An independent investigation into the care and treatment of a mental health service user (Mr EF) provided by Barnet, Enfield and Haringey NHS Trust

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Caring Solutions (UK) Ltd is a professional consultancy for mental health and learning disability services.

Web: Caring Solutions UK Ltd

Acknowledgements

The independent investigation team wish to thank all those who contributed to this investigation.

This includes members of staff who agreed to be interviewed and were open and honest with their views and reflections on the care and treatment of Mr EF.

Members of the patient safety team worked hard to arrange the interviews, provided the documents we requested and welcomed us into their offices.

We are grateful to the internal review team from Barnet, Enfield and Haringey Trust, who wrote the report which provided the springboard for our investigation.

We are grateful to the victim's brother and partner who provided their views on the care and treatment of Mr EF and told us about the significant impact that the homicide had made on their lives.

We appreciated the willingness of Mr EF's mother to talk to us and provide her unique perspective and insights into the treatment and care provided to Mr EF.

Finally, we wish to thank Mr EF himself, who again was open and willing to provide his perspective on his contact with Barnet, Enfield and Haringey NHS Mental Health Trust.

All parties provided invaluable information and insights which form the basis of this report.

Contents

1. Executive summary

1.1 NHS England commissioned Caring Solutions (UK) Ltd to carry out this independent investigation into the care and treatment provided to Mr EF by Barnet, Enfield and Haringey NHS Trust (the Trust) from his first contact with their services in 2004 until the time of offences he committed in May 2014. This is the executive summary of the report of that investigation.

1.2 The independent investigation panel are referred to in the first person throughout.

Terms of Reference

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

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Review the findings if relevant from any additional report such as Domestic Homicide Review (DHR) and the Trust's progress in implementing any recommendations.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.

- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a post investigation evaluation.
- To explore the clinical decision making and risk assessments specifically relating to risk to others.
- To review Mr EF's substance misuse and management plans.
- To review the effectiveness of the Trust's management of patients deemed difficult to engage.
- To establish how Mr EF managed to abscond from the inpatient facility on the 14 April 2014.
- To establish if the egress meets regulatory requirements.
- To understand if the instability of Mr EF's living arrangements had an impact on his care planning and understanding of risks.

Purpose

1.4 This investigation follows the guidance issued by the Department of Health in 1994, amended in 2005[1] and NHS England's Serious Incident Framework[2]. The guidance for commissioning an independent investigation is:

> "When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach, or is under the care of specialised mental health services, in the 6 months prior to the event."

1.5 The purpose of this investigation is to examine the care and treatment of Mr EF and to identify whether there were any gaps or deficiencies in the care and service provided. It will assess if the incident could have been predicted or prevented and will identify if there are any areas of best practice, opportunities for learning and areas where improvement to services could help prevent similar incidents from occurring.

[1] Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, as amended in 2005: - Independent Investigation of Adverse Events in Mental Health Services
[2] NHS England (2015) Serious Incident Framework: supporting learning to prevent recurrence

1.6 The overall objective is to identify risks and possible opportunities to improve patient safety with the Trust; and, where appropriate, to make further recommendations about organisational and system learning.

Introduction

1.7 Mr EF first received specialist mental services from the Trust in October 2004, following referral from his GP and, with gaps in contact with services between April 2008 and July 2010; and between December 2010 and July 2013. He was admitted to hospital as an informal patient for five months in 2005. In June 2013 Mr EF was detained under Section 2 of the Mental Health Act 1983, amended in 2007 (MHA), and remained in hospital for one month.

1.8 He was admitted informally in mid-April 2014, following an assessment for detention under the MHA. Two doctors recommended detention under Section 2 of the Act. The Approved Mental Health Practitioner (AMHP) agreed he should be in hospital, discussed this with Mr EF who agreed to an informal admission. As Mr EF was assessed as having the capacity to make that decision he was admitted informally. He was informed that if he tried to leave the ward an application for detention would be made. Mr EF left the ward by scaling the fence around the garden area the following day. The possibility of assessment for admission under the MHA was discussed with an AMHP, but it was decided to await review by his care coordinator (a student social worker) and a junior doctor, a trainee GP working in the Community Support and Recovery Team (CSRT). He was assessed as able to remain in the community with support from the CSRT.

1.9 Mr EF received care and treatment from a number of community services in Barnet and Enfield, including from Community Mental Health Teams and Crisis Resolution and Home Treatment Teams. His GP also monitored his mental health. His contact with community services was characterised by not attending appointments, not answering telephone calls and not being in when mental health care professionals tried to visit him at home. He sought help for practical matters such as applications for benefits, for housing and for a free travel pass.

1.10 Mr EF was diagnosed with paranoid schizophrenia, although there was also a question of drug-induced psychosis at some points. He was prescribed medication to control his psychotic symptoms but did not comply with the prescriptions, taking his medication intermittently. He also used alcohol and illegal drugs, primarily cannabis.

1.11 Mr EF's housing situation was unstable – he spent time in council accommodation rented in his own name with a support worker visiting; he lived in a supported hostel from September 2005. He was evicted in early 2008 for persistent breaches of the house rules and becoming abusive towards staff. The local housing service did not consider him to be sufficiently 'vulnerable' to be accepted as homeless. He turned down the offer of temporary accommodation. He stayed with friends, 'sofa-surfing' and slept rough during the period from 2008 to 2010 when he was not in contact with services.

1.12 The combination of non-compliance with medication and use of alcohol and cannabis was the trigger for acute illness leading to hospital admission. His symptoms included hearing voices which commanded him to harm or kill himself; fearing that others were going to kill him, to the extent that he did not go out for fear of being attacked, sometimes taking a knife with him and having knives in his accommodation for his own protection. He was arrested twice for carrying a knife, with a brief prison stay in 2012.

1.13 On 8 May 2014 he visited a "drinking friend", Mr BC at his flat. They were drinking beer and smoking cannabis. Mr EF, who had taken a knife with him for self-protection, became convinced that Mr BC was going to kill him. There was an altercation and Mr EF killed Mr BC in a 'frenzied attack'[3]. Mr EF left the flat and returned home. A week later, he returned to Mr BC's flat and set fire to it. He was arrested and charged with murder and arson, with reckless endangerment to life[4]. Following psychiatric reports, he pleaded guilty to manslaughter on the grounds of diminished responsibility and guilty to arson and being reckless as to whether life was endangered.

1.14 He was sentenced to be detained in a secure hospital indefinitely and can only be released with the permission of the Home Secretary.

Methodology

1.15 The investigation was carried out by suitably qualified and experienced investigators appointed from Caring Solutions (UK) Ltd. The team consisted of (brief biographies in Appendix C):

- Mr Tony Thompson (Panel Chair and Lead Investigator);
- Dr Michael Rosenberg (Independent Consultant Psychiatrist) for Caring Solutions (UK) Ltd; and
- Ms Maggie Clifton (Investigations Manager)

1.16 The investigation followed the principles of root cause analysis (RCA) as set out in the National Patient Safety Agency guidance.[5] As part of this methodology we completed a chronology of events and a 'fishbone' analysis, setting out what we concluded were 'contributory factors' in the period leading up to the offences. We recognised the limitations of this approach but find the methodology assists in identifying contributory factors which may have increased risks.

1.17 We used the RCA process to collect information and structure interviews. We interviewed a number of mental healthcare staff who had provided care and treatment for Mr EF prior to the homicide, and two members of the internal inquiry panel, the service manager responsible for implementing the action plan arising from the internal inquiry. We were unable to interview

[3] Judge's sentencing remarks.
[4] The crime of 'being reckless as to whether life was endangered' refers to when person engages in conduct which creates a substantial risk of serious physical injury to another person, without regards to the foreseeable consequences to others. In this case, setting fire to a flat was potentially dangerous to the safety of others living in the surrounding flats.
[5] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

some health and social care professionals as they had left employment with the Trust and either could not be traced or did not respond to our attempts to contact them. We felt that these staff could have given us useful insights in the events immediately prior to the homicide but unfortunately these were not available.

1.18 We were pleased to be able to talk to Mr CC (the victim's brother) and his partner about their views and the impact the homicide had on his family. They also provided useful information about the friendship between Mr BC and Mr EF, and they reported previous risk behaviours on the part of Mr EF.

1.19 We also were pleased to talk to Mrs GG, Mr EF's mother who gave us her perspective on his care and treatment. We interviewed Mr EF who also contributed his valuable insights to our investigation.

1.20 We evaluated Trust compliance with relevant national and local policy and guidance.

Internal Board level inquiry report and action plan

1.21 We reviewed three reports provided by the Trust as follows:

- Untoward Incident Document which contains a brief description of the incident, the immediate actions taken, administrative information and a summary of lessons learnt.

- The Board level panel inquiry report, which was approved by the service and the Trust Board on 1 June 2015, including an action plan.

- A desk top review, included as an appendix to the Board level review which was dated 10 June 2014.

1.22 We used an audit tool developed by Caring Solutions (UK) Ltd specifically for this purpose. The Board level inquiry identified good practice in a number of areas, identified key lessons learnt and made 13 recommendations. The team for the desk top review included staff directly involved in provision of the service which Mr EF attended. We did not consider this to be appropriate and note that this component of the process no longer appears in the current 'Management of Serious Incidents' policy.

1.23 The inquiry itself was carried out by Trust employees who were independent of the services provided to Mr EF, in line with good practice. Relevant staff were interviewed and panel members met Mrs GG.

1.24 We agreed with the panel that a key weakness in the delivery of services to Mr EF was the allocation of a student social worker to the role of care coordinator. The report made recommendations about the appropriate training for care coordinators and the supervision of trainees. They also recommended that, when a service user goes missing from a ward, that a qualified professional should be involved in the provision of community support. However, the Trust's own clinical risk assessment policy, current in 2014, is clear that a care coordinator must be a professionally qualified member of staff.

1.25 We were surprised on first reading that the report felt it necessary to recommend that all professional staff working in the psychosis service should receive training in the symptoms of psychosis. We would have expected that qualified staff should have knowledge and understanding of the symptoms of psychosis prior to joining such a service. Interviewees felt that the focus should be more on identifying the nuances of complex presentations of psychosis in combination with other conditions such as substance abuse. The importance of professionals updating skills, knowledge and competence was also recognised.

1.26 We were concerned that not all staff who had been interviewed had received a copy of the internal inquiry report and would expect that in future all staff who contribute to an inquiry should automatically receive a copy of the report.

1.27 The Terms of Reference required us to review the action plan and its implementation. We considered that the action plan appropriately reflected the recommendations in the report. We were provided with and reviewed evidence of the implementation of these actions. We considered that, for the most part, these had been implemented to Level 1 of the NHS Litigation Authority's standards. The evidence we were given indicates that policies and evidence had been described and documented, but we did not evaluate the evidence provided as indicating that the actions were embedded in practice and across the whole organisation (detail in paragraph 6.51)

Summary of main findings and conclusions

1.28 In line with the Terms of Reference for this investigation, we discussed a number of issues arising from the detailed description of Mr EF's contacts with the Trust. Our conclusions on these issues are summarised here.

Mr EF's departure from the ward in April 2014 and immediate follow-up.

1.29 We visited the ward from which Mr EF went missing in April 2014 and spoke to the current ward manager and observed the physical security arrangements inside the ward and in the garden and recreation area. Some interviewees expressed concern about the quality of the environment and we agree. The perimeter fence around this area has been heightened since Mr EF left the ward and has prickly thorn planting which acts as a deterrent. The area has a free-standing bench and basketball hoops. A security service monitors and patrols all property on this site.

1.30 We identified a number of features on the ward that weaken the barriers which may help prevent service users leaving the ward without passing nursing staff. We do however recognise that the Trust has to balance risks and benefits of increased physical security and with the aim of delivering services in the least restrictive way, the pressure on beds and high occupancy rates. In addition, although the ward is an open ward, a high proportion of its patients can be detained under the MHA, and people admitted to in-patient care have complex and severe mental health needs, often further complicated by other conditions such as substance misuse. This lessens the chance of ward objectives being met.

1.31 Mr EF was a patient on this ward for a very short time, which meant that it was not possible for staff to develop 'relational security' using therapeutic approaches. Mr EF was also aware that if he informed staff he was leaving the ward, he would have been reassessed for detention under the MHA and very likely detained on the ward.

1.32 The actions taken by staff when Mr EF scaled the fence were appropriate, and they appreciated that, being an informal patient, he could not be required to return to the ward when the police traced him to his home. The ward staff did discuss an MHA assessment when Mr EF was found, but it was decided to await the outcome of a prearranged visit by his (student) care coordinator from the CRST and a junior doctor.

1.33 Mr EF's recent history included recommendations for detention by two experienced doctors, recognition by the AMHP that he needed to be in hospital and further assessment by a junior doctor and the ward consultant psychiatrist that he should be detained if he tried to leave the ward. In that circumstance, we felt that a MHA assessment within 72 hours of him leaving the ward should have been actioned.

CPA and care planning

1.34 We reviewed the care planning carried out over the time that Mr EF was in contact with the Trust. We concluded that it was difficult to determine the effectiveness of early care planning as there were no care plans describing future interventions. Records of some CPA meetings were found to be incomplete. We agreed with the internal panel that Mr EF's lack of engagement with services since the beginning of his contacts had not been picked up in supervision and had not been escalated to senior members of the team. Again, along with the internal inquiry, we identified deficiencies in the recorded information. Particular issues arose around the practice of the student social worker/care coordinator and his supervision.

Application of the Mental Health Act 1983, as amended in 2007.

1.35 Mr EF did have a known history of risky behaviour, including his fears that people were going to kill him, the voices telling him to kill or harm himself, the arrests and a brief prison sentence for carrying knives, his self-reporting of keeping knives and a machete at home and an assault on his sister. There was no evidence in his past which foreshadowed the 'frenzied' knife attack on Mr BC on 8 May 2014. A CRHT doctor in 2005 had identified the possibility of serious harm but there was no evidence seen by the Trust that could have identified the risk of extreme violence when he committed the homicide.

1.36 The MHA assessment in April 2014 was thorough and followed good practice in pursuing the 'least restrictive' option, although the AMHP did not have access to Mr EF's full risk history. We agree with the internal inquiry that the lack of documentation with a full rationale for the decisions made was a weakness.

1.37 We concluded from our review of Mr EF's history, risk and relapse indicators that the medical recommendations for detention were appropriate and that the nature and degree of Mr EF's presentation warranted compulsory detention for

a period of assessment. We do not believe this would have necessarily prevented Mr EF from leaving the ward but he would have been absent without leave (AWOL) and therefore could have been returned to the ward by the police. The detention could have been reviewed and rescinded in a planned way if Mr EF had responded to medication and clinical interventions. This would have reflected the protective aspect of the MHA with regards to detention.

Risk assessment and clinical decision making

1.38 We could not find any evidence of standardised risk assessments, only risk summary sheets, dated 2008, 2010 and 2013. The absence of any standardised longitudinal risk assessment may have implied a lower risk than may have been the case. We also noted that Mr EF appeared quite adept at telling professionals what he felt they wanted to know. He tended to avoid interventions that would interfere in his life and selectively engaged in services which appealed to him.

1.39 We concluded that clinical decision making and judgements were reasonable on the basis of the information the practitioners had. However, this was in the context of incomplete, independently corroborated information, including where he was living, contact with substance misusers, erratic and non-compliance with medication, frequency of cannabis and alcohol intake and the relationship with the victim prior to the offences.

1.40 However, we did consider that, in April 2014, Mr EF should have been considered a 'medium' risk of harm to others when he left Sussex ward – given the circumstances of his admission, his behaviour on Dorset ward (harassing a female patient), medical recommendation that he should be detained if he tried to leave the ward – and that further assessment would have been appropriate.

1.41 The risk assessment processes highlighted problems associated with over-reliance on self-reporting. Some service users may be unaware of the risks they pose or deliberately obstruct accurate assessment. One of the problems presented appeared to be that of placing risk in the context of his behaviour and his irrational beliefs and ideas. It appeared difficult for professionals to be sure whether previous aggressive behaviour was due to the influence of drugs and alcohol or to a severe psychotic episode. The context and nature of the assault on his sister and his carrying a knife should have been examined in more depth. This would have been best practice.

The management of 'difficult to manage' service users, substance misusers and those with unstable living arrangements.

1.42 We noted that strenuous efforts were made to engage with Mr EF when he was unwilling to engage with services. Numerous abortive visits, telephone calls not taken and messages not responded to are recorded. Unfortunately, these efforts were largely in vain and Mr EF maintained his practice of only engaging with services when he could see a practical benefit – help with housing, welfare benefits, and access to free public transport.

1.43 We concluded that it was unlikely that Mr EF would have responded to specialist substance misuse services, on the basis of his reluctance to comply with interventions to help his psychotic symptoms. The evidence is clearly that willingness to change is the willingness of the client to engage with the service and interventions. However, we did consider that this aspect could have been given greater support in the earlier stages of his illness.

1.44 Mr EF experienced periods of literal homelessness (rough sleeping) and living in unstable accommodation such as 'sofa surfing' or bed and breakfast. He was often described as of 'no fixed abode' in the records. Research evidence[6] identifies a number of themes which were relevant to Mr EF's care, including poor communications, inappropriate/unsafe discharge, NHS systems not designed for mobile populations. Some of the issues identified were addressed some of the time over the time he was in contact with the Trust's mental health services. On the other hand, on some occasions, Mr EF's care did meet standards which might mitigate against the worst consequences of his unstable living arrangements. For example, efforts were made to find alternative accommodation: Mr PR went out of his way to coordinate a response and find Mr EF somewhere to live.

1.45 We concluded that this combination of non-engagement with services, non-compliance with medication, substance misuse and unstable housing made it significantly more difficult for services, as currently configured to carry out adequate care planning and therapeutic interventions and risk assessment and management.

Compliance with policies

1.46 We considered that, if it had been available when he first presented with symptoms of psychosis, Mr EF would have met all three criteria for referral to an Early Intervention Service (EIS). The aim would had have been to provide him with the benefits of receiving a consistent service for three years. However, we appreciate that this is speculative as he might not have been accepted by the EIS or they may have not continued to provide care given his additional substance misuse.

1.47 We identified several components of the Clinical Risk Assessment policy in place when Mr EF was in contact with services prior to the offences which Trust practice did not comply with. For example, there was a very clear and explicit statement that the care coordinator should be a qualified professional; the guidance for assessing risk was not properly followed. The 2015 policy is excellent, particularly the flow chart.

