about her needs.

s. The report concluded that she should be placed in supported accommodation rather than a 24 hour staffed hostel or care home. This will be discussed in section 10.5.

t. Ms A met with her allocated Community Psychiatric Nurse (CPN) on 17 March 2009.

u. Ms A had a Tribunal booked for 24 March, which she cancelled, in favour of the team requesting conditional discharge from the MoJ. This will be addressed in section 10.6.

v. On the 26 March the Social Worker, and the Associate Specialist in Forensic Psychiatry, met with Ms A's sister at her request. Following this meeting, the sister agreed to go ahead with supported contact with Ms A at the Bracton Centre.

w. On the 16 April Ms A had an interview with the staff from the proposed supported accommodation, with a view to her having overnight leave there if she was accepted. The team's intention was to request conditional discharge from the Ministry of Justice (MoJ), rather than Ms A obtain conditional discharge via the Tribunal, (although Ms A was aware of her rights to appeal to the Tribunal).

x. Ms A and her sister met on 24 April 2009 (for the first time since A had killed their mother). It was agreed that they would commence 'family therapy' and the next meeting took place on 1st May 2009.

y. It was documented after the session that her sister would not want to see Ms A in the community without support. Ms A's sister attended at least 3 further meetings before A was conditionally discharged from the Bracton Centre.

z. In May 2009 Ms A was accompanied by her Social Worker to view a flat which had a support worker present some days of the week, but was not staffed 24 hours. The decision not to consider 24 hour supported accommodation following discharge will be addressed in section 10.5.

aa. On the 2 June 2009 a CPA review was carried out, and it was noted by the Responsible Clinician "there is a concern that we are unaware of what Ms A does when she is on leave. She has leave until late at night sometimes and it is unclear what she does and how she uses this leave and who she sees or speaks to. She has a lot of leave outside the Bracton Centre and we need really to know what is happening in the community to contain her". Also stated within the notes was that

"Ms A was very frightened of becoming ill again". Her allocated CPN was not present at this meeting and no reason was noted.

bb. On 15 July Ms A was escorted by her CPN to the supported accommodation to sign the tenancy agreement.

cc. In July the CPN wrote to the care team regarding referral to MAPPA stating that "Ms A would obviously fit the criteria for violent mentally disordered offenders even if they decide she does not warrant active MAPPA follow up due to the framework which she will be subject to".

dd. On 28 September 2009 a MAPPA referral form was completed by the Social Worker (Ms A's Social Supervisor). This will be addressed further in section 10.5.

ee. On the 14 September 2009 the MoJ issued the following conditions for Ms A's conditional discharge under section 41 of MHA 1983:

- The patient shall reside at the address named in the conditions.
- The patient shall continue to be compliant with medication.
- The patient shall attend outpatient appointments when requested to do so by her care team.
- The patient shall be subject to regular urinary drug screening and alcohol screening as required by her care team.
- The patient shall not enter the exclusion zone without her care team's permission (This was the area where her mother's long standing partner lived).
- The patient shall comply with therapeutic activities in hospital and elsewhere as determined by the responsible clinician.

ff. On 22 September 2009 a Section 117 discharge meeting was held which Ms A attended. The Consultant Psychiatrist explained to her that she was subject to recall, and a major relapse of illness was not required for recall. Furthermore the seriousness of the index offence meant that the team had an obligation to inform the MoJ if they had any concerns. It was explained that the threshold for panic would be much lower than when she was on the ward. This was explained to Ms A clearly and in detail. Ms A was also informed about unannounced home visits.

gg. Ms A's conditional discharge date was set for the 28 September 2009. It was agreed that Ms A's CPN would visit weekly and supply her medication weekly, her Social Supervisor would visit weekly initially, and then reduce to fortnightly, and Ms A would see the Consultant Psychiatrist monthly. On 29 September 2009 Ms A was **c**onditionally discharged to the Housing Association flat. The contingency plan for Ms A as documented was:

- To have the CPN's mobile number.
- If there are concerns to arrange urgent medical review.
- Emergency acute admission via Home Treatment Team or by presentation to Oxleas House.
- To be given the crisis line number to the bed manager

hh. Five weeks later on 3 November 2009, there was a telephone call to Ms A's Social Supervisor from the Support Worker at the flats. The other tenants were expressing concerns as they had heard a disturbance in the early hours from Ms A's flat - crashing and banging, and someone saying, 'you're hurting me'.

ii. Ms A denied to her Social Supervisor any knowledge of a disturbance in her flat, suggesting that it was her washing machine. The CPN received the same response three days later.

jj. On 10 November 2009 Ms A had a confrontation with a train ticket inspector who had taken her Freedom Pass from her, as she was sitting in a first class compartment, and had refused to give her name or address, and was allegedly rude to him. She told her CPN "I wasn't rude, just sticking up for myself".

kk. On 16 December 2009, a CPA Review was held. The CPA notes of the meeting do not refer to the concerns raised by the tenants, or the confrontation with the ticket inspector. Ms A requested a two week trip to Jamaica to see her children. It was agreed that the Social Supervisor would approach the MoJ regarding this. It was noted that Ms A's sister had not attended any further meetings. Her sister's concerns about having only supported contact with Ms A were not raised at this meeting. This review will be discussed further in section 10.5.

ll. On 4 January 2010 the Social Supervisor completed a report on Ms A to the MoJ. In it she stated that "Her family has not been as supportive as expected and this has upset her on occasions. She arranged to spend Christmas with her father and went to a great deal of effort to make the time happy and was generous with food and presents.

mm. Unfortunately her father did not appreciate her efforts and became critical and verbally hurtful about her index offence". Also stated was "the previously positive relationship Ms A has had with her father has undergone a worrying change since Christmas which appears to be more as a result of her father's difficulties in settling in the UK. Ms A's manner and concern for her father has been consistent and full of warmth". The care team did not seek the father's account.

nn. When Ms A's father was interviewed by members of the External Independent Investigation Panel, he stated that when he arrived on Christmas Eve, A told him she was going out with a boyfriend for the night (someone she had met the night

before). This caused the argument, and she, unknown to her father, called the police, and when they arrived she told him to leave. This meant he had to travel back home late on Christmas Eve. Ms A phoned him the next day to apologise, and he travelled back to her flat and they spent the rest of Christmas day together.

oo. On 3 March 2010 a CPA Review took place, attended by Ms A's CPN, her Social Supervisor, and the Support Worker from the supported accommodation. As part of the CPA, Ms A's relapse indicators were reviewed. The Consultant Psychiatrist felt that "any likely early changes in A's mental health are unlikely to be marked but rather the quality of her interactions may appear less warm or sensitive to the needs of others". The dates for her trip to Jamaica were noted as March 31 to 20 April. The contingency plan noted that "there should be a low threshold for admission given the seriousness of the index offence...it is also known A was seen by a psychiatrist in the weeks before the offence and not thought to be psychiatrically unwell....this would appear Ms A can mask emerging symptoms of her illness".

pp. It was further noted that all tenants in Ms A's accommodation had access to an emergency number for the housing association, and Ms A had the local out of hours mental health team's emergency numbers, or could attend A&E at Queen Elizabeth Hospital.

qq. On 22 March 2010 a letter from the Casework Manager at the MoJ to the Bracton Centre stated "As you are aware the Secretary of State cannot prevent a patient travelling outside the UK, though he can raise objections to it. Additionally, we would normally only agree to a trip abroad after a patient had been in the community for at least twelve months. However, I accept that there are exceptional circumstances in this case and the trip has the support of the Family Court. Please provide me with a short note on her return and notify me immediately should there be any concerns". Ms A went to Jamaica as planned.

rr. On 12th April 2010 the CPN noted that "there was a telephone call from A's husband to my mobile. It was very hard to understand as he has a stammer and a very strong accent. I put the call on loud speaker so that colleagues may share the call in an attempt to understand what he was saying. I was able to pick out some words like "she's not listening to me ", "she drinking a whole heap", "she take a knife to me".

ss. The Social Supervisor had received a text at the weekend from A which did not express any worries or indicate concern. I rang the Supervising Psychiatrist's secretary and she had received a phone call from the local authority Social Services as the social worker wanted to discuss her concerns". A's husband had called her as she was A's older son's social worker before he left for Jamaica". He had told Social Services that:

- Ms A was trying to get the children to eat more than they usually do.

- He said that she had been drinking and was behaving outrageously.
- She had picked up a knife and had threatened to kill him.
- She had been accusing him of having sex with his cousins and nieces.
- He was asked if she was taking her medication and she said she had but he was not sure.

tt. The social worker advised him to call the police to have her removed from the family home if he was concerned about her behaviour or risks. It is stated in Ms A's notes that "the social worker was able to have a better understanding of what he was saying and said she would be happy to telephone him again on our behalf". The Social Supervisor telephoned Ms A and noted "I did not say that he had said she threatened him with a knife as I sensed that she was worried about her husband having phoned us and what this might mean".

uu. The care team kept in contact with Ms A for the remainder of her visit and there was no further concern expressed. Whilst Ms A admitted to drinking alcohol in Jamaica, she also stated that she was concerned about her husband's behaviour and the relationship difficulties between them. There is nothing in the Oxleas documentation to suggest that the Casework Manager from the MoJ was contacted immediately, as had been requested if there were concerns.

vv. In a report to the MoJ dated 22 April 2010, her Social Supervisor stated "Patient does not drink alcohol in Britain. On Saturday 10 April she acknowledged she had drunk two Pernods at a party with her husband. A's husband tried to persuade her to be intimate with him, but she declined. This led to an argument at the friend's party. (A had met a male partner in the UK. The Social Supervisor had been introduced to him on 31 March, he is 21 and mature for his years, a devout Christian attending church weekly). Her husband rang the CPN to say that A would not listen to him".

ww. In the section requesting a brief description of the patient's mental health it was reported that "Her mental state has been stable and she has managed many family and relationship issues with equilibrium".

xx. Ms A was unable to return home at the appointed time because of the Volcanic Ash crisis, and seemed unlikely to get a flight home before 5 May. The Social Supervisor was in contact with the British High Commissioner's office as was Ms A. There was concern about her running out of medication (she had enough anti-psychotic medication to last until 5 May 2010, but her Sodium Valproate would run out on 29 April 2010). The team kept in daily touch with Ms A, and she in fact returned to England on 26 April.

yy. On 11 May 2010 the Consultant Psychiatrist visited Ms A at home, and recorded in the notes "There was no evidence that Ms A had threatened her husband referring to a knife. Ms A reminded me that this had happened on a visit several

years ago when she was unwell. On that occasion she had an argument with her husband and picked up a kitchen knife on leaving the house. She went to a friend who ran a bar who supported her and advised her not to retain the knife, taking it into his safe keeping". Discussed small reduction of Sodium Valproate to 1000mgs daily would be most appropriate. The External Investigation Panel interviewed Ms A's sister and brother, and the sister said of her former brother-in-law "Whilst he spoke slowly you could understand him. He always cared about Ms A and if he told you things about her you would believe him." See section 10.1 for further discussion of this.

zz. On 3 August 2010, the CPN recorded in the notes that she received a telephone call from a Police Constable (PC) in the burglary squad who had arrested Ms A's ex-boyfriend on suspicion of breaking into her flat. The man gave the police an alibi for the times in question, and he was released with a warning not to contact Ms A directly or indirectly. He told the police that Ms A drank alcohol from time to time and that her behaviour changed, and he reported an occasion when she was threatening to someone who had jumped a queue in a night club. He claimed that she had threatened to pull a knife on the person. The police constable felt it was probably advisable not to share this information with Ms A at present, as if she thinks that her ex-boyfriend is making claims which might have consequences or get her into trouble, this might ignite further conflict. The CPN's plan was to share the information with the Social Supervisor and Supervising Consultant Psychiatrist. The Social Supervisor's view was that "the team should hold this in our minds and address issues of alcohol/clubbing and interpersonal relationships firmly and that each of them pursues a gentle inquiry when we meet her".

aaa. There is no record of any subsequent conversations taking place with Ms A by any member of the team regarding these issues.

bbb. On 29 September 2010 the CPN noted: "A is anxious to address the issue of a male patient from the Bracton Centre being able to visit her at home and does not see the reason for the delay; both are subject to restriction orders. A always finds it difficult when in a position where she is not in control and has to rely on others. She finds it difficult to wait and experiences delays as frustrating". The care team was concerned about her relationship with the male patient and arranged a meeting for them both to disclose their index offences. This took place on 4 November 2010.

ccc. On 8 November 2010 a medical entry was made in Ms A's notes which stated "Discussed with pharmacist A's high blood pressure and persisting tachycardia. She thought along with other causes it could also be caused by sporadic compliance with Quetiapine as this is likely to reduce her tolerance to a higher dose of 900mg a day, another possibility could be any substances she may have taken including illicit drugs and alcohol". When this was addressed with Ms A she stated "it looks like I will have to get a solicitor then, take bloods if you don't believe me".

ddd. On 26 November 2010 there was a CPA Review, at which it was recorded that "A's wish is for the Sodium Valproate to be reduced and stopped". The dates for the next visit to Jamaica are agreed – 24 December to 17 January 2011. It was noted also that the male Bracton patient now had unescorted leave for up to 4 hours to go to A's flat. The CPA plan documents that Ms A "has all relevant contact numbers for professionals and is aware she could contact the main Bracton or Joyden's clinic out of hours who could get a message to relevant professionals". This will be addressed further in section 10.5.

eee. On 12 January the Social Supervisor recorded that she had received a call from Ms A in Jamaica asking if she could stay two weeks longer, as her mother-in-law had died. She said she had extra medication with her. This was agreed and the plan was for Ms A to book a flight for 28 January. However she didn't manage the rebooking process correctly and the ticket was cancelled. Ms A then had to rebook the ticket in liaison with her care team and support, once again, from the British High Commission in Jamaica. The £600 ticket was funded by the Trust on the proviso that it would be paid back in regular instalments through the Social Supervisor, who would collect the money on a regular basis. The MoJ was informed of her extended stay.

fff. On 7 March 2011 the CPN noted that "A rang to tell me that she has been seen by her GP who thinks she might be pregnant". Her supervising psychiatrist then told her to stop taking Sodium Valproate. On 8 March 2011 Ms A did a home pregnancy test which she later described to her GP as faintly positive. The GP carried out a further more sensitive test which was negative.

ggg. On 18 March 2011 the CPN noted "She was quite agitated. Said she had been receiving nasty messages from her last boyfriend. He had sent some two days ago but they are getting worse and that he said he was living near and saw her every day".

hhh. Ms A had discussed this with the police. It was agreed that the Support Worker at her accommodation would alert the Safer Neighbourhood police team. Then on 31 March Ms A stated that the Bracton male patient who had been granted permission to visit her flat unescorted, had made threats towards her.

iii. On 19 April 2011 during a home visit by the Supervising Psychiatrist, it was noted **"**She acknowledged in our discussion that she could see that reporting two boyfriends as threatening to kill her was potentially concerning". The Psychiatrist noted that "she did not consider there to be any fragility in A's mental state". She recorded "She does present an aspect in interpersonal relationships that verges on hostile rather than just assertive – this was noted on many occasions during her inpatient stay and did not seem to be overtly linked with any deterioration in her mental state".

jjj. On 22 June 2011 there was a CPA meeting (the last prior to the further homicide). There was no information discussed that would suggest Ms A was relapsing into a psychotic illness. The only change of significance noted was that she had stopped taking Sodium Valproate, based on concerns about possible pregnancy, this having been agreed by her Consultant. The relapse and contingency plan remained in place.

kkk. On 23 June 2011 the CPN noted that Ms A was "working three days a week for a security company. Her primary tasks are cold calling". There is nothing in the records to show that the team considered the appropriateness of this employment, or thought about making contact with the employer so that there was a point of contact if any deterioration in her mental health was noticed at work.

lll. In September 2011 the Bracton male patient was conditionally discharged to a supervised hostel. Ms A was calling at the hostel, although she was not allowed in. The CPN had to intervene between them. On 22 September 2011 the Supervising Psychiatrist carried out a home visit to Ms A and noted "Discussed the argument with the male patient. I raised the question that information of this kind does raise from our perspective whether she is OK mentally. Explained our responsibilities". Ms A told the psychiatrist that her new boyfriend had been sending threatening texts to her, telling her to kill herself and that he was going to have her beaten up. The psychiatrist read the texts on Ms A's phone and recorded their content.

mmm. On 28 September 2011 the CPN noted "A had been to GP as concerned about early miscarriage. She felt she had been brushed off by GP". In an interview which the External Independent Investigation Panel held with the GP, she said that he felt he had taken Ms A seriously, but he had done a pregnancy test, which was negative. The CPN recorded that "Ms A asked me to drop her off at Queen Elizabeth. We were able to have a discussion about recent events and A was able to identify many recent stressors. Her relationship and recent conflict with husband about money and the boys, her relationship with the male patient and threatening texts from her ex partner".

nnn. At the Panel interview with Ms A, she said that she had begged the CPN to stay with her in A&E, but that the CPN left. Ms A argued with the doctors, saying she needed a D&C (dilatation & curettage, a procedure sometimes carried out after early miscarriage), but they did not think it was necessary, and she was then verbally abusive to them, before walking out. There is no record of the care team contacting the GP for information regarding the supposed pregnancy.

ooo. On 30 September 2011 the Social Supervisor notes that Ms A had "told the male patient about the miscarriage and also her brother. This was something unusual, she had for the first time written to him on Facebook".

ppp. On 6 October 2011, the Social Supervisor phoned Ms A as she had not been at home for a booked appointment. She recorded that in the phone conversation, Ms A "said her brother had replied to her in an offensive manner last Wednesday". The Social supervisor arranged to meet her on the following Monday at 5pm" (10 October 2011). Later that evening Ms A rang 999 on three occasions in ten minutes.

qqq. The first at 11pm was to request police attendance as "she was receiving death threats from individuals known to her and she had some thirty threatening text messages from them". The call handler was unable to obtain from her the address she was calling from.

rrr. In the second phone call she said that the police needed to come now. The communications officer obtained her full name and address and "an intelligence check was conducted by local police when they received the call from the police communication centre. The check showed Ms A as flashing 'violent' and 'manslaughter'.

sss. On the third call, Ms A told another communications officer not to send anyone round, and she would visit the police station the following day. Ms A didn't go to work, telling her employer that she needed time to get over her miscarriage. She attended the local police station that same day and reported the threats made against her, but would not substantiate the allegation. The reporting officer stated that A was "difficult to understand and was aggressive at times".

ttt. On Saturday evening 8 October 2011, Ms A's brother phoned the Bracton Centre reception and told them his sister had contacted him and he did not think she was well. Her brother stated that he was told that if Ms A was bothering him, he should call the Police.

Conclusions to Section 10.3.1

1. The Consultant Forensic Psychiatrist who assessed Ms A on behalf of the Bracton Clinic (on 13 December 2005) concluded that there was some evidence that Ms A was "suffering from a mental illness as evidenced by her over-valued or delusional ideas in relation to her ex-boyfriend and family members, and the apparent deterioration in her social and occupational functioning in the weeks leading up to the alleged index offence" (in November 2005). He felt she would benefit from a period of assessment in medium security.

2. Despite the prison Inreach Team initially recording no evidence of mental illness, the External independent Investigation Panel agree that she was appropriately transferred to a medium secure bed at the Bracton Centre in February 2006, under Section 48/49 of the Mental Health Act 1983 (Appendix 5).

3. The internal inquiry described Ms A's diagnosis as "schizophrenia with a prominent mood component, complicated by emotionally unstable personality traits and a history of substance misuse", which is the formulation given by the Bracton Associate Specialist in a report for the solicitors in May 2006. At other times in her records, the diagnosis is variously given as paranoid schizophrenia with a prominent mood component, and schizoaffective disorder. The External Independent Investigation Panel understands that the clinical team's working diagnosis of Ms A lay between Paranoid Schizophrenia with a strong mood component and Schizoaffective disorder, and that she was not diagnosed with a personality disorder.

4. The Millon Clinical Multiaxial assessment tool carried out by the Psychologist, gave a good insight into Ms A's personality and should have played a larger part in informing her management. An example of her boundary pushing occurred when her care team tried to stop the relationship between Ms A and the male Bracton patient, and yet, due to her ongoing insistence, subsequently allowed him 4 hours unescorted leave to visit her flat on more than one occasion.

5. A mental state examination by the Consultant Psychiatrist who prepared a report for the Crown Prosecution Service after she fatally stabbed her mother, noted that "it is likely that when psychiatrists assessed her in the past she was able to hide her symptoms for the duration of the interview", and concluded that an acute psychotic episode of schizophrenia was present, and that she also exhibited emotionally unstable personality traits.

6. This mental state examination further recommended that Ms A would require a long period of time in a secure hospital environment for further treatment, risk assessment, and long-term rehabilitation. Ms A spent just over 3 years in the Bracton Centre.

7. The External Investigation Panel note the Psychologist's comments that "A is trying to present herself in a good light and may be minimising any psychological difficulties in order to obtain her conditional discharge, and that she had little insight into the offence and therefore the duration of her treatment, and is fixated on making fast progress to discharge".

8. A letter dated 24 May 2007 was sent from the Bracton Centre to the Mental Health Unit, Ministry of Justice, clarifying their escorted leave request: "Generally we have been very satisfied with Ms A's progress since October 2006 and particularly during the last four months when not only has she remained very settled in her mental state but has also been demonstrating a striking co-operation and willingness to participate in all treatment and rehabilitation."

9. This does not fully reflect the demanding behaviour of Ms A as noted in her records – see table 10.

10. As early as November 2007 Ms A was asked to move to the Cottages, within the Bracton Campus, for a trial period. The Cottage is for patients who can manage more independent living. This was not a planned move, rather it came about because there was a patient in the Cottage who needed to be moved back urgently to Joydens Unit. Ms A was told that if the move was successful, she would be able to remain in the cottage.

    The External Independent Panel has concerns about the appropriateness of this move given that Ms A was still exhibiting confrontational and difficult to manage behaviour.

11. The Annual Statutory Report 2007 – 2008 stated "There has been improvement in her mood stability since Sodium Valproate was added to her treatment." The External Independent Panel noted Ms A was already on Quetiapine, an oral anti-psychotic which also has mood stabilising properties, at above British National Formulary (BNF) maximum dose.

12. Ms A had appeared to improve on Sodium Valproate, which is perhaps reinforced by the fact that when it was reduced in November 2008, it was noted that "There were some concerns in relation to changes in her mental state during the last few days. Increased impatience, more argumentative, critical of others, less tolerant, mood instability. This may relate to her recent change in medication – reduction of Sodium Valproate by 100mgs last week".

13. Both Ms A's sister and father had contact with her when she was at the Bracton Centre. Her father, sister and brother, in interviews with the External Investigation Panel, felt that they were not consulted, and their views were not considered by the care team. For example, the incident at Christmas when her father visited Ms A, and a judgment about what took place was made by the team on the word of Ms A only. As Ms A's husband lived in Jamaica, Ms A's father was legally Ms A's next of kin under the Mental Health Act 1983 – see table 11.

14. When Ms A was discharged, her risk assessment, relapse indicators, and the contingency plan should she become unwell, were well documented. The External Independent Investigation Panel commend the Bracton Centre clinical staff for keeping excellent process and contact records in relation to Ms A, both as an in-patient and a community patient - see table 12.

15. The HCR-20, the scenarios in which Ms A might become violent were not developed, and nor was this risk assessment updated during her period of conditional discharge. The RiO risk summary seems not to have been updated after June 2011.

16. The External Independent Investigation Panel was concerned that the two incidents shortly after Ms A's conditional discharge - the sounds of disturbance in her flat, and

the incident on a train with the ticket inspector - were not referred to or recorded in the notes of the CPA Review carried out on 16 December 2009. This was potentially important information about her behaviour in the community soon after conditional discharge. This will be addressed in section 10.5.

17. At the next CPA Review on 3 of March 2010, the Consultant Psychiatrist stated that "any likely early changes in Ms A's mental health are unlikely to be marked but rather the quality of her interactions may appear less warm or sensitive to the needs of others". Throughout Ms A's period of conditional discharge, there was evidence of problems in her interaction with others - including family, neighbours, previous partners, and people in positions of responsibility in the community.

18. When Ms A went to Jamaica, the Casework Manager at the MoJ requested notification "immediately should there be any concerns". However, there was no evidence of immediate contact being made with the MoJ, when concerns arose following Ms A's husband in Jamaica contacting the team, and the elder child's social worker.

19. When a report was later submitted to the MoJ by the Social Supervisor on 22 April 2010 she stated that Ms A acknowledged she had drunk two Pernods at a party with her husband, but added that "Her mental state has been stable and she has managed many family and relationship issues with equilibrium", which seems to the External Independent Investigation Panel to rely on Ms A's account of events.

20. When the Consultant Psychiatrist subsequently visited Ms A at home following her return from Jamaica, she recorded in the notes that "There was no evidence that A had threatened her husband referring to a knife", and appeared to accept Ms A's account that this incident had occurred several years previously when she was unwell. There is nothing in the record to suggest that this claim was investigated.

21. The CPN was informed by a police officer that Ms A's boyfriend at the time, had told them when he was arrested on suspicion of burglary at her flat, he informed them she drank alcohol from time to time, and that her behaviour changed and he further reported an occasion when she was threatening to someone who had jumped a queue at a night club, threatening to pull a knife on them. The care team's response was that they should "hold this in their minds and address issues of alcohol/clubbing and interpersonal relationships firmly and that each of them pursues a gentle inquiry when we meet her". There is no record of any further questioning of Ms A about this. The panel's view is that this approach was insufficiently forceful– see table 13.

22. By March 2011 Ms A's stress factors had increased significantly, given that she believed she had miscarried, and she was receiving threatening messages from her last boyfriend. She also stated that the Bracton male patient was threatening her. At this time, her Sodium Valproate was stopped because of side effects and her wish to become pregnant, and because she reported to the Supervising Psychiatrist that she might already be pregnant. The Consultant Psychiatrist noted that while A reporting

that two previous boyfriends were threatening her was potentially concerning, nevertheless she did not consider there to be any fragility in A's mental state. The External Independent Investigation Panel questions whether there should have been more concern about Ms A's level of risk to others, given the various circumstances at the time - see Table 14.

23. On 23 June 2011 the CPN recorded that Ms A was "working three days a week for a security company. Her primary tasks are cold calling". There is nothing in the records to suggest that consideration was given to making contact with the employer, or considering the appropriateness of the job – see table 15.