1.48 The CPA policy (2013) is also comprehensive, accurate and reflects current national guidance. It includes a 40-point list of skills and knowledge for CPA care coordinators – and we consider it unreasonable to expect a student (of whatever discipline) to fulfil this role. We also note that that policy states that a person new to this role or the service should undergo a two-week induction – we have not seen any evidence that this was provided to Mr PR (student social worker and Mr EF's care coordinator).

[6] Queen's Nursing Institute (2008) 'Homeless health initiative, service user consultation', QNI

1.49 The current Crisis Resolution and Home Treatment Team (CRHTT) operational policy (2015) should lead to better assessment of service users like Mr EF – it requires two staff to be involved, one of whom should be a senior practitioner.

Information from relatives of Mr BC and Mr EF, and from Mr EF

1.50 Mr CC described to us the severe and lasting effects that the homicide had on him and his partner. More than two years afterwards its impact on his emotional and psychological state was apparent. We identified the need for the Trust to ensure that relatives of victims of homicide carried out by mental health service users are offered appropriate professional support as soon as practicable after the incident.

1.51 Mr CC informed us that his brother and Mr EF had been 'drinking friends' for some years, and that Mr EF had been exhibiting risk behaviours towards Mr BC. We were unable to corroborate this information.

1.52 Mrs GG informed us that she felt that her son should not have been allowed out of the ward into the garden area so soon after his admission and that he should have been returned to hospital after he went missing from the ward.

1.53 Mr EF himself told us that he thought it would have been better for him if he had been sectioned in April 2014.

Preventability and predictability[7]

1.54 Although Mr EF did have a known history of risk behaviours and violence, there was nothing in his history which might have indicated a risk that was comparable to the severity of the attack on Mr BC on 8 May 2014.

1.55 We concluded that the homicide and arson committed by Mr EF were neither predictable nor preventable.

Contributory factors

1.56 We identified a number of contributory factors arising from Mr EF's presentation and his care and treatment by the Trust. These included:

- Patient factors – Mr EF's complex needs, including psychotic illness, substance misuse, non-engagement with staff, non-compliance with medication and unstable housing.

- Task factors – the limited risk information available to the AMHP who assessed him on 13 April 2014; the ease with which Mr EF was able to go missing from the ward; the application of the Care Programme Approach (CPA) (student care coordinator, weak professional supervision); and the need to balance safety with 'least restrictive environment'.

[7] Definitions provided in Section 7 of this report

Root causes

1.57 We concluded that the combination of factors identified constituted the root causes for these offences (as described in paragraph 8.10).

Good practice

1.58 We identified four additional examples of good practice:

- Clear communication between the Barnet service and GPs in 2006 to 2007;
- Advice given to Mr EF by his GP regarding accessing his medication, advice on taking it and sources of help if symptoms worsened;
- Ward invitation of GP to CPA meeting; and
- Occupational therapy assessment which was detailed and comprehensive, was carried out by a student and senior OT and was signed by both.

Recommendations

9.1 We are conscious that trusts are responding to recommendations for changes from a number of sources, and that this can become counter-productive. We are aware that regulatory authorities have already made recommendations for the Trust to address, so were open to enter into a dialogue with the Trust. We have not replicated recommendations made by the internal report, but have added a limited number of further recommendations.

Recommendation 1: Although we recognise that the capital implications and future plans for the site must be taken into account, we recommend that, in conjunction with its commissioners the Trust takes urgent steps to ensure that all admission wards are gender specific or, at a minimum, to create gender-specific bedroom and functional areas within mixed-sex wards.

Recommendation 2: The Trust ensures that equipment that is currently free-standing (bench, basketball hoop) in the garden area of the ward from which Mr EF went missing is fixed to the floor. The aim is to put barriers in place, recognising that a recreational area can be high risk

Recommendation 3: The Trust undertakes a detailed and comprehensive audit of the safety and security of the Sussex ward.

Recommendation 4: The Trust should ensure that all service users with psychosis who misuse alcohol and/or illicit substances are considered for referral to substance misuse services. If the decision is to not make a referral, the rationale for the decision should be recorded.

Recommendation 5: Commissioners and the Trust consider working together to devise a more innovative, assertive outreach type of service for those service users who do not organise their lives by diaries and appointments and who move readily and frequently between organisational boundaries. Such services would be more flexible in going to service users where they are and remaining open to service users who move across team or service boundaries within the Trust.

Recommendation 6: The Trust should follow the clinical risk assessment policy and deploy qualified staff to the CPA care coordinator role. If, in exceptional circumstances, a student is considered appropriate for the role, arrangements for role preparation (understanding of the role and appropriate training) should be made with the university programme head and include monitoring by appointed external examiners to the course.

Recommendation 7: The Trust moves towards the development of a more personalised approach to risk assessment, which is individual to each patient, assesses current risk factors and past history and includes a management plan that follows on from the risk assessment. In the meantime, we recommend that the current training on risk assessment and guidance on the use of the existing tool is strengthened.

Recommendation 8: The Trust should revise the CPA policy in order to ensure that the status of care coordinators is consistent with the clinical risk assessment policy.

Recommendation 9: In future instances of homicide by a service user in contact with mental health services, and where practicable, the Trust should offer professional support to meet any mental health needs arising from the incident and should signpost families to help with any other needs arising from the incident, such as financial costs. If the victim is unknown to the Trust, a senior manager should approach the police victim liaison officer to offer assistance to victim's relatives and put them in touch with the Trust if support is requested.

2. Offence

2.1 On 8 May 2014 Mr EF killed the victim, Mr BC, whilst under the influence of alcohol and cannabis. Mr EF subjected the victim to a 'frenzied attack'[8] with a knife. On 15 May 2014 he returned to the flat where Mr BC's body remained undiscovered and set fire to the flat.

2.2 Clinical records completed after the homicide report indicated that Mr EF was convinced that Mr BC was going to kill him, so that Mr EF perceived his attack to be for his own protection.

2.3 Mr EF was charged with the murder of Mr BC, reckless endangerment and perverting the course of justice and was remanded to prison. In August 2015 he pleaded guilty to manslaughter on the grounds of diminished responsibility and he also pleaded guilty to arson and being reckless as to whether life was endangered[9]. On 6 February 2016 Mr EF was given an indefinite hospital order[10].

2.4 At the time of the internal review the panel did not know what the relationship, if any, there had been between Mr EF and Mr BC. We identified from Mr BC's brother that Mr EF and Mr BC had been friends for some years. Mr BC's brother described them as 'drinking partners'. His brother reported that Mr BC had visited Mr EF when Mr EF was a hospital inpatient.

2.5 At the time of this offence, Mr EF was receiving care and treatment from the West Barnet Community Support and Recovery Team (WCSRT).

3. Independent investigation

Approach to the investigation

3.1 NHS England (London) commissioned Caring Solutions (UK) Ltd to carry out this independent investigation, in line with the Serious Incident Framework[11]. An independent review has to be conducted when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services within the six months prior to the homicide, including service users treated under the Care Programme Approach (CPA).

3.2 The Serious Incident Framework approach aims to facilitate learning by promoting a fair, open and just culture that does not use blame as a tool. It promotes the belief that an incident should not simply be linked to the actions of individual staff involved but rather to the system in which the individuals were working.

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[8] Judge's sentencing remarks.
[9] The crime of 'being reckless as to whether life was endangered' refers to when person engages in conduct which creates a substantial risk of serious physical injury to another person, without regards to the foreseeable consequences to others. In this case, setting fire to a flat was potentially dangerous to the safety of others living in the surrounding flats.
[10] An 'indefinite hospital order' means that a person is required to receive treatment in a mental hospital for an unlimited period of time and can only be discharged from hospital when the clinician responsible for his treatment and the Secretary of State for Justice agree to it.
[11] NHS England (2015) Serious Incident Framework: supporting learning to prevent recurrence.

3.3 The independent investigation follows the Department of Health guidance (94) 27[12], on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The guidance for commissioning an independent investigation is:

> "When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach, or is under the care of specialised mental health services, in the 6 months prior to the event."

3.4 The main purpose of an independent investigation is to discover whether there were any aspects of the care and treatment which could have been improved or have prevented the incident. The investigation process may also identify areas where improvements to services might be required which could help reduce the likelihood of similar incidents occurring.

3.5 The overall aim is to identify common risks and opportunities to improve safety, and make recommendations about organisational and systems learning. Any recommendations are implemented through effective action planning and monitoring by providers and commissioners.

3.6 The terms of reference for this investigation are given in full in Appendix B.

Purpose and scope of the investigation

3.7 The purpose of this investigation is to examine the care and treatment of Mr EF and to identify whether there were any gaps or deficiencies in the care and service provided. The investigation will identify if the incident could have been predicted or prevented and will identify if there are any areas of best practice, opportunities for learning and areas where improvement to services could help prevent similar incidents from occurring.

3.8 The overall objective is to identify risks and possible opportunities to improve patient safety with the Trust; and, where appropriate, to make further recommendations about organisational and system learning. We also came to a conclusion as to whether we considered the homicide to be either predicable or preventable.[13]

[12] Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, as amended in 2005: - Independent Investigation of Adverse Events in Mental Health Services

[13] Definitions in Section 7 of this report

Investigation Team

3.9 The investigation was carried out by suitably qualified and experienced investigators appointed from Caring Solutions (UK) Ltd. The team consisted of:

- Mr Tony Thompson (Panel Chair and Lead Investigator);
- Dr Michael Rosenberg (Independent Consultant Psychiatrist) for Caring Solutions (UK) Ltd; and
- Ms Maggie Clifton (Investigations Manager).

3.10 Brief details of the investigation team are included in Appendix C. The investigation team will be referred to in the first person in the report.

3.11 Dr Colin Dale, Chief Executive, Caring Solutions (UK) Ltd quality assured the process of carrying out the investigation and the report.

Methodology

3.12 The investigation was carried out in accordance with the NHS England Serious Incident Framework (2015) and the National Patient Safety Agency (NPSA) guidance[14].

3.13 Root cause analysis (RCA) methodology has been used to examine the information supplied for the investigation. This approach is chosen because it aims to be characterised as looking at the role of the systems in place in care and service delivery, rather than looking solely at the role and functions of individuals. The panel recognise the limitations of this approach and the RCA process is considered later in this report. Whilst it is likely that no single root cause for such an event can be identified, the procedure assists in identifying a range of contributory factors which may have increased risks. One of these may be accountability for professional actions or lack of them.

Panel consideration

Given the complexity of the nature of Mr EF's mental health problems and the degree to which they manifest at specific times in his life, the context of professional help and interventions differed considerably. We are aware that it is unlikely that a single root cause based on RCA procedure would be identified. Whilst the process of RCA is useful in our examination, we are mindful of weaknesses in the method based on published work.[15] This work describes the modification of the 'Human Factors Analysis Classification System' based on James Reason's theory of causation for use in healthcare. This was helpful in our analysis as it resolves some difficulties of RCA, including:

- The use of RCA is neither standardised nor reliable between organisations.
- The emphasis tends to be on 'who' did 'what' rather than 'why' errors occurred.
- The identifiable causes are often nonspecific to develop actionable plans for

[14] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

[15] Diller, T Helmrich G and others, (2015) 'The Human Factors Analysis Classification System' (HFACS)

correction.
- Standardised nomenclature does not exist which would allow accurate analysis of recurring errors across the organisation.

3.14 We used the RCA process to collect information and reconstruct the particular events through asking questions during interviews. We were able to identify any latent features within the services which may have adversely affected risk management.

3.15 Where appropriate we have referred to national and local policies and standard guidelines, to Department of Health (DH)[16] best practice guidelines and National Institute for Health and Social Care Excellence (NICE) guidelines.

3.16 We were aware of the need to reduce hindsight bias. The information we relied upon was in the main available to the service at the time. However, where outcome or hindsight assisted us in forming an opinion this has been recognised[17].

3.17 We interviewed the following people:

- Ms HJ (Approved Mental Health Practitioner);
- Dr KL (Consultant Psychiatrist);
- Mr MN (Psychosis Service Line Manager/Assistant Clinical Director);
- Prof OP (Executive Director of Nursing, Governance and Quality and author of the Board Level Panel Inquiry Report);
- Dr QR (Consultant Psychiatrist, Complex Care Team and member of the Board Level Panel Inquiry);
- Dr ST (Section 12 doctor[18], Consultant Psychiatrist);
- Dr UV (Clinical Director and Consultant Psychiatrist);
- Dr WX (Consultant Psychiatrist, Sussex Ward at the time of Mr EF's admission);
- Dr YZ (Consultant Psychiatrist, Section 12 doctor);
- Dr BD (Associate specialist psychiatrist, Section 12 doctor);
- Mr FG (Approved Mental Health Practitioner);
- Mr EF (Perpetrator);
- Mrs GG (Mr EF's mother – telephone interview);
- Mr CC (Mr BC's brother);

3.18 We would have wished to interview the following staff members but neither the Trust nor ourselves were able to either trace or make contact with them:

- Dr JK (GP trainee on psychiatric placement);
- Mr LM (Nurse, WCSRT);
- Mr NO (Social Worker, Principal Practitioner and Supervisor of Mr PR);

[16] DH (March 2008) 'Refocussing the Care Programme Approach: Policy and Positive Practice'; and Code of Practice Mental Health Act 2983 (revised 2008)
[17] Hindsight bias is when actions that should have been taken at the time leading to the incident seem obvious because the facts have become clear after the event (NPSA, 2008)
[18] A doctor trained and approved to assess whether or not a person requires detention under the MHA.

- Mr PR (Student social worker and care coordinator of Mr EF at the time of the incident);
- Ms TU (Agency social worker, previous care coordinator for Mr EF);
- Mr GF (Ward nurse who referred Mr EF for assessment under the Mental Health Act 1983, as amended in 2007, (MHA) on 15 April 2014, retired).

3.19 We considered that interviews with these people who had been employees of or on placement in the Trust and contributed to Mr EF's care and treatment in the period leading up to the incident may have been helpful, but unfortunately this was not possible.

3.20 Interviews were managed in liaison with the Trust and with reference to the NHS England guidance[19] and Salmon principles[20].

3.21 The identities of interviewees have been anonymised within the report.

3.22 We have identified services and any units as the nature and type of care delivery is relevant to specific panel comments in line with the Terms of Reference.

3.23 We refer to the subject of this investigation as Mr EF, and to the victim as Mr BC.

3.24 We have reviewed the following documents and websites to further inform the investigation. We requested a policy on 'difficult to engage' patients, but were informed this does not exist. (Full details of in Appendix G).

- Trust policies
    - Incident management policies (2013 and 2015);
    - Sussex ward operational policy (2014);
    - Missing patients/absent without leave policies (before 2014 and 2015);
    - Barnet early intervention service operational policy (2008);
    - Clinical Risk Assessment and Management policies (2011 and 2014);
    - CPA policy (2013);
    - CRHT operating framework (2013) and operational policy (2015); and
    - Psychosis service line operational policy (2011);
- Current research;
- National guidance; and
- Examples of good practice.

Involvement of Mr EF, members of his family and members of the victim's family

[19] NHS England (2015) Serious Incident Framework

[20] The Salmon principles are six principles of fair procedure for an investigation: in this type of investigation this means that people who are asked to provide evidence have prior notice of the questions to be discussed. Any individuals and the organisation should be informed of the criticism, and be given access to all the evidence on which the criticism has been based and give individuals or organisations the opportunity to review the evidence on which the criticism is based and to respond to the investigators.

3.25 The NHS England Serious Incident Framework states that

> "all investigations should ensure that families, including friends, next of kin and extended families of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into the investigation."

3.26 Caring Solutions (UK) Ltd are most aware that its investigations should seek the views of the subject of the investigation and those of the families of the perpetrator and the victim. It is our policy to explore with families their views about the care and treatment of the perpetrator leading up to the specific incident and also about views they may have about how improvements to their experience of the service might contribute to future prevention of similar events.

3.27 Two members of the team interviewed Mr EF himself on the ward where he was resident. We first sought confirmation from his Responsible Clinician that he was well enough to be interviewed, and obtained his agreement to meet the team.

3.28 The investigations manager and our case manager from NHS England visited Mr CC, the victim's brother. Following this visit, further support was arranged for Mr CC and two members of the team interviewed him.

3.29 Mr EF's mother responded to an invitation to speak to us, and the investigations manager carried out a telephone interview with her.

Structure of the report

3.30 We have described Mr EF's early years, the history of his contacts with the criminal justice system and with mental health services, and we have analysed the care and treatment provided by the Trust, in line with the Terms of Reference in Appendix B. We have also looked at alcohol and substance misuse, and housing issues.

3.31 This is followed by a review of the Board level panel inquiry report and a review of the action plan and the extent to which it has been implemented.

3.32 We have drawn conclusions about the factors which contributed to the incident, we have identified root causes[21], and concluded whether the homicide was predictable and/or preventable.

3.33 We have made recommendations where we considered that this would add to the work completed by the internal review report. We have endeavoured to keep recommendations to a minimum as we are aware that too many recommendations can be overwhelming and counterproductive. We have not duplicated the recommendations made by the internal review.

3.34 A detailed chronology from the point of Mr EF's first contact with mental health services is contained in Appendix C.

[21] Section 8 of this report

3.35 Appendices contain the full terms of reference, details of the investigation team, a fishbone analysis showing the contributory factors we identified, a list of anonymised contributors to this investigation, full details of Trust documents, national guidance and research we have referred to in this report, abbreviations and definitions, anonymisation index and the Trust's action plan.

4. The care and treatment of Mr EF

Childhood and family background

4.1 Mr EF was born in Uganda but the Trust's clinical records are inconsistent. Mrs GG provided us with accurate information. Some records state that he was born in the UK. This inconsistency of personal history information extends to the reported number of siblings. It is reported at various interviews that he is one of five siblings, with two brothers and two sisters, which is correct. The family moved from Uganda to the UK when he was four years old. His personal history is reproduced in various medical records and information contained in psychiatric and psychology interviews. Therefore, the content of reports is mainly based on his personal accounts unless formal records have indicated otherwise. Records show that Mr EF has lived at various times in several locations in North London.

4.2 The records show that Mr EF's father abused alcohol and was violent to Mr EF. His parents separated during his childhood, he has no contact with his father. For periods of time he had lived with his mother and her partner, he reports that this was mostly to keep away from his father.

4.3 Psychology records show that Mr EF has denied any behavioural problems during his childhood or adolescence. However, he had previously acknowledged that he was involved in fights at school although he denied being expelled or suspended. This information is also inconsistent in the various health records. This revolves around him experiencing being bullied at secondary school and he later informed health professionals that his mother's advice to retaliate led to him fighting back. He reports that he was suspended twice as a result.

4.4 The frequency of Mr EF experiencing house moves during his formative years is recorded in psychiatric notes as being due to Mr EF's father starting to drink heavily when Mr EF was approximately eight years old. The father then started physically abusing his mother. In order to evade the father tracking the family and claiming custody of his children, Mr EF's mother moved houses.

4.5 Mr EF reported that he purposefully entered any room his parents were arguing in so that he might try to stop his father assaulting his mother.

4. 6 Mr EF describes his home life as 'not having the best relationship but it's fine' and has at times explained that 'we come from a broken family. We used to fight a lot because of that'.

4.7 It is recorded that Mr EF had commenced primary school aged five years old. He moved primary school up to three times to coincide with moving house.

This situation meant that he had to attempt to make new friends. During secondary school the family settled in where Mr EF's father had not managed to find them. He describes in mental health reports during interviews that school was 'fairly alright'. He is reported as achieving three GCSEs in English, Maths and Science. Whilst stating to health professionals that school was all right he also stated that he 'beat other people up' and he attributed this behaviour as being influenced by his father's conduct.

4.8 Mr EF remains in contact with his mother and one sister. Periodically he has lived with his mother whilst receiving care and treatment from the Trust. His most recent care coordinator was reported by his mother to the internal inquiry panel as having been supportive of her and having established a good relationship with her. One incident of violence against his sister is recorded in 2004 (he threw an iron at her, which hit her in the face) and he was subject to an injunction to stay away from his mother's house. Despite this incident, both his mother and sister visited him in hospital during his admission in 2013 and he was granted leave from the ward with his mother and lived with her 'on and off' until the homicide.

Training and employment

4.9 Mr EF left school aged sixteen and worked for a self-employed painter and decorator. He had a variety of manual jobs, the longest was working in a factory making prescription lenses which he did for two years.

4.10 Again, the records are inconsistent – elsewhere it is recorded that in the year 2000, aged seventeen, he was becoming 'unwell' and was signed off by his GP as unfit to work. From this point Mr EF was unemployed.

Relationships

4.10 It is recorded in contemporary psychology reports that Mr EF reported that his first and most significant relationship had begun when he was fourteen years old. The relationship apparently lasted approximately one year before it was 'time to move on'. Mr EF estimates that he has had about four or five relationships since he was sixteen years old, none of which were serious.

4.11 It is reported by Mr EF that it was during this time of adolescence he started to use cannabis. He states that the 'spliffs' made him feel good. The stresses he was responding to at the time included school bullying, exams and peer pressure amongst other things.

Panel Consideration

It is evident from the records of formal interviews with Mr EF both before and after the index offence that despite inconsistencies of recording, mainly due to having to rely on self-reporting, some facts can be identified.

These include acknowledgement that Mr EF grew up in a volatile family environment. During this time he witnessed and was a victim of physical violence from his father.

Mr EF's mother suffers from ill health and it is possible that Mr EF would not have developed secure attachment during his formative years of childhood and adolescence.

The environmental instability due to frequent moving of home has led to professionals taking a view that one consequence may have resulted in Mr EF's view of the world as an uncertain place.

He was bullied at school and got into fights, so leaving very few options as to a safe place to be.

He began smoking cannabis with peers and drinking alcohol to cope. It appears likely that the substance misuse may have been an initial contributory factor regarding his psychotic symptoms.

We will describe later how when periods of psychosis appeared Mr EF resorted to using substances and alcohol as a means of coping, which in turn, seems to have led to further disintegration of his perceptions. This manifested in paranoia, social isolation and fear for his own safety.

4.12 Despite his transient lifestyle, Mr EF did acquire some friends and amongst these a particular one, Mr X, was sufficiently concerned about the presentation of Mr EF in July 2010 and he supported Mr EF in seeking help.

4.13 Mr X also agreed that Mr EF could stay with him in his flat on a temporary basis. Mr EF lived there until he was advised to leave a month later, following Mr X's departure from the flat and a drug-related police raid when another friend of Mr X had been arrested. During this time, Mr EF was also being supported by mental health services[22].

Primary care

4.14 Mr EF's primary care notes were provided by two medical practices (Practice 1 and Practice 2) where he had been registered over this period. He was registered with Practice 1 between 2004 and January 2010; and with Practice 2 from August 2013 to date.

4.15 Earlier contacts with primary care included routine immunisations which were given in 1994 and 1999).

4.16 Whilst the chaotic nature of Mr EF's life meant that his contact with various GPs and medical practices was sporadic, they were also predominantly made in relation to presentations of his mental illness. This included the need for prescribed medication during acute phases. The contemporary local GP record path showed repeat medication of an anti-depressant and an atypical anti-psychotic drug.

4.17 The GP records include a helpful synopsis of identified problems in Mr EF's primary care, as follows:

[22] Further detail in paragraphs 4.31 to 4.37

- Minor past problem - August 2004, anxiety with depression;
- Significant past problems:
  - September 2004, counselling for non-dependent cannabis abuse;
  - October 2004, crisis intervention;
  - March 2005, crisis intervention;
  - August 2005, enhanced CPA and non-dependent cannabis abuse.
- Active problems:
  - October 2004, homeless and social withdrawal;
  - March 2005, hallucinations;
  - August 2005, psychotic episode.

4.18 In July 2004, in Practice 1, Mr EF was examined following attendance at A&E complaining of breathing difficulty. The GP attributed this Mr EF's reporting that he had suddenly stopped smoking cannabis and cigarettes four days previously. At that time Mr EF was also showing signs and symptoms of agitation and restlessness. In 2006, a letter from a junior psychiatrist to another GP, noted the presence of a chronic productive cough. This was again attributed to smoking and cannabis use, although Mr EF would not admit to either the amount or frequency.

4.19 Apart from these events there is no reference to any physical health issues until after the index offence. In April 2015 Practice 2 was alerted by the local biochemistry laboratory that a blood sample of Mr EF received by them showed a raised glucose level. The GP did not know where and by whom the sample had been sent. It later transpired that the laboratory traced its origin to a ward of the North London Forensic Services. It is now recorded that Mr EF is being treated for type 2 diabetes in his current placement. This was confirmed by both Mr EF and his forensic social worker during our interview in August 2016. It is possible that, if this condition had been present but undiagnosed in the period leading up to the offences, it might have had a negative impact on his mental state.

Panel consideration

During our review of Mr EF's primary care path notes, it became apparent that a number of GPs from various practices and locations in different London Boroughs, were managing a predominant mental health need whenever Mr EF presented to them. Relatively little contact with any of the GP services was focussed on physical health problems. This was somewhat atypical of a homeless person but Mr EF confirmed during our interview that he did not recall a need to visit the GP for any physical illnesses. If present, they were mainly around self-neglect associated with being homeless, periodic alcohol and cannabis use and the need to obtain 'unfit for work' certificates.

It was also clear that successive GPs made highly relevant referrals to specialist mental health services, whilst recognising any general physical health needs. Further, the notes from GPs indicated periods when Mr EF was not taking anti-psychotic medication.

Of particular note in the 2006/7 period was the clear written communication between Barnet mental health services and the GPs in a health centre. The information to the GPs from the consultant psychiatrist and the SHO in the Recovery Community Mental Health Team and the Barnet Community Mental Health Team was detailed. It provided the GP with a clear account of the challenges presented by Mr EF.

We were able to evidence that following CPA reviews and any discharges from in-patient services, GPs were sent updated care plans. However, there was no evidence of clear risk assessments and risk management plans contained in the letters to any GPs.

During the period of 2013/14 Practice 2 participated in the Quality and Outcome Framework (QOF)[23]. The QOF system promotes the care of vulnerable people such as Mr EF, especially regarding physical health. However, as the pattern of Mr EF's attendance showed, this patient group is transient and will often only seek primary care services when in a crisis or to comply with welfare benefit demands for certification by the GP.

4.20 In the same year as the index offence occurred (2014) the care coordinator was concerned that Mr EF may not have been taking his medication. Mr EF told the care coordinator that he did not want to leave the house as he was afraid that he may be violent to someone. As a result, the care coordinator accompanied Mr EF to his GP at Practice 2 in January 2014. Mr EF was advised by the practice that he needed to make an appointment to be seen by the GP prior to being issued with a prescription. The records show that a prescription for anti-psychotic medication was issued. He was instructed to take this medication regularly and if he experienced any deterioration in his

[23] QOF is a system of financial incentives to reward practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services, example, in managing chronic conditions and measure to prevent ill health. NHS Digital, QOF NICE advises on the indicators to be included in the QOF NICE quality standards

symptoms, he should call his care coordinator, the GP or the out of hours service.

4.21 In February 2014 a telephone consultation was recorded by his Practice 2 GP as Mr EF was requesting another prescription. The prescription was amended to monthly and he was advised that before the next prescription was due he should book an appointment for a review at the surgery. This took place on 25 March 2014. Mr EF was challenged about his non-concordance with medication and he initially denied not taking it. The GP recognised that he could not have been if using it correctly. The GP recorded that Mr EF had some conflicts, got into a fight and had damaged cars.

4.22 We noted that a few weeks later that the good practice of inviting the GP to a CPA/professionals meeting was made by Sussex ward, Chase Farm Hospital. This was sent however on 14 April 2014 the day of admission and for the CPA meeting to take place 2 days later. Mr EF left the ward before the scheduled meeting and did not return to the ward.

Psychiatric history

4.23 In this section, we report Mr EF's contact with mental health services. We have summarised his contacts between 2006 and 2009 and described his contacts from 2010 until after the homicide in more detail. Full detail is included in the chronology in Appendix D.

4.24 Mr EF was first identified as displaying signs of mental illness from approximately 20 years of age, in 2004. He was also noted to be have been using cannabis for several years previously.

2004 – 2005

4.25 During this period:

- Mr EF was referred by his GP to the practice counsellor/psychotherapist, who felt he needed specialist drug rehabilitation treatment and help to find living accommodation.
- His youth worker requested his GPs help in relation to perceived 'mental problems'.
- Assessment by the Barnet Crisis Resolution and Home Treatment Team (CRHTT) was abandoned when Mr EF left the building.
- Two days later, further assessment by the CRHTT identified 'high' levels of risk in relation to violence/aggression to his family; and 'high to medium' levels of risk for current drug misuse, but was referred back to his GP and given self-help advice.
- Six months later, his GP felt that Mr EF might be suffering from schizophrenia and referred him to a consultant psychiatrist which led to involvement by the CRHTT.
- Assessment by the CRHTT noted medium risk of aggression/violence to his family, warning signs of paranoia and command hallucinations and acceptance into the team's services.
- Mr EF did not meet the team on four occasions when they visited him in his B&B accommodation, did not answer the door or his mobile phone.

- An attempt to assess him in the team office was not possible as Mr EF was guarded and evasive: the team referred him for in-patient care as they considered he could be a danger in the community on the basis of hallucinations telling him to fight, hurt or 'even kill' people.
- Three days after the assessment, at a home visit, the CRHTT persuaded Mr EF to accept informal hospital admission because of his psychotic symptoms. This was an important referral as Mr EF was stating that he was hearing commands instructing him to hurt people. He was homeless, having been evicted from his family home after assaulting his sister with an iron. Following assessment under the MHA, he agreed to an informal admission to hospital in Barnet in March 2005.
- He remained there until discharged to supported accommodation (Baytree Community Care Ltd)[24] in August 2005.The discharge letter from the ward to the GP reported that Mr EF had admitted to continued auditory command hallucinations.
- There is evidence in the record of two CPA meetings being planned, but no evidence of the outcome. A further CPA meeting was held but the record was incomplete – there were no relapse indicators, the plan was not signed by Mr EF and a copy was not given to him.
- A health and social care plan was completed prior to his discharge to supported accommodation, where staff would monitor his medication. The plan included fortnightly visits from his care coordinator and outpatient appointments. Relapse indicators and contingency plans were clearly set out.
- A CPA meeting in November 2005 noted that Mr EF was not fully complying with medication, had not been attending a gardening project he had asked for and was using cannabis intermittently.
- Following this discharge several different health and care services became involved over the next two years in attempts to support him. These included outpatient contacts, support from Barnet (North West Recovery Community Mental Health Team), Barnet social services and Barnet Housing.

[24] In 2005 this was a limited company with head offices in London. The project aimed to provide community care and support and to provide housing to people to lead independent lives. They are regulated by the CQC and flexible care based on user-led care planning. Emphasis was placed on accessing the full range of available welfare benefits,

Panel consideration

Mr EF's risk for current drug misuse and violence/aggression to his family were assessed as 'high to medium' or 'high', yet it was considered appropriate to put the responsibility back on the GP to provide care and treatment. No rationale was provided for referring Mr EF back to his GP. Although this decision predated the incident by nearly 10 years and we do not consider that a different decision would have had any impact on the eventual outcome, we do feel that at least a rationale should have been provided and, without that rationale, question the appropriateness of the decision. Specialist input at this stage (which may have included access to an early intervention service if available) may have improved the quality of service Mr EF received. Although speculative, we can surmise that a different decision could have altered the trajectory of his illness.

Mr EF appeared to become stable over the period of his inpatient treatment, when his compliance with medication was monitored and he was provided with activities. Although he did leave the ward on two occasions, he returned of his own will on the same day.

The health and social care plan prior to his discharge was appropriate and addressed the specific issues of relapse indicators and contingency plans.

2006 - 2008

4.26 During this period:

- Mr EF presented challenges to the staff in his accommodation - they found alcohol in his room, cannabis was found in his room, he was absent from the home up to two nights a week and had attempted to 'sneak in' to the house a female friend and her baby.
- His stopped taking his medication and psychiatric symptoms reemerged, which were assessed as likely to affect his ability to function.
- After several attempts to keep him in his accommodation, he was asked to find alternative accommodation and finally issued with notice of eviction. He was evicted in February 2008 on account of his threatening behaviour.
- He was followed up by the CRHTT, with social worker support and help to find alternative accommodation, made particularly difficult by his continued use of illicit drugs.
- For a short period he did agree to take his medication under supervision of the home staff, but reverted to non-compliance.
- He continued to miss visits from the CRHTT, and was eventually discharged back to his GP, who was informed that he could re-refer Mr EF in the future.
- He did not provide the information requested by the Homeless Person's Unit to help them find alternative accommodation for him.

- He was supported by the CMHT for a while, then agreed to see the CRHTT – but was finally discharged back to the care of his GP on the grounds of his non-engagement with the team, non-compliance with medication and the fact that his mental health had not shown signs of further deterioration.

4.27 We took note of the unhealthy and risk prone behaviours of Mr EF, particularly when homeless, which were recorded in the electronic patient record (RiO) risk summary in January 2008. These included:

- risk caused by medication /services/treatment;
- risk caused by emotional /psychological abuse including being bullied;
- risk of financial abuse;
- risk of physical harm;
- risk of violence /aggression /abuse to family;
- risk of violence/aggression /abuse to general public;
- risk of weapons and visitors.

Panel consideration

We note that mental health services (Dr WX, the CRHHT, the CMHT) went to some lengths to maintain or reestablish contact with Mr EF, despite him continuing to not engage with them, take his medication or accept a depot version. We also note that the supported housing service also made serious efforts to keep Mr EF in his accommodation despite his substance misuse, threatening behaviour and other breaches of the house rules. They only moved to formal eviction procedures when they felt that his behaviour was too threatening for either staff or other residents.

4.28 Between April 2008 and 20 July 2010 there is no recorded contact between Mr EF and any specialist mental health service. However, it became known following contacts in July 2010 that, for at least some of this period, he had been sleeping rough, 'sofa surfing' with friends and of 'no fixed abode'.

2010 - 2011

4.29 Further contact between Mr EF and mental health service commenced on 20 July 2010 when he telephoned the Barnet service sounding very confused.

4.30 Mr EF had been beaten up quite badly a few days earlier. This had resulted in admission to hospital for surgery to a broken arm. On being discharged from general hospital on 19 July 2010 Mr EF reported he was hearing voices and expressing delusions. He did not recognise the voices but reported that they were telling him to do things such as to jump off a bridge and to steal cars. He did not act on the comments but he did feel that he was a 'victim of mind control'[25].

4.31 Following discussions between Mr EF, his friend Mr X and a social worker from the Barnet mental health services, Mr X took Mr EF to the Emergency Assessment Centre, Chase Farm Mental Health Unit on 21 July 2010. This

[25] In the clinical records, Mr EF is reported to have said this.

was considered the most appropriate place, as Mr EF was at that time living in Enfield.

4.32 Mr EF was assessed by the duty doctor, leading to a plan to refer Mr EF to the Barnet CMHT, seek social services support with housing and prescribed medication (an anti-psychotic, but at a low dose[26] - this was later increased to the 'minimum effective dose' on 26 July 2010).

4.33 Mr X the friend spoke with the social worker at this time and reluctantly agreed for Mr EF to stay with him for a couple of days. The Enfield East Home Treatment Team (Enfield EHTT) were informed and the hospital issued him with seven days' supply of medication**.**

4.34 Over the next month the Enfield EHTT provided intensive support to Mr EF, with visits every other day and persisting to contact him when he was not in and/or did not answer his telephone.

4.35 A month later Mr X was urging Mr EF to leave the flat. The nursing staff of the Enfield EHTT visited the flat on the 8 August 2010 to find that there had been a drugs related police raid and a flatmate of Mr X had been arrested. Mr X had not been seen for a week. Two neglected dogs were in the flat and Mr EF reported to the HTT that he was to be homeless and the voices were telling him to commit suicide but he said he could not do it.

4.36 The Enfield EHTT enquired further and it was recorded that Mr X had moved away. He assumed that the landlord of the flat might not be aware of the situation and that was why he had asked Mr EF to move out.

4.37 It transpired that Mr X was himself suffering from mental illness with paranoid symptoms and had disengaged from Barnet mental health services three years previously. Mr EF then entered a trajectory of intermittent contact with mental health and homelessness services. According to the internal report, he had limited friends, and clinical records note that he described the victim of the homicide his 'only' friend. Practitioners will be aware that this type of presentation is typical of service users with a diagnosis of psychosis and substance misuse.

4.38 The HTT accepted Mr EF on 29 July 2010 and he received this service until January 2011, as all attempts to reconnect him with the Barnet HTT had failed. This was attributed to Mr EF's history of non-engagement. Two days prior to this, the Enfield EHTT undertook a home visit, supervised him taking his medication. He provided a urine sample and this proved positive for cannabis.