24. In September 2011 Ms A again believed that she had had a miscarriage, even though this was not confirmed by the GP. Although she discussed this with the CPN, there may not have been adequate recognition of the significance of this risk factor.

25. On 6 October 2011 the Social Supervisor wrote about a telephone conversation she had with Ms A, after Ms A had not been at home for a scheduled appointment "She said her brother had replied to her in an offensive manner last Wednesday". The Social Supervisor arranged to meet Ms A on the Monday (October 10) at 5pm. Given the significance of Ms A thinking that she had been pregnant and had miscarried, and then contacting her brother via the social networking site, and getting a terse reply, the External Investigation Panel's view is that she should have been reviewed before the weekend – see table 16.

26. Later that evening 6 October, Ms A rang 999 on three occasions in ten minutes. The first call was to complain that she had received threatening text messages. In the final call, she said she did not want the police to attend, and she said she would report the matter the following day.

27. On Saturday evening 8 October, Ms A's brother phoned the Bracton Centre reception and told them his sister had contacted him, and he did not think she was well. Her brother said to the External Independent Investigation Panel that he was told if Ms A was bothering him, he should call the Police. This response was inadequate and unhelpful in terms of risk management and sensitivity. If anyone in her clinical team had been made aware of this, and it was combined with knowledge of the events of the previous week, there could possibly have been an effective intervention.

28. The External Independent Investigation Panel note the change to the Bracton Centre's processes, following the Trust Independent Investigation (recommendation 9.1.2) to try to ensure a phone call such as this, is dealt with more effectively.

Table 10: Section 10.3.1 – Service Delivery Problems

Service Delivery Problem
The MoJ process must be followed, the Trust to ensure compliance by auditable means. Correspondence to the MoJ did not fully reflect Ms A's behaviour and presentation, and in one particular instance, the MoJ request to inform immediately if concerns arose during a trip to Jamaica was not followed. The MoJ can overrule clinical judgements and recall a restricted patient, but relies on the clinical team to give full information regarding the patient

Table 11: Section 10.3.1 – Notable Practice

The External Independent Investigation Panel commend the Bracton Centre clinical staff for keeping excellent process and contact records in relation to Ms A, both as an in-patient and a community patient.

Table 12: Section 13.3.1 – Care Delivery Problems

Care Delivery Problem
There was a failure to gain a view of family members involved in specific situations with Ms A. The care team were too ready to accept Ms A's account of potentially worrying situations, and not enough weight was given to alternative accounts, or no attempt was made to get the views of family members involved. Specifically the views of both Ms A's husband in Jamaica, and of her father, were not explored in relation to situations which occurred. The Judge in her first trial noted her accounts of some events did not coincide with the evidence.

Table 13 - Section 10.3.1 – Care Delivery Problems

Care Delivery Problem
Ms A's potential risk of violence to others in the community was not adequately considered by her care team, particularly on occasions when there were worrying reports about her behaviour, and/or stresses to which she was subject. This view is reinforced by the HCR-20 not being fully completed.

Table 14 - Section 10.3.1 – Care Delivery Problems

Care Delivery Problem
There was no overview of Ms A's presentation and changing level of risk when experiencing stresses which were identified in her care plan as associated with relapse. The care team responded on a reactive basis to issues as they occurred, and did not adequately consider the overall impact of these events on Ms A's mental state and behaviour, and her level of risk to others.

Table 15 - Section 10.3.1 – Care Delivery Problems

Care Delivery Problem
There was no communication with Ms A's employers, The Panel recognises that the team would have had to ask Ms A's permission to talk to her employers, and if refused, to have decided if they were justified in breaching her confidentiality. However, the Panel considers that these issues should have been discussed by the team. Ms A remained a conditionally discharged restricted patient.

Table 16 - Section 10.3.1 – Care Delivery Problem

Care Delivery Problem
There was telephone contact only on 6 October 2011 after Ms A missed her appointment. The panel considers that there should have been a review of Ms A before the weekend, when it was clear that she was subject to several significant stresses, had engaged in uncharacteristic behaviour in sending a message to her brother on Facebook, and that she was likely to react badly to his response. She believed that she had miscarried, even though this was not true.

10.3.2 <u>The Mental Health Liaison Service</u>

1. The External investigation panel have taken information relating to Ms A's presentation from 1) the Minicab office; 2) A&E; and 3) the Independent Police Complaints Commission Independent Investigation into the Police Contact with Ms A prior to the fatal stabbing of Mrs Sally Hodkin.

2. The Greenwich Mental Health Liaison Team (MHLT), within the Acute Adult Mental Health Directorate of Oxleas NHS Foundation Trust, offers a specialist multi-disciplinary service for individuals suffering with mental ill health.

3. The team forms part of a planned and integrated whole system approach to care that is delivered in conjunction with inpatient, community and specialist services. There is also a Bromley MHLT.

4. The Greenwich MHLT is now based in Queen Elizabeth Hospital (QEH) A&E Department, following the homicide committed by Ms A on 10 October 2011. Prior to this it was based in Oxleas House, which is a Mental Health Unit based in the grounds of Queen Elizabeth Hospital, several minutes' walk from A&E.

5. The primary purpose of the MHLT is to provide a specialist frontline emergency mental health assessment service, for individuals who present in acute mental health crisis, with the formulation of an appropriate ongoing management plan. It also provides advice, training and consultation to teams referring into the service (liaison role), including the Emergency Department and other medical, surgical, and midwifery departments of QEH (South London Healthcare NHS Trust), primary care, the London Ambulance Service (LAS), and the police.

6. The MHLT Operational Policy states 'Individuals coming to the team at a time of crisis will have their individual needs and particular issues of safety assessed, and a management plan will be devised in consultation with the individual. It is the intention of the team to ensure that the safety of the individual or others is not put at risk as a result of the individual's mental health crisis and the care they are receiving'.

7. Clinical staff within the Mental Health Liaison Service include an Associate Specialist Psychiatrist, qualified Mental Health Nurses, and Support Workers.

8. Whilst the Chronology (Appendix 5) sets out in detail Ms A's presentation overnight on 9/10 October, some key points are noted in this section, as follows:

    a. On 9 October 2011 Ms A called the police three times in the late evening. She complained that she had let some 'crackheads' into her flat and they had stolen her keys. In the third call she said she had found her keys and did not need the police.

    b. On 10 October 2011 at 03:00 am Ms A reported to the Police that she left her flat because she was sure that she was going to be murdered there that night. She went to a minicab office and asked for a cab to Lewisham Hospital. When they reached the hospital she said "I think it's closed". The cab driver noticed that her head was down and that there was saliva coming from her mouth. She asked to be taken to Queen Elizabeth Hospital. On arrival, she had no money to pay for the fare. The driver returned with her to the cab office. There was a short struggle as she tried to leave. The driver noted that she was very shaky and distressed.

    c. At 4:01 am the Police received a call from the mini cab controller, stating that Ms A kept crying, was shaking and distressed, and was saying she needed to be

sectioned, and needed to be in hospital. He reported that she seemed paranoid, and had moved from the public seating area to the back of his office, and she was refusing to leave. An ambulance and police were dispatched.

d. At 4:15 am two police constables (PCs) arrived, asked Ms A to calm down, and told her she had not done anything wrong, and that she was not under arrest. She informed them that she had mental health issues and needed medication.

e. It is documented that she was deemed to be agitated but (also) meek in her behaviour. The PCs walked with her out of the office, and she appeared to them to have the self-control and capacity to understand what was said to her.

f. The PCs decided to take her to hospital voluntarily as they genuinely thought she was seeking help. She then refused to get into the ambulance, saying "I'm not getting in that box". Ms A stated to the PCs that she had claustrophobia and didn't like confined spaces. In one of the PC statement's it is stated that "Ms A appeared distressed and I did not want to upset her further as she seemed to be making an honest effort to seek help. I told Ms A that if she preferred and the ambulance crew were satisfied she could travel in our car". The PCs did not at any stage carry out a Police National Security[9] (PNC) check which would have shown that Ms A had a conviction for manslaughter.

g. The Police took Ms A to A&E at QEH, and helped her to book in at reception. She told the A&E receptionist that she needed to be seen by the mental health team. The officers explained to her that she had to remain there. There were at least 15 people waiting to be seen by the triage nurse at that time. Given that the police officers had taken their decision not to invoke section 136 it would be good practice on all future occasions for the A&E receptionist to notify immediately the nurse in charge of the A&E unit so that the immediate handover set out in Recommendation 9.14 above can be fulfilled. When the handover is completed it will be a key area for operational consideration between A&E departments and their Mental Health Trusts to ensure there is a smooth pathway that moves a patient through the crisis care system expeditiously and according to the presenting clinical needs.

h. At 4:31 am as the PCs were about to leave the car park, she ran out to them. They reassured her and ushered her back inside at 4:34 am. CCTV footage showed one of the Policemen having a conversation with Ms A by the main entrance. During this time Ms A was seen to move around a lot and appeared to be agitated. Ms A then picked up the dedicated taxi phone by one of the PCs and said she was going to call a cab. The PC replied "you don't have any money", she then put the phone down and stood near the reception area away from the PC. She then repeated the call to the taxi company in the PC's presence, the PC intervened and disconnected the call.

i. At 4:37 am the police left the hospital, only to be followed by Ms A again. She reassured the police she was only having a cigarette. Both PCs waited for a few minutes and then left to attend to another call.

j. At 4.37 CCTV footage recorded Ms A entering the hospital by the main entrance. From this time onwards she is recorded as constantly moving around and she appeared agitated. On her return to the A&E waiting area, Ms A asked the receptionist “how long am I going to be here?”, and “is it going to take for me to kill someone, as I’ve done it before, so I can get seen?”. She used the dedicated taxi phone line on a further three occasions.

k. At 4:45 am Ms A called the Bracton Centre. The statement by the staff member who answered the call reads as follows: “A lady telephoned, very distressed with a muffled voice and talking very fast. She said she had a taxi waiting and if she passed the phone to him would I tell him that we would pay for the cab as she desperately needed to come back here. I said I wasn’t authorized to do that but would pass her to the relevant unit, which she said was Joydens. I passed the call straight through and 2 minutes later Joydens called back to reception and said the call I had put through needed to be passed to the Duty Doctor, then hung up. The phone to the caller was dead so I called the Unit Coordinator and he telephoned me back 5 minutes later saying it wasn’t the procedure to pass the calls to the Duty Doctor. And that he had spoken to Joydens and they didn’t manage to get her telephone number”. A witness waiting in A&E saw Ms A leaving the unit and getting into a taxi and then getting out and then she put herself in the front seat of an ambulance, to be brought back by two ambulance ladies.

l. At 4:52 am Ms A called the police stating “she has had a breakdown and needs to go to a mental hospital and the last time she felt like this she killed someone”. Furthermore she stated she was confused and did not know who she was, adding she was on a 37/41 ministry section and could not sit in A&E.

m. At 4:53 am Ms A was seen by the triage nurse, she said she wanted to see a mental health person and go into hospital. She said everyone wanted to hurt her and she was hearing voices. The psychiatric team accepted her referral.

n. At 5:13 am Ms A called the police once more, asking for help before she hurt someone, asking for police attendance and to take her into custody, adding that her psychiatrist had told her “when she feels scared and paranoid she can be very dangerous”. She informed the controller again that she wanted to be taken into custody, and asked “do you want me to hurt someone here?” She was crying. The call was sent to the communications dispatch officer, being classified as an immediate, and to the local police.

o. It was decided that “as officers had just left the female in question at hospital, a recognised place of safety, there was no further deployment as they have their own security and the Police had not received any calls from the hospital requesting that officers re-attend”.

p. At 5:21 am Ms A made another call to the police. She was crying and stated she was a dangerous schizophrenic, and if the police did not arrive on scene, she was

going to harm somebody, repeated over and over that she would like some assistance. She once again told the communications officer that she was a very dangerous schizophrenic. Ms A was told she was in a place of safety, to which she raised her voice and shouted back “no I’m not in a place of safety, I am in an exposed area”, and “the more scared I get the more dangerous I become”.

q. When asked what the emergency was she replied “That I will hurt someone”. She was heard saying to someone that she was not going back into the hospital, she was going to the police station. A woman’s voice was heard on the recording saying to Ms A that they had got her some help. The call ended.

r. At 5:27 am Ms A made her last call to the police. She reiterated that the last time she felt like this she killed her mum. When asked where she was, she said she felt she was at the gates of heaven. When asked why she would not go back into the hospital, she said she felt someone was going to kill her, and she asked again for police attendance.

s. The hospital was contacted and the response was that they were aware of her and she was awaiting assessment and apparently it was not happening fast enough for her, security had the matter in hand, no need for police attendance.

t. The Charge Nurse of A&E reported that security came to him saying that there was a lady in the waiting area who was saying that she wanted to kill someone, and she was really distressed and shouting and screaming, and she was shaking and scratching her arms constantly. He called the Mental Health Liaison nurse (MHLN) and asked him if he knew about the lady. The MHLN did know about her as he had had a referral from the triage nurse.

u. At 5:30 am Ms A was seen by the MHLN, who could not access her RiO notes whilst assessing her in A&E as the RiO connection was not working properly, however he had looked at her RiO notes in Oxleas House before he came to assess her. He told the External Independent Investigation Panel that he knew she was known to the Bracton Centre and that she had killed her mother. However he did not look at the care plan or community crisis plan before coming to assess her.

v. He recorded that she told him that she had been feeling suicidal but had no plans to hurt herself and that she needed to sleep. She stated “I have not slept for weeks and weeks and want to be in hospital”. Ms A asked to be sectioned because she does not feel safe on her own. She did feel safe when she was talking to the MHLN. Ms A reported hearing lots of voices telling her different things, however those voices were not commanding her to kill herself or do anything silly.

w. She reported that she had stopped taking both Sodium Valproate and Quetiapine for months. She talked about flashbacks of being abused as a child, and her concern that her children were being sexually abused in Jamaica. She

also stated that she had used Skunk (a form of strong cannabis) recently. She appeared suspicious and wanted the assessment room door left open. The MHLN recorded that Ms A self-presented as he was unaware that she had been brought to A&E by the Police.

x. The plan made by the MHLN was for Ms A to have an informal admission, and she was placed on level 2 (15 minute) observations while she waited to be escorted to Oxleas House. This assessment will be addressed in section 10.5.

y. Following a discussion with the duty doctor (a GP trainee who had just commenced this post as part of his rotation) the MHLN recorded the plan as informal admission, with risks to self, harm to others and self neglect being marked "low", and substance misuse and forensic risk being marked "high" – the latter was said to be "based on the past".

z. Ms A was placed on level 2 observations - described in the Trust 'Safe and Therapeutic Observation Policy (2012)' as: 'patients on level two observations should be observed no less frequently than every fifteen minutes'. This will be addressed further in section 10.5.

aa. The MHLN left the assessment room in A&E and went back to Oxleas House (several minutes' walk away) to type up his assessment. The Charge Nurse reported to the External Independent investigation Panel that immediately after he left, Ms A came out of the assessment room and started shouting "when are they taking me to Oxleas, because I'm really unwell I need to be in Oxleas, you people don't understand".

bb. He further stated that she again ran off, he and the security guard caught up with her, and together with the Triage Nurse, got her back to A&E, from where she was then escorted to Oxleas House by a security guard and an A&E Nurse. It was recorded in the Consultant Psychiatrist's Report to the Court post the internal investigation, that on the way over to Oxleas House she was scared the escorting staff would kill her, and that she was going to be jumped on and torn to pieces by evil demons.

Conclusion to 10.3.2:

The first conclusion relates to the action of the Police in relation to their escorting Ms A to A&E and will be covered in 3 sections:

1.1 Was there an opportunity, at any point, for the Officers to apply a section 136 of the MHA, rather than escort Ms A voluntarily?

1.2 Could the Police take a different view on the application of section 136 of the MHA at any point?

1.3 Did the action taken contribute to Ms A being able to abscond and commit the homicide?

1.1 Was there an opportunity, at any point, for the Officers to apply a section 136 of the MHA, rather than escort Ms A voluntarily?

The External Independent Investigation Panel finds that there was enough evidence for the police to place Ms A under section 136 of the MHA 1983 on one occasion in the small hours of the 10 October 2011, when she was observed by the Police (as stated in their statements) coming out of A&E for the second time after trying to contact a taxi firm on two occasions from within the A&E department. The PCs recognised that she had mental health problems and although she appeared to be willing to go to hospital, she did in fact leave A&E twice, the first time being escorted back to reception by one of the PCs. When she came out of hospital a second time the Police had an opportunity to question her willingness to remain. Ms A was also attempting to use the dedicated taxi telephone line to summon a mini-cab, being reminded by the PC that she had no money. The Panel question Ms A's willingness to stay, given her behaviour. The panel note the following:

- The definition of Section 136 of the Mental Health Act 1983 states:

  'If a constable finds in a place to which the public have access a person who appears to him to be suffering from a mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or the protection of others persons, remove that person to a place of safety within the meaning of section 135'.

- The [17]Jones Mental Health Act Manual states that:

  "Although informal admission should be the preferred mode of admission there is nothing in the Act which expressly prevents an application being made in respect of a mentally capable patient who is willing to enter hospital as an informal patient. Whilst it is true that Section 5 can be invoked to prevent an informal patient from leaving hospital circumstances can arise which justify the use of compulsion on "willing" patients. The Code of Practice at para.4.11 suggests that compulsion should he considered for patients whose history suggests that they might have a change of mind about being admitted informally".

- [18]The Mental Health Act Code of Practice - Alternatives to detention—patients with capacity to consent to admission

[17] Jones Mental Health Act Manual 14th Edition – Richard Jones September 2011 (Page 520)
[18] Code of Practice Mental Health Act 1983 Published 2008, Pursuant to Section 118 of the Act. Department of Health (4.9-4.11).

When a patient needs to be in hospital, informal admission is usually appropriate when a patient who has the capacity to do so consents to admission. *However, this should not be regarded as an absolute rule, especially if the reason for considering admission is that the patient presents a clear danger to themselves or others because of their mental disorder.*
Compulsory admission should, in particular, be considered where a patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people".

The Code at Chapter 10 refers to police powers and places of safety and from 10.12 specifically concerning Section 136: Mentally disordered people found in public places.

"10.12 S. 136 allows for the removal to a place of safety of any person found in a place to which the public have access … who appears to a police officer to be suffering from a mental disorder and to be in immediate need of care and control.

10.13 Removal to a place of safety may take place if the police officer believes it necessary in the interests of that person or for the protection of others.

10.14 The purpose of removing a person to a place of safety in these circumstances is only to enable the person to be examined by a doctor and interviewed by an AMHP, so that necessary arrangements can be made for the person's care and treatment … "

1.2 <u>Could the Police take a different view on the application of section 136 of the MHA at any point?</u>

The key to this question is the necessity to apply a section 136 of the MHA. It is the External Investigation Panel's view that there are three situations where the question " was it necessary to apply a section 136" apply:

1.2.1 Situation 1: In the Taxi Office. Statements later taken by the police and used at Ms A's trial portray a picture of her presentation at this time:

Taxi Driver 1. She asked him to take her to Lewisham Hospital. "I saw she was sitting with her head hanging and there was quite a lot of saliva dripping from her mouth. I thought then there was something wrong. I was concerned…because of her strange behaviour". As she was unable to pay he took her to the taxi base. " She told the Taxi Office Manager to call the Police as, according to her, I had beaten her up…she was being a bit hysterical. I only heard him (the Taxi Office Manager) ask her why she needed to go to hospital and she said something about 'mental

problems.' After a while Taxi Driver 2 said to me 'she needs to be sectioned.' Taxi driver 3 told me, "the previous evening he was also driving the same girl to various locations for about an hour and then she did not pay at the end either…"

Taxi Driver 4 stated. "She appeared very scared…I told her to calm down and asked her what was wrong, she said she needed to be sectioned and she provided the name of the place where she had been before and wanted to go back... the lady had a mobile phone with her and began calling for the police and ambulance. I heard her say to them 'I need to be sectioned, I need to go to the place I was before'…I think she was scared more than anything else."

There are two parts to the involvement of the Taxi Office Manager. Firstly, the transcript of his interaction with the emergency services. "I think she needs medication or something, she's saying that she thinks that the cab driver's gonna drive the car through the window or something. I was telling the Police that obviously she needs to be sectioned don't she but I think she seems a bit paranoid about everything". Operator, Is she refusing to leave the cab office? "Well she's gone running to the back of the office now and she's sitting in the back; she's all paranoid in the back. She don't wanna go anywhere".

Secondly, in his witness statement he states, 'she was shaking and seemed distressed I could see that something was wrong so I buzzed her through our secure door to our area at the back where our drivers wait….she was very shaky, half in tears and very paranoid…at first I thought she might be on drugs, but from what she was saying I could see (there was) a bit more underlying…she was saying things like 'its in my head, its in my head' and 'I need to be sectioned', and 'I'm not well'…she was talking about 'voices in her head' and 'needing to be sectioned'…all the time she was very shaky and upset…the police asked her if she had any history, which she said she did…the ambulance also turned up".

The Panel thought that on receipt of information from personnel at the taxi office and the police controller who had relayed the message "woman at location wants to be sectioned" (Operation Globelands timeline of events 4.03 a.m.) that this may have been an opportune time for the police officers to interrogate the Police National Computer on their way to hospital.

1. In addition to the police attendance at the taxi office the ambulance arrived to convey Ms A to Hospital. She then refused to get into the ambulance citing claustrophobia as the reason but then went 'willingly' with the PCs. In this instance the Panel felt that her willingness to go to hospital in the Police car mitigated against the [19]necessity in applying a section 136 of the MHA 1983It is also noted in the Jones Mental health Act Manual (page 552):

"NECESSARY TO DO SO – there is nothing to prevent the person from being escorted to hospital without this section being evoked, if a person is willing to be

[19] Code of Practice for the Statutory Powers of Arrest by Police Officers 1st January 2006

admitted as an informal patient, is thought not likely to abscond, and the hospital is prepared to admit him" . However, in transporting Ms A to hospital in this way the two police officers were in breach of the Metropolitan Police Services (MPS) Operating Procedure for such an activity whereby a paramedic who had attended the scene at the taxi office should have formed part of her escort in the police car to the A&E department.

12.2 Situation 2: At the Hospital the PCs delivered Ms A to reception, waited until she had seen the receptionist and then left, only to see Ms A come running out of the unit over to the police and stating "She did not want to wait on her own and wanted us (the police officers) to wait with her" (PC Statement). One of the Police officers intervened to return her to the area. Again Ms A went willingly and did not require restraint. Despite this again it is agreed by the Panel that her seeming compliance mitigated against the necessity to apply a section 136 of the MHA 1983.

12.3. Situation 3: Once inside the A&E unit Ms A attempted to telephone mini-cabs to collect her from the unit and on the second occasion had her call terminated by the escorting PC. One of the police officers in their statement states that "she did not feel safe there". When Ms A followed the police officer out of the unit it could be interpreted that she was clearly demonstrating that she could have a change of mind over informal admission (which she had now demonstrated 3 times in quick succession and had only complied in each of these situation in the presence of police officers). At this point, it is the view of the External Panel that it would have been reasonable for the PC to conclude it was necessary to apply section of the 136 of the MHA 1983 as in their view she met both the necessity test and met the criteria set out in the current 'Policing Mental Health Standard Operating Procedure' which came into effect on 2 February 2011, which states:

Either finding or being directed towards a person with a mental disorder in a public place is not enough in itself to detain under section 136. The power to remove requires 3 conditions to be fulfilled before police act:

- *The person must appear to the officer to be suffering from a mental disorder, and*
- *They must appear to the officer to be in immediate need of care or control, and*

The officer must think they need removing in their own interests or for the protection of others.[20]The Panel set out below their application of the facts to each of the criteria in support of their conclusion

<u>The person must appear to the officer to be suffering from a mental disorder:</u>

- In both Police statements it is stated that a male in the mini cab office told them that Ms A had said that she wanted to be sectioned. In one of the PC's statement, when noting his dealings with Ms A throughout it is stated " she

[20] It is noted that this standard operating procedure makes no reference to the 'necessity' test – a legal requirement for consideration when applying any restriction of liberty under the Mental Health Act

seemed relaxed but there was something about her personality that gave me cause to believe that she had some kind of mental health issue".

They must appear to the officer to be in immediate need of care or control:

- Ms A asked for help – in one of the PC's statements it states that "she seemed agitated and in need of help so we very quickly came to a joint decision that we would take her to hospital so that she could be assessed by a mental health team".

- After the PCs had taken Ms A to A&E and helped her register at the reception desk, she twice went back outside the hospital and spoke to the officers. One of the PC's stated that "At the hospital, 'she became agitated telling us she did not feel safe there.... she calmed down a little....just as we were about to leave she came running out to us.' And also "'at A&E she stated that she didn't want to wait and tried to call mini-cabs. "I informed the control room that she had been fine, but appeared a bit nervous and ultimately was not happy with having to wait to be given her medication".

The officer must think they need removing in their own interests or for the protection of others:

- At A&E, one of the PC's stated that "Ms A became agitated after it was explained her that she needed to be assessed by the mental health team telling us that she did not feel safe. We then explained again that she needed to stay so that she could get the medication she needed".

The panel accepts that section 136 of the Mental Health Act is an emergency power and that whether to use it is a judgement call. Given this set of circumstances some Police officers may have applied Section 136 of the Mental Health Act whilst others may not have. The Police Officers involved reached their decision in good faith and were satisfied that Ms A did not meet the relevant test. However, the Panel believes that Ms A could have been placed on a section 136 in light of her level of agitation and her demonstration of intention to leave the unit by twice attempting to arrange a taxi via the dedicated free taxi phone in the presence of the police officer. This was followed by Ms A's leaving of the A&E unit for a second time and it is the view of the Panel that the likelihood of her remaining to undergo voluntary admission had by now been placed in serious doubt. When leaving the QEH the police officers had felt that Ms A "had appeared fine, that she was a little nervous but ultimately was not happy with having to wait to be given her medication", the accompanying PC stated that "She genuinely seemed as though she wanted help". Both PC's stated that the Hospital was where she was repeatedly asking to be. They left the situation therefore feeling that she was nervous but presenting no threat and that she was in a place where she both wanted to be and would receive the support and care that she needed. The panel view is that throughout the period of her interaction with the emergency services Ms A was expressing the view that she wanted treatment and care.

The panel also took into consideration witness statements and CCTV footage which was eventually made available to the panel at a very late stage by the police:

The CCTV footage in the A&E unit has been edited and does not capture activity outside the reception area of the hospital and in the assessment unit. CCTV footage confirmed that at 4.29am Ms A and the two officers entered the Queen Elizabeth hospital accident and emergency department. One of the PC's is shown speaking with a receptionist. The receptionist stated she was on duty when approached by two officers and a female. She said that one of the officers spoke with her whilst the other was standing with the female. She further stated that the officer speaking with her provided her with the female's full name, date of birth, address and said she needed to be seen by the mental health team. This information was taken and inputted straight on to the system by the receptionist so that a triage nurse could see her. There were at least 15 people waiting to be seen by the triage nurse at that time. The Police Officers departed (4.31 a.m) leaving Ms A to wait in the public area. When Ms A ran out of the department over to the police officers before they had left (4.32 a.m), one of the PC's returned her to the unit on his own (4.33 a.m). The CCTV footage shows a very animated Ms A speaking in an agitated way to the PC, she then twice is seen making calls on the free taxi telephone line in front of the police officer, on the second occasion the police officer cuts off the call. Her intention to the officer, who had just driven her to A&E, must have indicated to him she was unlikely to stay. The whole episode lasted four minutes before the officer leaves (4.37) the unit for a second time and is followed out of the unit by Ms A. According to the PC, Ms A reassured him that she was only having a cigarette. Both the officers then waited in their vehicle for a few minutes before attending to another call. At 4.37am CCTV footage recorded Ms A entering the hospital from the main entrance by herself and from this time onwards she is recorded constantly moving around and appeared agitated. According to the receptionist, Ms A approached the reception area a few times and asked the reception staff, 'how long am I going to be here?' and 'is it going to take for me to kill someone as I've done it before so I can get seen?' Taking into consideration what we were told and read in a witness statement, the receptionist statement that "after the police left she became agitated again and pacing again" (the use of the term 'again indicates that she had been agitated previously) and what CCTV is available in our opinion further confirms our conclusions.

A member of the public waiting in the A&E in a witness statement given to the police and included in Professor Eastman's report to the court stated: "From the moment the woman came in she was shouting that she was there to be sectioned…always talking in a raised voice. She was saying things like she wanted help…the woman began to rant and rave...her voice became more raised…she began to say that if she didn't get help that she would kill somebody…this continued for some time…the woman's behaviour seemed to have got worse…she seemed excitable and walked around very fast, waving her hands around and shouting and asking for help…she used the telephone, she said she needed a taxi to take her to a psychiatric hospital…the woman left the hospital and got into a taxi…it had only travelled 50 to 100 feet when it stopped and the woman got out…she made her way back towards us but was still shouting… she kept saying she needed help or she would kill someone. I saw her go back outside again and get in the front passenger seat of an ambulance parked outside…she was only out briefly when two ambulance ladies brought her back into the hospital waiting area. Later the woman had gone outside…about 30 minutes

later the woman came back into the waiting area…she was excitable and saying if she didn't get help she was going to kill someone…this was loud so everyone could hear her." The panel were unable to determine if either PC, at any time, heard Ms A make threats to kill but felt that on the balance of probability the events described, by this witness had occurred after the police had departed.

1.3 Did the action taken contribute to Ms A being able to abscond and commit the homicide?

Had Ms A been detained on Section 136 she would have been taken immediately to the locked Section 136 assessment unit within Oxleas House. Once there, the Trust standard is that the Duty Psychiatrist should assess the patient within 60 minutes. This assessment would have revealed that Ms A was a conditionally discharged restricted patient with a conviction for manslaughter; this would have allowed a much more considered assessment to take place, with Ms A detained throughout and unable to abscond. It should be noted that this was the only form of legal detention that could be applied both in the A&E unit and the Oxleas House reception area. The only holding powers available to medical or nursing staff would have been following her admission to one of the wards of Oxleas House (Nurses of the "prescribed cla ss" may invoke section 5.4 of the Act in respect of an hospital in-patient who is already receiving treatment for mental disorder – Jones 14th Edition 4-112 page 818) It is an area for future operational consideration that that A&E departments and their Mental Health Trust partners consider how the Mental Health Act powers are deployed in support of the crisis care pathway including the powers that may be enacted by the hospital alone.

Other conclusion points to section 10.3.2 are as follows:

1. The External Investigation Panel also note that had the PCs carried out a PNC check it would have shown Ms A had a conviction for manslaughter which would have heightened their awareness of her potential risks to others, although the Panel recognise that this in itself would not have been grounds to place her on Section 136.

2. When Ms A called the Bracton Centre in a clearly distressed state, there was a missed opportunity to manage the call by getting her name and establishing the facts, and possibly encouraging her to go straight to Oxleas House. Information could then have been recorded in her RiO notes, and passed to the MHLT at Oxleas House, and the A&E. A process is now in place at the Bracton Centre to try to ensure that such calls are responded to more effectively.

3. Communication between A&E and the MHLN seems not to have been effective. It is clear that Ms A was extremely agitated, distressed, loud, and demanding in A&E, and Casualty staff tried to manage her, but with difficulty.

Ms A asked the reception staff “how long am I going to be here?”, and “is it going to take for me to kill someone, as I’ve done it before, so I can get seen?” The Triage Nurse in her statement to the police stated: “She told me she wanted to see a mental health person…she told me she hadn’t slept for weeks and wants to go to any mental health hospital…and thought everyone wanted to hurt her as well as the fact that she was hearing voices…something about her made me feel uneasy, so I triaged her with the door wide open…she was not making eye contact and was very, very agitated”. I referred her to Oxleas, “after I put the telephone down she accused me of not actually telephoning anyone, pretending to make the call. I could still see her walking up and down the triage area…at some time I saw her on the public telephone… she was talking at the top of her voice, I could hear her saying ‘they are not listening to me.’” The Charge Nurse when interviewed by the External Independent Investigation Panel, stated that he became involved after the police had left Ms A in the unit and told the MHLN “I’ve brought her into a room because she’s been threatening to kill someone in the waiting area”. This however was not confirmed by the MHLN. The MHLN stated “when I went there she was sitting down quietly using her mobile phone so I never knew that she was brought by the police”. Following this incident, dedicated space has been given to the MHLT within the A&E to try and ensure more effective communication between the two services. Communication between A&E staff and the MHLT must be reviewed on a regular basis to ensure that it remains effective – see table 17.

4. At 5:30 am Ms A was seen by the MHLN, who could not access her RiO notes whilst actually assessing her as the RiO connection was not working properly, however he had looked at her notes before he came to assess her, so was aware that she was known to the Bracton Centre and that she had killed her mother. The difficulty with the RiO connection in A&E has now been addressed by the Trust’s Internal Review action plan recommendation 10.1.2, which states that ‘Staff should have remote access to RiO whilst assessing patients in Accident & Emergency, in case of failure of connection to the PC’.

Service Delivery Problem

Communication between A&E and the MHLT must be review regularly by auditable means to ensure it remains effective.

The communication between the A&E department and the MHLN did not ensure that important elements of Ms A's presentation were understood by all.

The communication between the police and the A&E department did not ensure that important elements of Ms A's presentation were understood by all. The circumstances of this case highlight the need for a process by which members of the police and emergency services are able to conduct, on arrival, an appropriate handover of the patient with appropriate health professionals regardless of the manner through which crisis mental health care is sought

10.3.3 Oxleas House

1. Oxleas House is situated within the grounds of Queen Elizabeth Hospital. It provides 24 hour Inpatient Mental Health services for adults and older adults living in the borough of Greenwich, who are deemed to need admission to hospital either informally or under a Section of the Mental Health Act 1983.

2. Oxleas House has four inpatient wards covering the Borough, a Psychiatric Intensive Care Unit (PICU), and a secure Section 136 suite. There is also a day hospital at Oxleas House called Mary Seacole, which is open Monday to Friday 9am - 5pm.

3. Clinical professionals working at Oxleas House include Psychiatrists at all levels, Nursing staff, Support Workers, Occupational Therapists, Psychologists and Social Workers.

4. Whilst the Chronology (Appendix 5) sets out in detail Ms A's presentation during her time in Oxleas House, some key points are noted in this section, as follows:

    a. Ms A was escorted to Oxleas House from the A&E department of Queen Elizabeth Hospital at 06.30 and arrived at Oxleas House at 06.37. The Independent Investigation Panel, as part of the investigation, walked the route that Ms A would have taken, and shared their concerns with the Trust that the walk was likely to be additionally distressing for someone who was mentally unwell, perhaps paranoid, and needing admission. The walk goes through a public area which may be busy and loud, and part of the walk is out of doors, creating the opportunity to abscond. The Panel has asked that the Trust review this in terms of the quality and safety of the patient experience.

    b. Once in the unit, Ms A was seated in the Mary Seacole Unit (the assessment area), which was separated from the reception area by a door, but one which the patient could open to go back into the reception area. There was a bed available for her on a ward upstairs, but it seemed to be accepted practice that the ward would not admit a patient until the assessment was fully written up and the drug chart completed. Practice within the Trust has now changed.

    c. Ms A sat on her own for a while in the assessment area, during this time she had a cigarette in the inner secure courtyard, but she then asked if she could sit in the reception area, as she didn't want to be on her own.

    d. The MHLN stated that during Ms A's time in Oxleas House, he did go and offer her a cup of tea, and checked on her two or three further times, but that it was the night senior nurse who was responsible for managing the 15 minutes observations.

e. At 06.30 the main door to OH was unlocked for staff arriving for the morning shift. This allowed staff to get into the lobby area of OH. In order to get into the reception area, the lock on the inner lobby door has to be released. It is documented that the night duty senior nurse usually positions himself/herself in the reception area at this time. The Trust clarified that the lock on the inner lobby door was not there to keep patients in the building, but rather to manage the flow of people coming into (and out of) the building.

f. At approximately 06.40, the Duty Doctor was told that Ms A was in the building. The Duty Doctor did not see her straight away as he was waiting for the MHLN to complete his assessment notes. The Duty Doctor started to look at Ms A's RiO notes on a separate computer, and according to the MHLN, he also started to write out a prescription card.

g. Ms A continued to sit on her own in the reception area. When interviewed by the External Independent Investigation, she said she could see that the staff were tapping on their computers.

h. Footage from the CCTV camera situated outside Oxleas House shows that at 07.05 Ms A walked out of Oxleas house alone, and then after a few seconds, she walked back inside.

i. The CCTV camera footage then shows that at 07.06 Ms A walked out of Oxleas House alone, and turned right, leaving the vicinity of OH. CCTV footage does not record any staff following her or trying to catch up with her.

j. Further information supplied by the Metropolitan Police is that at 07.11 Ms A got on a 178 bus, and that at 07.11 she also made a fifty second phone call to the Bracton Centre.

k. When the Consultant Forensic Psychiatrist on the Independent Investigation Panel asked Ms A why she left Oxleas House, she replied "I was scared of being alone and they left me on my own – they kept leaving me on my own and I was getting scared". When asked why she left the building a second time, Ms A replied "I was going to Bracton, but after this it was very confusing, I don't remember changing buses".

l. During her interview with the Independent Investigation Panel, Ms A also stated that when she left Oxleas House, she went to Queen Elizabeth Hospital Reception and sat and waited for daylight, and she said that the receptionist should have contacted Oxleas House to say she had one of their patients. The time frame from her leaving Oxleas House to getting on the bus is 5 minutes, which raises a question about Ms A's accuracy on this point.

m. At 7:19 am the Oxleas House Duty Doctor reported to the police that Ms A had left the building. He advised them that they should detain her under Section 136, and bring her straight back to Oxleas House, adding that "we are concerned about this lady's safety and there is a possibility that she could pose a threat to the public".

Conclusion to Section 10.3.3

1. Ms A waited on her own in Oxleas House, moving between the Mary Seacole Unit (the assessment area) and the reception, for 29 minutes in an agitated and scared state. Whilst some staff were aware of her, she was not at any stage spoken to by the Duty Doctor, and the priority, as stated by the MHLN, was to document the mental health assessment and write-up the drug chart, before Ms A could be admitted to a ward, even though there was a bed available. This system has now been changed by the Trust, so that patients seen by the Mental Health Liaison Team who are judged to require admission, are taken straight to the ward (where nursing staff and junior doctors can exercise a holding power under the Mental Health Act 1983).

2. The phone call by the Duty Doctor to the Police after Ms A had left OH, is the first indication of the MHLT appreciating the severity of her forensic history, and the danger she could pose to the public. The Trust has now taken steps to ensure that patients known to the Bracton Centre who are assessed by the MHLT as requiring admission, are placed on continual observation from the time of assessment until admission to the ward.

   The Trust has also taken steps to ensure that when a patient known to the Bracton Centre is being assessed, the assessing clinician contacts the Bracton Centre in hours, or the Duty Consultant/Specialist Registrar out of hours, for advice.

3. CCTV footage makes it clear that no OH staff followed Ms A when she left the building - this will be addressed in section 10.4.2 with reference to the Trust's Absconding Policy.

10.4 What are the admission processes and the security arrangements at Oxleas House for informal patients and are they adequate?

1. Section 10.3.3 describes Ms A's admission process from assessment at A&E to the point when she left Oxleas House. This section sets out the following:

   10.4.1 The admission process for informal patients.

   10.4.2 The security arrangements relating to in-patient services at Oxleas House.

10.4.1 <u>The admission process for informal patients</u>.

1. A care pathway has been developed for patients assessed as requiring admission to Oxleas House Acute Adult Mental Health Services. In response to failures within Ms A's care, there are statements within the care pathway as follows:

   - In carrying out an assessment, clinicians will make reference to all care, crisis and contingency plans, risk assessments and relapse indicators detailed for the patient in their RIO records. This information will inform the assessment and resulting management plan'.

   - 'Where the patient is identified to be either currently or previously under the care of Forensic Mental Health Services (Bracton Centre), the assessing clinician will immediately contact the Duty Consultant/Specialist Registrar for advice (this will also include patients making contact through the Urgent Advice Line).

   - 'All patients presenting to assessment services who are noted to be subject to past/current care by forensic services (Bracton), will be placed under continuous care and observation by mental health staff from the point of their contact with the Bracton being identified, until completion of the assessment/management plan and (where indicated) the patient is admitted to a ward'.

   - 'When a patient is assessed as requiring admission, the admission is discussed and agreed by the assessing clinician and the Duty Doctor. Where professionals disagree advice must be sought from the Specialist Registrar and/or the Duty Consultant Psychiatrist'.

   - 'In the case of patients assessed in the Acute Trust (Queen Elizabeth Hospital), the assessing clinician informs the nurse in charge of ward/department (e.g. A&E), of the plan to admit the patient, detailing any risks, and need for Queen Elizabeth Hospital staff to provide continuous care and observation pending a transfer to Oxleas House for admission. If Queen Elizabeth Hospital staff are unable to provide staff, the Assessment Nursing Assistant (ANA) to be contacted to fulfil this role'.

   - 'In case of patients assessed in the Acute Trust, Queen Elizabeth Hospital staff transfer the patient to Oxleas House for admission, accompanied by the ANA where present'. This is in conflict with section 3.3 (vii) of the Mental Health Liaison policy, which states that 'where practicable, the mental health clinician should remain with the patient and transfer the patient, accompanied by the security guard from the Queen Elizabeth Hospital, directly onto the ward. Where this is not practicable, the assessing clinician will ensure that the care team within the QEH (e.g. nurse in charge of the A&E) is informed of the management plan for the patient, including risks, and the need for the patient to have someone remain with them'. Also recommendation 9.2.2 of the Trust's internal action plan states in part that 'where possible the mental health liaison nurse should remain with the patient and transfer the patient'.

- ‘All patients attending for admission must be taken directly to the admitting ward. Under no circumstances must any patient remain in the Mary Seacole Unit or reception for any period of time, once the decision has been made that the patient is for admission. If there is any delay in identification of a bed, the patient must be admitted to a ward at Oxleas House pending identification of a bed. This includes patients requiring transfer to another unit for admission (e.g. Woodlands / Green Parks, out of area patients)’.

- ‘Wherever possible, the assessing clinician (Mental Health Liaison Team / Home Treatment Team/ Duty doctor / Community Mental Health Team staff) should accompany the patient to the ward in order to provide a full face to face handover to the admitting ward staff.

- Handover will include the formulation, identified risks and management plan (including level of observation and actions to be taken if patient wishes to leave). If the assessing clinician is unavailable to provide a face to face handover to the ward, they will do so by telephone *prior* to the patient’s arrival’.

- ‘On arrival at Oxleas House, in reception-staffed hours, the patient and accompanying staff (e.g. QEH staff, security) report to reception, who will direct them to the admitting ward. Out of hours, the staff accompanying the patient will gain access to Oxleas House though use of the coded keypad entry system, or by buzzing the entry phone for admitting ward’.

- ‘The assessing clinician completes a summary of the assessment (formulation) and management plan in the patient’s progress notes on RIO to include:-

  i. Status of admission (formal / informal)
  ii. Reason for admission
  iii. Types and levels of risk
  iv. Level of observation required
  v. Actions to be taken in event of patient wishing to leave the ward (e.g. need for detention under MHA)
  vi. Medications prescribed (medication chart to be completed by duty Doctor either prior to or immediately following admission to the ward)

- It is preferred that all the above is completed before the patient arrives on the ward but in the cases that this has not been possible, this must be done within 30 minutes of the patient arriving on the ward. The full core and risk assessments to be completed within two hours’.

- ‘If not seen prior to arrival on the ward, the duty doctor will admit the patient into the hospital system. This will include the doctor reviewing the patient’s RiO records, personally engaging with, interviewing and examining the patient

(including physical examination), documenting a brief assessment and management plan and writing a medication card. Where this is possible, the doctor should do this immediately following the patient's arrival to the ward, but always within 2 hours from the time of the decision to admit the patient'.

Conclusion to Section 10.4.1

1. The admission process to Oxleas House from any part of the mental health services has been reinforced by clear standards to ensure the patient is admitted in a timely and effective manner. The External Independent Investigation Panel was reassured by evidence and interviews that these standards are followed.

2. The Admission Care Pathway and the Mental Health Liaison Policy disagree on who accompanies the patient from Queen Elizabeth Hospital to Oxleas House. This will be addressed in table 18.

Table 18 - Section 10.4.1 – Service Delivery Problem

Service Delivery Problem
There must be no divergence between policies and procedures At present the Admission Care Pathway and the Mental Health Liaison policy differ on who escorts patients from the A&E department to Oxleas House.

10.4.2 <u>The Security arrangements relating to in-patient services at Oxleas House</u>

1. As stated in section 10.4.1, patients assessed as requiring admission are now escorted straight to the inpatient wards. They do not wait in the reception area. During the External Independent Investigation Panel interviews, staff noted that this process adds to the pressure on ward staff, as they may have to look after a patient who is not yet fully admitted. However staff were clear that this was the right process to employ. The new procedure should be regularly assessed to ensure it is working safely.

2. Patients escorted from Queen Elizabeth Hospital A&E to Oxleas House for admission, are escorted by a mental health nurse and a security staff member from Queen Elizabeth Hospital.

3. A security review was carried out between Oxleas House and the Trust Estates' Department, as stated in the Trust's internal action plan (recommendation 9.4.1). As a result of this, the front door of Oxleas House has been changed to allow for more visibility. A coded keypad entry system is in place, monitored by reception staff during the day, and the Senior Nurse on Duty in the evenings.

4. Out of hours, staff accompanying a patient for admission will gain access to Oxleas House though use of the coded keypad entry system, or by buzzing the entry phone for the admitting ward.

5. It is stated in the care pathway for patients requiring admission to Oxleas House, that 'Staff have a duty to follow absconding patients and encourage them to return, whilst balancing the safety of the patient, the public and themselves'. The pathway further states 'In circumstances where it is appropriate to contact the police, this should be done immediately, giving as much information as possible regarding the description of the person and where they may possibly be located. Staff assessing, observing or escorting patients should ensure that they are able to readily access appropriate communication equipment (e.g. mobile telephone) for use to notify the team or police in the event of an emergency or if the patient absconds'.

6. All Emergency Department referrals will be classified as either emergency or urgent, to ensure there is a high level of priority with this potentially high risk patient group.

7. The Trust Policy for missing/absconding patients (reviewed in May 2012) states that 'when a patient who is not an in-patient wishes to leave prior to commencement of an assessment, the staff must decide whether, in their clinical opinion, the patient presents a risk to self or others. If it is believed a significant level of risk is present, the staff must restrain the patient in order to allow the assessment process to be completed in order to prevent the risk of harm to self or others'. The Policy advises that if the patient is not already subject to the Mental Health Act or Community Treatment Order[21] then consider using the Mental Capacity Act[22].

Conclusion to Section 10.4.2

1. The security arrangements in relation to a patient's admission have been reinforced with clear standards and protocols to underpin the process.

2. The Oxleas House front doors have been replaced with a secure system which allows better monitoring of people entering and leaving the building.

3. If a patient who is assessed as at risk of harm themselves or others, attempts to leave/abscond, there is a clear policy statement for staff to apply. This is underpinned by standards for staff to follow when assessing a patient, especially those known to the service where there is risk information available, as in the case of Ms A.

4. There are clear policy statements for staff to apply should a patient leave/abscond, both from A&E and from Oxleas House.

[21] A Community Treatment Order is made so that someone can leave hospital to be treated in the community, but with a doctor having the power to be able to recall that person to hospital if necessary

[22] The Mental Capacity Act 2005 (c 9) is an Act of the Parliament of the United kingdom applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lacks the capacity to make particular decisions for themselves

10.5 Were assessments and care planning to Ms A appropriate and of good quality?

1. The previous sections raise questions in relation to several assessments throughout Ms A's care, namely:

    10.5.1 Mental Health Tribunal/Ministry of Justice decision

    10.5.2 Referral to MAPPA

    10.5.3 CPA and Risk reviews

    10.5.4 Supported accommodation

    10.5.5 Assessment on return from first Jamaican trip

    10.5.6 Reporting to the MoJ

10.5.1 Mental Health Tribunal/Ministry of Justice decision

1. Prior to the RC's application to the Ministry of Justice for a conditional discharge, Ms A had applied to the Mental Health First Tier Tribunal for a review of her need for continuing detention in hospital. Ms A withdrew the application in favour of her RC applying to the Ministry of Justice later in the year. Ms A's RC explained that a patient applying to the Mental Health Tribunal can be premature in terms of their readiness to go into the community. Whilst the RC explains to the patient that they have the right to apply to the Tribunal, she prefers them to take the route of the RC applying to the Ministry of Justice at a later date.

2. The Independent Investigation Panel were told by the RC that to be granted a conditional discharge by the MoJ was seen as reaching a "gold standard" of readiness to leave.

Conclusion to Section 10.5.1

1. In the case of Ms A, who was a high profile patient and who by the clinical team's own account, was challenging when faced with controls placed on her, it seemed to the Independent External Investigation Panel that continuing with her application to the First Tier Mental Health Tribunal would have had her stage of readiness and mental health tested by a Tribunal appointed Judge, Independent Consultant Psychiatrist and a lay member. Ms A's father had made a statement to her solicitor and would have been able to attend the Tribunal as the Nearest Relative under the Act. Her brother and sister, who were victims, did not have the opportunity offered to them to write to the Tribunal with their opinions regarding discharge. There is a requirement for the Probation Victim Liaison Service to contact them on behalf of the Tribunal. None of the family had the opportunity to make representation to the MoJ.

2. At the meeting of the Board of Directors held on 12 of January 2012, Item 14 'Bexley Heath Serious Incident Inquiry Report' led to a general discussion in which the

question was posed, “would the general public agree the conditional discharge decision was correct?” The Medical Director indicated that it was more common, “for such decisions to be taken by a Tribunal. In this instance it was based on the recommendation of the RC and agreed by the MoJ.

3. The Chair of the internal inquiry commented that “there is evidence the decision was correct on the basis of the improvements seen”, with the Deputy Chief Executive noting that, “The previous Tribunal hearing six months earlier prior to the discharge acknowledged the progress made and was aware that discharge was imminent”. This Tribunal, as noted above, did not take place and the statement infers that her discharge had some form of implicit support from such a body, when it did not.

4. The Trust and Ministry of Justice should jointly discuss the actions taken in the decision to grant conditional discharge to this restricted patient without recourse to the First Tier Tribunal, and the quality of the reporting of her progress when an inpatient.

10.5.2 Referral to MAPPA

1. Prior to her discharge from the Bracton Centre Ms A’s eligibility for MAPPA was discussed. A MAPPA referral form was supported by the care team, and was completed to send to MAPPA for their decision on her eligibility and level. The referral indicated consideration for level 2/3. The referral did not present a complete picture of Ms A in that it stated:

> “Any concerns would trigger an increased level of support by immediate admission to Oxleas House via QE Hospital should her mental health deteriorate. Her sister and brother no longer appear to be hostile towards her”.

2. This was an assumption given that her sister had said she would not see her in the community without support, and Ms A had yet to meet her brother.

3. It was noted in the MAPPA referral that apart from a caution for shoplifting as a teenager, there were no previous convictions. It does not note the following concerns:

   - Aged 15/16 cautioned by the Police for Actual Bodily Harm to her mother.
   - Aged 17/18 Ms A was convicted for shoplifting and received a 12 month conditional discharge sentence.
   - In 2005 MS A was arrested and convicted for Criminal Damage.
   - In 2005 Ms A had been seen shouting at the public, and her sister raised concerns about her mental state, as she was acting in a bizarre manner and had shown inappropriate sexual behaviour to her son.

- In 2005 an emergency order was granted to remove Ms A's son from her.

- Ms A allegedly threw brick through neighbour's window, threatened a neighbour with knife.

4. The referral, completed by the Social Supervisor, was sent to the Bracton Centre's link for MAPPA referrals but was not referred on to the Coordinator for MAPPA. This point has been addressed by the Trust Internal Investigation (10.2.1) which states that 'There must be a robust process of ensuring all referrals to MAPPA are sent and documented'.

5. Ms A's care team did not during the period of conditional discharge, document discussion about the lack of liaison with MAPPA, and the absence of MAPPA involvement was not reported on the quarterly form to the MoJ.

6. There is no data held centrally by MAPPA for those on MAPPA level 1. The External Independent Investigation Panel raise this as a concern in relation to accessibility of this essential information by other agencies. This will be addressed in section 10.7.