4.39 During 2010 Mr EF typically presented to the Enfield EHTT and also to the Homeless Persons Support Unit with fluctuating mental states. At this time he was living in temporary accommodation and was unlikely to have been concordant with medication. Significantly during a Enfield EHTT visit on 23 October 2010 he experienced deterioration in his mental state. This manifested as hearing voices, feeling unsafe around others, paranoid ideas, not taking medication for two weeks and remaining isolated in his flat. The

[26] This was below the 'minimum effective dose' - that is, the lowest dose which is likely to be have the desired clinical effect.

outcome plan was a supply of medication being issued and the HTT would telephone Mr EF later to remind him to see them with relevant paper work, to assist them in progressing his benefits claims. Poor engagement with the Enfield EHTT continued and on 26 November 2010 the HTT decided that as Mr EF was then residing in Barnet, they would be looking to discharge him from their service and transfer him back to the Barnet service.

4.40 It transpired during December 2010 that a 'floating support' worker for Barnet Outreach was seeing Mr EF weekly but this was to be changed to twice per month. The worker proposed that a joint visit with the Enfield EHTT could be undertaken, this was planned to take place on the 17 December 2010. Mr EF then objected to the proposal but could not offer any reason for this objection. Subsequent appointments to make transfer arrangements were not kept by Mr EF. An Enfield West HTT planning meeting was held on 13 January 2011 regarding non-engagement of Mr EF. He was then discharged and referred to the Barnet CMHT.

4.41 The Enfield CHTT referred Mr EF to the manager of the Barnet Primary Care Mental Health Team (PCMHT) on 23 January 2011. The referral letter was not received until eight days later. Based on the team manager's conversation with the 'floating support worker' who had reported no current concerns and a review, there was no plan to take Mr EF into the Barnet service and the case was closed on 31 January 2011.

4.42 We note Mr EF's known history of paranoid schizophrenia, the recorded risk history in RiO summaries, and aspects of dual diagnosis and homelessness. We consider that the decision not to accept him onto the caseload of Barnet HTT at the end of January 2011 did lead to a period of some 18 months when he was not receiving any specialist mental health care or intervention.

4.43 However, we acknowledge the abortive time and effort the Enfield HTT put into in trying to engage with Mr EF in the weeks immediately prior to that decision, and fully understand the rationale for the decision not to accept him onto the caseload. From that point and including the type, range and amount of different services experienced by Mr EF in 2013 following his arrest for criminal damage the issues reflected in the QNI research[27] became apparent (details in paragraphs 5.75 to 5.79).

4.44 There was no recorded psychiatric history between the decision not to accept him onto the Barnet service on 31 January 2011 and the police contacting mental health services on 11 June 2013.

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4.45 The next significant event in his psychiatric history occurred on 11 June 2013 when the Colindale police enquired of the Barnet CMHT if Mr EF was known to the service. He had been arrested for smashing car windows and displaying bizarre behaviour.

4.46 Mr EF was subsequently assessed under the MHA by two Section 12 trained doctors, one of whom we were able to interview, and on 11 June 2013 he was

[27] Queen's Nursing Institute (2008) 'Homeless health initiative, service user consultation', QNI

admitted to Thames ward, Dennis Scott Unit, Edgware community hospital, under Section 2 of the MHA. On admission to the ward it was noted that Mr EF had last received a service from Enfield West HTT in January 2011. Mr EF refused a physical examination at the time of admission. He did consent the following day and no physical abnormalities were recorded. This included no skin scars but it is likely that the scar tissue which would have been present from Mr EF's previous fractured arm surgery had been overlooked.

4.47 The admission process revealed some further details of Mr EF's likely mental state in the gap between January 2011 and him being detained on Section 2 on 11 June 2013. Mr EF reported that he had been intermittently taking medication which belonged to his mother who was prescribed the same medication. However, his mother was later to report that Mr EF had been mentally unwell for periods since December 2012 and she had been giving him some medication from his earlier prescription. This was only taken irregularly. She confirmed that Mr EF was taking drugs including cannabis and also alcohol. She also confirmed that Mr EF had been acting on commanding voices and it had been getting worse over time.

4.48 On 26 June 2013 Mr EF was introduced to a care coordinator, Ms TU, an agency social worker. Following an altercation with a peer on the ward, which did not appear to have been the fault of Mr EF, he requested a ward move and was transferred to Trent ward on 30 June 2013.

4.49 On 7 July 2013 in the early hours of the morning Mr EF became paranoid. He threatened staff, pushed boundaries, was shouting, abusive and accusing staff of using black magic. He was given tranquillising medication. He remained disturbed and unpredictable but later settled.

4.50 A planned CPA meeting took place on 8 July 2013, with the ward doctor, Mr EF's mother and Ms TU in attendance. Mr EF's mother expressed a view that although her son was not back to normal he did appear better. The plan was to give Mr EF four hours unescorted leave with his mother. The Section 2 was allowed to lapse that day and he was to remain as an informal patient, gradually increasing his home leave. He was advised to ensure he was registered with a GP.

4.51 Mr EF was discharged from the ward to live with his mother on 13 July 2013.

4.52 On 13 July 2013 Mr EF attended Hendon Magistrates' Court in relation to the arrest for damaging cars. He was given unconditional bail and told to reappear on 16 July 2013 and he was to receive services from the Barnet HTT. He attended the Dennis Scott Unit as agreed the following day. The intention was for the HTT to see him daily for a couple of days. However, Mr EF was not at home when they visited. His mother was upset and she stated that Mr EF was not doing what was asked of him.

4.53 On 16 July 2013, Mr EF was seen by the HTT nurse and he was informed that he needed to attend the Hendon court promptly or he would break bail conditions. The Barnet HTT visited him regularly although he was not always in. They also spoke to his mother who reported that Mr EF was not doing what he was supposed to do, and on occasion seemed upset.

4.54 Mr EF was discharged from the HTT on 1 August 2013, and transferred to the service delivered by the West Community Support and Recovery Team (WCSRT). During this time the care coordinator (Ms TU) maintained her attempts to keep Mr EF engaged with the HTT service and to ensure he was properly registered with a GP at Practice 2. She only met with limited success when visiting him at his flat he occupied in Barnet and could not rely on his phone contact numbers given to her.

4.55 This pattern of infrequent engagement with Ms TU continued until the 11 November 2013, when a CPA review meeting took place. The coordination of Mr EF's care in the community was being taken over by a new person as Ms TU was leaving the service.

4.56 The new coordinator was a student social worker (Mr PR) on placement from Middlesex University and was under practice supervision of the Principal Practitioner (Mr NO) in the team. Mr PR wrote progress notes of the meeting and arranged Mr EF's next appointment for 9 December 2013.

4.57 The appointment was kept by Mr EF and it is recorded by Mr PR as being a very difficult one. Mr EF was showing no motivation to undertake the vocational courses he had requested previously. Mr PR enquired of Mr EF if he would see a doctor as he felt there were indications that he may be unwell. The meeting ended with Mr PR booking the next appointment to meet on 15 January 2014 at the Dennis Scott Unit. He intended to use that meeting to encourage Mr EF to see a doctor and recorded that he would book him in anyway and 'hope that he attends'.

4.58 Mr PR did in fact book Mr EF to see Dr BD on 9 January 2014 due to his concerns. The meeting took place and appears to have relied on self-reporting of mental state. The record shows that he felt paranoid and scared of going out as someone may follow him and kill him. He denied carrying a knife or keeping one behind his bedroom door as he had done in the past.

4.59 Despite limited insight he had agreed to continue with medication. The plan was 'ongoing case coordinator input'.

4.60 Throughout February 2014 Mr PR coordinating Mr EF's care focussed efforts to arrange a transport 'Freedom Pass' for Mr EF and relied on leaving several voice mail messages in an attempt to engage with him.

4.61 In early March 2014 Mr EF's mother informed Mr PR that her son was appearing unwell and advised that Mr EF was staying at her home quite a lot when she was out at work.

4.62 The record entered by the student care coordinator on 20 March 2014 was due to Mr EF presenting at the Dennis Scott Unit unexpectedly. He admitted to not taking his medication since the beginning of the month because he was scared to leave the house. He stated that he was afraid he may be violent to somebody. He did not specify further when Mr PR enquired. Mr PR then attempted to discuss Mr EF's reasons for feeling violent but to no avail. He then accompanied Mr EF to the GP practice but they would not dispense medication until Mr EF had seen the GP first. He was given details regarding

calling the surgery. Mr PR then booked a further appointment to meet with Mr EF on the 1 April 2014. He also booked a medical review for Mr EF with Dr JK for 15 April.

4.63 Mr EF did not arrive on time for the meeting on 1 April 2014 but he called the following day. However, Mr PR was on another visit. Mr EF was advised to call as arranged on the following day, 3 April 2014

4.64 Mr EF kept the 3 April appointment and was recorded as presenting well. There were some issues with food and sleep which he attributed possibly to being connected with medication and he said he would discuss these at his next medical review. This was booked for 15 April 2014 with Dr JK (GP trainee undergoing a placement in psychiatry). Mr EF did not want to participate in any activities or to work. He explained to Mr PR that he keeps to himself in order to avoid trouble.

4.65 Mr PR provided Mr EF with a printed information sheet from a GP website detailing how to obtain repeat prescriptions to save him having to attend the GP once a month. He also provided assistance relating to finance and accessing the Freedom Pass. He also confirmed with the Employment Support Agency that the sum of £400.20 had been paid into Mr EF's bank account that day. The outcome of the meeting was for Mr PR to see him at the medical review on 15 April 2014 with Dr JK. He would also telephone prior to that appointment to monitor the situation.

4.66 Mr PR phoned Mr EF on 10 April 2014 and he informed him that he was 'okay' but needed help, he declined to elaborate on the statement. He was given advice about passport photographs for the Freedom Pass and it was left that Mr EF would get these and bring them to the Dennis Scott Unit on 15 April 2014 at the medical review meeting.

Panel consideration

After his discharge from hospital on 13 July 2014, the HTT and members of the WCSRT made persistent efforts to maintain contact with and engage Mr EF, with only limited success. It would appear that Mr EF was primarily or solely interested in services when he needed practical help such as applying for his 'Freedom Pass' or with regards to his benefits. His compliance with medication remained erratic with consequences for his mental health.

In the absence of a policy on non-engagement, we consider that the team did make efforts to maintain contact.

We note that a student social worker was allocated as his care coordinator, under the supervision of a Principal Practitioner. Mr EF was also being seen at this time by a GP trainee for medical support. We comment elsewhere on the reliance on trainee professionals in Mr EF's care. We consider that it is most unfortunate that we have not been able to interview these three people, who we believe would have been able to shed additional light on his care and treatment, his non-engagement and his mental state at this time.

We also note that contact was maintained with his mother and sister – the

clinical records and internal inquiry report indicate that the care coordinator's contact and support was appreciated by them.

12 April - 1 July 2014

4.67 On 12 April 2014 Mr EF's sister telephoned the Barnet Home Treatment Team because she wanted to report her concerns regarding Mr EF's recent behaviour. She felt that he was returning to a state he had been in previously. She described her brother on a visit to their mother's house as 'being off his face'. She also believed that he had started drinking again. The HTT advised her to make contact with the West Community Support and Recovery Team (WCSRT), and that if she felt there was an increase in risk to contact the police or take him to the A&E.

4.68 Less than an hour later the HTT received a call from an Approved Mental Health Professional (AMHP)[28]. She had received a call from the Colindale police. Mr EF had been apprehended for following a woman in the community. The AMHP was completing her evening shift and she required someone to conduct an assessment. As no other AMHP was then available, she told the HTT that she would hand over to a colleague with the intention of the MHA assessment being undertaken that night. That information was then passed to the Community Support and Recovery Team at Night Service (CSRT@Night).

4.69 A night staff member of that team contacted Colindale police station. The police informed them that Mr EF had been sexually inappropriate to a woman in the community. He was drunk and the woman he was following had run into a shop in order to avoid him. Whilst being detained at the police station, he had attempted to grab a female officer. At other times he was crying like a baby and licking his hands. The night staff rang the AMHP service and the duty AMHP (Ms HJ) agreed that an assessment should be arranged.

4.70 In the early hours of the morning of 13 April 2014 a MHA assessment was undertaken at the police station. This was based upon the police referral the evening before to the out of hours AMHP service which covered Barnet and Enfield. Ms HJ was familiar with the service. She was employed by the London Borough of Enfield, and managed a Community Rehabilitation and the Enfield AMHP service. In addition Ms HJ worked in the Barnet out-of-hours AMHP service. This arrangement enabled her to maintain her professional practice as well and her role as a manager. She had contacted the CSRT@Night service in order to find some information about Mr EF as she was unable to access the RiO electronic records system.

4.71 The plan was for the assessment to proceed with a team composed of Ms HJ and two qualified doctors (Dr YZ and Dr ST). A fourth professional (community mental health nurse) from the CSRT @ Night Service was busy and was expected to join them when able but the assessment was to commence regardless of the presence of this person.

4.72 Contemporary information was given to the assessors by the desk sergeant. He informed the assessors that Mr EF had been arrested at 11am the

[28] AMHPs may be qualified health or social care professionals who are trained and warranted to carry out this role. The AMHP is involved in the assessment of people who are considered potentially a risk to themselves or others, as well as suffering from a specific mental disorder. In order to detain a person in a psychiatric service against their will, the law requires that two (specially trained doctors) must recommend the detention, and, crucially, that an AMHP applies for the detention to be activated.

previous day, following reports of him harassing a woman and making lewd comments to her. The woman had sought refuge in a shop and had photographed Mr EF on her mobile phone. Mr EF was in a state of increased arousal and under the influence of alcohol. The team were informed that Mr EF had been particularly difficult to manage during the arrest and he had been very confused. The level of intoxication had delayed the initial request for the MHA assessment. During the process of arrest Mr EF was unable to follow instructions from the police. This included his refusal to make telephone calls. He was reported as having assaulted police officers, including attempting to 'grope' a female officer.

4.73 The community psychiatric nurse who had arrived later in the assessment process recorded the outcome as did Dr YZ and Ms HJ. The medical and the nursing entry described Mr EF as lying on a mattress on the cell floor. He was forthcoming with information about how he exhibited usual relapse indicators. He appeared to minimise the impact of his behaviour towards both the woman in the community and the female officer. He was able to confirm that he had been hearing voices and was unsure when he had last taken prescribed medication. The doctor recorded that when asked, he initially responded that he did not want to be admitted to hospital and he expressed a wish to return home.

4.74 The medical opinion concluded that Mr EF had presented with features of a relapse of a psychotic illness, in the context of alcohol misuse. Mr EF needed a period of mental health assessment in hospital for his own health and safety and the safety of others.

4.75 The two doctors felt that the nature and degree of Mr EF's presentation warranted detention in hospital under Section 2 of the MHA. They completed the required forms of recommendation for compulsory admission. They did not think that an option for home treatment was appropriate.

4.76 However, the Section 2 was not implemented. Ms HJ, as required by good practice, held further discussion with Mr EF and ascertained that he was prepared to go into hospital on a voluntary basis. She felt that Mr EF had the capacity to make such a decision and that it would offer the 'least restrictive alternative' as promoted in the MHA Code of Practice[29]. The outcome of the assessment was that Mr EF would be admitted voluntarily to Dorset ward at Chase Farm Hospital.

4.77 The internal inquiry panel reflected a particular interest in the above assessment process in their report. They were concerned as to the significance of differing views of the participants in the assessment process. We have examined this aspect and we comment elsewhere[30] regarding the conclusions drawn by the AMHP and doctors during this important sequence of events in the assessment process.

4.78 Mr EF was admitted to Dorset ward at approximately 0.35am on 13 April 2014 in the presence Ms HJ. She had previously indicated to Mr EF that if he was to

[29] Department of Health (2008) Code of Practice: Mental Health Act 1983, paragraph 1.3 and repeated in the 2015 revision of the Code of Practice at paragraph 1.1.
[30] Paragraphs 5.39 to 5.51

choose to leave she would be prepared to reconsider making an application under the MHA. Mr EF was guarded, suspicious and appeared anxious but requested to go to bed. He was commenced on 15 minute intermittent nursing observations. The police handed the ward staff a bottle of Vodka from amongst Mr EF's personal belongings. A comprehensive account of the admission process was made in the RiO notes by the lead clerking nurse. This nurse recorded that Mr EF had the capacity to make the decision to be admitted and that he had consented to taking prescribed medication. The impression gained by the receiving nurse was possible relapse in mental state due to non–concordance with prescribed medication.

4.79 The nursing record on admission referenced some key features Mr EF reported, including:

- he felt he was arrested for no reason;
- he was mistreated by the police;
- the police took his property and threw him in a cell;
- he was not allowed to telephone his mother;
- he was not drunk;
- he took his medication regularly; and
- he agreed to admission because he was told to by the social services.

4.80 Mr EF went on to state that he hears voices which he could not make out but it was normal for him. He further stated that he felt the government were after him and that he had a phobia against soldiers. He declined to elaborate further on the latter point when questioned further.

4.81 Later that day (11.09 on 13 April 2014) the nursing staff recorded that Mr EF appeared agitated, restless, demanding, pacing around and was sexually inappropriate towards female patients on the ward. He had confronted a patient and propositioned her for sex. During an escorted break off the ward to smoke a cigarette, as soon as he saw a female patient he touched her inappropriately. Later, Mr EF had to be prevented several times from attempting to enter the female areas of the ward. He was considered a clear risk to females on the ward. There is no reference in the records to his risk behaviour in harassing women, including a female police officer, prior to allocating him a bed on a mixed gender ward. We were informed that there was no bed available on the male ward.

Panel consideration

We were concerned by the fact that Mr EF was able to harass female patients on this ward.

We know that admission wards particularly should aim to be gender specific, and the following planning considerations should be made:

- provision of gender-specific wards;
- provision of gender-specific bedroom areas with multi-functional female only

accommodation for sitting, dining, activities and therapies; and
- gender-specific bedroom areas with swing-zones (allowing for the possibility of moving boundaries to accommodate gender exclusive functions)[31].

Recommendation 1: Although we recognise that the capital implications and future plans for the site must be taken into account, we recommend that, in conjunction with its commissioners, the Trust takes urgent steps to ensure that all admission wards are gender specific or, at a minimum, to create gender-specific bedroom and functional areas within mixed-sex wards.