7. "Oxleas has partnership arrangements at Board and other levels with local agencies, under the refocusing CPA policy (2009). It is important that service managers ensure that relationships are built (e.g. through shared inductions, joint training events, focused meetings) and contact details and information sharing protocols are well worked out and communicated in each local area. MAPPA (Multi-agency Public Protection Panels) should be informed, through the Oxleas representative senior manager and clinician, where offenders who present immediate and high risk to the community are identified".

8. "In the local services, collaboration with the sector police mental health liaison officers and community beat officers is very helpful and supportive in risk management. The locality safety planning panels which involve the senior operational staff from housing, mental health liaison, police, local authority ASBO units (where appropriate), social services and CMHTs and complex needs, have been found to be invaluable in designing and implementing creative risk management and make community living safe and feasible". Page 61, 'A Guide to the Assessment and Management of Risk', April 2010

Conclusion to Section 10.5.2

1. The MAPPA process was not completed fully in terms of information supplied on the referral form, the form was not dispatched by the MAPPA Co-ordinator for the Greenwich area, and the clinical team did not appear to discuss the lack of MAPPA involvement – see table 19.

Table 19 - Section 10.5.2 – Service Delivery Problem

Service Delivery Problem
The MAPPA Guidance must be followed. The care team did not provide full information on the referral form, and following Ms A's discharge, there is no evidence that they discussed MAPPA involvement.

10.5.3 CPA and Risk reviews

1. The team completed the risk assessment tool [23]HCR-20 (Historical Clinical Risk-20) dated 5th February 2009. This is an assessment tool that helps mental health professionals assess the risk of violence in patients with mental disorder. This stated "The risk factor that is most pertinent for Ms A is her index offence, an incident of serious violence. This shows A has the potential to be very violent, and this violence has been demonstrated from the age of 15. It is important to remember that the offence occurred in concordance with her deteriorating mental state after she became pregnant, and consequent late termination under pressure, and conflictual relationship with the victim". It further stated "If Ms A was to become mentally unwell in the future this would increase her risk of violence. Other historical factors that put Ms A at risk of behaving violently include a difficult childhood, relationship instability, employment problems and substance use problems; which may not be mutually exclusive.

2. Future risks for Ms A include becoming destabilized by pregnancy, conflict in relationships, manic defence to anxieties and substances. Stress factors that may put Ms A at risk include relationship dynamics with her brother or sister. Additional stress may come from employment issues, as she hopes to get a job in accountancy and has an idealized view about the job she hopes for".

3. When Ms A was in the community the Risk, Crisis and Contingency Plan did not reflect all documented risk factors – such as Ms A's increased stress levels in relation to pregnancy or her employment.

4. This has been addressed by the Internal Investigation as recommendation 9.1.1 which states in part 'The Bracton Centre CPA Care Coordinator should ensure that the Crisis, Relapse and Contingency Plan takes into account all relevant documented risk indicators'.

[23] The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a person's probability of violence. Version 1, 1995, now on version 3

5. On the 9 of June 2009, the Consultant Forensic Psychiatrist (RC) and Associate Specialist in Forensic Psychiatry, jointly wrote to the MoJ requesting consideration for conditional discharge of Ms A. Along with proposed details of a community based treatment plan, a list of relapse indicators was given:

   "Insomnia, extreme weight loss, hypomania, crying a lot, avoiding appointments, being chaotic, increased agitation, anxiety, argumentative, aggressive and hostile. Wandering the streets or going to places with no particular reason".

6. Pregnancy issues were also reported as future difficulties. The MoJ subsequently agreed to Ms A's conditional discharge based on the team's proposed discharge plan.

7. In addition "we are recommending this proposal prior to her application to another Mental Health Review Tribunal (MHRT). We believe that it will be very therapeutic to get a discharge at this stage without the need for a Tribunal and will develop further her therapeutic relationships with the team".

8. On 16 December 2009, a CPA Management Review was carried out. The CPA documentation or notes of the meeting do not refer to the concerns raised by the tenants at Ms A's supported accommodation, or the confrontation with the ticket inspector. Ms A requested a two week trip to Jamaica to see her children. It was agreed that the Social Supervisor would approach the MoJ for a possible Easter journey. It was also noted that Ms A's sister had not attended for further Family Therapy. Her sister's concerns about having unsupported contact were not raised.

9. It is not clear from the clinical notes which agencies were invited to the Bracton Centre CPA reviews for Ms A. Her GP did not contribute, but had information concerning Ms A's assumed pregnancies which would have been useful in terms of considering Ms A's stress levels about pregnancy. Ms A's father was not invited to attend, yet he was the legal next of kin, given that her husband was not resident in the UK and therefore was ineligible to exercise the Nearest Relative function. He also had useful information about Ms A's concerning behaviour in the community.

10. When Ms A took a part time job as a telephone call sales person, the appropriateness of this role was not questioned as part of her CPA review, or by the care team at any other time. When interviewed by the External Independent Panel the Social Supervisor did not think it necessary to contact Ms A's employer to see how she was progressing, though it is documented in the clinical records that Ms A felt she was probably bullying a member of staff at her place of work. Ms A was working three days a week, The Social Supervisor should have encouraged Ms A to consent to her contacting Ms A's employer. Had consent not been achieved the Social Supervisor should have discussed this with the contact for Ms A within the MoJ. The External Independent Panel take the view that the MoJ would have supported the Social supervisor in contacting the employer, given the MoJ guidance to social supervisors,(18 March

2008) which states, "A social supervisor will have many difficult decisions to make when working with a conditionally discharged patient....the patient should consult the supervisor when considering any significant change in circumstances, for example a new job... careful consideration of risk should precede any such proposal and the supervisor should advise the patient against taking any step which, in the supervisors view, would involve an unacceptable degree of risk. Some proposals will involve the supervisor making a special report to the MoJ". This was a missed opportunity to observe how she was relating to her peers and managing the additional stress of work, which was identified in her clinical notes as one of her potential relapse indicators. This is addressed in table 15 as a care delivery problem.

Conclusion to Section 10.5.3

1. The concerns raised by the supported accommodation tenants, and the confrontation with the ticket inspector just after Ms A's conditional discharge, were not referred to in her CPA review carried out on 16 December 2009. This would have been an important reflection on her behaviour in the community. This is also addressed by the Trust's Internal Investigation in recommendation 9.1.1.

2. The Bracton Centre CPA reviews of Ms A did not include all the key people who could have provided useful information regarding Ms A's behaviour and presentation – see table 20. There is nothing recorded to indicate that Ms A would not have been willing for them to be invited.

Table 20 - Section 10.5.3 – Care Delivery Problem

Care Delivery Problem

CPA reviews must refer to all key people, and ensure either that they are invited to contribute to the review, or explain why they are not invited.

CPA reviews did not refer to all the key people who could have provided useful information regarding Ms A's behaviour and presentation

10.5.4 Supported accommodation

1. On 15 January 2009 a Social Circumstances report for the Mental Health Tribunal, notes that Ms A is nervous about moving to an environment where she will be alone at night. The care team considered that Ms A had good self care and was very compliant with medication and treatment, and was prepared to be open with her care team about her needs. For those reasons the decision was made that she should be placed in supported accommodation, rather than a 24 hour staffed hostel. The Independent Investigation Panel questions this decision. Although she was living fairly independently

within the Bracton Centre, she was still a detained inpatient and could easily be moved if necessary to a more secure part of the service. If Ms A had been based in 24 hour supported accommodation for the first year of her conditional discharge there would have been more opportunity to observe her behaviour, in particular her relationships with men.

2. Examples of concerning behaviour during her first year of discharge are:

   - The two incidents in November 2009 referred to in section 10.5.3.1
   - Her interaction with her father – the team did not seek collateral information from him
   - Her behaviour in Jamaica – the team accepted Ms A's account of what had happened with her husband and family in Jamaica
   - The information from her (ex) boyfriend to the police, that Ms A sometimes drank alcohol, and when she did, it was associated with changed behaviour, and on one occasion, a threat to pull a knife on a member of the public. There is nothing in the records to suggest these issues were addressed with her

3. It is documented that the first support worker at Ms A's accommodation, communicated with Ms A's CPN when the CPN visited Ms A at her flat. However the subsequent support worker reported to the Independent Investigation Panel that communication was poor, and that he had very little contact with Ms A's Social Worker and her CPN. He would see them coming in, but he said that they would walk past him, see Ms A, and leave. The CPN stated that this was because the nature of the support was different, and the previous support worker would often stay.

   It is the External Independent Panel's opinion that If Ms A had been in a 24 hour staffed hostel, it is likely that hostel staff would have been aware of her deterioration over the weekend 7-10th October, given her general behaviour and contact with the Police and this would have afforded more of an opportunity to effect a safe admission to hospital and to communicate directly with duty staff from the Trust to raise their concerns.

Conclusion to Section 10.5.4

1. The practice of discharging conditionally discharged restricted patients to supported accommodation without 24 hour staffing, should be reviewed to ensure that the patient feels supported in the community, and so that the patient's mental state, behaviour, and risk, can be kept under close scrutiny – see table 21.

2. When patients are in supported accommodation, the care team and the staff at the accommodation should work together so that communication remains timely and effective – this is addressed in table 21 as a care delivery problem.

Table 21 - Section 10.5.4 – Care Delivery Problem

Care Delivery Problem
The practice of placing conditionally discharged patients in low support accommodation should be reviewed. Patients should feel closely supported in the community, and the care team can ensure that the patient's presenting behaviour is kept under closer scrutiny

10.5.5 Assessment on return from first Jamaican trip

1. During Ms A's first trip to Jamaica to see her children, her husband contacted the team saying that Ms A had threatened him with a knife. On her return to England, the Consultant Psychiatrist visited Ms A at home, and wrote the following in the RiO notes "There was no evidence that A had threatened her husband referring to a knife".

2. This assessment seems to have been based on Ms A's word, and there is no evidence of further attempts to get collateral information from her husband in Jamaica. The Oxleas NHS Foundation Trust's *Guide to the Assessment and Management of Risk* states Page 52, **Intent** – 'A statement from the patient that they intend to harm others is the strongest indicator of risk and should never be dismissed.' This information should have been explored fully, and should have been shared with the MoJ. The report of threatening to pull a knife on a member of the public outside a nightclub was also not explored by the supervising team with Ms A, nor reported to the MOJ.

Conclusion to Section 10.5.5

1. The assessment of Ms A on her return from Jamaica did not adequately explore the concerns raised by her husband. This care delivery problem is addressed in table 12 in section 10.3.1.

10.5.6 Mental Health Liaison Assessment

1. At 5:30 am 10 October 2011 Ms A was seen by the MHLN who although, he was unable to use RiO in the A&E department, had accessed her RiO notes before he came to see her, and knew that she was known to the Bracton Centre and that she had killed her mother. It is documented that she told the MHLN that she had been feeling unwell and paranoid and had not slept for weeks. She reported that she had stopped taking Sodium Valproate and Quetiapine for months. She talked about flashbacks of being abused as a child, and her concern that her children were being sexually abused in Jamaica. She also stated that she had used Skunk (a form of strong cannabis) recently. She appeared suspicious and wanted the assessment door left opened.

2. The MHLN reported to the External Independent Investigation Panel that he did not look at her care plan or community crisis plan before he came to assess her. Whilst the decision to admit her was the correct one, the MHLN set her risk level as low, and her observation levels as level 2 – which is to observe every 15 minutes. This is described in detail in section 10.3.2.

Conclusion to Section 10.5.6

1. Whilst this has been addressed within the Internal investigation (recommendation 9.1.1), the External independent Investigation Panel's view is that the lack of recognition of the level of risk, and the subsequent poor follow up within Oxleas House, gave Ms A the opportunity to leave Oxleas House without challenge. - see section 12.

2. At 5:30 am Ms A was seen by the MHLN, who could not access her RiO notes whilst assessing her in A&E as the RiO connection was not working properly, however he had looked at her RiO notes in Oxleas House before he came to assess her. He knew that she was known to the Bracton Centre and that she had killed her mother. However he did not look at the care plan or community crisis plan before coming to assess her. He recorded that she told him that she had been feeling suicidal but had no plans to hurt herself and that she needed to sleep.

3. She stated "I have not slept for weeks and weeks and want to be in hospital". Ms A asked to be sectioned because she does not feel safe on her own. She did feel safe when she was talking to the MHLN. Ms A reported hearing lots of voices telling her different things, however those voices were not commanding her to kill herself or do anything silly. She reported that she had stopped taking both Sodium Valproate and Quetiapine for months. She talked about flashbacks of being abused as a child, and her concern that her children were being sexually abused in Jamaica. She also stated that she had used Skunk (a form of strong cannabis) recently. She appeared suspicious and wanted the assessment room door left open. The MHLN recorded that Ms A self presented, he was unaware that she had been brought to A&E by the Police. The MHLN did not look at her care plan or community crisis plan before he came to assess her. Her contingency plan in part stated "there should be a low threshold for admission given the seriousness of the index offence...it is also known A was seen by a psychiatrist in the weeks before the offence and not thought to be psychiatrically unwell....this would appear Ms A can mask emerging symptoms of her illness".

4. The Panel does acknowledge that the MHLN accurately assessed Ms A as needing admission and accurately scored her high as a forensic risk, and that following a discussion with the Duty Doctor at Oxleas House, her observation level was set at level 2 – which is to observe every 15 minutes.

    4.1 Given what the nurse knew of the patient and his interview notes this does not seem to the panel an unreasonable judgement. Ms A did not show any signs of wanting to abscond to the nurse. However the panel do believe that had the nurse availed himself of the full information available then a different outcome may have resulted.

    4.2 If the nurse had read the balance of paperwork that was not read, would it have made any difference to that assessment of presentation?

    The balance of the paperwork available to the MHLN included the Care Plan and

the Community Crisis Plan. These documents would have informed him that: she was stated to require a low threshold for admission; that she could mask the signs of her psychiatric illness; and emergency acute admission should be facilitated via home treatment team or via presentation at Oxleas House.

Given this additional information the panel believe that the correct level of observation should have been one to one constant observation.

4.3 If Ms A had been observed constantly by a nurse following her arrival at A&E, would her presentation have led to 1:1 observation?

An observer of Ms A following her arrival at the A&E department would have been witness to:

- Her arriving under police escort
- Her agitation and distressed behaviour
- Her leaving the department on several occasions
- Her attempting to phone for taxis to take her away
- Her threats to kill
- Shouting, disruptive and abusive language
- Phone calls to the police (999)
- Her fear of being in the unit
- Her wanting someone to be with her

Given this presentation the panel believe that it would have significantly have raised the risk profile for Ms A and that one to one observation levels would have been indicated.

4.4 If Ms A had been observed constantly and had the balance of her clinical notes read would this have changed the observation level?

Given the above the panel believe that the additional written information and observations of her behaviour following arrival at the A&E unit would have significantly raised the risk profile for Ms A and that one to one observation levels would have been indicated.

5. Whilst the External Independent Panel accept that this was a judgement made by the MHLN and the Duty Doctor, they judge the observation level to be inadequate given her forensic history and clinical presentation. Had Ms A's observation levels been set so that she was in eyesight at all times (as indicated by her forensic history and clinical presentation at that time) then this would have provided an opportunity to support Ms A and discourage her from leaving before being admitted to the in patient service.

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6. Once Ms A was escorted to Oxleas House it would have become obvious to anyone observing her that Ms A was not settled, she asked to sit in a reception area where she could see staff and she pushed open the inner and outer doors of Oxleas house and then went back into the Unit, before absconding one minute later. Had Ms A been on eyesight observation there would have been, as described in the Trust Policy, an opportunity to engage with Ms A whilst continuing to clinically assess her. There would also have been an opportunity to persuade her from leaving Oxleas house by the observing staff member. This observation level assessment and the consequent poor follow up within Oxleas House, gave Ms A the opportunity to leave Oxleas House without challenge.

10.6 Was A's care provided in accordance with statutory obligations, relevant national guidance from the Department of Health, and local operational policies?

1. This section sets out both national and local guidance in relation to the following Mental Health services used by Ms A.

2. In 2007 the Department of Health (DH) provided Guidance for Medium Secure Services – Best Practice Guidance: Specification for Adult Medium Secure Services (2007). The guidance should underpin the delivery of care for patients of the forensic services within the Trust. The guidance covers the following:

   - *'Patient Safety: Patient safety which is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients. Patients are detained in safe and secure environments, which also protects those they may harm'.*

   - *'Clinical and cost effectiveness: Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes'.*

   - *'Governance: Managerial and clinical leadership and accountability, as well as an organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of a healthcare organisation'.*

   - *'Patient focus: Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being'.*

   - *'Accessible and responsive care: Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway'.*

- *'Care environment and amenities: Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences, in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients'.*

- *'Public health: Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups'.*

3. Whilst Ms A's care was provided within this framework, there are two areas which are of concern in relation to Ms A's care, namely:

    - *Governance*: While systems and process were in place, the application of these was not always robust in terms of documentation, responsiveness and communication.

    - *Patient focus:* Ms A's healthcare provision did not always take account of potential information from the support worker at her supported accommodation, her husband in Jamaica, her father, or the GP.

4. The Bracton Centre Patient Leave and Escort Policy – covers the therapeutic leave granted as part of the treatment plan for inpatients. Within this, the type of leave is clearly specified and the authorisation associated with each type of leave is described. During her time as a detained inpatient at the Bracton Centre, Ms A's leave was always appropriately authorised.

5. 'Guidance for Working with MAPPA and Mentally Disordered Offenders (2009)', the 4 edition, was published in 2012, after the homicide, and 'London MAPPA : Guidance for working with Health' contain the following statements:

    - 'Mentally disordered offenders (MDOs) who are MAPPA-eligible are those who are convicted of a specified sexual or violent offence – Schedule 15 to the Criminal Justice Act 2003 (the 2003 Act) and sentenced to twelve months or more imprisonment, or detained in hospital subject to powers of the 1983 Act', thus Ms A was MAPPA eligible.

    - 'All MAPPA eligible offenders should be identified within three days of sentence or admission to hospital'. There is nothing in the records to indicate that this happened with Ms A.

    - 'It is recommended that, at the first Care Programme Approach (CPA) meeting or equivalent, a designated member of the care team should be nominated as responsible for ensuring that the offender is marked as MAPPA-eligible on the

internal management system'. There is no evidence that this happened at Ms A's first CPA.

- 'The MAPPA Co-ordinator needs to be aware of all MAPPA-eligible offenders who are being managed in the community. It is recommended that at the first CPA meeting where a discharge or a community treatment order is considered, a designated member of the care team should be tasked with completing the appropriate notification form at appendix A and sending it to the MAPPA Co-ordinator. This will provide the opportunity both to share clinical information with the criminal justice agencies and to request information from the police and probation services to inform risk assessment'.

6. Ms A was considered for MAPPA prior to discharge however, as stated in section 10.5, the information was not complete and the referral form did not get processed by the Bracton Centre link person and sent on to MAPPA.

7. Ms A was subject to Section 117 aftercare (MHA 1983). Section 117 is in place to ensure that people detained under certain sections of the Mental Health Act 1983, do not leave hospital without a clearly thought through discharge plan based on decisions by both health and the local authority, who have a statutory duty to consider the needs of patients who have been detained.

8. The intention is to achieve a safe discharge, and to ensure that the patient is supported in the community with minimal risk, and so avoids a premature readmission to hospital on account of their mental health and social problems.

9. There was an invitation to the local mental health team in Greenwich to attend, which was sent a week before the section 117 meeting. Their presence was requested for their local knowledge of services but not to provide direct supervision. There was no record found of the local authority Social Services being invited, despite them having an interest in the welfare of Ms A's children in Jamaica, and they should have been party to the discussions about Ms A visiting them in Jamaica, and the implications of future pregnancy.

10. The Policy also states that Section 117 care plans must be subject to regular review on a 6 monthly basis, and consideration given to whether the after care package continues to meet the needs of the patient and to whether the patient still requires after care services. This must be done using the Care Programme Approach procedures but records must clearly state that the review is of S117 aftercare. This is not recorded as such in Ms A's care plans or reviews.

11. Ms A had a Mental Health Act Tribunal booked for the 24 March 2009 which she cancelled. A Mental Health Tribunal hearing gives a statutory right to the detained patient at specified times to have their detention reviewed, and the Tribunal must direct the discharge of any patients where the statutory criteria for detention are not met. Patients have the right to a hearing after a set period of detention depending on the

section under which they are detained. Ms A was detained under a Section 37/41 of the Mental Health Act (1983) and was eligible to apply at the end of the first 6 month detention period and annually thereafter.

12. The Tribunal, which in her case as a restricted patient, would be chaired by a judge, must make a balanced judgment on a number of issues such as:

    - the patient's diagnosis and the need for medical treatment
    - the freedom of the individual
    - the protection of the public and the best interests of the patient.

13. The principal powers of a tribunal are:

    - to conditionally discharge a detained restricted patient from hospital immediately. For some restricted patients, the conditional discharge will be deferred with a view to discharge when services are assembled**.**

14. Since the Care Programme Approach (CPA) was first launched in 1991, there have been various sets of Department of Health (DoH) Guidance relating to the process. Each Trust is required to embed this within Mental Health Services, and to include risk assessment and carer needs. In 2008 the Guidance was enhanced to refocus CPA and to combine both the CPA and case management processes. Each Trust was required to comply with this.

15. The Trust CPA is due to be reviewed in September 2013. The Policy covers all of the principles of CPA planning. Ms A had CPA meetings within the required time frame as set out by the Trust Policy, the outcome of which were noted in her RiO clinical notes within the required sections. Relapse indicators were well described, however could have included her stress factors in relation to both pregnancy, and contact with her siblings, in more detail.

16. The External Independent Panel was unable to elicit at interviews with the Social Supervisor and CPN a clear understanding of what the threshold would be for Ms A to be considered for readmission/recall. The Responsible Clinician had told Ms A at her 117 pre discharge meeting that it would be lower than that which had been accepted on the ward.

17. The Internal Investigation team recommendation at 9.1.1 stated in part that 'The Bracton CPA Coordinator should ensure that the Crisis, Relapse and Contingency Plan take account of all the relevant documented relapse indicators'.

18. The Trust's 'Discharging from Hospital' Policy sets standards to comply with when discharging a patient from the Trust's mental health services. It also states 'three months prior to the anticipated discharge date, the team should begin to plan and

coordinate the section 117 discharge meeting. This will include preparation of the discharge pack for the receiving team'.

19. There is no standard for those patients who will be in receipt of section 117 aftercare who are being discharged and followed up by the forensic service (rather than another receiving team). The policy does cross refer to both MAPPA guidance and CPA.

20. The Trust has an electronic clinical records system called RiO. There are several policies for this. The RiO Clinical Guidance Policy which was last reviewed in 2011 states that 'RiO should be considered as the primary care record for service users of Oxleas NHS Foundation Trust'.

21. All clinicians who will be using RiO are required to have relevant RiO training in order to use it, and do not receive their personal SMART card (required to access RiO) until they have received their training.

22. The Policy clearly guides staff to the relevant domains within each record section. Ms A's relapse and care plan was not accessed at the time of the MHLT assessment, though it was accessible and available.

23. Other issues relevant to the care of Ms A are the Clinical Observation Policy, and the management of informal patients, and absconding procedures. Both these issues in terms of policies have been addressed in sections 10.4.1 and 10.4.2

Conclusion to Section 10.6

1. The relevant Trust clinical policies are in place and refer to national guidance where applicable.

2. Statutory obligations were met, however further clarification is required in the section 117 Aftercare Policy to ensure there is a clear standard for section 117 planning when a patient is to be discharged and followed up by the Bracton Centre – see table 22.

3. While CPA reviews were carried out regularly, it was not stated that the review was of section 117 aftercare as per policy requirements.

Table 22: Section 10.6 – Service Delivery Problem

Service Delivery Problem
The Discharge from Hospital Policy to be reviewed to include set standards when patients are discharged and followed up by the Bracton Centre/Forensic Service. There is no document setting standards for those patients who will be in receipt of Section 117 aftercare who are being discharged and followed up by the forensic service.

10.7 Are there other matters of public interest which need to be considered?

1. Patients on Level 1 MAPPA are managed by the service primarily responsible for their care. There is no data held centrally by MAPPA for those on MAPPA level 1. The External Independent Investigation Panel raises this as a concern in relation to accessibility of this information by other agencies, should a crisis occur.

2. Under the new commissioning arrangements for Health Services, NHS England will be responsible for the commissioning of all forensic services. This will include community forensic services.

   Whilst it is acknowledged that specialist clinical advice has been sought in order to shape the new arrangements, the Trust Board should ensure that these new arrangements do not create a gap in services for patients who could fall between general mental health and forensic psychiatry, such as those discharged from Forensic Services to main stream Mental Health Services.

11. Contributory or Associated factors

1. The National Patient Safety Agency (NPSA) determines "contributory factors as those which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to Service Users and hence the likelihood of Care Delivery or Service Delivery problems occurring". Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. The removal of the influence may not always prevent incident recurrence but will generally improve the safety of the care system; whereas the removal of causal factors or 'root causes' will be expected to prevent or significantly reduce the chances of reoccurrence".

2. The Independent Investigation Panel, following application of a Root Cause Analysis approach described in section 4.6 point 1 of the main report, concluded that there were fundamental root causes or causal factors for this incident, which will be addressed in section 11. There are also several contributory factors which affected the delivery of safe and effective care to Ms A. These are set out under the following headings, as follows:

   11.2.1 Service user
   11.2.2 Involvement of Family members and other Stakeholders
   11.2.3 Clinical assessments

11.2.1 <u>Service user</u>

1. The Consultant Forensic Psychiatrist who assessed Ms A on behalf of the Bracton Clinic (on 13/12/05) concluded that there was some evidence that Ms A was "suffering from a mental illness as evidenced by her over-valued or delusional ideas

in relation to her ex-boyfriend and family members, and the apparent deterioration in her social and occupational functioning in the weeks leading up to the alleged index offence" (in November 2005). He felt she would benefit from a period of assessment in medium security. Despite the prison Inreach Team initially recording no evidence of mental illness, the External Independent Investigation Panel agree that she was appropriately transferred to a medium secure bed at the Bracton Centre in February 2006, under Section 48/49 of the Mental Health Act 1983.

2. The internal inquiry described Ms A's diagnosis as "schizophrenia with a prominent mood component, complicated by emotionally unstable personality traits and a history of substance misuse", which is the formulation given by the Bracton Associate Specialist in a report for the solicitors in May 2006. At other times in her records, the diagnosis is variously given as paranoid schizophrenia with a prominent mood component, and schizoaffective disorder. The External Independent Investigation Panel understands that the clinical team's working diagnosis of Ms A lay between Paranoid Schizophrenia with a strong mood component and Schizoaffective disorder, and that she was not diagnosed with a personality disorder.

3. A mental state examination conducted by a Forensic Psychiatrist preparing a report for the Crown Prosecution Service after she fatally stabbed her mother, indicated that "it is likely that when psychiatrists assessed her in the past.... she was able to hide her symptoms for the duration of the assessment interviews", and concluded that "an acute psychotic episode of schizophrenia was present" and that she also had some "emotionally unstable personality traits". In conclusion, she recommended that Ms A would require a long period of time in a secure hospital environment for further treatment, risk assessment, and long-term rehabilitation.

4. On the 29 September 2009, after spending 3.5 years in the Bracton Centre, Ms A was conditionally discharged, with MoJ approval, to the Supported Accommodation Housing Association flat. This was not 24 hour staffed accommodation. The External Investigation Panel note the Psychologist's comments, that "A is trying to present herself in a good light and may be minimising any psychological difficulties" in order to obtain her conditional discharge, and that she had little insight into the offence and therefore the duration of her treatment, and is fixated on making fast progress to discharge'.

5. Ms A appeared to improve on Sodium Valproate, which is perhaps reinforced by the fact that when it was later reduced in November 2008, it was noted that "There were some concerns in relation to changes in her mental state during the last few days. Increased impatience, more argumentative, critical of others, less tolerant, mood instability. This may relate to her recent change in medication – reduction of Sodium Valproate by 100mgs last week".

6. At a CPA review on 3 of March 2010, the Consultant Psychiatrist stated that "any likely early changes in Ms A's mental health are unlikely to be marked but rather the quality of her interactions may appear less warm or sensitive to the needs of others".

Throughout Ms A's period of conditional discharge, there was evidence of problems with her interaction with others, including family, neighbours, former and current partners, and people in positions of responsibility in the community, but this seems not to have been adequately considered.

7. When Ms A went to Jamaica, there was no evidence of immediate contact with the MoJ, when concerns arose following Ms A's husband in Jamaica contacting the team, and the elder child's social worker. When a report was later submitted to the MoJ by the Social Supervisor on the 22 April she stated that Ms A acknowledged she had drunk two Pernods at a party with her husband, but added "Her mental state has been stable and she has managed many family and relationship issues with equilibrium", which does not seem to reflect the situation adequately.

8. When the Consultant Psychiatrist subsequently visited Ms A at home following her return from Jamaica, she recorded in the notes that "There was no evidence that A had threatened her husband referring to a knife", and appeared to accept Ms A's account that this incident had occurred several years earlier when she was unwell.

9. The CPN was informed by a police officer on 3 August 2010 that an ex partner of Ms A had said that she drank alcohol from time to time, and that her behaviour changed when she did, and further reported an occasion when she was threatening to someone who had jumped a queue at a night club and threatened to pull a knife on them. The care team did not do enough to explore this.

10. In 2011 Ms A's stress factors increased significantly, given that she believed she had miscarried, and she was receiving threatening messages from her last boyfriend. She also stated that a Bracton male patient was threatening her. At this time, her Sodium Valproate had stopped, following a planned and gradual reduction which commenced on 15 July 2010 because of side effects and because she reported that she might be pregnant. There is no evidence to suggest that the team checked with the GP whether Ms A was pregnant. The Consultant Psychiatrist noted that while A reporting two previous boyfriends were threatening her was potentially concerning, she did not consider there to be any fragility in A's mental state. This raises the question of whether the care team should have been more alert to the impact of her personality traits and volatile relationships with men, both in relation to putting her at risk of relapse, and in relation to potential risk to others.

11. In June 2011 Ms A was "working three days a week for a security company. Her primary tasks are cold calling". There does not appear to have been consideration given to gaining her consent to make contact with the employer, or to considering the appropriateness of the job.

12. In September 2011 Ms A again believed that she had had a miscarriage, even though this was not confirmed by the GP. Although she discussed this with the CPN, there does not seem to have been adequate recognition of or response to the

significance of this risk factor, or its subsequent relationship to her trying to contact her brother, and telling the Bracton patient - inferring the baby would be his.

13. On Thursday the 6 October 2011 the Social Supervisor wrote about a telephone conversation she had with Ms A after Ms A was not at home for a scheduled appointment “She said her brother had replied to her in an offensive manner last Wednesday”. The Social Supervisor arranged to meet Ms A on the Monday (October 10) at 5pm.

14. Given the significance of Ms A thinking she had miscarried, trying to contact her brother to tell him this, and the likely impact of his terse reply, in retrospect it is easy to suggest that Ms A should have been seen on 6th or 7th October (before the weekend).

15. If Ms A had been in a 24 hour staffed hostel, it is likely that hostel staff would have been aware of her deterioration over the weekend 7-10th October, given her general behaviour and contact with the Police and this would have afforded more of an opportunity to effect a safe admission to hospital and to communicate directly with duty staff from the Trust to raise their concerns.

16 However even if the significance of these developments was not apparent at the time, had Ms A been in 24 hour staffed accommodation, hostel staff may have been able to effect her safe admission to hospital over the 9 - 10 October.

17. Ms A was exhibiting signs of agitation and distress at the minicab office when the PCs attended, and she also clearly informed the Officers that she had mental health issues and needed medication. When she also refused to get in the ambulance, this should have raised their concerns about the fragility of her mental health and her level of cooperation. The Officers did not carry out a PNC check which would have shown them that she had a conviction for Manslaughter.

11.2.2 <u>Involvement of Family members and other Stakeholders</u>

1. Both Ms A’s sister and father had contact with her when she was at the Bracton Centre. Her father, sister and brother, in interviews with the External Investigation Panel, felt that they were not consulted, and their views were not considered by the care team. For example, the incident at Christmas when her father visited Ms A, and a judgement about what took place was made by the team on the word of Ms A only.

2. As Ms A’s husband lived in Jamaica, Ms A’s father was legally Ms A’s next of kin under the Mental Health Act 1983. There was a missed opportunity for the Bracton team to seek collateral information about Ms A’s history and behaviour from family members.

3. Throughout Ms A's period of conditional discharge, evidence of problems with her interaction with others, whether it be family, neighbours, previous partners, or people in official positions in the community, seem not to have been adequately considered by the team.

4. There was an invitation to the local mental health team in Greenwich to attend a section 117 aftercare meeting, which was sent a week before the meeting. Their presence was requested for their knowledge of local services, not to provide direct supervision. There was no record found of the local authority Social Services being invited, despite them having an interest in the welfare of Ms A's children in Jamaica, and they should have been party to the later discussions about Ms A visiting them in Jamaica.

5. It is not clear from the clinical notes which agencies were invited to the Bracton Centre CPA reviews for Ms A. Her GP did not contribute, but had information concerning Ms A's assumed pregnancies which would have been useful in terms of considering Ms A's stress levels about pregnancy. The GP practice did not have a record of the relapse indicators. Ms A's father was not invited to attend, yet he was the legal next of kin, given that her husband was not resident in the UK and therefore was ineligible to exercise the Nearest Relative function. Mr also had useful information about Ms A's concerning behaviour in the community.

6. On 23 June 2011 the CPN recorded that Ms A was "working three days a week for a security company. Her primary tasks are cold calling". There does not appear to have been consideration about making contact with the employer, or considering the appropriateness of the job.

7. On Saturday evening 8 October, Ms A's brother phoned the Bracton Centre reception and told them his sister had contacted him and he did not think she was well. Her brother said to the Independent Investigation Panel that he was told if Ms A was bothering him, he should call the Police. This response was inadequate in terms of risk management. If her clinical team had been made aware of this, and it was combined with knowledge of the events of the previous week, there would have been a possibility for intervention, although it was, of course, out of hours.

11.2.3 <u>Clinical assessments</u>

1. Whilst the External Independent Investigation Panel accepts that applying to the MoJ for a conditional discharge is a legal route open to the clinical team, In the case of Ms A, who was a high profile patient and who by the clinical team's own account, was challenging when faced with controls placed on her, it seemed to the Independent Investigation Panel that continuing with her application to the First Tier Mental Health Tribunal would have had her stage of readiness and mental health tested by a Tribunal appointed Judge, Independent Consultant Psychiatrist and a lay member.

2. Prior to her discharge from the Bracton Centre, Ms A's eligibility for MAPPA was discussed. A MAPPA referral form was completed to send to MAPPA for their

decision on her eligibility and level. The referral indicated consideration for level 2/3. The referral did not present a complete picture of Ms A's history of previous convictions and aggressive behaviour, and was in other respects also, not fully accurate, in that it stated:

"Her sister and brother no longer appear to be hostile towards her".

3. This was an assumption, given that her sister had said that she would not see her in the community without support and Ms A had not seen her brother since before killing their mother.

4. The referral, completed by the Social Supervisor, was sent to the Bracton Centre's link for MAPPA referrals but was not sent on by the Bracton Coordinator for MAPPA.

5. The Risk, Crisis and Contingency Plan did not reflect all documented risk factors – such as Ms A's increased stress levels in relation to pregnancy, or her employment.

6. On 16 December 2009 a CPA Management Review was carried out. The CPA documentation or notes of the meeting do not refer to the concerns raised by the tenants at the supported accommodation, or the confrontation with the ticket inspector.

7. When Ms A took a part time job as a telephone call sales person, the appropriateness of this role was not questioned as part of her CPA review, or by the care team at any other time. It is documented in the clinical records that Ms A felt she was probably bullying a member of staff at her place of work. Ms A worked three days a week, and this was a missed opportunity to learn more about how she was relating to her peers, and managing the additional stress of work.

8. On 15 January 2009 a Social Circumstances report for the Mental Health Tribunal, notes that Ms A is nervous about moving to an environment where she will be alone at night. The care team considered that Ms A had good self-care and was very compliant with medication and treatment, and was prepared to be open with her care team about her needs. For those reasons the decision was made that she should be placed in supported accommodation, rather than a 24 hour staffed hostel or care home.

9. If Ms A had been based in 24 hour supported accommodation following her conditional discharge, there would have been more opportunity to observe her behaviour, in particular her relationships with men.

10. It is documented that the first key worker at Ms A's accommodation communicated with Ms A's CPN when the CPN visited Ms A at her flat. However the subsequent key worker reported to the External Independent Investigation that communication was poor, although he reported to the Internal investigation that he had met both the CPN and Social Worker and that they would visit Ms A first and then have a brief word with him.

11. During Ms A's first trip to Jamaica to see her children, her husband contacted the team saying that Ms A had threatened him with a knife. On her return to England, the Consultant Psychiatrist visited Ms A at home, and wrote the following in the RiO notes "There was no evidence that Ms A had threatened her husband referring to a knife". This assessment was based on Ms A's word, there is no evidence that this was corroborated by her husband in Jamaica. Had this report been explored more fully, and the information shared with the MoJ, the possibility of recall could have been considered.

12. Root Causes/Causal factors

The NPSA determines a root cause as “a fundamental contributory factor which if removed will be expected to prevent or significantly reduce the chances of reoccurrence”. The Independent Investigation has concluded that there are two fundamental contributory or causal factors as follows:

1 The External Independent Investigation Panel is of the view that there was enough evidence for the police to place Ms A under section 136 of the MHA 1983 on one occasion in the small hours of the 10 October 2011, when she was observed by the Police (as stated in their statements) coming out of A&E for the second time. The PCs recognised that she had mental health problems and although she appeared to be willing to go to hospital, she did in fact leave A&E twice, the first time being escorted back to reception by the Police Officers, after they reassured her and the second time saying that she had only come out for a cigarette. When she came out of hospital a second time the Police had an opportunity to question her willingness to remain. Ms A had used the dedicated taxi phone on two occasions to call a mini-cab in the presence of the PC and had her call terminated by the PC on the second occasion. At this point the Panel felt it would have been reasonable for the PCs to conclude it was necessary to detain her under section 136 of the MHA. In their view, Ms A met both the criteria for section 136 set out in the Policing Mental Health Standard Operating Procedure, February 2011, and the justification of compulsion for willing patients.

The panel accepts that section 136 of the Mental Health Act is an emergency power and that whether to use it is a judgement call. Given this set of circumstances some Police officers may have applied Section 136 of the Mental Health Act whilst others may not have. The Police Officers involved reached their decision in good faith and were satisfied that Ms A did not meet the relevant test. However, the Panel believes that Ms A could have been placed on a section 136 in light of her level of agitation and her demonstration of intention to leave the unit by twice attempting to arrange a taxi via the dedicated free taxi phone in the presence of the police officer. This was followed by Ms A's leaving of the A&E unit for a second time and it is the view of the Panel that the likelihood of her remaining to undergo voluntary admission had by now been placed in serious doubt. When leaving the QEH the police officers had felt that Ms A "had appeared fine, that she was a little nervous but ultimately was not happy with having to wait to be given her medication", the accompanying PC stated that "She genuinely seemed as though she wanted help". Both PC's stated that the Hospital was where she was repeatedly asking to be. They left the situation therefore feeling that she was nervous but presenting no threat and that she was in a place where she both wanted to be and would receive the support and care that she needed. The panel view is that throughout the period of her interaction with the emergency services Ms A was expressing the view that she wanted treatment and care.

Had Ms A been detained on Section 136 she would have been taken immediately to the locked Section 136 assessment unit within Oxleas House, being the designated safe place. Once there, the Trust standard is that the Duty Psychiatrist should assess the patient within 60 minutes. This assessment would have revealed that Ms A was a conditionally discharged restricted patient with a

conviction for manslaughter; this would have allowed a much more considered assessment to take place, with Ms A detained throughout. The circumstances of this case highlight the need for a process by which members of the police and emergency services are able to conduct, on arrival, an appropriate handover of the patient with appropriate health professionals regardless of the manner through which crisis mental health care is sought. The circumstances of the case also highlight the need for A&E departments and their Mental Health Trust partners consider how the Mental Health Act powers are deployed in support of the crisis care pathway including the powers that may be enacted by the hospital alone.

2. At 5:30 am Ms A was seen by the MHLN, who could not access her RiO notes whilst assessing her in A&E as the RiO connection was not working properly, however he had looked at her RiO notes in Oxleas House before he came to assess her. He knew that she was known to the Bracton Centre and that she had killed her mother. However he did not look at the care plan or community crisis plan before coming to assess her. He recorded that she told him that she had been feeling suicidal but had no plans to hurt herself and that she needed to sleep.

   She stated "I have not slept for weeks and weeks and want to be in hospital". Ms A asked to be sectioned because she does not feel safe on her own. She did feel safe when she was talking to the MHLN. Ms A reported hearing lots of voices telling her different things, however those voices were not commanding her to kill herself or do anything silly. She reported that she had stopped taking both Sodium Valproate and Quetiapine for months. She talked about flashbacks of being abused as a child, and her concern that her children were being sexually abused in Jamaica. She also stated that she had used Skunk (a form of strong cannabis) recently. She appeared suspicious and wanted the assessment room door left open. The MHLN recorded that Ms A self-presented as he was unaware that she had been brought to A&E by the Police. The MHLN did not look at her care plan or community crisis plan before he came to assess her. Her contingency plan in part stated "there should be a low threshold for admission given the seriousness of the index offence...it is also known A was seen by a psychiatrist in the weeks before the offence and not thought to be psychiatrically unwell....this would appear Ms A can mask emerging symptoms of her illness".

   The Panel does acknowledge that the MHLN accurately assessed Ms A as needing admission and accurately scored her high as a forensic risk, and that following a discussion with the Duty Doctor, her observation level was set at level 2 – which is to observe every 15 minutes.

   2.1 Given what the nurse knew of the patient and his interview notes this does not seem to the panel an unreasonable judgement. Ms A did not show any signs of wanting to abscond to the nurse. However the panel do believe that had the nurse availed himself of the full information available then a different outcome may have resulted.

2.2 If the nurse had read the balance of paperwork that was not read, would it have made any difference to that assessment of presentation?

The balance of the paperwork available to the MHLN included the Care Plan and the Community Crisis Plan. These documents would have informed him that: she was stated to require a low threshold for admission; that she could mask the signs of her psychiatric illness; and emergency acute admission should be facilitated via home treatment team or via presentation at Oxleas House.

Given this additional information the panel believe that the correct level of observation should have been one to one constant observation.

2.3 If Ms A had been observed constantly by a nurse following her arrival at A&E, would her presentation have led to 1:1 observation?

An observer of Ms A following her arrival at the A&E department would have been witness to:

- Her arriving under police escort
- Her agitation and distressed behaviour
- Her leaving the department on several occasions
- Her attempting to phone for taxis to take her away
- Her threats to kill
- Shouting, disruptive and abusive language
- Phone calls to the police (999)
- Her fear of being in the unit
- Her wanting someone to be with her

Given this presentation the panel believe that it would have significantly have raised the risk profile for Ms A and that one to one observation levels would have been indicated.

2.4 If Ms A had been observed constantly and had the balance of her clinical notes read would this have changed the observation level?

Given the above the panel believe that the additional written information and observations of her behaviour following arrival at the A&E unit would have significantly raised the risk profile for Ms A and that one to one observation levels would have been indicated.

Whilst the External Independent Panel accept that this was a judgement made by the MHLN and the Duty Doctor, they judge the observation level to be inadequate given her forensic history and clinical presentation. Had Ms A's observation levels been set so that she was in eyesight at all times (as indicated by her forensic

history and clinical presentation) then this would have provided an opportunity to support Ms A and discourage her from leaving before being admitted to the in patient service.

Once Ms A was escorted to Oxleas House it would have become obvious to anyone observing her that Ms A was not settled, she asked to sit in a reception area where she could see staff and she pushed open the inner and outer doors of Oxleas house and then went back into the Unit, before absconding one minute later. Had Ms A been on eyesight observation there would have been, as described in the Trust Policy, an opportunity to engage with Ms A whilst continuing to clinically assess her. There would also have been an opportunity to persuade her from leaving Oxleas house by the observing staff member. This observation level assessment and the consequent poor follow up within Oxleas House, gave Ms A the opportunity to leave Oxleas House without challenge.

13. Lessons Learned

The Internal Investigation report identified a number of areas of concern with which the Independent Investigation Panel agreed. The independent Investigation Panel added some further observations about the recommendations in terms of substance, format and implementation (details in sections 9.1, 9.2). The Independent Investigation Panel also commented on potential improvements to the involvement of family members of victims and perpetrator, and the victim of attempted murder (details in section 9.3).

13.1 Additional requirements following the External Independent Investigation process

1. The Independent Investigation Panel identified a number of care delivery problems and service delivery problems. This section sets out these additional issues.

    a. The practice of discharging conditionally discharged patients to low support accommodation which does not have 24 hour staffing.

    b. The approach taken when patients on a 'conditional discharge' gain employment, in terms of communication with the employer and assessing the appropriateness of the job.

    c. The Trust should satisfy itself that the practice and approach sometimes taken by the RC in applying to the MoJ, rather than the patient seeking this through the MHA Tribunal, is acceptable.

    d. A review of the Bracton Centre's communication with the MoJ, as information to the MoJ did not fully reflect Ms A's behaviour and presentation.

    e. A review of the Bracton Centre practice and culture in its communication with families and other stakeholders involved in the care of the patient, both during the CPA process, and during day to day management of care.

    f. A review of the Bracton Centre staff working practices in responding to a contact made to the clinic reporting concerning behaviour by a community forensic patient, as when Ms A's brother phoned the Bracton Centre to report his concerns.

    g. A review of the Bracton Centre's decisions to support restricted patients who are on a conditional discharge to visit other countries without taking account of all the documented risks.

    h. The circumstances of this case highlight the need for a process by which the police and other emergency services are able to conduct, on arrival, an appropriate handover of the patient with appropriate health professionals

regardless of the manner through which crisis mental health care is sought. The circumstances of the case also highlight the need for A&E departments and their Mental Health Trust partners to consider how the Mental Health Act powers are deployed in support of the crisis care pathway including the powers that may be enacted by the hospital alone.

i. A review of the training on risk assessment and management and clinical observation for all the Mental Health Liaison Team, to ensure it is being accessed by all staff and mandatory training.

j. To review communication between the A&E Department at QEH and the Mental Health Liaison Service, to ensure it remains effective.

k. A review of the walk undertaken by patients assessed by the MHLS as in need of admission who then have to walk to Oxleas House through a public area which may be busy and loud, with part of the walk being outdoors, creating the opportunity to abscond. The Trust to review this in terms of the quality and safety of the patient experience.

l. The Trust to ensure that Policies and procedures complement each other, such as the Admission Care Pathway and the Mental Health Liaison Policy, which currently differ as to who accompanies the patient from the A&E department to Oxleas House.

m. To review the Discharge from Hospital Policy, to ensure it includes standards when patients are discharged and followed up by the Bracton Centre.

n. To review the effectiveness of clinical supervision and clinical leadership at the Bracton Centre, the Mental Health Liaison Service, and at Oxleas House, to ensure all areas are supported by robust structures for both.

14 Post Investigation Risk Assessment

1. Given the immediate response by the Trust (detailed in section 9.1) to change and improve the practice in assessment and admission of patients in crisis, the impact on the likelihood of a reoccurrence of a homicide is reduced to 2 (unlikely), with the impact of such an occurrence remaining at 5. This gives an overall score of 10, which is a reduction on the pre-investigation score of 15.

15. Recommendations

1. The recommendations and action plan of the Trusts internal investigation should be reviewed to take account of the External Independent Investigation Panel additional findings.

2. Actions developed from additional recommendations must be auditable to ensure compliance.

3. The Trust to ensure that the action plan continues to be monitored and its progress reported upwards via its governance reporting systems.

4. The Trust should ensure that all recommendations from Internal Investigations are SMART and auditable, leading to effective learning.

5. The Trust should ensure that all Policies identified within the report are updated to address the findings.

6. The Trust should ensure that all those involved or affected by a serious incident, have the opportunity to contribute to an investigation and to receive support.

7. The Trust should assure itself that leadership at both clinical and managerial level is effective.

8. The Trust should review the Practice of discharging conditionally discharged patients to low supported accommodation which does not have staffing over a 24 hour period.

9. The Trust should review the approach taken when patients on a 'conditional discharge' gain employment, in terms of communication with the employer and assessing the appropriateness of the job.

10. The Trust should satisfy itself that the practice and approach sometimes taken by an RC in applying to the MoJ, rather than the patient seeking this through the MHA Tribunal, is acceptable.

11. The Trust should review the Bracton Centre's communication with the MoJ, as correspondence to the MoJ did not fully reflect Ms A's behaviour and presentation.

12. The Trust should review its practice and culture relating to communication with families and other stakeholders involved in the care of the patient, both during the CPA process, and during day to day management of care.

13. The Trust should ensure that robust processes are in place to support a clinical decision to allow patients who are on a conditional discharge to visit other countries.

14. The circumstances of this case highlight the need for a process by which the police and other emergency services are able to conduct, on arrival, an appropriate handover of the patient with appropriate health professionals regardless of the manner through which crisis mental health care is sought. The circumstances of the case also highlight the need for A&E departments and their Mental Health Trust partners to consider how the Mental Health Act powers are deployed in support of the crisis care pathway including the powers that may be enacted by the hospital alone.

15. The Trust to review the uptake of training relating to risk assessment and management, and clinical observation, for all Mental Health Liaison Team staff to ensure staff are up to date.

16. The Trust should ensure an auditable process is in place to monitor communication between the A&E Department and the Mental Health Liaison Service, so that it remains effective.

17. The Trust should review the route undertaken by acutely mentally unwell patients, who are admitted via the MHLS to Oxleas House.

18. The Trust must ensure that given the new commissioning arrangements for Forensic Services, no gap is allowed to develop for Service Users who are forensic inpatients, but then discharged to the care of a general team.

19. The Trust should review their Duty Doctor on-call arrangements to consider the use of a specific Doctor on-call rota for the Forensic services.

20. MAPPA should hold a central database for those patients on Level 1 MAPPA.

21. NHS England should ensure that the terms of reference guide the Panel to identify where it may become necessary to invite additional Panel members with specialist knowledge of other organisations such as Police or Housing. The Panel acknowledge that their reports must not only be fair but be seen to be fair and wider membership may be a way to achieve this.

APPENDICES

Appendix 1: Mental Health Act Sections

Introduction:

The purpose of the 1983 Mental Health Act is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they may need for their own health and safety, and for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for service users.

Section 37: This is a court order imposed instead of a prison sentence on a finding of guilt, if the offender is sufficiently mentally unwell at the time of sentencing to require hospitalisation. It has the same duration as a section 3, and in many ways operates exactly the same way.

Section 41: This is also known as a Restriction Order, and can be imposed by a Crown Court Judge when a defendant is made subject to **Section 37**, usually following a serious violent offence. The Judge has to hear oral evidence from at least one psychiatrist, but does not have to follow the advice, so can impose a restriction order even if the psychiatrist advises against it. The Restriction Order means that the patient cannot move from the secure perimeter of the unit named on the Hospital Order, without Ministry of Justice (MoJ) permission. It also means they can only be discharged either by a Mental Health Review Tribunal chaired by a Crown Court Judge or senior lawyer – the more common route - or by the Responsible Clinician making an application to the MoJ. Furthermore when the patient is discharged to the community, he/she is **conditionally** discharged, i.e. subject to a range of conditions which, if he/she breaks, or if risk is thought to be increased for any reason, he/she can be recalled to hospital without having to be re-assessed for Section, or having had a relapse of mental illness. It is the MoJ which decides whether to recall, on the basis of information from the clinical team, and they can go against clinical advice about to whether to recall or not. The clinical team has a duty to inform the MoJ of any significant developments, as well as the Responsible Clinician (RC), and Social Supervisor, writing regular reports to the MoJ about the patient. Many patients in medium secure units are on Section 37/41 Orders

Section 48: Allows the Secretary of State the power to transfer prisoners with mental health disorders to appropriate hospital settings

Section 49: Refers to special restrictions which can be applied by the Secretary of State on the advice of the Responsible Medical Officer to prisoners who have been transferred to hospital settings.

Section 117: Concerns aftercare and places a legal duty on the NHS and Social Services to provide aftercare, free of charge, to people who have been detailed under Sections 3, 37, 45a, 47 and 48 of the Mental Health Act. Aftercare lasts as long as someone requires if for their mental health condition and only ends when Health and Social Care authorities have assessed that someone is no longer in need of aftercare services.