4.82 Mr EF remained very unpredictable in terms of both his behaviour and his mental state. Later that morning when being escorted outside the ward he stated that he did not want to stay in hospital 'because it is like a prison'.

4.83 In the afternoon of 13 April 2014 staff arranged with the duty bed manager and the nurse in charge of Sussex ward on the same site, to exchange Mr EF for another patient. Sussex ward admits only male patients. He was subsequently transferred to Sussex ward after being seen by the duty doctor. The doctor had explained to Mr EF that if he no longer was prepared to stay on the ward, the doctor would likely request a further MHA assessment. This would be due to relapse and harm to others. The doctor was prepared to apply for a holding order utilising Section 5(2)[32] of the MHA. Mr EF replied that he understood the information and wished to remain as an informal patient. He had also been informed that it was the intention to transfer him to Sussex ward and that the ward had a garden area.

4.84 The plan was that if Mr EF requested to leave the ward the duty doctor needed to be contacted as he may require to apply the Section 5(2) to detain until further assessment.

4.85 The transfer took place at 6.15pm on 13 April 2014. He was again placed on 15 minute intermittent observations and appeared slightly restless and anxious. The observation record showed that Mr EF then slept throughout the night.

4.86 In the morning of 14 April 2014, a Sussex ward 'whiteboard meeting'[33] was held. This included the ward consultant psychiatrist, a locum senior house officer and first level registered nursing staff, together with the ward administrator. A full meeting was planned to take place on 16 April 2014 at 11.15 am and all relevant parties associated with Mr EF's care were to be

[31] Care Services Improvement Partnership (2008) 'Laying the foundations for better acute mental health care: a service redesign and capital investment workbook, Department of Health
[32] Section 5(2) is a 'holding power' which can be signed by a nurse or doctor and enables ward staff to detain immediately for up to 72 hours a person who wishes to leave the ward but is considered to meet the criteria for compulsory admission, so that the full formal process of assessment can be undertaken.
[33] This refers to a staff meeting when the needs and any changes in the needs of service users are discussed and decisions on care and treatment are confirmed or amended.

invited. Mr EF was to remain on 15 minute observations. The staff were instructed that Mr EF should not leave the ward and if he decided to do so the consultant should be informed and that it may prove necessary to undertake a further MHA assessment.

4.87 Shortly after the whiteboard meeting the ward received the results of a magnetic resonance imaging (MRI)[34] head scan, which had been undertaken the month before. There were no abnormalities noted and the results were faxed to the GP. At this time the sister of Mr EF telephoned as she was concerned that her brother was unwell and she had not seen him at the weekend. She was advised to contact Sussex ward. At 5.20pm that day, the invitation to the meeting planned for 16 April 2014 was sent. This included emails to the care coordinator (student), Mr EF's sister, his mother and his GP.

4.88 The daily record noted the general presentation of Mr EF throughout the day on the hour. The record depicted Mr EF as appearing in a settled mental state from 7am to 7pm. The record entered at 7.53pm states that during the staff handover it was reported that Mr EF was given a fresh air break in the ward garden at 7pm. It was reported by staff at handover that Mr EF 'climbed the fence in the garden' and went missing from the ward. It was recorded that efforts were made to encourage him to return but he ran away. An immediate ground search was conducted but he was not found. Due to the known risk the police were notified, as was Mr EF's sister and the unit bleep holder. An email was sent to the care coordinator (student) by the staff nurse informing him of the incident.

4.89 Police telephoned the ward, informing them that Mr EF was at his mother's address and he had refused to return to the ward. As he was an informal patient they had to accept his decision. By informing the ward they had acted appropriately.

4.90 Dr WX recorded the outcome of the whiteboard meeting, which was to refer to the AMHP office and ask his care coordinator, Mr PR, to follow him up. Mr EF was discharged from the ward. Mr PR (student social worker) rang Mr EF and arranged for himself and Dr JK (trainee GP) to visit him at home that lunchtime.

4.91 Mr GF, ward nurse, spoke to Mr FG (duty AMHP) to request an assessment of Mr EF for detention under the MHA. Following discussion and on the basis of the information provided to him about Mr EF, Mr FG concluded that an assessment was not appropriate at that time and that they should await the outcome of the prearranged visit by Mr PR and Dr JK on 15 April 2014.

4.92 A detailed and comprehensive report of this visit was recorded by Dr JK shortly after they saw Mr EF. This report covers:

- Mr EF's diagnosis and medication;

[34] MRI or Magnetic resonance imaging is a combination of strong magnetic fields and radio waves used to produce detailed images of the inside of the body. The results can be used to help diagnose conditions and plan treatments.

- Mr EF's report of the events of the previous two days, in which he minimizes the extent of his drinking and denies the alleged sexually inappropriate behaviour;
- Mr EF's fear that if he goes outside the police will remove him to hospital;
- Mr EF's confirmation that he was taking his medication and knew he should avoid alcohol;
- his mental state – he 'currently appears well'; and
- plan – to continue to review in the community; Mr PR to liaise with the police and to contact Mr EF's mother regarding his care; Mr EF advised to avoid alcohol and illicit substances.

4.93 Mr PR made two further telephone calls to Mr EF (24 April and 7 May 2014). The conversations were about his housing benefit, Freedom Pass and possible police action following the alleged sexual harassment. The next visit was arranged for 23 May 2014, which Mr NO (student supervisor) was to observe – but clearly this meeting did not take place as Mr EF had been arrested.

4.94 An entry for 23 May 2014 records that a client had informed the WCSRT that Mr EF had been arrested in connection with a murder. Relevant professionals and managers were informed and the police station contacted to confirm this information and ensure that they were aware of Mr EF's medical needs.

4.95 A further entry on 23 May 2014 confirms the arrest and that Mr EF will be remanded to prison and sent to the hospital wing. Relevant clinical information was sent to the mental health nurse based at the police station.

4.96 The following day information was requested by and provided to the police.

4.97 On 28 May 2014, the service manager contacted Mr EF's mother and offered support and this was arranged the following day but did not take place as she had forgotten about the meeting.

4.98 On 29 May 2014 a CPA review took place in the prison in order to discharge Mr EF from the care of WCSRT to the prison mental health team. We note that at this point Mr NO had taken over as Mr EF's care coordinator.

4.99 On 1 July 2014 members of the WCSRT attended a meeting in the prison with Mr EF's new care team. Dr JK recorded that they were asked if they felt Mr EF's mental health might have contributed to the alleged crime, but they were not in a position to comment - they were not aware of any deterioration in his mental health at that time.

Panel consideration

We have made some comments on practice in relation to the AMHP decision-making process, and the administrative procedures adopted in this case. We have also considered in more detail the deployment of a student as care coordinator and the reliance on two trainees to review Mr EF immediately after

he left the ward.

At this point we note that further efforts were made to engage with Mr EF, but reiterate that the team seemed not to challenge the fact that he only engaged with interventions on his terms – for example, the practical and financial issues he faced.

4.100 The trial judge informed the court that Mr EF remained a substantial risk to himself and others. In the light of his serious mental disorder he was placed on a hospital order under Section 37 of the MHA 1983 with a restriction order under Section 41 without limit of time.

Contact with criminal justice system

4.101 Mr EF had limited but significant forensic history and full details do not appear to have been available to his care team(s) at the Trust. This point was made in interview that, when assessing Mr EF at the police station on 12-13 April 2014, the police did not provide any information about his previous offences, which might have informed their decision making.

4.102 It was recorded that in 2011 he was arrested for carrying a knife.

4.103 It was recorded that in 2012 he was arrested for carrying a knife, spending a week in prison.

4.104 In June 2013, he was arrested and charged with criminal damage (smashing car windows on the demands of voices telling him to do so). As a result of this behaviour he was diverted to the mental health service and detained in hospital under a Section 2 order of the MHA.

4.105 One record reports that in early 2014, he was arrested and spent a week in prison, but no further detail had been found.

4.106 In 2004 he threw an iron at his sister – there is no record that charges were brought, but his mother did take out an injunction to prevent him from going to her house.

4.107 The risk assessment documentation records that ‘at some time in the past’ Mr EF had assaulted a member of the public, but again there are no details of this incident or whether charges were brought.

4.108 At interview we were informed that this was a relatively minor risk, in the context of that particular area of London, the complexity of other service users’ needs, and the higher level of risk presented by some other services users. We are concerned that this may indicate a ‘desensitization’ or ‘normalisation’ of people carrying knives that we considered should be seen as indicative of increased risk. However, we also appreciate the pressures on services which may lead to the need to prioritise levels of risk.

5. Arising issues, comment and analysis

Absconsion from Sussex Ward, April 2014

5.1 Mr EF was a newly admitted patient to Sussex ward, Chase Farm Hospital on 14 April 2014. He had been subject to a transfer to the ward at 6.15pm the day previously from Dorset ward where he had initially been admitted as an informal patient in the early hours of the morning of 13 April 2014.

5.2 He was being observed every 15 minutes intermittently and was noted to have slept well throughout that night despite appearing anxious and restless when first being processed through admission. During the day of the 14 April 2014 the records show that he appeared settled on the ward during the day. He was escorted from the ward for a fresh air break into the ward garden area at 7pm. Mr EF then took the opportunity to climb the perimeter fence and despite requests from staff to return to the ward he ran away.

5.3 We have been asked to as part of our Terms of Reference to establish how Mr EF managed to abscond from the ward, together with our consideration of the integrity of the ward environment including egress. The function of Sussex ward is to provide an 18-bed single sex inpatient facility for men of working age. It provides short term inpatient care for men who are experiencing an acute and serious mental health crisis of a functional nature, to a degree that cannot be contained by Community Mental Health Teams alone. It also provides emergency care to a degree that maintains a person's safety until appropriate arrangements for transfer are made to the Trust of origin as part of the London bed management protocols. The patients are treated and discharged either to the community or transferred to specialist wards for continuing care.

5.4 We were able to evidence a clear and comprehensive ward care and treatment philosophy as part of the Sussex ward operational policy. The policy was due for review at the time of our examination (August 2016).

5.5 The ward has an establishment of 25 staff with a skill mix comprised of Level 1 registered nurses, and support workers. The staff work two shifts of long days. The day shift has three qualified and two unqualified staff and there are two qualified and two unqualified staff on the night shift.

5.6 We were able to undertake a short meeting with the ward manager as part of our brief examination of the general safety and security aspects of the ward. Although the manager was not in post during the time of this incident he was most helpful and informative regarding the organisation of the ward and its role and function. The manager was aware of the type of national policy drivers, legal requirements and best practice for acute mental health care.

5.7 Most senior staff whom we interviewed as part of the investigation had a good understanding of the local "whole system" influences on the demand for acute care services and they were aware of any weaknesses of the physical security of the ward environment.

5.8 The general layout of the ward and the facility it offers gave us concerns about design and quality of the environment. The treatment model appears to be one that promotes the contemporary objectives of care pathway relationships, as set out in Trust policies, including those between the CRHTT (Crisis Resolution and Home Treatment Team) and acute inpatient wards. The quality of the ward environment does not appear to be conducive to ensuring that the ward attains the objectives of the Trust's acute care pathway treatment model.

5.9 Doors to the ward are locked from the outside but open from the inside. However, there is the facility to over-ride this arrangement if necessary. Therefore, patients are able to move throughout the ward subject to specific observation protocols and any necessary individual restrictions to maintain safety. Entry from the main door which acts as a modified airlock area is monitored by the ward staff. Exits are not continually monitored but staff are expected to periodically check who is present on the ward. The ward is continually locked from 8pm to 8am. Doors to staff offices and non-patient areas are self-locking.

5.10 The exterior area and gardens have a perimeter fence which provides a barrier to unauthorised egress. This has been heightened since the incident and also has a prickly thorn planting which acts as a deterrent. Security guarding is shared with the acute Trust on the same site. The service that provides security is aimed at attaining effective crime prevention measures and a rapid response when required in respect of security related issues. The tasks undertaken by the service consist of:

- monitoring trust property;
- responding to the activation of alarms;
- site patrolling;
- monitoring of fire exits;
- suspicious object reporting response;
- visitor/patient surveillance; and
- visitor assistance.

5.11 We felt it was important to view the acute ward from a perspective of where its role and function fits within the Trust's acute care pathway. The contacts that Mr EF had during his psychiatric history highlighted contact with a number of teams, services and agencies which were interlinked. Therefore, the admission and acute wards form part of the Trusts endeavours to establish an 'integrated acute care pathway'. The relationships between the component parts are as important as the actual qualities of the parts themselves. The typical services experienced by Mr EF included:

- Crisis Respite housing provision;
- Inpatient care; and
- Step-down/supported housing accommodation.

5.12 The role of the WCSRT featured a lot in the care of Mr EF as typically it was a 'gate-keeper' when assessing the appropriateness of any admission. In common with CRSTTs nationally, the teams in the London Boroughs face an

immense demand for their service. We did not examine the workload in depth but we were able to gauge its effectiveness when we enquired about the throughput on Sussex acute ward. The yardstick which tends to be used when CRHTTs are formed is identified in national guidance. This recommends that a standard CRHTT covering a population of 150,000 should have 14 staff[35].

5.13 Clearly, the complexity of mental health challenges and the consequent resource demands have become greater in the last decade.

5.14 A number of environmental features occur on Sussex ward that weaken the barriers which may help prevent a patient such as Mr EF taking an opportunity to leave unauthorised. These range from a perimeter fence that can be scaled, obstacles and equipment in the area used as a foil or to assist mounting the fence, polycarbonate window sheeting which can be pushed through in a corridor leading to egress, a number of doors capable of supporting a ligature. As well as being a direct ligature risk, these doors can, potentially, also be used as a means of distracting staff, whilst egress is attempted. It would be easy to criticise such environmental features but they need to be balanced against the following:

- operating in a difficult financial climate;
- the polarisation of the risks and benefits of increasing the use of locked doors in such wards;
- the aim of delivering the service in the least restrictive way;
- changing patterns of provision in the Borough health economy;
- the variable involvement of the patients and families in both the care available on acute wards and the organisation of supporting services;
- the pressure on the ward reflecting a continuing decline in Borough wide bed numbers, accompanied by high occupancy of beds and difficulties of discharge;
- the increased levels of acuity of patients such as Mr EF; and
- only the most unwell or those presenting with greatest risk are admitted to acute wards.

5.15 We considered Sussex ward to represent a “microcosm” of what is seen as a national challenge for mental health service provision. There is no record of either the number or proportion of patients who face these types of difficulties or the length of time an admission takes but the latest report from the Commission on Acute Psychiatric Care[36] on improving acute psychiatric care for adults in England describes many of these types of pressures facing wards such as Sussex.

5.16 This Commission has identified that crisis bed management is a daily occurrence with staff trying to free up beds by transferring patients between wards, sending them on home leave or discharging some prematurely into alternative accommodation or into their own homes. These are system problems and lead to the components of the mental health system doing more than they were set up to do when under excessive demand pressures. Dorset ward, operating as a mixed gender

[35] DH (2006) Guidance statement on fidelity and best practice for crisis services. Joint publication with Care Services Improvement Partnership.
[36] Crisp, N, Smith, G and Nicholson, K (Eds) Old Problems, New Solutions- Improving Acute Psychiatric Care for Adults in England . (The Commission on Acute Psychiatric Care, 2016).

ward, relied on a transfer to Sussex ward; and Sussex relied on the CMHT to support Mr EF after he went missing.

5.17 It was against this backcloth that we considered how Mr EF went missing from Sussex ward. We noted that the Trust has a comprehensive range and type of services, together with clinical and organisational policies aimed at supporting patients like Mr EF. We felt this to be important as Mr EF was not placed in hospital because of the lack of alternative options being available. He was admitted in a voluntary capacity as a result of the state of his mental health and senior clinicians' decision making and diagnosis. During our interviews with senior clinicians we heard how their decision making regarding the consideration for recommending a mentally ill person for detention for assessment or treatment Sections 2 and 3 MHA can be affected by the awareness of chronic bed shortage in the inpatient units. We do not suggest this occurred with Mr EF but it does reinforce the internal investigations' concerns with regard to their views about aspects of the decision making process during the MHA assessment in Colindale police station. We shared their concerns and whilst the process met legal criteria the resulting informal status with which Mr EF was subsequently admitted, created a weakness in the capability of the practitioners to detain him using environmental security measures.

5.18 The aspects of relational security using therapeutic approaches were weak, firstly because of the very short time Mr EF was on Sussex ward, and, secondly due to his mental state. He had previously expressed his view that he wanted to go home as he felt he was in prison. It was likely that he knew if he tried to exercise his right to just walk out his informal status would be challenged and a holding order under section 5(2) MHA would be used to detain him until further assessment. He had already been warned by Ms HJ that if he were to deteriorate she would reconsider her decision to accept his willingness to stay voluntarily. Having established the ward routine regarding being taken out periodically to the garden area it was a simple action to scale the fence in view of staff and to run away.

5.19 We recognise that up to 18 of the service users can be detained under the MHA, with complex mental health needs. We appreciate that this is not a secure ward, but consider that a more robust physical environment should be considered.

Recommendation 2: The Trust ensures that equipment that is currently free-standing (bench, basketball hoop) in the garden area of the ward from which Mr EF went missing is fixed to the floor. The aim is to put barriers in place, recognising that a recreational area can be high risk

Recommendation 3: The Trust undertakes a detailed and comprehensive audit of the safety and security of the Sussex ward.

The context of Mr EF leaving the ward

5.20 We were able to confirm from our interview with the current Sussex ward manager that his staff had received instruction, and were aware of procedures within reason, that they should be aware of the whereabouts of each patient at all times. Procedures are in place which are designed to clarify the process for reporting patients who are missing from the ward, or who have not returned from an agreed period of leave. These procedures were implemented when Mr EF spontaneously scaled the Sussex ward garden perimeter fence.

5.21 We feel it is important to distinguish between:

- patients detained under a Section of the MHA and unauthorised absence classed as absent without leave (AWOL); and
- patients, who are not detained under the MHA, and are voluntary or informal patients, as was the case of the subject of this investigation, Mr EF.

5.22 For patients who are not detained the term AWOL does not apply. The term 'missing person' should be used rather than 'absconding'.

5.23 Whilst we could not locate a detailed care plan in the records, we felt that given the short period of time Mr EF was in Sussex ward there were sufficient details in the RiO notes to inform staff of any risks should Mr EF leave the ward. Indeed, the medical entry instructs staff to notify the consultant if Mr EF should express a wish to leave and that a Section 5(2) may be used. The response to an informal patient being or becoming missing should have been based on the level of risk identified in the recent risk history summary and the comments from the medical reviewer which were available in the RiO notes.

5.24 The actions taken by Sussex ward staff when Mr EF scaled the garden fence followed good practice guidelines. It was apparent that nursing staff were clear that an informal patient is able to decide that they do not want to return to the ward, either at the point of egress or at a future time. There is no obligation on them to return without lawful authority.

5.25 The correct procedure when Mr EF went missing, was that if it was felt that he required further assessment and or treatment in hospital and it would likely to be unsafe to leave him in the community a MHA assessment should be organised under Section 2 or 3. The request for such an assessment was made by the staff nurse on Sussex ward. This was in light of the police locating Mr EF who then refused to leave the house. It is normal practice that a person so located ceases to be regarded by the police as missing once they have informed the clinical team.

5.26 The request from the ward to the AMHP service resulted in a preliminary visit being undertaken by Mr PR and Dr JK. The process is described below[37]. The key points are that a ward nurse did contact the duty AMHP (Mr FG) and that, after discussion, the AMHP decided that there was not a sufficient level of risk to arrange an assessment. We had no information about the conversation between the AMHP and the ward nurse. There was no detail in the clinical records, the AMHP did not recall the details and the ward nurse had retired and was not available for interview.

5.27 The circumstances of Mr EF's admission to the acute ward included two recommendations from psychiatrists and a further entry by a junior doctor and his Consultant Psychiatrist (Dr WX) stating they would consider applying a Section 2 if necessary, together with the nature and degree of his mental state within a 72 hour period. On the basis of these facts we felt that a comprehensive MHA assessment should have been actioned. When we interviewed Mr EF in the forensic unit he stated he recognised he would have benefited had he been detained in that period.

The adequacy of CPA and care planning

5.28 We were able to consider the aspects of care planning and CPA, together with any involvement of Mr EF and his family in this process, against practice guidelines at the commencement of his contacts and at the time of the offence.

5.29 Initially local policies were grounded in the application of care planning based on earlier statutory obligations. Central guidance was issued in 1990 as a Health Circular. The Department of Health guide to discharge planning was issued as Health Service Guidance in 1994. Whilst these documents provided a template for use by the forerunner of the organisation of the Trust, they were superseded. Contemporary local CPA procedures and policies have been implemented and these are based on periodic reviews which reflect updated practice standards. Current policy reflects:

- 'The National Service Framework for Mental Health'[38];
- 'Refocussing the Care Programme Approach'[39]; and
- 'No Health Without Mental Health'[40].

5.30 Within the above context we considered the extent to which any treatment and care plans for Mr EF were:

- documented correctly;
- agreed with him;
- communicated with and between appropriate agencies and his family; and
- implemented properly and whether they were complied with by Mr EF.

[37] Paragraph 5.51
[38] NHS (1999) The National Service Framework for Mental Health. Modern . Standards and Service Models
[39] Department of Health (2008) Refocussing the care programme approach Policy and positive practice guidance.
[40] Department of Health (2011) No Health Without Mental Health, A cross –government mental health outcomes strategy for people of all ages

5.31 The key components of the CPA which are informed by the policies of the Trust are contained in the 'Care Programme Approach Policy, incorporating section 117 of the MHA 1983 as amended 2007. The Trust's policy was subject to a three yearly review at the time of the independent investigation (July 2016).

5.32 In common with most other NHS Trusts the main elements of the CPA process consists of:

- systematic arrangements to be put in place for accessing the health and social care needs of people who are accepted by specialist mental health services;
- the formulation of a comprehensive care plan to address the identified health and social care needs;
- the appointment of a Care Coordinator to continuously monitor the care plan; and
- undertaking regular reviews and implementing agreed changes to the care plan if required.

5.33 The standards of implementation of CPA are featured as part of NHS trusts' performance management. They also form criteria by which the CQC reviews a mental health service as part of its regulatory framework. The internal Board level inquiry panel wanted to understand why Mr EF who had been under the care of West Barnet Community Support and Recovery Team since August 2013, had on the departure of his care coordinator (Ms TU) been allocated another care coordinator who was a student social worker (Mr PR) on practice placement from Middlesex University. Further, they were concerned that no member of the CSRT appeared to have any knowledge of Mr EF at that time despite his contact with services over a ten year period. The panel were informed by the manager of the CSRT that his first coordinator was chosen despite being an agency worker, as she had knowledge and experience of navigating housing issues and the state benefits system. These aspects were felt by the manager to match current needs of Mr EF at that time.

5.34 We shared the internal (Board level) panel's views and concerns. In fact the first appointed care coordinator for Mr EF was not Ms TU as recorded in the internal report. We were able to establish from the case records that Mr EF had a care coordinator in 2005, a Ms LB. She had planned a CPA meeting on 17 March 2005 which eventually took place ten days later on the Ken Porter Ward Barnet Psychiatric Unit. No recorded details of the outcome of this meeting were available and the care plan form was incomplete. It did not contain any identified relapse indicators, it was unsigned, and Mr EF was not issued a copy. This CPA coordinator planned another CPA meeting in July 2005 and again we were unable to evidence from records any relevant outcomes from this meeting. We have identified other CPA meetings and care coordinator contacts in our chronology of Mr EF's psychiatric history.

5.35 It is difficult to determine the effectiveness of early care coordination and CPA since no detailed care plans appeared to have been designed as a basis for subsequent interventions. Mr EF was allocated Ms TU as care coordinator from the West Barnet Community support and Recovery Team in August 2013. She was an experienced social worker although not contracted to the Trust as an employee as she was an agency worker. The introduction of the

care coordinator to Mr EF occurred at a joint (CRHTT) home visit on 1 August 2013. The needs identified at this meeting revolved around Mr EF's pending court case for smashing car windows, non-compliance with medication, benefits advice and the renewal of a Freedom Pass. This coordinator remained until Mr PR on placement took over the role and function on 11 November 2013. He remained so until the time of the homicide on 15 May 2014. During this time Mr EF was seen by Mr PR five times, four of these being at the Dennis Scott Unit and once at home.

5.36 The Board level internal inquiry panel recorded their concern regarding the overall level of engagement and they examined why this lack of engagement had not been noted in the supervision sessions between Mr PR and Mr NO with subsequent escalation within the team.

Panel consideration

The interpretation, application and administration of CPA was a fundamental weakness in care delivery to Mr EF. Whilst much of the anomaly may be focussed on the care coordinator, who was a student on placement experience, this was only one feature of any weakness. It appears likely that a more systemic problem existed at the time and the internal inquiry panel made accurate and pertinent comment, together with recommendations regarding those areas of concern.

We agree with the internal panel report comment that the panel:

> "were concerned with the overall level of engagement achieved and queried why this lack of engagement had not been picked up in supervision and escalated within the team. Mr EF's history of non-engagement was well known by the senior managers and according to the team manager the team was used to and aware of how to respond to such clients. It is the panel's view that if the difficulties Mr PR was experiencing with Mr EF's non-engagement had been picked up by his supervisor (or by team colleagues at the team meetings) more pertinent advice could have been given to Mr PR and the matter escalated for fuller discussion" (page 28).

5.37 Another weakness in the care delivery was the task of designing a comprehensive care plan and relevant documentation for this. The internal inquiry considered this important aspect of role and function and exposed deficiencies in the care records of Mr EF.

5.38 The above weaknesses begged questions about the performance of the care coordinator and also that of his supervisor. These weaknesses also highlighted the way in which the paucity of recorded information may have acted as a further barrier to any communication between contributing services. Unfortunately, we were unable to interview either of these staff members who had left the Trust by the time of this investigation.

Application of the Mental Health Act 1983, as amended in 2007

5.39 Mr EF's young adult life was overshadowed by the development of mental illness. He was suffering from paranoid schizophrenia. This condition manifested as auditory command hallucinations accompanied by persecutory beliefs, with episodes of depression. Despite short periodic admissions to mental health units and support from community services, compliance with anti-psychotic medication was poor. Further, Mr EF's mental illness was complicated by his use of alcohol and cannabis. In early March 2014 Mr EF stopped taking his medication and his condition relapsed with an associated increase in auditory hallucinations. In particular on the evening of 8 May 2014 he became convinced that his friend Mr BC was intending to kill him. This situation led to him making the knife attack and the subsequent death of Mr BC.

5.40 Mr EF did not have a history of serious violence. None of the assessments or interventions undertaken by the Trust were able to identify that Mr EF represented such a serious risk of extreme violence, although in 2005 a doctor in the CRHT team highlighted concern as to such a possibility when seeking to refer Mr EF for admission to the Dennis Scott Unit, Edgware.

5.41 We were interested to note the remarks of the trial judge when recording that 'it was indeed a tragedy that it was not appreciated at the time of this terrible episode and that Mr EF represented a risk of such violence'. Mr EF was informed that he remained a substantial risk to himself and others. In the light of his serious mental disorder he was placed on a hospital order under Section 37 of the MHA 1983 with a restriction order under Section 41 without limit of time.

5.42 The internal inquiry panel felt that a thorough assessment of Mr EF's mental state had been undertaken by the team at Colindale police station. The panel acknowledged that the AMHP acted lawfully when overruling the medical recommendations for a Section 2 admission. The rationale for this was that the 'least restrictive option' had been taken which reflected best practice.

5.43 The panel was critical with regard to the absence of documentation which should have described the content of the assessment particularly with regard to the differing views of the participants. Such was the panel's concern they made a clear recommendation that in future any reasoning for non-implementation of medical recommendations must be fully documented by the AMHP.

5.44 We agree with this important aspect of conducting MHA assessments and we comment elsewhere in our report regarding the progress the Trust has made when implementing this recommendation[41].

5.45 We wished to explore these aspects further as we are aware of what appears to be an emerging generic problem when professional practitioners are endeavouring to follow best practice in areas that may deprive a person of their liberty. This revolves around the interpretation of the notion of 'least

[41] Paragraph 6.49 and following table

restrictive option'. Whilst anecdotal, we are aware that, when pursuing this intention, there is likelihood that as a result a person may be diverted from benefiting from admission to an acute ward and therefore not being given sufficient time to perform an accurate and more reliable process of assessment.

5.46 We do not suggest this occurred during the Colindale police station assessment as a bed was made available for Mr EF to accept the resource as an informal patient. However, as the internal panel pointed out in their report, the interpretation of the presence or absence of aggressive/violent behaviour at that time could reasonably have had a bearing on the decision making process. We established through our interviews with the participants that the AMHP did not have sufficient background risk information available at the time as she reported that she did not have access to RiO in the police station. She did, however, on her assessment that Mr EF held capacity, use the criterion of least restriction to guide her judgement and not concur with the medical recommendations for detaining Mr EF for a period of assessment as defined under the MHA.

Panel Consideration

We note the following statement from the 2008 Reference Guide to the Mental Health Act 1983, as amended in 2007:

> "AMHPs must also be satisfied that detention in a hospital is the most appropriate way of providing the care and medical treatment the patient needs. In making that decision, AMHPs are required to consider "all the circumstances of the case". In practice, that might include the past history of the patient's mental disorder, the patient's present condition and the social, familial and personal factors bearing on it, as well as the other options available for supporting the patient, the wishes of the patient and the patient's relatives and carers, and the opinion of other professionals involved in caring for the patient."[42]

This paragraph is repeated in the current Reference Guide.[43] We would stress that a decision not to detain a person in hospital should follow the same information requirements.

5.47 We concluded from our detailed review of Mr EF's history of relapse indicators and periods of psychosis which included command hallucinations that the medical recommendations were most accurate and that the nature and degree of Mr EF's presentation warranted compulsory detention for a period of assessment. Although as we have commented elsewhere we do not believe that Mr EF would have necessarily have been prevented from going missing from the ward, he would however been classed as AWOL and could have

[42] Department of Health (2008) Reference Guide to the Mental Health Act 1983, TSO
[43] Department of Health (2015) Reference Guide to the Mental Health Act 1983, TSO

been returned. Conversely, had Mr EF presented with different behaviour and with medication compliance together with clinical intervention, the detention could have been reviewed and revoked in a planned way. This would have reflected the protective elements of the MHA with regards to detention.

5.48 During our examination of the concept of least restriction we were assisted by the publication of some rare and useful clarification as to the seriousness of the consideration that must be given when giving medical treatment and depriving someone of liberty. Although based in the context of covert medication the principles that guide practitioners in decision making appeared to be most appropriate in mental health assessments[44].

5.49 Although not a decision with binding precedent value, being a decision of a District Judge it is very useful for highlighting that the decision making process in measures of interference with Article 8 of the European Commission on Human Rights (ECHR) must be fair. The greater the interference the more rigorous the decision process must be. We felt it to be valuable to point out the principle of least restriction and how that is to be achieved. Under the ECHR, 'before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. Such intervention must be proportionate to the circumstances of the case and accord with the principle of minimum intervention consistent with best interests.'

5.50 We did not feel that had Mr EF been compulsory detained that such action would have been inconsistent with his best interests. The resulting admission would have meant a comprehensive care plan being devised, setting out clear roles and responsibilities for monitoring medical interventions and addressing risk management based on an extended period of assessment.

5.51 We examined these aspects, not because they were an issue for us to determine but because they reflected the care and treatment and the clinical decision making alongside risk assessments, specifically relating to others in our Terms of Reference. We felt that the circumstances surrounding the MHA assessment during the early hours could have attracted an application by the AMHP to reinforce the medical recommendations. We came to this conclusion because the objective behind the decision made appeared to be based on any possible negative effects on Mr EF of compulsory admission and interference with his rights and self-determination. However, it could have been regarded as an opportunity for Mr EF to benefit from a period of supervision and control and facilitate assessment in stable conditions. Therefore, the objective would be fair and the subsequent restriction would be in accordance with the conditions under the MHA which includes proper safeguards proportionate to the robust assessment of the nature and degree of Mr EF's mental illness during the 28 day period. Although speculative, we also note that Mr EF could have been transferred on to Section 3 for further treatment and better aftercare, including the possibility of a Community Treatment Order.

[44] 39 Essex Street Chambers Mental Capacity Law Newsletter August 2016 Court of Protection: Health, Welfare and Deprivation of Liberty: AG v BMBC & Anor (2016) EWCOP 37 (District Judge Bellamy).

Risk assessment and clinical decision making

5.52 Subsequent to our scrutiny of the CPA process from 2005 until the date of the offence, we felt that the Board level internal inquiry captured important weaknesses in the implementation of the CPA. This included aspects of faulty supervision arrangements regarding the function of a student being allocated as a care coordinator for Mr EF. One result was that of concern regarding not escalating the periods of non-engagement by Mr EF to senior colleagues in the West Barnet Community Support and Recovery Team, a lack of understanding of the care coordinator's role and inadequate record keeping.

5.53 CPA process and procedure based on national guidance and the correct implementation of local CPA policy was not being closely monitored by the CSRT - West. We considered that this contributed to a weakness in risk management of Mr EF during this phase of his contact with the service. We concluded that, whether any risks were accurately assessed and recorded or not, there was insufficient emphasis on the mechanism of correct CPA implementation. Had there been sufficient emphasis the WCSRT may have been more alert to relapse indicators. Our view was reinforced when considering that the day after Mr EF ran away from Sussex ward, a mental state examination was conducted by two trainees one of whom was the allocated care coordinator.

5.54 It was within the context above that we agree with the Board level investigation which recognised that the care coordinators approach to clinical documentation and CPA, appeared to be an indication of the absence of an understanding of its importance. It also formed part of their pertinent recommendations which we consider elsewhere in this report[45].

5.55 In some respects the periods of contact and care provided to Mr EF up until the time of the offence acted as a "window" on the risk management systems in place during those specific times. In turn, the quality of the risk assessments informed the nature of the associated clinical decision making which determined when and where Mr EF received mental health services input.

5.56 At various times during his contact with services Mr EF appeared quite adept at telling professionals what he felt they wanted to know. It also meant that by doing this he tended to avoid what he felt was interference in his life at the time. Mr EF was selectively engaging with parts of the service which appealed to him such as wanting to pursue a gardening course then abandoning that and requesting to pursue a college course and not registering but simultaneously urging the care coordinator to seek benefit payments and arrange a Freedom Pass to enable him to use free public transport. His somewhat chaotic life style and the association with alcohol and substance misuse increased his reluctance to reveal information to professionals.

5.57 We could not evidence any detailed or standardised risk assessment, only risk summary sheets. These were recorded electronically and differed in quality of input. They were dated 2008, 2010 and 2013.They became more detailed after the date of the offence in 2014. The risk summary form warns the

[45] See paragraphs 6.30, 6.39 – 6.40.

assessor that they have been modified and that any previous information may be available in the 'risk archive'. We could not find any such archive form from the case records of Mr EF. We considered that the absence of any standardised longitudinal risk assessment may have implied a lower of risk than may have been the case to assessors on different occasions. If so, the care plans and risk management may have been weakened if based on that assumption.

5.58 We concluded that, for the most part, clinical decision making and judgements were reasonably based on how Mr EF presented at the time to the respective services and individual practitioners involved. This included some feedback from a youth worker, Mr EF's self-reported mental state and on some occasions, the absence of any observable signs of psychosis. However, this was in the context of incomplete, independently corroborated information including where he was living under what circumstance, particularly during periods of homelessness. It also included any contact he had with substance misusers, his erratic or non-compliance with the taking of prescribed medication, frequency of cannabis/skunk use, frequency of alcohol intake and his relationship with the victim prior to the offence.

Panel consideration

Mr EF was typical of many such patients who are complex and do not engage with services. Attempts to coordinate consistent care and attempts either to visit or to rigorously assess them prove very difficult for treatment teams in the community. Often when questioned, they will confirm they are taking medication, provide false addresses; deny excessive substance or alcohol use. Assessors then acquire risk information which is difficult to verify. Since Mr EF had experienced a number of psychotic episodes from being a young man and also had periods of remission, we felt it to be understandable that any summarised brief risk assessments which relied mainly on self-reported information would appear plausible to some practitioners. The Trust is most familiar with the type of risks such people present. This was reinforced by the authors of the Board level inquiry report when we discussed our views with them.

5.59 However, it may have been the case that, in April 2014, they classed Mr EF's risk as low – but, given the circumstances surrounding his admission, two medical recommendations for compulsory assessment, his behaviour on the Dorset ward and his consultant's indication that a 'holding' section should be used all within a short (72hr) period we concluded that Mr EF should have been considered a 'medium' risk of harm/violence to others'

5.60 We considered the aspect of risk assessment, care management and decision making against criteria for best practice. These were identified from a relevant evidence base and national standards and guidance. The next section expresses contemporary practice guidance.