Section 136: Section 136 of the Mental Health Act 1983 gives the police powers to remove a person who appears to be suffering from mental disorder and who is “in immediate need of care or control” from a public place to a place of safety. Removal may take place if a Police Officer believes it is necessary in the interests of that person, or for the protection of others. The purpose of removing a person to a place of safety is to enable them to be assessed by a Doctor or interviewed by a Mental Health Professional.

Mental Health Act Tribunal: Exists to protect the rights of persons subject to the Mental Health Act 1983 (amended 2007).Essentially, it provides for consideration of appeals against detention in hospital made by people thus detained.

Conditional Discharge: This type of discharge only applies to restricted patients, whose discharge can only be granted by the Tribunal or, less commonly, the Ministry of Justice. Invariably, conditions are imposed on the patient at the time of discharge (Under s73(4)(b) by the MHRT or under s42(2) by the Ministry of Justice).

Usual conditions include the following, depending on the nature of the case:

- Residence at a particular address, or "as directed by the Supervising Psychiatrist.
- Co-operation with supervision by a community CPN and a Social Supervisor.

Other conditions often imposed include:

- Abstinence from illegal drugs and excessive consumption of alcohol
- Urine drug screens
- Compliance with treatment as directed by the Supervising Psychiatrist (albeit on a voluntary basis)
- Exclusion zones
- Not to contact victim or victim's family

Appendix 2: Investigation Terms of Reference

Independent Mental Health Investigation into the Care and Treatment provided to Ms A
Terms of Reference

Commissioner

This independent review is commissioned by NHS England (London) in accordance with guidance published by the Department of Health in circular HSG 94 (27). *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33 – 6 issued in June 2005.

Terms of Reference

The aim of the independent review is to evaluate the mental health care and treatment provided to Ms A to include: -

- A review of the Trust's internal investigation to assess the adequacy of its findings, recommendations and action plans
- Reviewing the progress made by the Trust in implementing the action plan from the internal investigation
- Involving the families of both Ms A and the victims as fully as is considered appropriate in liaison with the police
- A chronology of the events to assist in the identification of any care and service delivery problems leading to the incident:
- An examination of the mental health services provided to Ms A and a review of the relevant documents
- An examination of admission processes and the security arrangements at Oxleas House for informal patients
- The appropriateness and quality of assessments and care planning
- The extent to which Ms A's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
- Consider other such matters as the public interest may require
- Complete an Independent review report for presentation to NHS London within 26 weeks of commencing the investigation and assist in the preparation of the report for publication

Approach

The review team will conduct its work in private and will take as its starting point the Trust Internal Investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

If the review teams identify a serious cause for concern then this will immediately be notified to the Investigations Manager, NHS England (London).

The Review Team

The review team will consist of appropriate qualified senior professionals.

Consultant Forensic Psychiatrist

Project Manager from Caring Solutions

Social Worker

Appendix 3 Trust Action Plan External Investigation Evidence Framework

Recommendation	Action	Evidence
9.1 Care & service delivery problem 1: There were gaps in the management of A following her presenting in crisis.		
9.1.1 The Bracton CPA Care-Coordinator should ensure that the Crisis, Relapse and Contingency Plan takes into account all the relevant documented relapse indicators. On discharge of all patients, the consultant psychiatrist or deputy should approve the Care Planning, Crisis, Relapse and Contingency Plan and Risk Assessment sections on the RiO record	Relapse indicators will be clear, concise and accessible within the clinical record. For each Bracton patient, relapse indicators will be signed off by the responsible clinician: a) prior to the Section 117 discharge meeting thereafter at each CPA review (or more frequently as required)	• Discharge from Hospital Policy – Next Review 2016 • Forensic and Prison Services Risk Register entry – completed July 2012 • CPA audits December 2012 **NHSLA Level 3**
9.1.2 When a discharged patient contacts the Bracton Centre in crisis, the clinical staff member involved should: • make an entry in the patient's RiO record as soon as possible • alert the Mental health Assessment & Liaison team to the nature of the contact Immediately contact the on call consultant/specialist registrar for further advice	The operational policy will be revised to incorporate these requirements. All unit coordinators personally will be updated on the revisions by the Inpatient Services manager. To ensure full dissemination, all band 6s and 7s at the Bracton Centre will receive a copy of the revised operational policy, with their attention drawn to the relevant changes. The revisions also will be disseminated via nursing team handover meetings, and the Good Practice Newsletter.	• Trust Good Practice News letter (Summer 2012) • Bracton Unit specific protocol – Role of the Unit Coordinator – next review 2014. • Greenwich Mental Health Liaison Policy – next review date September 2014. Bromley Mental Health Liaison Policy – next review date January 2013. • Evidence that staff received a copy of the revised operational policy triangulated during External Interviews with staff **NHSLA Level 3**

Recommendation	Action	Evidence
9.1.3 All assessments for current of former Oxleas patients presenting to Accident & Emergency must be informed by and include reference to the Care Planning, Crisis Relapse and Contingency Plan and Risk Assessment sections of RiO	The assessment protocol will be revised to incorporate these requirements, ensuring consistency with the Trust guidelines on risk assessment and management Training on the revised protocol will be implemented and the new protocol will be put on the Intranet	• Greenwich Mental Health Liaison Policy – next review date September 2014] • Forensic and Prison Services Risk Register entry - completed July 2012 • Bromley Mental Health Liaison Policy does not state this within the main body of the Policy – next review January 2013 • Training Policy/protocol confirmed as having been received by the General Nurses in A&E • Evidence of staff awareness from Mental Health Liaison staff **NHSLA Level 1**
9.1.4 The on call consultant/specialist registrar immediately must be contacted for advice following any out of hours contact to an Oxleas service by a patient known to have been discharged from the Bracton Centre. This will include patients who phone the Trust crisis line, who are assessed by the Mental Health Assessment & Liaison team in A&E or who contact the Bracton Centre.		• Greenwich Mental Health Liaison Policy – next review date September 2014] • Bromley Mental Health Liaison Policy – next review date January 2013 • Appendix 6 of the Policy does not include contacting the out of hours on call Consultant where a patient is known to the Bracton Centre • Junior Doctor Handbook **NHSLA Level 3**

Recommendation	Action	Evidence
9.2 Care & service delivery problem 2: The process of assessing and admitting A in Accident & Emergency was lengthy for someone presenting in mental health crisis, involving a number of professionals and multiple steps		
9.2.1 The mental health assessment and liaison nurse should be permanently located in the Accident and Emergency department	The Greenwich Liaison Team is based in QEH A&E Dept at night, but not during the day because of a lack of an office base Arrangements for permanent accommodation in QEH and the PRUH will be agreed with SLHT.	• Trust Board minutes, Agenda item 6, 5 July 2012 • External Interview of staff members • Greenwich Mental Health Liaison Policy – next review date September 2014 **NHSLA Level 1**
9.2.2 Where practicable, the mental health assessment and liaison nurse should remain with the patient and transfer the patient, accompanied by the security guard from Accident & Emergency, directly on to the ward.	The assessment nurse now ensures that patients are appropriately supervised after a decision to admit has been made. This new requirement will be in the revised operational policy. (see 9.2.3)	• Stated in text of Greenwich & Bromley Mental Health Liaison policy – next review date June 2013 for Greenwich and January 2013 for Bromley • Appendices 5 and 6 do not accurately reflect this recommendation in either the Greenwich or Bromley Mental Health Liaison policy. • Practice not carried out at Greenwich, this confirmed by external staff interviews. Not ascertained for Bromley. **NHSLA Level 1**

Recommendation	Action	Evidence
9.2.3 The Mental Health Assessment & Liaison team policy must be reviewed to include the following: • All patients assessed within A&E as requiring admission to be admitted directly to a ward • Any patient presenting to A&E who previously has been discharged from the Bracton Centre or has ever been on the caseload of the Bracton Community Forensic Team to be kept under continuous supervision by a mental health clinic from first contact until admitted. • Respective roles and responsibilities of staff involved in an admission, (mental health assessment and liaison nurse, duty senior nurse and duty doctor) to be reviewed and clarified. • As part of the admission process for each patient, the duty doctor must review the RiO records, personally engage with, interview and examine the patient, write a brief assessment and immediate treatment plan and medication card. This may happen during the assessment in A&E or post admission to the ward (in a timely manner).	The Operational Policy will be revised to incorporate these requirements and ensure that: • All patients assessed as requiring admission are sent directly to a ward • After a decision has been made to admit, the patient will be supervised appropriately until admitted onto a ward. • If a Bracton patient, supervision will always be continuous until the patient is admitted onto a ward. • The revised operational policy will clarify the respective roles and responsibilities of all the staff within the assessment team. • All admissions will continue to be reviewed by the duty doctor who will prescribe medication and clerk the patient into the ward. The standard is that this will occur within a maximum of 2 hours from the decision to admit. Actions set out in the Operational Policy will make specific referral to services with an A&E present on site (O.C.. & G.P.C.) and for the Woodlands Unit where relevant	• Greenwich and Bromley Mental Health Liaison Policies • Trust Board Minutes, agenda item 6, 1 November 2012 • Mental Health Liaison Manager Work Plan – April - June 2012 • RiO notes submitted to demonstrate patients admitted within two hours of decision to admit. • External interviews triangulated this process of managing of Bracton patients who present to A&E. **NHSLA Level 3**

Recommendation	Action	Evidence
9.3 Care and service delivery problem 3: Patient admission, supervision and engagement arrangements in Oxleas House were not sufficiently robust		
9.3.1 Staff have a duty to follow absconding patients and encourage them to return, whilst balancing the safety of the patient, the public and themselves. In circumstances where it is appropriate to contact the police, this should be done immediately. New guidance should be issued to staff, to this effect.	New guidance has been issued. It includes the requirement for staff who are with patients as assessors, escorts or supports to ensure they have appropriate communication equipment (i.e. mobile phone) to enable them to contact the team or police in an emergency of when the patient absconds	• Email from Director of Adult Services – dated 13 October 2011 • Procedure for missing/absconding patients or detained patients who are absent without leave – next review May 2015 **NHSLA Level 3**
9.3.2 The Director of HR be asked to consider whether formal disciplinary processes are appropriate in relation to the evidence given to the panel by both duty senior nurses.	A disciplinary investigation has commenced and a hearing date has been established.	• Letter to Senior Nurse in relation to the outcome of a Disciplinary Hearing – January 2012 **NHSLA Level 3**
9.4 Care and service delivery problem 4: The Oxleas House main entrance door security practice was unclear.		
9.4.1 The security policy and procedure at Oxleas House should state that the security arrangements at the entrance are to provide protection from people coming into the building. To reflect this, the lock to the exterior doors should be changed so that there is a green exit button on the inside wall of the lobby to be used by people wishing to leave Oxleas House.	A security review of Oxleas House will jointly be held with the Estates Department and the lock will be fitted.	• Queen Elizabeth Hospital Tender Evaluation Report January 2013 • External Panel visit to Oxleas House 17 June 2013 • External Investigation staff interviews **NHSLA Level 3**

Recommendation	Action	Evidence
10.1 Care and treatment in Accident and Emergency		
10.1.1 The Medical Director be asked to consider whether any patient presenting in Accident and Emergency in crisis with possible psychotic symptoms always should be discussed with the on call consultant/specialist registrar (SpR) as to whether admission is appropriate	The Panel Chair will as the Trust Medical Director to consider the Panel's request.	• Memorandum from the Trust Medical Director to Consultants and SpRs – 25 May 2012. **NHSLA Level 2**
10.1.2 Staff should have remote access to RiO whilst assessing patients in Accident and Emergency, in case of failure of the connection to the PC.	Remote access will be made available to the assessment team in the event that access to desktop computers is not available.	• Remote access provided to Mental Health Liaison staff. • External panel visit 17 June 2013. • External investigation staff interviews. **NHSLA Level 3**
10.1.3 The Mental Health Assessment room in Accident & Emergency Departments should be improved so it is conducive for the completion of mental health assessments.	Dedicated space will be negotiated with SLHT in respect of Oxleas House and Green Parks House.	• Anti-risk devices have been fitted. • Photographic evidence submitted to show updated assessment room. • Evidence Mental Health Manager Work Plan – April-June 2012. **NHSLA Level 3**

Recommendation	Action	Evidence
10.2 MAPPA Process		
10.2.1 There must be a robust process of ensuring all referrals to MAPPA are sent and documented.	The Trust MAPPA policy will be reviewed to ensure consistency in thresholds for referral, in a manner reflecting local Borough practices. Trust MAPPA leads will engage with the Jigsaw leads for each Borough and agree clarification of the procedure. All relevant Bracton staff will be given an nhs.net account for the purposes of MAPPA communication.	• London MAPPA guidance – May 2012 • Core Board minutes – 17 September 2012 • Community Workstream meeting minutes – 15 May, 13 November, 11 December 2012 • External Panel staff interview – confirmed. **NHSLA Level 3**
10.2.2 The Trust must liaise with police in local Boroughs to ensure that the receipt of referrals is acknowledged and the level (1 to 3) is confirmed by the MAPPA Panel.	The Forensic Directorate will review current processes to ensure that there are robust systems in place to ensure all MAPPA referrals are sent and received.	• Community Services Workstream meeting – 15 May 2012 • Forensic and Prison Services Risk register entry – completed March 2013 • Staff interview triangulated • MAPPA audit process **NHSLA Level 2**

Appendix 4: Documents Reviewed by the External Independent Investigation Panel

Documents reviewed in relation to the recommendations of the internal Investigation

- Discharge from Hospital Policy 2016
- Greenwich Mental Health Liaison Policy 2014
- Bromley Mental Health Liaison Policy 2013
- A Guide to the Assessment and Management of Risk April 2010
- Bracton Centre Protocol – Role of the Unit Coordinator 2014
- London MAPPA Guidance – May 2012
- Adherence to MAPPA Protocol June 2012
- Section 117 Policy
- Procedure for Missing/ Absconding patients, or detained patients who are absent without leave 2015
- RiO Clinical guidance, recording of risk information on RiO,
- Greenwich Mental Health Liaison Team structure
- Strategy and Ward Philosophy for Joydens Clinic
- Forensic and Prison Services Risk Register, July 2012
- Forensic and Prison Services Risk Register, March 2013
- Care Programme Approach audit, December 2012
- Forensic Good Practice News letter, Summer 2012
- Trust Good Practice News letter January 2012
- Trust Board Minutes, July 2012
- Trust Board Minutes, September 2012
- Trust Board Minutes, November 2012
- Community Workstream meeting minutes – May, November, December 2012
- Mental Health Liaison Manager work plan
- RiO notes evidencing patient admission time
- Director of Adult Services email – dated 13 October 2011
- Letters to Senior Nurses in relation to the outcome of a Disciplinary Hearing – January 2012
- Queen Elizabeth Hospital Tender Evaluation Report – Building Alteration Security Works Suite 136 – January 2013
- Memorandum from the Trust Medical Director to consultants and SpRs – 25 May 2012
- Floor plan of Oxleas House
- The Doctors Handbook

- Role of the Mental Health Assessment Nursing Assistant 2012
- Position on A&E staff training – email September 2013

Additional documentation reviewed by the External Independent investigation Panel

Oxleas NHS Foundation Trust

- RiO progress notes, CPA care plans and risk assessments from the time of admission to the Bracton Centre to the November 2011
- Psychological reports
- Psychiatric Report 2005 at the request of the East Sussex county Health Care Court Assessment and Diversion Scheme
- MAPPA referral – 1 September 2009 Notification of leave forms
- Ward round notes,
- Annual Statutory Reports
- Notification of leave forms and leave applications
- HCR – 20 C Factors
- Client Information and Consent to Share Information – July 2007
- MoJ Conditional Discharge Authorisation & Discharge Reports
- Letters from the Care Team to the GP, MoJ, Appeals Department British Embassy, Resettlement Team Manager Supported Accommodation, Link Peron Greenwich CMHT
- Joydens Clinic contact sheets
- Transcript of the call made from the Duty Dr to the Police following Ms A's absconding
- Transcripts of Internal Investigation interviews and statements
- Policy on Assessment and Care Planning including Care Programme Approach for all Oxleas Service Users 2013
- Section 136 Police power to remove to a place of safety review date January 2014
- Forensic Mental Health Directorate Working Practice Manual – Patient Leave and Escort Policy 2013
- Trust Internal investigation Report – Board of directors Inquiry Into the Care and Treatment of A by Oxleas Foundation Trust – December 2011
- Internal Review Panel meeting notes
- Terms of Reference for the Internal Inquiry Panel
- Incident report Form – 10 October 2011
- Adult Service Management Review Report – 10 October 2011
- Forensic Service Management Review Report – 12 October 2011
- Interview statements from Oxleas Foundation Trust staff
- Safe and Therapeutic Observation Policy 2014
- Letter from the Chief Executive of Oxleas NHS Foundation Trust 11 November 2013

Supported Accommodation

- Support Accommodation Personal Development Plan and Activity Programme for Ms A

- Interview statements from the Supported Accommodation Service

Family of Mrs Sally Hodkin, Ms B:
- High Level meeting notes with Ms B
- High Level meeting notes with family of Mrs Sally Hodkin

Ms A and family:
- High Level meeting notes with Mr A Senior
- High level meeting notes with Ms A's siblings
- High Level meeting notes with Ms A

Independent Police Complaints Commission (IPCC): Independent Investigation Final Report, May 2012

Metropolitan Police:
- Metropolitan Police Report – Operation Globelands 28 October 2011
- Transcript of the call made from the Duty Dr to the Police following Ms A's absconding (supplied by the Trust)
- Standard Operating Procedure for Policing Mental Health, February 2011
- Letter from the Commander to the IPCC Investigator, April 2013
- Letter to the chair of the External investigation Panel from the Metropolitan Police Directorate of Legal Services, 11 October 2013
- Letter to the chair of the External investigation Panel from the Metropolitan Police Directorate of Legal Services, 13 November 2013
- Letter to NHS England from the Metropolitan Police Directorate of Legal Services, 21 January 2014
- Police Constables Police statements
- Police Constables statements to the IPCC Investigation

Others
- Sentencing Remarks of the Judge QC 4 March 2013
- Defence notes for opening for the jury 24 December 2012
- Independent Psychiatric Report prepared at request of Ms A's Solicitor 19 May 2012
- Independent Psychiatric Report prepared at the request of the Crown Prosecution 21 June 2013
- Mental Health Integrated Assessment by Psychiatrist HMP Holloway March 2013
- MHP Bronzfield Patient records from March 2013
- Psychiatric Report prepared at the request of Ms A's Solicitors April 2006
- Independent Psychiatric Report prepared at the request of the Crown Prosecution 11 October 2006
- Transcript of Court proceedings October 2006
- Sentencing Remarks Judge QC October 2006
- Daily newspaper article (16 March 2013)
- Mental Health Act Manual 14th Edition, Richard Jones September 2011

- Mental Health Act Code of Practise 1983 - Published 2008
- Code of Practice for the Statutory Powers of Arrest by Police Officers January 2006

Appendix 5 Ms A Chronology

09/09/1980. Ms A was born four weeks premature; brother and sister born in 1982 and 1985 respectively.

1985. Parents separate, father moved to Russia as correspondent for a national newspaper, and subsequently marries. Mother employed as a diamond sorter for a well known international company. Ms A lived with her father for a short period aged 16-17 in North London; also telephoned father regularly and reports at that time suggest that she craved attention from him. Ms A has made allegations that her father sexually abused her, and beat her, when he had been drinking and at other times. She also at one point made a similar allegation concerning her mother, resulting in her being taken into local authority care for several weeks, until she disclosed she had made up the allegation. Ms A's brother and sister, at interview by the External Investigation Panel, strongly repudiated these allegations made by their sister.

Aged 11/13. Self reports that she began to truant from school, and leave home for periods of time as mother became aggressive towards her. She began to smoke cannabis and drink alcohol. She reports first having sex aged 13.

Aged 14. Her mother moved the family to Sussex in an attempt to start afresh. However Ms A's difficult behaviour continued, resulting in her being taken into the care of the local authority because of her violent outbursts at home. Several foster placements broke down. She was asked to leave several schools due to bullying, truancy and selling stolen goods. At this time she started to carry knives when she went out. Her brother and sister were sent to boarding school, in an attempt to shield them from the problems associated with Ms A. Her brother stated he was unhappy about returning home at weekends.

Aged 15/16. Aged 15, she was cautioned by the police for assaulting her mother with a telephone (Actual Bodily Harm). She left home completely then, and went to Central London, living occasionally on the streets, and taking large quantities of illegal drugs, including ecstasy, cocaine and crack cocaine. At this time she first heard voices, which told her she was "going to the next life." She took an overdose of Paracetamol, and was seen by a Child and Adolescent Psychiatrist, who prescribed Fluoxetine, an antidepressant medication, which she only took for a couple of weeks. Some time afterwards, she took another overdose of aspirin and paracetamol, and left notes for her family. She began to have relationships with men at this time, mainly of Jamaican descent. She was seen by a Clinical Psychologist who noted "Relationships within the family are very complex and difficult for all concerned. Conflicting and explosive feelings lead to some very angry and rejecting behaviour". She was cautioned for shop-lifting, and acquitted of assaulting a police officer. There is reference around this time to an incident of arson, but no prosecution.

Aged 17. She presented to A&E telling doctors she had heard unfamiliar voices telling her that "it was time to go to the next life". She also presented to Casualty having set fire to her T-shirt, and was noted to be "threatening to harm herself and her mother with a knife, and set fire to the house." She moved from her father's house to live with a man, and reports being pregnant with twins and miscarrying at eight weeks, following an assault by her partner. She describes feeling that she was going mad and remembers being "blinded by a bright light". She went to stay with her mother for two weeks. Suffering with insomnia, she was referred to a psychiatrist, but this was not followed up as she moved back to London.

Aged 17/18. 1 May 1998, she was convicted in a Juvenile Court of Shoplifting, and received 12 months' conditional discharge. After a brief relationship she became pregnant, and gave birth to a son prematurely who then remained in hospital for three months. The father of the child was deported for drug dealing. Social Services became involved, and agreed she could look after her son if she lived with her mother. Her relationship with her mother improved somewhat. Ms A moved out of her mother's home following an incident where she reported that her mother threw hot water at her and her son.

Aged 19 onwards. Married a Jamaican man, also aged 19 and gave birth to her second child. When she first lived with him, she drank large amounts of alcohol and suffered self - reported "blackouts", and during these episodes she would get into "fights with other people" which her husband did not like. She joined the 'Universal Church of the Kingdom of God', and said that ministers advised her to terminate the marriage. She alleged that her husband assaulted her. (Ms A's brother and sister give a very different account of his personality in their interview with the External Investigation Panel, saying that he was caring, tolerant and supportive towards her, and giving examples of such).

1999. Mention in the record of her being charged with Arson, but not convicted. Not clear if case went to Court.

Ms A visited Jamaica to try to unite her family, having become disillusioned with the church. Her husband was then refused entry back into the UK, and he in turn refused to let her take their son back with her. On her return she stopped attending church and began a downward spiral, seeing her old 'friends', clubbing, and meeting men. She worked in men's clubs frequently smoking cannabis, and she often left her son with friends and neighbours. Her next relationship, some two years before she killed her mother, she described as bizarre and destructive, with both consuming large amounts of alcohol, as well as smoking cannabis. She became pregnant, aged 25, and she reported that her partner held a knife to her throat, and threatened to kill her if she didn't have an abortion. Her mental health deteriorated after this, and she reported asking her mother to contact Social Services to take her older child into care, as she could not look after him. Her mother gave her £1500 for her rent arrears. Ms A helped her partner with his pimping activities and would go and meet girls for him. She reported that her life was controlled by him and she was not allowed out of the house without his permission.

She convinced herself that he would poison her and that he had installed secret cameras to monitor her. When he stopped coming to her flat, she thought he was dead. She started to believe that people wanted to kill her, and she blocked her letter box so no-one could set a fire through it. Ms A stated that she sat next to her son's bed with a hammer, because she thought someone wanted to hurt them.

Ms A began to have arguments with people at her son's school, and staff at the job centre. She also shouted at her son and spoke with a Jamaican accent. Social Services were alerted and her son was placed in foster care. She contacted Social Services several times, accusing a friend of hers of having sent her seven year old daughter to Jamaica to be sexually abused. She began to believe that her recent partner was in fact the father of her first child and that he had undergone plastic surgery. She said that bus drivers' faces would change every second, and that she would go out for three days at a time, and these symptoms persisted up to her killing her mother. On reading the Bible, she once again realized that she was Jesus, after making a connection about a girl with brown hair described in the Bible. She stated that she put a sheet around herself, and went to a church to tell people she was Jesus, believing that she could hear people thinking, and that she could see invisible people. She began to spend time with homeless people, kept irregular hours, and received messages from the TV.

4 October 2005, Ms A was arrested and convicted at Magistrates' Court, of Criminal Damage. On September 14 2005 she had thrown a stone through a neighbour's window, as she believed the neighbour was having an affair with her boyfriend. It was reported that she thought other women were jealous of her and that all men wanted to have sex with her. Police subsequently confirmed to a national newspaper reporter that Ms A had also threatened the neighbour with a knife. (Daily Mirror 10 of November 2005).

5 October 2005, Ms A was seen shouting at members of the public. Her sister raised concerns to Social Services and the family GP regarding her mental state, and her bizarre and inappropriate sexual behaviour towards her elder child.

13 October 2005. Emergency Court Order granted to Social Services to remove the elder son from Ms A. Her younger son remained in Jamaica with his father.

Three months prior to her killing her mother, her family raised concerns about her mental health. She was interviewed and examined thoroughly by an experienced associate specialist in psychiatry in late October 2005, who did not find any evidence of current mental illness. Given his findings, he did not arrange to see her again.

The week prior to her killing her mother, she had met with her brother and sister. She was homeless and she asked to stay with her brother, which he refused, but he gave her money instead. They were all planning to visit their mother the following weekend. Ms A stole a hairdryer as a present for her mother. On the train journey to her mother's home, she felt "exciting things were happening", and that "the dead were coming back to life". She had a

diary with her in which she had made a list of “saved people”, and a list of those who were condemned. Her mother, father, sister and brother, were all on the condemned list.