Review of risk assessing

5.61 The nature of problems around Mr EF's sporadic contact with various practitioners were rooted in the generally poor identification of risk points and the potential contribution these may eventually have had when the nature of risk escalated. We could not establish a single and clear link between any likely cause and effect. However, we were able to evidence aspects of weak risk assessments which were sometimes based on inaccurate and inadequate record keeping and communication problems between teams.

5.62 In a number of ways the risk assessment processes highlighted the problems that may be encountered when professionals rely too heavily on self-reporting of information when they form judgements about risk. Contemporary research tends to reflect concerns that the views of service users are not paid sufficient attention in policy or practice. There is also a converse situation that needs to be considered by those undertaking the assessment of risk. That is, the possible consequences associated with someone who is either unaware of the risk they pose, or who intends to deliberately obstruct accurate assessment. This kind of dilemma is one of the reasons that careful, well-informed risk assessment and management is a key requirement for mental health practitioners.

5.63 One of the problems that presented to those assessing risks associated with Mr EF appeared to be that of placing previous assaultive behaviour within a context of his irrational beliefs and ideas. It appeared difficult for most of the professionals to be sure whether his prior aggressive behaviour was due to situational factors such as influence of drugs and or alcohol, or that due to a severe psychotic episode.

5.64 Those challenges of his risk behaviours for assessors meant that it should have been considered essential to explore in more depth the nature of his previous assault on his sister and the context of carrying a knife. The intention would have been to secure as much supporting information as possible to be built up over time.

5.65 The weaknesses identified above are not uncommon when time pressured risk assessments are made. It can however, result in the service user's family being unaware that practitioners were formally assessing risks. Qualified and experienced professionals tend to find the necessary discussions easier when they know the service user well. This of course means that a good relationship exists with them built up over time. Therefore, for effective collaborative risk management to follow the initial assessment, the content and quality of data entries can be critical. Hence our reinforcing of the internal investigations criticism of the placement of the social work student as a coordinator and the need for competent supervision of such students.

Review of the management of difficult to manage patients, substance misuse and those in unstable living arrangements

5.66 During the decade in which Mr EF was in intermittent contact with mental health services he experienced a variety of services available to support him. The range of provision available within the Trust's area of responsibility was wide. It was also typical of those settings within the London boroughs that hold significant experience in providing for mentally ill people with issues of addiction and who are not reliable when engaging with services. The range includes:

- Community – treatment in community drug and alcohol teams and day programmes;
- Inpatient unit for assessments, stabilisation and assisted withdrawal;
- Primary care via GP services with special interest in addiction treatment;
- Residential; and
- Recovery and supported housing.

5.67 Practitioners involved in reviewing or assessing Mr EF's mental state at specific times, tended to rely on self-reported accounts with regard to signs of psychosis, current living conditions and his relationship with substance misuse. There was little evidence available that Mr EF would benefit from specialist intervention and support due to him having any difficulty to overcome dependence on drugs or alcohol. The AMHP (Ms HJ) reminded us during interview with her that cultural aspects of this young black man had to be considered when assessing both his life style and his mental health. We agree with her view and when we examined the nature of Mr EF's resistance to engagement with services, the context of local culture was an important factor.

5.68 We have concluded that the level of substance and alcohol misuse may have exacerbated Mr EF's psychotic symptoms at specific periods. However, any attempts to utilise the expertise of a specialised service to reduce the harm from his relationship with these substances would be unlikely to have met with success. Such relevant services pursue evidence-based practices, rather than relying on what individuals think may work. It would have been futile to seek a specialised service unless Mr EF was prepared to engage in treatment first. The contemporary view shows that client engagement is the number one evidence based practice in this area[46]. This study was the result of reviewing forty years of research of what works in therapy. The strongest predictor of any success that either community services or in-patient care may achieve in this area, would depend on a working alliance with Mr EF. His psychiatric history shows that this was not likely to be something Mr EF would have been willing to do.

[46] Duncan, B. Miller, S. and Sparks J.(2004)The Heroic Client :A revolutionary way to improve effectiveness through client-directed outcome-informed therapy. San Francisco, CA:Jessey-Bass,Inc

Recommendation 4: The Trust should ensure that all service users with psychosis who misuse alcohol and/or illicit substances are considered for referral to substance misuse services. If the decision is to not make a referral, the rationale for the decision should be recorded. This should monitored as part of the audit programme.

5.69 However, we felt that this aspect could have been considered in greater detail during the early phase of his illness. There were opportunities for support to have been given in the community, within structured drug and alcohol settings where it was not necessary to be resident to use the service. The primary care service during his early presentation may also have identified a specialist service within the GP practice if a practitioner with a special interest in addiction treatment had been available. Any periods in prison may have offered the opportunity to have a structured drug and alcohol treatment delivered by a locally commissioned team.

5.70 We examined the demographic of the Trust catchment area regardless of particular boroughs. It can be recognised that the commissioning of drug services utilise partnerships in the area aimed at meeting the needs of the drug using population. This is an example of good practice as it expands the opportunities for recovery and integration, including employment and housing services. Using partnerships forms an integral part of care planning for an effective treatment system.

5.71 Mr EF experienced periods of homeless during and between periods of contact with mental health services. This included staying in temporary accommodation, in bed and breakfast accommodation, staying with friends and acquaintances, generally being of 'no fixed abode'.

5.72 Combined with the risks noted in the previous section, we have been able to examine the consequences of homelessness in research evidence. This suggests that the nature of the periods of hospitalisation may have been improved by more detailed core discharge planning and the transition processes associated with discharge from mental health services. This evidence includes the need to improve the transitions and care coordination at the interfaces between care settings and support for patient self-management. Simply put, it is more likely that people like Mr EF will be better placed to negotiate such transitions if they are not stressed by inadequate or no housing, diminished family support and little contact with a GP. It can be evidenced in care records that these aspects were considered on the whole when mental health services planned any discharge.

5.73 The main challenges experienced in the transition of care of homeless patients are well illustrated in the Queen's Nursing Institute[47] (QNI) research which was available in 2008.

[47] Queen's Nursing Institute (2008) 'Homeless health initiative, service user consultation', QNI.

5.74 The following themes (paras 5.75 to 5.79) identified in this QNI report were relevant to Mr EF's situation and to the management of his care and treatment between 2007 and the index offences in April 2014.

5.75 Poor communications, for example:

- discharge planning is poorly communicated, little forward planning and the patient subsequently discharged to no fixed abode;
- a lack of joined up working e.g. having to chase up where people are and track discharge summaries;
- hospital staff not getting in touch with community staff even when contact numbers have been left and vice versa; and
- poor knowledge of discharged patients and not being provided with an accurate mental health summary to know what to do next to be effective.

5.76 Inappropriate/unsafe discharge which means that:

- patients may be discharged to the streets or hostels that are so full they sleep on the floor;
- patients may be discharged inappropriately with no realistic care management plans, especially if alcohol dominates;
- underfunded housing with staff who struggle to provide competent support and knowledge; and
- discharge back into chaotic hostels or temporary bed and breakfast accommodation where there is lack of supervision and support to meet complex health and social care needs.

5.77 NHS systems are not designed for mobile populations, so that:

- people move between boroughs and so care is fragmented; and
- NHS IT systems and the rapid transfer of health notes are not designed with a mobile population in mind.

5.78 Reasons for these challenges were identified as:

- poor joint working between organisations;
- lack of local supported housing;
- working in overstretched/under resourced mental health systems;
- lack of awareness of community Homeless Healthcare Teams amongst hospital staff;
- staff from all sectors require support to improve skills in working with homeless people; and
- homeless people receive poorer experience of general healthcare.

5.79 The QNI study identified useful possible solutions and highlighted the following:

- better communication and integration;
- better advanced discharge planning;
- specific staff training in homelessness;
- dedicated accommodation;
- appointment of 'leads'/coordinating professional practitioners; and
- identified dedicated treatment pathways.

5.80 We can evidence, from examination of Mr EF's care records, that significantly and as good practice some of these highlighted issues were

addressed some of the time. However, his discharge to the HTT in 2005 from the Dennis Scott Unit in Barnet may have been planned more effectively if a more standardised and integrated approach had been taken, from the initial admission.

5.81 While some of the challenges faced by services for homeless people may be attributed to System or Organisational weakness, the aspects of the behaviour by Mr EF when offered support also highlighted 'patient factors' as a possible root cause of serious incidents, as a consequence of his non-engagement with available services. This included for example his unwillingness to comply with necessary house rules in supported accommodation in Baytree, non-compliance with medication, use of alcohol and illicit substances, non-engagement with services. Contemporary research evidence[48] reinforces the need for Trusts and other agencies to address these challenges. In their description of lessons learned over 20 years of the national confidential inquiries, this includes suggestions for crucial clinical interventions:

- drug and alcohol misuse and dual diagnosis services; and
- services to maintain engagement with patients who are likely to lose contact.

5.82 Other clinical and social characteristics of risks for these groups include:

- isolation; and
- economic adversity.

5.83 The most effective transition of care management for this group of service users is best evidenced when robust joint protocols and systems of effective sharing of information exist between hospital and community health staff, social care, housing services and voluntary organisations. An example of good practice is provided below.

5.84 The demographic of the North London area covered by the Trust has meant that various agencies are responsible for contributing to the duty of meeting challenges associated with mentally ill homeless people. However, there is scope for further development within local partnerships, between health, social services, education providers and the third sector. The objective should be to specifically support those living in the most challenging circumstances, as experienced by Mr EF.

5.85 In practical terms this may involve for example, developing an inter-disciplinary forum, which would share ideas and best practice at a local level. This would be facilitated using shared resources in order to incorporate them into practice development and staff training initiatives.

5.86 There is good evidence that homeless people and men in particular will lead unhealthy and risk prone lives. This manifests itself in the clinical history of Mr EF. They are more likely to drink alcohol to excess, to misuse drugs, to be disengaged from any employment, to be non-compliant with prescribed care and treatment, to be less likely to eat a healthy diet and unlikely to engage

[48] National Confidential Inquiry into Suicide and Homicide buy People with a Mental Illness (2016) 'Making Mental Health Safer, Annual Report and 20 year review' University of Manchester, page 10 para 22

with health improvement programmes. These issues remain a major challenge to services because[49] there is known correlation between poor physical health and mental illness.

5.87 Numerous local and national programmes promote healthier lifestyles with the objective of improving population health. Very few of these programmes target homeless people and in any case the emphasis is on benefits to physical health. Contemporary evidence of meeting these challenges is reflected in Making Every Adult Matter[50]. This coalition is made up three national charities - Mind, Homeless Link and Clinks. This has managed service pilots aimed at better co-ordination of services for people with multiple and complex needs such as mental health, addiction, homelessness and criminality. The result is to improve practical support and outcomes for people like Mr EF.

Recommendation 5: Commissioners and the Trust consider working together to devise a more innovative, assertive outreach type of service for those service users who do not organise their lives by diaries and appointments and who move readily and frequently between organisational boundaries. Such services would be more flexible in going to service users where they are and remaining open to service users who move across team or service boundaries within the Trust.

5.88 We have concluded that this combination of non-engagement, substance misuse and unstable living arrangements made it significantly more difficult for services, as currently configured, to carry out adequate care planning and interventions and risk assessment and management.

BME Factors

5.89 Another area we identified when reviewing periods of contact with services was that of examining the provision of care to Mr EF as a member of the black and minority ethnic community. We felt this was essential as it established that people from these groups are more likely to be diagnosed with mental illness; be subject to coercive forms of care; experience poor outcomes from treatment; or dis-engage from mainstream services. Our scrutiny of the governance systems within the Trust, policies and procedures made available to us and formal information from the Trust to the local community, revealed a level of commitment to meet their responsibilities under the Race Relations (Amendment) Act 2000. In some areas of Barnet, Enfield and Haringey, services and community partnerships have been developed specifically to meet the needs of black and minority ethnic groups.

5.90 When Mr EF first had contact with mental health services, the role of Community Development Workers (CDWs) had recently been established nationally under the government's agenda of 2005 'Delivering Race Equality in

[49] Queen's National Institute (2008) 'Homeless health initiative, service user consultation', QNI,
[50] Barcley J. (2016) Making Avery Adult Matter (MEAM), changing systems, changing lives: a brief review of the MEAM Coalition, MEAM; and website Making Every Adult Matter accessed 15 September 2016.

Mental Health Care'[51]. This was a five year initiative in response to the death of David (Rocky) Bennett who died in a secure mental health unit. The role has now mainly been subsumed within third sector organisations. In the London boroughs the CDWs were instrumental in challenging discrimination, stigma, and promoting mental wellbeing in BME communities of the kind known to Mr EF. We felt that the positive legacy of the initiative remains in the awareness of the Trust staff we interviewed. The involvement of the youth worker during 2004 to 2005; the development of policies screened on completion for equality and impact; and the advice and guidance offered throughout his periods of contact reflected actions by practitioners in local services. These actions emphasised continuing commitment to try and meet the specific needs of BME communities.

5.91 The various episodes of care appear to be rooted in services which aimed to offer this care and support to improve mental health outcomes for Mr EF as an individual and also to the local community he was in at any one time. The services attempted to offer the support together with timely interventions. They did this to give Mr EF the greatest choice and control over his own life in the least restrictive environment.

Compliance with policies

AWOL/Missing person policy

5.92 This current policy does in fact make the distinction between 'AWOL' and 'Missing', as we have described above[52].

5.93 The policy states that 'the Responsible Clinician is responsible for reviewing the status of missing patient together with the responsible team' (paragraph 4.5). Mr EF's consultant had already recorded that Mr EF could be subject to a Section 5(2) holding should he express a wish to leave, such was the concern. This meant that he had indicated his intention to get a MHA assessment and further to this the ward nurse did request this on the consultant's instructions after Mr EF went missing. We consider that the policy was followed by the in-patient ward Sussex but it fell down when Mr FG preferred to rely on a review already arranged, which was to be carried out by two trainees. Hence a MHA assessment based on the correct policy did not happen and practice was not compliant with the policy.

5.94 These comments apply to both the earlier policy on AWOL and the latest one. We considered the most recent policy to be excellent, particularly the included flow chart.

[51] Department of Health (2005) Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett

[52] See paragraph 5.21 above.

Early Intervention Service policy (2008)

5.95 The first aim of the EIS lists the criteria for providing the specialist service to a service user. These criteria are (paragraph 3.1):

> "To provide a specialist service, for the early identification, assessment and treatment of clients between the ages of 14 to 45 years who:
> - Present with a first episode of psychosis
> - First episode began less than three years earlier
> - This three year period includes any period of untreated psychosis."

5.96 Mr EF would have met all three criteria, if this service had been available at the time of his first presentation to services with symptoms of psychosis. If he had been referred to the EIS he would have remained under a consistent service for three years. This is speculative but we also note that the sooner someone with schizophrenia is treated, the more likely they are to have a better long-term outcome.

5.97 We also note that the policy was to be reviewed annually from the date ratified (2008) and we do not have any evidence that this has in fact been done.

Clinical Risk Assessment Policy – dated 2011 and due for review 2015

5.98 Under the Risk and the CPA heading (paragraph 9) it clearly states that 'the CPA care coordinator must be a professionally qualified staff member and have appropriate training for the role'. This is a very clear statement that a CPA care coordinator should not be a student (of whatever discipline) and it is equally clear that this did not happen in Mr EF's case and therefore practice was not compliant with this policy.

Recommendation 6: The Trust should follow the clinical risk assessment policy and deploy qualified staff to the CPA care coordinator role. If, in exceptional circumstances, a student is considered appropriate for the role, arrangements for role preparation (understanding of the role and appropriate training) should be made with the university programme head and include monitoring by appointed external examiners to the course.

5.99 This policy is sound and if followed it should evidence highly competent approaches to assessing and subsequently recording risk. This includes the requirement to seek expert help in cases where there is doubt (paragraph10.7). Mr PR did report to Mr NO (the principal practitioner and his supervisor) that he was concerned about Mr EF. An 'observed visit' was scheduled to take place but the offences were committed before the date of the visit. Therefore this visit did not happen.

5.100 We conclude that paragraph 10.8 applies particularly in this case, which states that 'research indicates there are particular situations and circumstances

which may indicate an increased level of risk – for example violence is more likely when drug or alcohol misuse co-exist with mental illness'. This combination of serious mental illness and drug/alcohol abuse clearly relates to Mr EF.

5.101 Similarly, paragraph 10.10 of the policy describes other circumstances regarding increased risk – for example, when the patient stops taking medication and had previously been aggressive during an acute phase of illness. Again, this was true of Mr EF.

5.102 The policy notes that all risk assessment tools are held on RiO (paragraph 10.15), including the tool for assessing risk of violence. We note that the NCISH report (paragraph 286), quotes recent research which recommends that risk assessment should become more personalised rather than relying on checklists. This research[53] suggests that 'risk assessment and management should:

- be individual to each patient;
- assess current risk factors and past history; and
- include a management plan that follows on from the risk assessment,'

It also concludes that 'risk assessment and management should not:

- ignore current circumstances or past history;
- equate the completion of a checklist with good risk formulation and management; and
- rely on a generic plan of clinical management.'

Recommendation 7: The Trust moves towards the development of a more personalised approach to risk assessment, which is individual to each patient, assesses current risk factors and past history and includes a management plan that follows on from the risk assessment. In the meantime, we recommend that the current training on risk assessment and guidance on the use of the existing tool is strengthened.

5.103 In paragraph 10.18 there is a requirement that on discharge from hospital a risk assessment MUST be done and a risk management plan agreed by all concerned. This was done after Mr EF went missing – he was discharged due to 'being informal'. He was later reviewed by the two trainees and there is no evidence that a standardised risk assessment was carried out. (Dr JK did give a good account of Mr EF's presentation but there is no evidence of any contribution to a risk assessment by Mr PR.)

5.104 The guidance for risk of violence contained in the policy is sound. We considered that if this had been actually followed more appropriately, Mr EF

[53] Rahman MS, Gupta S, While D, Windfuhr K, Shaw J, Kapur N, Appleby L (2013). Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study, p. 13.

would have been more likely to fallen into the appropriate category of risk level.

5.105 We also note that in paragraph 10.13 of the policy it requires the Trust to 'remove or cover all likely ligature points', which applies to the issue identified with door hinges on Sussex ward.