4 November 2005. On arrival at her mother’s home, she announced that she was Jesus and that she had schizophrenia. She had spoken to a neighbour, and she was angry because she felt her mother had been involved in Social Services taking her son into care. Her brother took her out to several pubs in the area, and she was behaving in a bizarre and disinhibited manner. She did not speak to her brother, instead she was writing notes in her book.

She left her brother, telling him he was evil, and went into a nearby Church of Scientology, where she spoke to staff in an aggressive manner. She eventually accepted a lift from them to her mother’s home, and during the journey she was heard to use the words “kill her brother”. She later claimed that when she got to her mother’s home there was no-one there, and she then travelled to North London to stay with a friend. However, two next door neighboursheard a row in her mother’s home.

Her mother’s body was discovered by her brother on his return home with his younger sister in the early hours. Nearby was a copy of the condemned list. Her mother had suffered nine stab wounds to her face, head, neck, shoulder and upper back. Ms A had previously made threats to kill her mother, and this was supported by a number of people to whom the mother had expressed fears that her daughter Ms A was going to kill her. (Lewes Crown Court Transcript of Proceedings, and Operation Globelands 28 of October 2011).

21 November 2005. After a protracted police search, Ms A was arrested, though she gave her name as Stephanie Smith and told police that her brother had killed their mother. A further copy of the condemned list was found in her possessions. Her mother’s name had been crossed out. She was assessed in police custody by a member of the Mental Health Court Diversion Scheme, who found her to be “actively psychotic.”

23 November 2005. Ms A was moved to a women’s prison. The Consultant Forensic Psychiatrist who assessed Ms A on behalf of the Bracton Clinic (on 13/12/05) concluded that there was some evidence that Ms A was “suffering from a mental illness as evidenced by her over-valued or delusional ideas in relation to her ex-boyfriend and family members, and the apparent deterioration in her social and occupational functioning in the weeks leading up to the alleged index offence” (in November 2005). He felt she would benefit from a period of assessment in medium security. Despite the prison Inreach Team initially recording no evidence of mental illness, the independent inquiry panel agree that she was appropriately transferred to a medium secure bed at the Bracton Centre in February 2006, under Section 48/49 of the Mental Health Act 1983.

14 February 2006. She was transferred from prison to Bracton Centre medium secure unit under Section 48/49 of the Mental Health Act 1983.

7 April 2006. She became abusive and threatening to staff, claiming unfair treatment regarding getting her new TV set.

3 May 2006. She had to be restrained after a disagreement with a nurse, about whom she had paranoid ideas.

May 2006. She was deemed unfit to plead by her psychiatrist.

August 2006. she was considered fit to plead, by the Associate Specialist in Forensic Psychiatry, following treatment with high dose antipsychotic medication. He diagnosed a psychotic illness, most likely paranoid schizophrenia, with a prominent mood component, complicated by immature personality, with impulsive and emotionally unstable personality traits, and a history of substance abuse.

19 June 2006. Clinical Psychology Report, commenting on the findings of the 'Millon Clinical Multiaxial Inventory' personality assessment tool:

"A produced a valid profile and she obtained a significantly elevated score on the desirability index (94). This suggests that she is trying to present herself in a good light and may be minimizing any psychological difficulties.

Of the clinical personality patterns, Ms A obtained significantly elevated scores on the Histrionic (96) and Narcissistic scales (82), and a slightly elevated score on the Compulsive scale (76). This type of profile highlights a need for attention and conspicuousness, and describes people who tend to be 'vivacious histrionic' individuals who believe they are special and may view themselves as being intelligent, outgoing, charming or sophisticated. They often exaggerate their own abilities, constructing rationalizations to inflate their own self worth and belittling others who refuse to enhance the image they try to project. Individuals with this pattern tend to make good first impressions because they are able to express their feelings. These individuals are often perceived to be friendly and helpful. Furthermore individuals with histrionic and narcissistic elements have been found to have good coping skills although they are bored easily and lack self-definition when they are alone."

26 September 2006. Mental state examination by the psychiatrist preparing the report for the Crown Prosecution Service, noted that Ms A said that she no longer believed all the bizarre ideas she had previously described, and denied hearing voices or seeing anything unusual. She was able to sleep properly. She had no recollection of entering her mother's house, and denied killing her mother. She suggested that her brother, sister or step-father could have killed her mother.

The psychiatrist wrote that "it is likely that when psychiatrists assessed her in the past, she was able to hide her symptoms for the duration of the assessment interviews" and she concluded that an acute psychotic episode of schizophrenia had been present, coupled with emotionally unstable personality traits before and after the alleged offence.

In conclusion, it was recommended that Ms A would require a long period of time in a secure hospital environment for further treatment, risk assessment and long-term rehabilitation.

23 October 2006. Ms A appeared at Lewes Crown Court and pleaded guilty to Manslaughter on the grounds of diminished responsibility. She dismissed her solicitors three times in the course of the proceedings.

The Judge commented that "in relation to a number of occasions that when the defendant was giving a history of her life, her relationship with her mother and family, to psychiatrists, that what she said was on many occasions completely contrary to what could be established by the evidence", adding that "there was a degree of dissembling by the defendant that may well have deflected the investigation by those seeing her, so as to make her condition not as apparent as it is".

The Judge stated that the sentence he was passing " is to allay any anxieties that members of your family have about your future conduct, and it is necessary I impose these orders in order to protect the public from serious harm because of the real risk of you committing further offences if set at large". Ms A was sentenced under Section 37/41 of the Mental Health Act 1983 and returned to the Bracton Centre. The Section 41 Restriction Order is without limit of time.

13 April 2007. Letter from Mental Health Unit, Home Office requesting clarification following clinical team's request for Ms A to commence escorted leave, sent in January.

April 2007 to March 2008. The Annual Statutory Report dated 7 April 2008, notes:
She (Ms A) is currently denying any memory of the index offence, having monthly visits from her son who was in care and is soon to move to Jamaica to live with his brother and stepfather. No contact from her siblings. Father currently living in Cyprus, remains in contact and is main support from outside the hospital. Recently her brother in law was shot dead and she was unable to attend the funeral. She was asked to leave the AA meeting as she was disruptive, believing she will soon be released as she is well and "high functioning", has little insight into the offence and therefore the duration of her treatment, and is fixated on making fast progress to discharge.

17 April 2007. Concerns raised by the care team that she was spending a lot of time surrounded by men, talking aggressively on the phone to her husband in Jamaica, and demanding more escorted leave in the grounds.

24 April 2007. Was explicit at the ward community meeting about having sex in a toilet with a male patient at the beginning of her admission, and was verbally abusive to another patient with whom she got into an altercation.

1 May 2007. Seen with male patients and talking very closely to a particular male. The general picture is of concern that she is putting herself at risk by being provocative to male

patients within the grounds. Ms A angry that an issue was being made about this and did not feel this was unsafe - “she feels we are restricting her and being ridiculous and what we are doing is illegal and wrong”. Left the room in an extremely agitated state.

8 May 2007. Rude to visiting nurses and other residents, generally acting out. Was personally abusive to nursing staff, trying to create friction. Seemed to have an issue with a certain member of staff. “Feels she has to act as the voice of the other patients and is organizing a petition against a member of staff. Denies making personal attacks on staff but felt something had to be said”.

15 May 2007. Keen to go to a low secure unit now; has been ringing them up.

22 May 2007. Very concrete in thinking. Made demand that she wishes to send letter to brother. Does not think her mother would want her to stop contact with her siblings – says it’s the fault of the psychiatric services that the offence occurred. Splitting behaviour, demanding and threatening, and unable to tolerate frustration and work with the care team.

24 May 2007. Letter to Mental Health Unit, Home Office, clarifying escorted leave request. “Generally we have been very satisfied with Ms A’s progress since October 2006, and particularly during the last four months when not only has she remained very settled in her mental state, but has also been demonstrating a striking co-operation and willingness to participate in all treatment and rehabilitation. She has been fully compliant with all prescribed medication which has remained unchanged. It proved to be effective treatment and helped Ms A to reach her current level of stability.

In conclusion, our multidisciplinary team are very satisfied with her progress, compliance and motivation to remain well. At the present time we are less concerned about her faking progress, but instead we see true change”.

4 June 2007. Psychology Report. “Ms A’s Full Scale IQ Score of 104 places her in the ‘Average’ range of cognitive functioning”.

12 June 2007. Nursing staff concerned about her being abusive, and each week there is at least one area of concern re her abusive attitude to vulnerable patients. There is no remorse, only fear of criticism, and needs to cope with not having immediate reassurance and should learn how to cope with “no”.

19 June 2007. Really annoyed at reports written by psychology.

3 July 2007. Ward meeting notes “Narcissistic character traits very visible. She attracts negative attention in the community when becoming critical and controlling”.

10 July 2007. CPA meeting. “Her narcissistic, attacking, defensive presentation has gradually developed. Her powerful pushing attempts to persuade that she is doing exceptionally well keep her in denial. She is not appropriate in public when on leave – very

critical, bullying, making others feel uncomfortable. There is remaining denial re index offence, loss of mother. Her mental state changed around the time of her child's court case which decided her son will be allowed to live with his father (in Jamaica)".

24 July 2007. Ward round "Feels picked on by staff for being too demanding and interfering. Tends to be domineering on the ward, telling staff how to do their jobs especially with respect to medication. Can be argumentative with nursing staff and feels they are disrespectful to her".

28 August 2007. Ward Round. "Angry that her weekly summary mentions she has been warned to stay out of other people's business. Is angry with her sister and brother regarding her mother's will".

25 September 2007. "Complaining no one wants to work or talk with her. Giggling, overactive and pushy. Intrusively asking about nurse's husband. Later shouting at member of staff. Threatening and wanted a female member of staff sacked. Abusive and very threatening to another patient. Monotonously complaining about nursing staff, defensive and critical".

9 October 2007. "No change in mental state, remains demanding and confrontational. Needs supervision in the kitchen. Reported inappropriate behaviour – critical, intensely confrontational, hostile and arrogant, and refusing to learn at times. Very demanding and ruling the ward particularly around leave issues. Splitting staff and in denial that she is a restricted patient".

23 October 2007. "Involved in very complicated dynamics. She set up and created situation where a few patients were heavily involved re the distribution of clothes among others which appeared to belong to a particular patient.

The previous day involved in confrontation with nursing staff. Emphasised personality disorder problem contrary to affective disorder. Appeared manic, was talking to herself. In denial and constantly provoking people around her. Mental state is deteriorating and she is falling apart – getting manic with dysphoria. Attempting to sack her primary nurse. Difficult to manage and she is becoming more manic. Needs very boundaried containment. Asking for more medication and saying that nurses are rude".

15 November 2007. Asked if she would move temporarily to the Cottage for a trial period. If successful she would be able to move permanently.

16 November 2007. Started on Sodium Valproate (mood stabiliser).

20 November 2007. Happy in the cottage, getting on well with other residents, however some concerns that she is bullying another resident.

18 December 2007. "When on leaves she can be quite demanding and impatient. It was reported that she entered the Farmhouse with a male patient. She denied this ever

happened. She continues to push limits and boundaries, but no clear psychotic behaviour. Very emotional and angry that people are saying that she was going into the Farmhouse with men. She completely denies this and is furious".

15 January 2007. No change in mental state. Struggling with how to relate to other residents. Little regard to what others feel and think. There is a risk of her getting involved with a dangerous male patient.

18 January 2007. Need to increase Sodium Valproate from 500mg to 700mg. Gets defensive and critical when she talks about OT (Occupational Therapist). She wrote a complaint to the care team about the OT.

12 February 2008. CPA Meeting. Wanted to get in touch with her brother and is keen to know about her brother via her father. There are some issues with her fellow residents which have led to a few very heated arguments e.g. over the bathroom, which have escalated into a painful exchange of anger. Has had three leaves with her father which went well.

26 February 2008. Continuing to avoid direct contact with the OT. Contemplating obtaining photographs of her dead mother which were exhibited in court.

11 March 2008. Ms A feels she can help her brother with what she believes are his alcohol problems, despite her father saying that her brother wants nothing to do with her. She is now considering a family acquaintance as an intermediary. Seems desperate to re-establish contact with her siblings despite their desire not to.

7 April 2008: Summary of Annual Statutory Report: "There has been improvement in her mood stability since Sodium Valproate was added to her treatment. Her insight as well as her ability to relate to members of staff and to other patients is improving.

Being a high profile patient, her case is very sensitive and complicated. Faced with the issues of the index offence does create a high level of anxiety in everyone, including the general public. Ms A's traumatic experience would require years of therapy and support. We are aware of her history of disguising and dissimulating symptoms of her mental illness".

21 November 2008. "There were some concerns in relation to changes in her mental state during the last few days. Increased impatience, more argumentative, critical of others, less tolerant, mood instability. This may relate to her recent change in medication – reduction of Sodium Valproate by 100mgs last week".

15 January 2009. Social Circumstances Report for the Mental Health Tribunal. Notes that she is nervous about moving to an environment where she will be alone at night. The care team have decided she has good self care and is very compliant with medication and treatment, and is prepared to be open with her care team about her

needs, and for that reason she should be placed in supported accommodation rather than 24 hour staffed hostel or care home.

5 February 2009. Clinical Psychology Report - HCR-20 Risk Assessment. “The risk factor that is most pertinent for Ms A is her index offence, an incident of serious violence. This shows Ms A has the potential to be very violent, and this violence has been demonstrated from the age of 15. It is important to remember that the offence occurred in concordance with her deteriorating mental state after she became pregnant, and consequent late termination under pressure and conflictual relationship with the victim. If Ms A was to become mentally unwell in the future this would increase her risk of violence. Other historical factors that put Ms A at risk of behaving violently include a difficult childhood, relationship instability, employment problems and substance use problems; which may not be mutually exclusive. Future risks for Ms A include becoming destabilized by pregnancy, conflict in relationships, manic defence to anxieties and substances. Stress factors that may put Ms A at risk include relationship dynamics with her brother or sister. Additional stress may come from employment issues, as she hopes to get a job in accountancy and has an idealized view about the job she hopes for”.

12 March 2009. Incident report whereby she had made a bet with male patient which he lost and Ms A was demanding her money. Flicked the butt end of her cigarette at him, leading to a stand off.

20 March 2009. “Yesterday at the community meeting Ms A appeared rather confrontational. Her strong reference to a prison-like-hospital where the emotional development of a person is paralysed and is replaced with a criminal culture. Very critical particularly towards nurses. She then referred to her own experience of her time being stopped for all the years of her admission, and there was nothing positive that she had received or learned”.

2 June 2009. CPA Review Management. Medical – “there is a concern that we are unaware of what Ms A does when she is on leave. She has leave until late at night sometimes and it is unclear what she does and how she uses this leave and who she sees or speaks to. She has a lot of leave outside the Bracton Centre and we need really to know what is happening in the community to contain her”.

Ms A has told doctor that she spends some time wandering around where she used to live, testing the reality that people will be hostile to her following her offence. Ms A has also said that she is hoping to meet a man. Probably she will also wish to have a child and this is likely to be a risky period”.

22 July 2009. The CPN wrote to the care team regarding referral to MAPPA and stated that Ms A “would obviously fit the criteria for violent mentally disordered offender even if they decide she does not warrant active MAPP follow up due to the framework which she will be subject to”.

24 July 2009. The Associate Specialist wrote to the CPN "I think it's the best way forward to link Ms A with MAPP. How do we refer and is Social worker familiar with the referral process?"

31 July 2009. 03:00am nurse on duty saw a man coming out of Ms A's room and on seeing nurse he dashed back into the bedroom. Nurse went to summon assistance and challenged male patient who denied he was in Ms A's room. Ms A concerned she would lose her overnight leave and said nothing happened and that it was all a misunderstanding. This is the same patient she continued to meet when she was in her community placement and visited him prior to and post his discharge. Both patients' care teams made attempts to dissuade them from this relationship.

10 August 2009. Initial registration at GP practice and health screening. Practice sister surprised when told the index offence in relation to her diagnosis and long inpatient stay, and was confused about the relationship between Bracton's location and Oxleas services in Greenwich. She also asked why Ms A was managed by Bracton directly.

10 September 2009. Used unescorted leave with the male inpatient.

15 September 2009. CPN invites Team Manager from the Greenwich Recovery Team to attend the next week's Section 117 meeting, explaining that the Bracton team are not requesting formal joint working as aftercare will be provided by the Forensic Team, but that allocation of a link worker would help with local resource issues.

16 September 2009. "Ms A has been told of the team's concerns about her altercation with her male inpatient boyfriend. Ms A said she didn't want to stir up any trouble as she was close to her discharge".

22 September 2009. CPA Section 117 Meeting. "The Consultant explained that Ms A is subject to recall for a period of assessment and a major relapse is not required for recall. The seriousness of the index offence means we have an obligation to inform the MoJ if we have any concerns. It was explained that our threshold for panic would be much lower than when she was on the ward. This was explained to Ms A clearly and in detail. Ms A was also informed about unannounced home visits". Child care needs would also need to be incorporated into the care plan.

The contingency plan was:

1. To have CPN mobile number.
2. If there are concerns to arrange urgent medical review.
3. Emergency acute admission via Home Treatment Team or by presentation to Oxleas House.
4. To be given the crisis line number to the bed manager.

28 September 2009. MAPPA referral form completed for level 2 or 3 MAPP meeting. "Any concerns would trigger an increased level of support by immediate admission to Oxleas House, QE Hospital should her mental health deteriorate. Her sister and brother no longer appear to be hostile towards her".

29 September 2009. Management round. Ward doctor raised the concern that she had difficult relationships with men in the long term past and the immediate past. Ms A denied that her relationships or friendships with men are of a concerning nature. Social Supervisor reiterated that the team needs to be aware of the people Ms A is spending time with and visiting often. A asked if a friend can visit with his children. Conditionally discharged to housing association flat.

3 November 2009. Telephone call to Social Supervisor from support worker at flats. Tenants expressed concerns they had heard a disturbance in the early hours, crashing and banging and someone heard saying 'you're hurting me'. Ms A denied to Social Supervisor any knowledge of a disturbance in her flat. CPN received the same response three days later.

9 October 2009. Letter to Mental Health Unit, MoJ from Supervising Psychiatrist/Associate Specialist "I am writing to thank you for your careful work in relation to Ms A's care leading to her conditional discharge. We have felt very supported by our liaison and I believe Ms A has also valued your responsive, thoughtful and wise approach".

10 November 2009. Had confrontation with ticket inspector who had taken her Freedom Pass off her as she was sitting in a first class compartment and had refused to give her name or address to him and was rude to him. She told CPN "I wasn't rude just sticking up for myself".

11 November 2009. Progress e-mail to the Care Team from CPN. Reported the support worker's account (she works Monday and Thursday at the project) reiterating the event, adding 'stop that, you are hurting me', and 'you are going to bruise me'. Presented mentally stable with no evidence of mood or behavioural disturbance to the CPN.

16 December 2009. CPA Management Review. Ms A requested two week trip to Jamaica to see her children. MoJ to be approached for possible Easter journey.

4 January 2010. Report on Conditionally Discharged Restricted Patient to Mental Health Unit, MoJ, by Social Supervisor. "Her family has not been as supportive as expected and this has upset her on occasions. She arranged to spend Christmas with her father and went to a great deal of effort to make the time happy and was generous with food and presents. Unfortunately her father did not appreciate her efforts and became critical and verbally hurtful about her index offence".

(Her father told the Independent Investigation Panel that when he arrived Christmas eve, Ms A told him she was going out with a boyfriend for the night. This caused the argument and she, unknown to her father, called the police and when they arrived she told him to leave - with him having to travel back to his home late Christmas eve. Ms A phoned him the next day to apologise). "The previously positive relationship Ms A has had with her father has undergone a worrying change since Christmas which appears to be more as a result of her father's difficulties in settling in the UK. Ms A's manner and concern for her father has been consistent and full of warmth".

6 January 2010. Visit by Supervising Psychiatrist to Ms A's flat. "Currently on Sodium Valproate 600mgs mane and 600mgs nocte and Quetiapine 300mgs mane and 600mgs nocte. Ms A would like a reduction in her Sodium Valproate to be considered in due course. She suggests after her return from Jamaica as she is anxious not to compromise these plans. This seems reasonable. It is possible she may be better on Lithium but I did not want to discuss this at this visit".

22 January 2010. Entry by CPN. "Ms A had been to see father and book ticket to Jamaica. She told him that she had seen somebody who looked like her brother. She described how her father had 'flipped out' calling her a disgrace saying she had ruined her siblings' lives, saying she was poison, and questioning her illness in relation to the index offence, and questioning 'so called professionals'. It was the intensity of his anger that seemed to have shocked and scared her".

3 March 2010. CPA Management Review. Residents in Ms A's accommodation have access to an emergency number for the housing association, and Ms A has local out of hours mental health team's emergency numbers, or can attend A&E at QEH. The Consultant felt that "any likely early changes in Ms A's mental health are unlikely to be marked but rather the quality of her interactions may appear less warm or sensitive to the needs of others". Dates for trip to Jamaica March 31 to 20 April. Social Services will take an interest in Ms A's sons. The contingency plan in part includes "there should be a low threshold for admission given the seriousness of the index offence...it is also known Ms A was seen by a psychiatrist in the weeks before the offence and not thought to be psychiatrically unwell....thus would appear Ms A can mask emerging symptoms of her illness".

18 March 2010. "Dear Colleague" letter from Psychiatric Supervisor to receiving Doctor should Ms A become unwell in Jamaica: "A has this letter so that you have a formal note of her psychiatric condition. She has been well for over four years following treatment for a schizo-affective disorder and is now fully recovered. Signs of relapse in her mental state include arousal, heightened anxiety, aggression and paranoid feelings of people being against her. In the past she has also experienced auditory hallucinations of God/demons speaking to her and feeling she might be Jesus and could cure people".

22 March 2010. Letter from Casework Manager, Mental Health Unit, Ministry of Justice: "As you are aware the Secretary of State cannot prevent a patient travelling outside the UK,

though he can raise objections to it. Additionally, we would normally only agree to a trip abroad after a patient had been in the community for at least twelve months. However, I accept that there are exceptional circumstances in this case and the trip has the support of the Family Court. Please provide me with a short note on her return and notify me immediately should there be any concerns".

12 April 2010. CPN record notes. "T/C from Ms A's husband to my mobile. It was very hard to understand as he has a stammer and a very strong accent. I put the call on loud speaker so that colleagues may share the call in an attempt to understand what he was saying. I was able to pick out some words like "she's not listening to me ", "she drinking a whole heap", "she take a knife to me". Social Supervisor had received a text at the weekend from Ms A which did not express any worries or indicate concern. I rang the Supervising Psychiatrist's secretary and she had received a phone call from Social Services as the social worker wanted to discuss her concerns. Ms A's husband had called her as she was Ms A's older son's social worker before he left for Jamaica. He told her that:

1. Ms A was trying to get the children to eat more than they usually do.
2. He said that she had been drinking and was behaving outrageously.
3. She had picked up a knife and had threatened to kill him.
4. She had been accusing him of having sex with his cousins and nieces.
5. He was asked if she was taking her medication and she said she had but he was not sure.

The social worker advised him to call the police to have her removed from the family home if he was concerned about her behaviour or risks. The social worker was able to have a better understanding of what he was saying and said she would be happy to telephone him again on our behalf".

Social Supervisor telephoned Ms A and noted, "I did not say that he had said she threatened him with a knife as I sensed that she was worried about her husband having phoned us and what this might mean".

22 April 2010 Extract from Report on Conditionally Discharged Restricted Patient to Mental Health Unit, MoJ, by Social Supervisor. "Patient does not drink alcohol in Britain. On Saturday 10 April she acknowledged she had drunk two Pernods at a party with her husband (in Jamaica). Ms A's husband tried to persuade Ms A to be intimate with him, but she declined. This led to an argument at the friend's party. (Ms A has met a male partner in the UK. Social Supervisor had been introduced to him on 31 March, he is 21 and mature for his years, a devout Christian attending church weekly). Her husband rang the CPN to say that Ms A "would not listen to him". In the section requesting a brief description of the patient's mental health it was reported that, "Her mental state has been stable and she has managed many family and relationship issues with equilibrium".

11 May 2010. Supervising Psychiatrist conducts home visit. "There was no evidence that Ms A had threatened her husband referring to a knife. Ms A reminded me that this had happened on a visit several years ago when she was unwell.

On that occasion she had an argument with her husband and picked up a kitchen knife on leaving the house. She went to a friend who ran a bar who supported her and advised her not to retain the knife, taking it into his safe keeping". Discussed small reduction of Sodium Valproate to 1000mgs daily would be most appropriate.

8 June 2010. Report on Conditionally Discharged Restricted Patient to Mental Health Unit, MoJ, by Supervising Psychiatrist. Report states "She managed a challenging visit to her family at Easter".

22 August 2010. Report on Conditionally Discharged Restricted Patient to Mental Health Unit, MoJ, by Social Supervisor. "The team have discussed at length the comments that her ex-partner (husband) made about her becoming aggressive in Jamaica at a party they both attended. Ms A was happy to discuss this with us. Her view was that his friends were smoking cannabis and she wanted to move away to the other end of the hall. She said her husband felt humiliated by this and was annoyed she would not be with him. This became the source of a disagreement which resulted in her husband calling the CPN the following day".

28 July 2010. CPN RiO entry. Had spoken to police regarding the break in to Ms A's flat. Explained Ms A's status and the need for her to avoid high levels of stress. Requested that if Ms A called police she will be considered as a priority response. Officer said she would pass details to the relevant system to activate.

3 August 2010. CPN RiO note. "Telephone call from PC in burglary squad, had arrested her boyfriend on suspicion of breaking into her flat. Released with a warning not to contact Ms A directly or indirectly. He gave police alibis for the times in question and felt perfectly fine with the relationship ending. He did say to the police that Ms A drinks alcohol from time to time and that her behaviour changes, and reported an occasion when she was threatening to someone who had jumped a queue in a night club. He claimed that she had threatened to pull a knife on the person. Discussed with police constable who felt it was probably advisable not to share this information with Ms A at present, as what is wanted whilst the dust settles, and if Ms A thinks that J is making claims which might have consequences or get her into trouble, this might ignite further conflict. Will share this info with the Social Supervisor and Supervising Consultant".

4 August 2010. "Social Supervisor's view is that the care team should hold this in our minds and address issues of alcohol/clubbing and interpersonal relationships firmly and each of us pursues a gentle inquiry when we meet her". (Note - there is no record of any subsequent conversations taking place with Ms A regarding these issues by any team member.)

16 August 2010. Ms A is now visiting more regularly GH (a male inpatient at the Bracton Centre). “She feels compassionate towards him as she is out and he is still struggling to get out and she feels she can support him especially about keeping off drugs”.

18 August 2010. “Ms A contacted medicines information via the patient line asking whether Quetiapine and Sodium Valproate would be suitable for use in pregnancy. She was advised that Sodium Valproate was considered unsafe in pregnancy, and with Quetiapine the literature advised weighing benefits against malformations”.

26 August 2010. Interview note of Supervising Psychiatrist. “I raised the question of whether Ms A was aware of the increased genetic risk of severe mental illness if Ms A were to have a child with a partner who also has a severe mental illness. Ms A said she was aware, but she did not feel too concerned about this”.

29 September 2010. CPN note. “Ms A is anxious to address the issue of GH being able to visit her at home and does not see the reason for the delay – she and GH are both subject to restriction orders. Ms A always finds it difficult when in a position where she is not in control and has to rely on others. She finds it difficult to wait and experiences delays as frustrating”.

4, 5, 6 October. File notes. GH has permission for a community leave which does not include going to someone’s home. Ms A wants to challenge the situation and says she will seek solicitor’s advice. Ms A was clearly fed up with not being able to engineer the visit and seemed not to be able to appreciate the complexities of the situation, “A said that GH had told her that his care team had told him that we (Ms A’s care team) think she is dangerous”.

25 October 2010. Social Supervisor’s notes. “Ms A wanted to know when she and GH will meet to disclose index offence information”. This took place on 4 November 2010.

8 November 2010. Medical note. “Discussed with pharmacist Ms A’s high blood pressure and persisting tachycardia. She thought along with other causes it could also be caused by sporadic compliance with Quetiapine, as this likely to reduce her tolerance to a higher dose of 900mg a day, another possibility could be any substances she may have taken including illicit drugs and alcohol”.

9 November 2010. CPN note. “Reminded me that the Quetiapine dose is above BNF levels and informed one factor which has to be excluded (for her tachycardia and high blood pressure) is intermittent compliance. Looked startled and said ‘it looks like I’ll have to get a solicitor then’. Told me she cannot visit GH on the ward. It would appear there have been some issues in relation to their behaviour on the unit. Blames one female nurse who she says does not like her”.

16 November 2010. Both patients’ care teams meet, “to discuss them extending relationship to an intimate one. Discussed issues around boundary pushing. Ms A found

lots of suggestions to increase original plan and the Dr said that she was worried that this was to be the pattern for the future. A assured team plan was not to have a baby with D. Ms A feels she was unfairly stopped from ward visits as she denies wrapping her legs round him".

26 November 2010. CPA Review. "Ms A's wish is for the Sodium Valproate to be reduced and stopped". Trip to Jamaica dates agreed – 24 December to 17 January 2011. GH now has unescorted leave to Ms A's flat; four hours. Action notes on the CPA plan indicate that Ms A **"has all relevant contact numbers for professionals and is aware she could contact the main Bracton or Joydens clinic out of hours who could get a message to relevant professionals".**

31 January 2011 onwards. Ms A arrives back from Jamaica two weeks later than planned, with the Trust paying £600 for her return flight. Would like to have longer next time, perhaps in September for six weeks. No record of discussion with her husband how this visit went. Relationship with GH ceased when away, recommencing in February when he is visiting her flat again. In March she believes he is interested in other women

7 March 2011. CPN note. "A rang to tell me that she has been seen by her GP who thinks she might be pregnant". Told to stop taking Sodium Valproate by Supervising Psychiatrist. Ms A has never believed that she has required a mood stabilizer with Quetiapine".

18 March 2011. CPN note. "She was quite agitated. Said she had been receiving nasty messages from J, her last boyfriend. He had sent some two days ago but they are getting worse and that he said he was living near and saw her every day." Ms A discussed with police.

22 March 2011. Support worker at the accommodation to alert the safer neighbourhood police team concerning her reported threats.

31 March 2011. CPN note. Concerns that patient GH had made threats towards her. She is surprised that he has lost all his leave and is upset that she may have contributed to this setback in his progress.

19 April 2011. Supervising Psychiatrist home visit. "Applying for jobs and has interview for a supported position with Greenwich Council. Told Ms A it was very likely she had jeopardised GH discharge planning by making an allegation that he had threatened her. I also said that this episode presented difficulties for us as her mental health team as if she had misinterpreted him then misrepresentations of this sort can be an early indicator of psychosis. Ms A said she was absolutely sure her mental state was not deteriorating. She acknowledged in our discussion that she could see that reporting two boyfriends as threatening to kill her was potentially concerning. I did not consider there to be any fragility in her mental state. She does present an aspect in interpersonal relationships that verges on hostile rather than just assertive – this was noted on many occasions during her

inpatient stay and did not seem to be overtly linked with any deterioration in her mental state.

26 May 2011. CPA Review. Noted no longer taking contraceptive pill. Noted also that Ms A had informed the team some eight weeks ago there was a possibility she was pregnant and that her Sodium Valproate had been stopped and her mental state closely monitored.

22 June 2011, last CPA prior to the second homicide. This includes no information to suggest that Ms A was relapsing, or at risk of relapse, into psychotic illness. The only change around this time of any significance noted, is that she had stopped taking Sodium Valproate based on concerns about possible pregnancies, this having been agreed by her Consultant.

23 June 2011. CPN note. "Working three days a week for a security company. Her primary tasks are cold calling."

4 July 2011. **Social Supervisor note**. "Ms A has been told she is to receive £8000 from a backdated claim she had made in 2007".

20 July 2011. CPN note. Has a new Jamaican friend. "She is questioning how she could have invested so much time and emotion into the relationship with GH. Ms A had pinned hopes of a future together".

10 August 2011. Social Supervisor given Ms A's new mobile number by CPN.

19, 22, and 26 September 2011, CPN and Social Supervisor notes. GH discharged to supervised hostel. A calling at the project, although is not allowed in. The CPN had to intervene in arguing between them and another former Bracton patient. "Reports job is going well, admits she can be bossy and overenthusiastic at times", (having told the Social Supervisor previously that she had seen several ways to expand the business). She was unkind to another female worker who she described as lazy and disinterested, indicating she may have bullied her.

22 September 2011. **Supervising Psychiatrist home visit**. "Discussed the argument at the project with GH. I raised the question that information of this kind does raise from our perspective whether she is OK mentally. Explained our responsibilities". Told that new boyfriend had been sending threatening texts telling her to kill herself and he was going to have her beaten up. Texts seen".

28 September 2011. CPN note "Ms A had been to GP as concerned about early miscarriage. She felt she had been brushed off by GP. He thought she did not need to present at A&E. Ms A asked me to drop her off at Queen Elizabeth. We were able to have a discussion about recent events and Ms A was able to identify many recent

stressors. Her relationship and recent conflict with husband about money and the boys, her relationship with GH and threatening texts from ex partner".

Her GP had told her to think very hard about whether she really wanted a child. She was upset with him, saying it was not his place". The CPN left her in A&E. Ms A argued with the A&E doctors that she needed a D&C, but they refused to do it so she told them to f... off, and walked out. (Ms A later told the defence Consultant Psychiatrist - in relation to trial for murder of Mrs Sally Hodkin & attempted murder of Ms B - that she begged the CPN to stay, and that she felt abandoned by her CPN.)

The GP's records were viewed and the GP interviewed for this investigation. Ms A had never been pregnant. No record could be located of the clinical supervisors from the Bracton Centre contacting the GP for information regarding Ms A's statements concerning pregnancy.

30 September 2011. **Social Supervisor note**, "She started by saying, 'I expect you are wondering why I am smiling?'. Unfortunately she has told GH about the miscarriage and also her brother. This was something unusual, she had for the first time written to him on Facebook". Wanted to go to Jamaica for three weeks in three weeks time.

6 October 2011. Social Supervisor note of telephone conversation re missed home appointment. She phoned Ms A because Ms A was not at home for a scheduled appointment, "Ms A said her brother had replied to her in an offensive manner last Wednesday. Meet next Monday at 5pm".

Her brother's words were to the effect "thanks for letting me find my dead mother's body, good news about the miscarriage, you should be sterilized for the good of the world, why not slit your wrists and do us all a favour".

Detail in the IPCC report indicates that later that evening Ms A rang 999 on three occasions in ten minutes; the first to complain that she had received threatening text messages. At the time of the last call she did not want the police to attend, and said she would report the matter the following day. Ms A told one of the psychiatrists assessing her for the Court that she had been to work that morning and had been shouted at by her manager.

11:21 pm. Called the police and requested police attendance as "she was receiving death threats from individuals known to her and she had some thirty threatening text messages from them". Police unable to obtain from her the address she was calling from.

11:23 pm. Called police saying that they needed to come now. This communications officer obtained her full name and address and "an intelligence check was conducted by local police when they received the call from the police communication centre. The check showed Ms A as flashing 'violent' and 'manslaughter".

11:42 pm. A told another communications officer not to send anyone round as she planned to visit the police station the following day.

7 October 2011. Did not go to work as she needed time to get over her miscarriage.

2:30 pm. Attended local police station and would only report the threats made against her and would not substantiate any further the allegation. The reporting officer stated that Ms A was "difficult to understand and was aggressive at times".

8 October 2011. Her brother phoned the Bracton Centre reception on the Saturday evening and told them his sister had contacted him and he did not think she was well. He reported that the Bracton Centre told him that if he was concerned, he should phone the Police.

9 October 2011. Called the police three times late evening. She was complaining she had let some 'crackheads' into her flat and they had stolen her keys. In the third call she had found her keys and did not need the police. Detail as follows:

9:43pm. Ms A made a 999 call to request police attendance as there were two males smoking crack cocaine in the communal living room of her accommodation. She further told the communications officer that she had kicked the two males out of her flat, but they moved into communal area.

9:46 pm. During this call a male was heard in the background, she informed the operator that her keys had been stolen and she thought it was the two males smoking crack. She further said that "the people who had stolen the keys were people she knew from the mental health clinic she attended".

9:52 pm. Ms A called the police again to tell the police she had found her keys and she was heard saying to someone in the background "I'm cancelling it now babes".

10 October 2011. 03:00 am: She reported that she left her flat because she was sure that she was going to be murdered in her house that night. She went to a minicab office and asked for a cab to Lewisham Hospital. When they arrived she said "I think it's closed". The cab driver noticed that her head was down and there was saliva coming from her mouth. She asked to be taken to Queen Elizabeth Hospital. On arrival she had no money to pay for the fare. The driver returned with her to the cab office. There was a short struggle as she tried to leave and she alleged the driver had beaten her up. She was very shaky and distressed.

Ms A said she needed to be sectioned and to go to the place she had been before. She appeared scared and agitated. Police officers and ambulance personnel attended. She would not get in the ambulance to go to hospital and was instead taken by the police.

IPCC Report, detail as follows:

4:01 am. Police receive call from mini cab controller stating Ms A kept crying, shaking and was distressed saying she needed to be sectioned and needed to be in hospital. She seemed paranoid and had moved from the public seating area and relocated herself to the back of his office and was refusing to leave. An ambulance and police were dispatched.

4:15 am. Two police constables arrived and asked Ms A to calm down, told her she had not done anything wrong and that she was not under arrest. She informed them that she had mental health issues and needed medication. She was deemed to be 'agitated but meek' in her behaviour. The police constables walked her out of the office and she appeared to them to have the self control and capacity to understand when spoken to. They both decided to take her to hospital voluntarily as they genuinely thought she appeared to be seeking help. She then refused to get into the ambulance. So they took her instead.

4:29 am. Booked into reception at A&E and the officers gave Ms A's full details and said she needed to be seen by the mental health team. There were at least 15 people waiting to be seen by the triage nurse at that time. The officers explained that she had to remain there. She became agitated and said that she did not feel safe there.

4:31 am. As the officers were about to leave the car park, she ran out to them, was reassured and ushered back inside at 4:34 am. The officers informed her she would not have to wait long before she was assessed.

4:37 am. The police left the hospital only to be followed by Ms A again, who told the police she was having a cigarette. Both officers waited for a few minutes and then attended another call.

On her return to the waiting area Ms A said to the receptionist "is it going to take for me to kill someone, as I've done it before, so I can get seen?".

4:45 am. A called the Bracton Centre. Staff statement. "A lady telephoned, very distressed with a muffled voice and talking very fast. She said she had a taxi waiting and if she passed the phone to him, would I tell him that we would pay for the cab as she desperately needed to come back here. I said I wasn't authorized to do that but would pass her to the relevant unit, which she said was Joydens. I passed the call straight through and 2 minutes later Joydens called back to reception and said the call I had put through needed to be passed to the Duty Doctor, then hung up. The phone to the caller was dead so I called the Unit Coordinator and he telephoned me back 5 minutes later, saying it wasn't the procedure to pass the calls to the Duty Doctor. And that he had spoken to Joydens and they didn't manage to get her telephone number".

4:52 am. Ms A called the police stating “Has had a breakdown and needs to go to a mental hospital, and the last time she felt like this she killed someone”. Furthermore, she stated she was confused and did not know who she was, adding she was on a 37/41 ministry section and could not sit in A&E.

4:53 am. Seen by the triage nurse. She said she wanted to see a mental health person and go into hospital. She said everyone wanted to hurt her and she was hearing voices. The psychiatric team accepted her referral.

5:13 am. Called the police once more, asking for help before she hurts someone, asking for police attendance and to take her into custody, adding that her psychiatrist had told her “when she feels scared and paranoid, she can be very dangerous”. She informed the controller again that she wanted to be taken into custody and asked “do you want me to hurt someone here?” She was crying. The call was sent to the communications dispatch officer, being classified as an immediate, and to the local police. It was seen on later examination of the PNC record that no checks were made against it to establish her history. It was decided that “as officers had just left the female in question at hospital, a recognized place of safety, there was no further deployment as they have their own security and we had not received any calls from the hospital requesting that officers re-attend”.

5:21 am. Call to the police. Crying and stating she is a dangerous schizophrenic, and if the police do not arrive on scene asap she is going to harm somebody, repeating over and over that she would like some assistance. She once again told this communications officer that she was a very dangerous schizophrenic. Ms A was told she was in a place of safety, to which she raised her voice and shouted back “no I’m not in a place of safety, I am in an exposed area”, and “the more scared I get the more dangerous I become”. When asked what the emergency was she replied “That I will hurt someone”. She was heard saying to someone that she was not going back into the hospital; she was going to the police station. A voice was heard on the recording of a woman saying to her that they had her some help. The call ended.

5:27 am. Ms A made her last call to the police. Speaking to a different communications officer she reiterated that the last time she felt like this she killed her mum. When asked where she was, she said she felt she was at the gates of heaven. When asked why she would not go back into the hospital, she said she felt someone was going to kill her, and asked again for police attendance.

The hospital was contacted and the recorded response was, that they are aware of her and she is waiting assessment and apparently it’s not happening fast enough for her, security have the matter in hand, no need for police attendance.

5:30 am. Seen by the psychiatric nurse, telling him she had not slept for three weeks and needed to be sectioned. He told her the process was a voluntary one, and made arrangements for her to be transferred.

6.17 am. **Assessment Team Notes on RiO:** "Referral by A&E Department, Queen Elizabeth Hospital. Reason stated that she has not slept for weeks and wants to go to hospital. She is a well known patient of Bracton Forensic Team. She self-presented at A&E Department.

She was tearful and in distress. She was uncooperative and kept on saying I am unwell and need some sleep. Stated she has been feeling unwell, scared and feels paranoid. She reported she had stopped taking her mood stabilizer and her Quetiapine. Asked when she had stopped taking her medication, she answered 'months'. She does not feel safe on her own. She feels paranoid and worried about her two children and feels her children are being sexually abused in Jamaica. Scared that other people are going to hurt her. She appeared suspicious and wanted me to leave the assessment room door open. Reported hearing lots of voices telling her different things, not commanding her to kill herself or do silly things. Since breaking up with her boyfriend she has been stressed – she lives alone and has no friends. Denied use of alcohol, but said she had been using skunk recently. Risk – Self Harm, low; Harm to Others, low. Informal admission, level 2 observation". (This level of observation would require staff to see her at a minimum every 15 minutes).

6:30 am. She was walked over to Oxleas House by A&E staff and security. On the walk there she was scared the escorting staff would kill her, and that she was going to be jumped on and torn to pieces by evil demons.

The entrance to Oxleas House consists of an inner and outer door with a lobby in between. The inner door is generally kept locked but this is to regulate the flow of people into the building, and not to keep patients in. As it happens, the lock on this inner door was faulty.

Once in Oxleas House, Ms A was waiting in the assessment area adjacent to reception, and not in a secure ward. There was a door separating the assessment area from reception but it could be opened from the assessment side. She sat on her own for a while, smoked in the garden, and then came through the door to reception, and asked if she could wait in that area, near to the reception desk where the unit charge nurse was sitting. His duties included manning the inner locked door of the unit, which had to be unlocked and kept open from 6:45am, to allow for the staff shift change that occurred at 7:00am.

7:05 am. Ms A pushed open the inner and outer doors of Oxleas House, she came back at left again at 7.06. and this time she did not return.

7:19 am. Oxleas House Doctor reports to police that Ms A has left the unit. He advised them they should detain her and bring her straight back to Oxleas House under Section 136, adding that "we are concerned about this lady's safety and there is a possibility that she could pose a threat to the public".

8:20 am. She entered a supermarket and purchased a kitchen knife, going to the ladies' toilet, taking the knife out of its packaging, concealed it, and left the building at 8:29 am.

8:30 am. A attacked a young woman at a nearby bus stop, who managed to disarm her of the knife. Witnesses described it as "a ferocious attack". Ms A saw a local butchers shop, entered it and stole a large 12 inch long 'steak' knife, and left the shop, finally coming across her second victim who was crossing the ground of a small memorial garden on her way to work. The victim had little prospect of defending herself, as the attack aimed at her head and neck was forceful.

The victim was pronounced dead at 8:41 am. On arrest Ms A said "It was me, I did it". Following arrest Ms A tested positive for cannabis.

10 October 2011. **Supervising Psychiatrist's note** "Ms A is at Lewisham police station....I considered her to require a higher level of security and felt WEMSS (enhanced medium secure service for women) would be appropriate in the first instance". MoJ informed and agreed Recall to WEMSS.

11 October 2011. Medical entry. Ms A seen by Bracton doctor who had previous inpatient knowledge of her. "She was clearly elated and expansive in mood. Her behaviour was suggestive of increased distractibility and disinhibition. She was distant and guarded in her interaction whilst maintaining an attempt to engage and converse in an appropriate manner". She was manic in her presentation and began singing and screaming loudly in the cells. 17:30 admitted to The Orchard Unit, WEMSS. Admitting psychiatrist's overall impression was "that she was not right in terms of her mental health, but that specific psychotic symptomatology could not be delineated". (The Orchard Unit/WEMSS is a 60 bedded women's unit completed in June 2007, which was the result of the DoH consultation paper 'Women's Mental Health: Into the Mainstream', coinciding with the end of women patients being detained in Broadmoor Hospital).

October 2011 – December 2011. Board of Directors' Inquiry Into the Care and Treatment of Ms A by Oxleas NHS Foundation trust, commissioned and reported.

19 May 2012. Psychiatric report for the defence, mental state examination "The content of her discussion for those events was essentially in terms of blaming others for her predicament. She did not display any current psychotic symptoms, or mood symptoms at interview. Overall, she was frustrating to interview because she tended to strongly dominate the conversation and there was something of a histrionic aspect of her presentation". The opinion contained within the report was that Ms A had "suffered a relapse of her schizo-affective disorder. It was noted that close to the commission of the previous homicide, she was seen by a psychiatrist, based upon family concern, and, despite it being accepted later that she was indeed likely to have been psychotic, he had elicited no signs of mental illness. Hence, there is a record of signs of mental illness in the defendant being capable of being unseen or undetected.

There were specific relapse risk factors recognised as having been present close to time of the defendant's previous episode of psychosis and associated with the previous homicide, which appear to have recurred prior to the time of the current offences; as well as further risk factors having been identified by clinicians treating her very close to the time of her arrest. These various risk factors reinforce the likelihood of her having indeed suffered a psychotic relapse. She had also not been on one of the medications considered appropriate for treatment of her illness for approximately six months, albeit with medical approval, sodium valproate, and this is likely to have made her more vulnerable to relapse. It is unclear whether she had been taking her anti-psychotic medication during some time up to the offences, that is Quetiapine, in that her description of what she had been taking, as given after her arrest, varied between her saying she had been, or had not been, taking the drug. She acknowledged having taken 'skunk' cannabis, this being confirmed on drug testing, and is likely again to have made her more vulnerable to psychotic relapse".

21 June 2012. Psychiatric report for the Crown Prosecution Service, mental state examination. A was interviewed twice, "her presentation was similar on both occasions, and she was polite, talkative, controlling of the interview, difficult to interrupt, digressing and not keeping to the point in question. These features were apparent without any evidence of hypomania. She became angry when I challenged her about her claimed amnesia for the events. There were no psychotic features evident at interview". Opinion was that "she showed sufficient personality dysfunction to satisfy criteria for the diagnosis of personality disorder.

The most likely diagnosis is an emotionally unstable or borderline personality disorder characterized by emotional instability, impulsivity, the formation of intense relationships, outbursts of anger when criticised or goals are thwarted. I believe that as part of her personality disorder she is extremely needy and demanding in her relationships with others. If her needs are not being met she feels abandoned leading to intense rage and serious violence. Not surprisingly she felt very upset receiving the e-mail from her brother and I believe this was the onset of her disturbed feelings. As a result of her emotionally unstable personality disorder she felt abandoned, not only by her brother but also by the mental health staff looking after her. She complained to me that when she saw her CPN she did not spend the usual two hours with her because she was too busy and did not remain with her at the hospital where she went following herself reported miscarriage. I believe she experienced feelings of rejection which turned to feelings of fear and anger that she had been abandoned in this way. She sought support from various males on the evening leading up to the events of the following morning, who smoked cannabis and took crack cocaine. She had casual sex with one of them who she did not know. Cannabis was detected in her blood on arrest. She became fearful and wanted to return to psychiatric hospital as a way of dealing with her feelings of rejection and abandonment.

I do not believe that she has ever suffered from a mental illness such as schizophrenia or schizoaffective psychosis. Her symptoms have disappeared too quickly to indicate such a diagnosis and indeed the new treating consultant told me that no psychotic symptoms have been observed at all during her time under his care".

4 March 2013. Sentencing Remarks of the Recorder of London in the Central Criminal Court. "The psychiatrists that subsequently examined you accept that you were suffering from an abnormality of mental functioning, but disagreed as to what it was.

The jury concluded on all the evidence that any such abnormality did not substantially impair your ability to form a rational judgment or to exercise self-control during the crucial period and did not provide an explanation for the crucial conduct. In Russet Ward you continued to receive anti-psychotic medication but showed no signs of psychosis. What the records show is aggression, intimidation, disruption, anger and emotional instability, particularly when your needs are not being met and a regular feature was blaming everyone else for your situation. Your mental health difficulties are a borderline personality disorder with the ability to form rational judgment. What I conclude from the full spectrum is that you are manipulative and extremely dangerous. Taking all factors into account the minimum period of your life imprisonment term will be one of 37 years".

4 March 2013. IPCC Commissioner's Report made available: 'Investigation into the police contact with Ms A prior to her fatally stabbing Mrs Sally Hodkin. Extracts note: "It is of great concern that no Police National Computer (PNC) check was carried out which would have immediately alerted them to Ms A's violent history".

Without the PNC check, both the police and subsequently staff at the hospital and Oxleas Centre were without crucial information which may have increased the urgency of the situation and could have escalated the medical attention she was given. Ms A's forensic social worker e-mailed an electronic MAPPA referral form to the Clinical Director (at the Bracton Centre) in August 2009, which should have been forwarded to Greenwich police as Ms A was MAPPA eligible. This was not done. The Police National Computer (PNC), and the Serious Crime Directorate 1 (SCD1) Operation Globelands report, recorded that Ms A had a history of mental illness and had been convicted of manslaughter for fatally stabbing her mother, and that she had been sentenced to an indefinite hospital order and was released with conditions on 29 September 2009.

Although Ms A was a MAPPA eligible offender she was not known to the MAPPA system in Greenwich. It is a requirement for the Mental Health Casework Section (MHCS) of the National Offender Management System (NOMS) to inform the local police when a patient such as Ms A is to be released into the community. In this case a letter had been sent to Kent police because Ms A was released from the Bracton Centre in Kent. However her conditions of residence were in Greenwich and the local police were not notified as they should have been

16 March 2013. A daily newspaper article was published in which Ms A's brother's account was given of how he was referred to as 'It' by his sister. At the External Investigation Panel interview her brother was asked about the accuracy of reporting in the article, and he confirmed it was accurate. He indicated that Ms A argued with his mother over anything and everything, and by the age of 11 she was disappearing for days at a

time. He recalls she left school at 15 following an incident in which her behaviour was so threatening she had to be barricaded in a cupboard. (He and his sister recounted and verified the early family history recorded above). In the article he reserved his anger for the medical professionals who decided that Ms A was well enough to live back in the community. His sister indicated she stopped meeting with Ms A, the Social Supervisor, and Associate Specialist, when she knew they were going to discharge her sister, which she, like her brother, felt was a mistake.

Appendix 6: Glossary of terms

A&E	Accident & Emergency
ANA	Assessment Nursing Assistant
BNF	British National Formulary
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DoH	Department of Health
GP	General Practitioner
LAS	London Ambulance Service
MAPPA	Multi-Agency Protection Public Arrangements
MDO	Mentally Disordered Offenders
MHLN	Mental Health Liaison Nurse
MHLS	Mental Health Liaison Service
MHLT	Mental Health Liaison Team
MHA	Mental Health Act, 1983, (amended 2007)
MHRT	Mental Health Review Tribunal
MHU	Mental Health Unit
MoJ	Ministry of Justice
NHSLA	National Health Service Litigation Authority
NPSA	National Patient Safety Agency
PC	Police Constable
PNC	Police National Security
PICU	Psychiatric Intensive Care Unit
PSG	Patient Safety Group
QEH	Queen Elizabeth Hospital
RC	Responsible Clinician
RiO	Electronic Patient Record
SpR	Specialist Registrar
SW	Social Worker