5.106 We consider that the current (2015) policy which is due for review in 2018 is excellent. The points made above apply equally to the updated policy.

5.107 To sum up the Risk Assessment and Risk Management issues we conclude that If the policies had been followed accurately and the suggested questions contained in the appendix to the policy had been answered by individuals and teams, trained in the use of the techniques – a higher level of risk may have been attributed to him.

CPA policy 2013

5.108 This policy was in use when Mr EF was in contact with services. The CPA policy is being reviewed and this was ongoing at the time of writing the report.

5.109 We consider that the policy is comprehensive, appropriate and accurately reflects national guidance.

5.110 The policy reinforces the point that the "most suitably qualified and appropriate member of staff must carry out CPA assessment".

5.111 We wish to stress that the policy is clear (paragraph 11.12) that CPA care coordinators must have undertaken training and have attained the appropriate knowledge and skills[54] (document available to all staff on the Trust's Intranet). In para 11.15 of the Trust's policy there is a comprehensive and detailed 40 point list of 'roles and responsibilities'[55]. Even with supervision, we consider it to constitute an unreasonable expectation for any student regardless of discipline. It is also clear in the Clinical Risk Assessment and Management policy that the CPA care coordinator must be a qualified professional[56].

5.112 The policy (paragraph 11.13) also specifies that, if care coordinators are new to either the service or the role, 'they must have undertaken a two-week induction period 'shadowing' an established Care Coordinator in the local area or service'. It is not clear if Mr PR was new to the service or role, but we found no evidence that any induction of this nature was provided to him. There was evidence that he did not understand the role of a care coordinator. The internal report contained reference to Mr PR's 'limited understanding of the role and responsibilities of a care coordinator'[57]; in addition the records which Mr PR completed lacked detailed care plans and evaluation of those plans, which are core components of the role of a care coordinator.

[54] Department of Health Care Programme Approach: Care Coordination Core Functions and Competencies
[55] Reproduced in full in Appendix G
[56] Paragraph 5.102 above
[57] Section 13.8, Findings page 33

Recommendation 8: The Trust should revise the CPA policy in order to ensure that the status of care coordinators is consistent with the clinical risk assessment policy.

5.113 The policy acts as a "catalogue" of procedures that should have been very effective in ensuring such aspects transfer of services and discharges to another team are covered.

5.114 The flow chart accompanying the policy is appropriate and correct and particularly valuable as a tool to ensure the process meets national and regulatory standards and best practice.

CRHT Operational framework (2013) and operational policy (2015)

5.115 The first policy (2013) provided is very short and describes an outline of the role and function of the team. This is the policy that was in place when Mr EF was in receipt of services from the Trust.

5.116 It was updated and replaced in 2015. The following points are relevant to the care and treatment of service users with complex and acute needs like Mr EF.

- The assessment process described on page 13 is particularly comprehensive and if complied with should contribute to better assessment of patients like Mr EF. This particularly states that 'all assessments will be undertaken by 2 members of staff' and that one of these should be a Band 6 Senior practitioner.

- The treatment planning meetings information (paragraph 4.4) is helpful and acts as a safety net with risk 'prompts' regarding discharge.

5.117 This is also a well-designed and accurately constructed policy.

Psychosis Service Line Policy

5.118 The policy provided was first produced in 2011. Whilst needing to be updated the description of the service role and function is appropriate. The policy applies to the operation of the Community Support and Recovery Teams provided by the Trust.

5.119 The policy describes (pages 13-14) the AMHP process and provision available in the three local authority boroughs. The service can depend on a duty rota (as was the case when Ms HJ was called to assess Mr EF in the police station).

5.120 The policy regarding the AMHP service also includes matters of principle, including the role of the AMHP to evaluate the need for MHA assessment (as in the referral of Mr EF on 15 April 2014). In respect of the Enfield service specifically, the policy states that 'consideration is always given to alternatives to admission and only when all options are exhausted is admission considered'. Whilst we acknowledge the appropriateness of the focus on

alternatives to admission, we consider that there are circumstances, as in the case of Mr EF, when risk may be such as to require admission.

5.121 The policy includes a description of staff training and development (paragraph 9.9). Key points are:

- annual appraisal for all staff leading to a personal development plan;
- mandatory training records will be kept and monitored; and
- individual staff members are responsible for ensuring their training is up-to-date.

5.122 This process has also been reinforced by the internal Board level inquiry.

Record-keeping

5.123 We recognise the points made about recording in the Board level inquiry report. In addition, we identified a number of occasions in which there were inconsistences or inaccuracies in the clinical records. These included:

- Discrepancies as to where Mr EF was born;
- Discrepancies as to the number of his siblings;
- Discrepancies in the details of his employment history;
- Incorrect spelling of names of members of staff;
- Discrepancies in the date of admission to the Dennis Scott Unit (DSU) in March 2005; and
- Incomplete records of CPA meetings.

5.124 We appreciate that some of these discrepancies may be the result of reliance on self-reporting by Mr EF and that none would have impacted on his care and treatment.

5.125 However, such inaccuracies may undermine confidence in the accuracy of the records more generally.

Issues arising from conversation with Mr BC's family and Mr EF's family and with Mr EF

5.126 Following our visit to Mr CC and his partner, we feel strongly that the Trust should ensure that relatives of victims of homicide carried out by NHS mental health service users should be offered support as soon as practicable after the incident. In this particular case, we appreciate that the Trust did not know the name of the victim's brother nor have contact details. For the future and in similar circumstances, the Trust could, where possible, contact police support systems, such as the victim liaison officer, for information. The intention would be to support their recovery from the trauma of losing a loved one in this way – for example by ensuring that counselling or CBT is provided for as long as appropriate. Signposting to services to meet other needs, such as financial costs, incurred as a result of the incident should also be provided. Any such help would be offered 'without prejudice' – that is, without admitting any liability for the incident.

Recommendation 9: In future instances of homicide by a service user in contact with mental health services, and where practicable, the Trust should offer professional support to meet any mental health needs arising from the incident and should signpost families to help with any other needs arising from the incident, such as financial costs. If the victim is unknown to the Trust, a senior manager should approach the police victim liaison officer to offer assistance to victim's relatives and put them in touch with the Trust if support is requested.

5.127 Mr CC informed us that his brother and Mr EF had known each other for some seven to eight years, and they were described as 'drinking friends'. Mr CC and his partner were also able to confirm Mr EF's propensity to indulging in risky behaviour on a number of occasions. We were unable to corroborate this information, and recognise that mental health professionals could not have known about it.

5.128 Mrs GG told us that she wished she could turn the clock back. She felt that if Mr EF had not been allowed to leave the ward to go into the garden he would not have had the opportunity to scale the fence. Once he had done so, she felt he should have been required to return to the ward.

5.129 At our meeting with Mr EF, he told us that he now feels it would have been better for him if he had been sectioned on 13 April 2014.

5.130 Mr EF also identified as problems for him the transition between teams, in particular that he had got to know the Enfield EHTT well, and a lack of consistency in teams' operations.

6. Internal inquiry and action plan

6.1 We reviewed three reports provided by the Trust as follows:

- Untoward Incident Document: it is unclear when this report was completed, but the 'received date' (by NHS Enfield Clinical Commissions Group) was 4 June 2015. This report contains a brief description of the incident, the immediate actions taken, administrative information and a summary of lessons learnt.

- The Board level panel inquiry report, which was approved by the service and the Trust Board on 1 June 2015, including an action plan.

- A desk top review, included as an appendix to the Board level review which was dated 10 June 2014.

Audit of the Board level panel inquiry incorporating the desk-top review

6.2 We audited the report using the audit tool referred to in the Methodology. We noted that it was clear who the members of the investigation team were, who wrote the report and the date the report was completed. The team consisted of medical and nursing (executive director) personnel, a non-executive director

and a facilitator. There is no information as to whether members of the team had been trained in investigation skills, but we were informed separately that the root cause analysis training is provided to investigators.

6.3 The date, time and place of the incident are recorded. Whilst the report says the victim was discovered two or three days following his death, the court records that his body was discovered about a week later.

6.4 The report provides brief details of the incident, including Mr EF's going missing from the ward, although there is some inconsistency in the description of the offence at different points in the report.

6.5 The Trust's contact with and support offered to Mr EF's family immediately after the incident is described. The identity of the victim and contact details for his family were not known at this time.

6.6 The desk top review was dated on 10 June 2014 (well within the 60 day timescale set out by the NHS England Serious Incident Framework, although this did not meet other standards of the Framework, see paragraph 6.32 below). The Board level panel inquiry was approved in June 2015, well after the 60 day limit but it did meet other standards set out in the Framework.

6.7 The review recommended the terms of reference which we thought were clear and appropriate. These arose from areas which the review team felt required further inquiry and scrutiny.

6.8 The Board level panel inquiry reviewed supporting information, including the desk-top review, Trust clinical records, GP summary records and records arising from an assessment under the MHA. Trust policies were reviewed, along with a handbook about professional social work practice and the Mental Health Act Code of Practice.

6.9 Members of the multi-disciplinary team and others involved in Mr EF's care and treatment were interviewed, and appropriate procedures were followed, which included arranging, carrying out and recording the interviews. There was no additional input from his primary care team, but there was no indication that this would have added additional information to the inquiry.

6.10 Although Mr EF's family were interviewed, there is no evidence that either they or Mr BC's family were approached to contribute to setting the Terms of Reference for this review. This is now (since March 2015) a component of the NHS England Serious Incident Framework. Mr EF's family were contacted and met with members of the internal inquiry panel so that the panel could take into account their 'issues and concerns. Once the trial came to an end, the inquiry also wrote to the victim's brother, Mr BC, who did not respond to their letter.

6.11 The report notes that appropriate arrangements were made to share the learning with the teams and wards involved in Mr EF's care. However, during interviews, a number of staff who had contributed said that they had not seen the report. We are particularly concerned that those other than Trust employees (for example, both AMHPs who were consulted about possibly

detaining Mr EF in the weeks prior to the incident) should receive the report and any appropriate learning or support. The Clinical Governance committee were to monitor implementation of the lessons learnt during the inquiry.

6.12 The report includes a detailed account of Mr EF's family and personal history, psychiatric history, forensic history, history of homelessness, evictions, insecure accommodation. There is little reference to risk assessment and, apart from references to medication and social and financial support, no detail of any other therapies that might have been offered.

6.13 There is reference in the report to his previous assaults, criminal damage and association with knives, but very limited mention of risk assessment and management.

6.14 Assessment of Mr EF's care needs was considered. In particular, the student social worker's limited understanding of psychosis was noted, as was his limited understanding of his role as care coordinator. There is no consideration of whether or not substance misuse services might have reduced Mr EF's use of alcohol or illicit drugs.

6.15 The suitability of Mr EF's care and treatment in relation to his assessed needs was considered to some degree. The inquiry report does question the appropriateness of allocating a student as his care coordinator and the assessment by two trainees after he went missing from Sussex ward. There is no review of whether his medication was appropriate and of any attempts to manage his non-compliance.

6.16 The report does conclude that the supervision provided to Mr PR was inadequate and did not comply with Trust expectations. There is no reference to national guidance on the treatment of people with psychosis, nor to any Trust policies on engagement, AWOL/going missing from a ward, or observations of inpatients.

6.17 The report did review Mr EF's failure to engage with mental health services, and that he only engaged when he wanted help with practical matters such as benefits advice, travel pass and accommodation. The report concludes that attempts to engage with Mr EF following his departure from the ward in April 2014 were insufficient, and that matters could have been referred to more senior and experienced healthcare professionals.

6.18 There is reference to the support Mr RC provided to Mr EF's family, and the report notes that his mother was appreciative of the care coordinator's contribution.

6.19 There is a detailed examination of the MHA assessment carried out overnight between 12 and 13 April 2014 in Colindale police station. This was followed by an informal admission to Dorset ward. The report is critical of the documentation and the lack of a record of the discussion between the AMHP and the two doctors who recommended detention. It is also critical of the fact that the two medical recommendations were not recorded.

6.20 The report noted that the care coordinator (student social worker) was not adequately trained in his role (CPA policy not followed in this respect), and also noted shortcomings in post debrief incident (the 'Managing serious incidents' policy was not followed in this respect) – a number of relevant staff only found out about the homicide when informed by the police. The Trust should have informed them. Shortcomings in following the non-engagement policy was noted.

6.21 Issues around management of the service were examined – these include the supervision of the student social worker, team management and the use of agency staff.

6.22 The inquiry title includes reference to 'root causes and lessons learnt' – but there is no reference to 'root cause' in the report itself, whether identified or not.

6.23 There is some reference to a mismatch between what actually happened in practice and what should have happened. There is no assessment of the relative strength of the evidence reviewed. The conclusions are based on the evidence presented and the recommendations are clearly linked to the conclusions.

6.24 An action plan was drawn up when the report was completed, and a further progress report on completing the plan was also provided. Implementation of the action plan will be discussed in later in this section[58].

6.25 The practice of individuals was criticised (for example, the supervision of the student social worker) but no recommendations were made specifically in relation to those individuals. Clear recommendations are given where system faults were identified.

6.26 There is an Executive Summary to this quite lengthy report. The report is written to a good standard of grammar, punctuation and consistency. Emotive language is avoided. Sections are numbered, but not paragraphs.

6.27 The Board level panel identified a number of items of good practice, namely:

- the support provided to Mr EF's family;
- an impression on the part of the Panel of good clinical and managerial leadership in the WCSRT;
- weekly team meetings which provided an opportunity for discussion, of cases, learning opportunities, and team support;
- joint handover between the CRHTT and care coordinator in the WCSRT (August 2013) and from one care coordinator her replacement (student social worker) in November 2013;
- the rapid response by WCSRT in April 2014 when they were informed that Mr EF had left the hospital (although coincidently the appointment on 15 April 2014 had been prearranged a month earlier);
- supervision arrangements put in place by the consultant Dr KL for her trainee doctors, including Dr JK, and both parties took advantage of these arrangements for learning and discussion of cases; and

[58] Paragraphs 6.47 to 6.50.

- the training provided to Trust staff on the MHA, including training to junior doctors (this does not include AMHPs, whose training and quality assurance is the responsibility of local authorities).

6.28 Whilst we accept that the behaviours described here are good practice, we also consider that, in the main, these are examples of practice which are expected of health and social care professionals by the mental health services generally, service users and their carers and by the general public. We do however appreciate the factors associated with services having to adapt to multiple organisational changes, together with resource constraints and local commissioning criteria, particularly within the London Boroughs.

6.29 The report includes thirteen recommendations for improvements to care and treatment to improve services. In summary, these addressed:

- record the rationale for decisions not to apply for detention under the MHA when there are two medical recommendations;
- ensure that medical recommendations which have not been activated are brought to the attention of the MHA office and put onto the electronic record;
- consider allocating a service user with a history of non-engagement to a permanent member of staff;
- review supervision of social work students to ensure that it is taking place and being recorded in line with Trust policy and university requirements;
- the supervisor of a student professional must observe a meeting between the care coordinator and service user;
- a qualified professional must accompany the student professional at the first meeting with a service user's family to ensure that correct information sharing requirements are followed;
- if a patient leaves absconds (the report's wording) from hospital the care coordinator and team manager must be informed as soon as possible, so referral to a CHTT can be considered and, if a student care; coordinator is involved, a review can be held of who should carry out the visit or accompany the student, based on a risk assessment;
- all visits to service users by a student social worker must be fully recorded; if the visit follows a serious matter such as absconsion, details of the discussion with a professional about the visit are to be recorded;
- the team should be reminded of the importance of maintaining accurate and up to date records;
- the team should review its practice in working with difficult to engage clients and review their criteria for when these cases should be brought of the attention of senior management: this should include when a patient absconds from hospital: senior managers should be involved in the review and cases allocated to a professional member of staff;
- a joint training session in psychosis should be held for all members of the WCSRT; this training should then be rolled out to all CSRTs in the Trust and a synopsis of training to be included in the induction for junior doctors;
- the Trust CPA policy should be provided to all students in the CSRTs on induction and the requirements of the policy and the should be explained to them and monitored in supervision; and

- the Trust's serious incident policy should be followed to ensure that all professionals involved in the care are fully supported.

6.30 The report included key lessons learnt, which were:

- When a service user leaves a ward and there has been a recommendation from the ward consultant that MHA assessment should be carried out, the referral to the community team must include the service user's consultant and the team manager as well as the care coordinator. These senior staff can then discuss the case and make a decision at a senior level as to who should undertake the assessment.
- In this situation, if a service user then does not engage with the community services the case should be escalated to senior management.
- If the care coordinator is a trainee (regardless of discipline) there must be a rigorous and robust system of supervision in place.
- The Trust is to ensure that, if a case is allocated to a trainee, they understand the symptoms of mental illness and the role and responsibilities of a care coordinator.

6.31 We considered the recommendations to be appropriate on the basis of the evidence collected and conclusions drawn by the Board level panel, but we identified some concerns in our audit and through the interviews with panel members and Psychosis Service Line managers and clinicians. These are discussed below.

Discussion of the Board level panel inquiry report

6.32 The expectations of NHS England are that a review will be carried out following a homicide by a mental health service user which involves interviews of relevant staff and involvement of families and carers, and that this investigation should be carried out by Trust staff who have no direct responsibility for the care and treatment provided to the service user.

6.33 The Trust's 'Serious Incident Management Policy' (2013) confirms that the RCA report should be 'independent'. This policy also requires a 'desk-top review' to be commissioned by the Director of Nursing, to inform a Board level panel inquiry, and includes a six-month timescale for completion of a Board level panel inquiry.

6.34 The current policy for investigating serious incidents (Management of Incidents Policy, 2015, Appendix 2) does not include reference to either a 'desk top review' or 'Board level panel inquiry'. The requirement is for a RCA investigation which should be completed within 45 working days.

6.35 We were interested in the process of commissioning the Desk Top review before the Board level panel review, which was to inform its terms of reference and scope. The Desk top review was carried out by the clinical director and community manager for the psychosis service line and two members of the WCSRT who were providing care and treatment to Mr EF at the time of the incident.

6.36 The current Psychosis Service Line manager (Mr MN) argued strongly that this system allowed the service to have a rapid review and learn immediate lessons, and facilitated 'ownership' by the service and the team of the outcome and recommendations.

6.37 We felt that the system of having managers of the service in which the incident occurred conducting this desk top review left the Trust open to the perception that there could be a conflict of interest. We categorically did not consider that there was cause for concern in this case but consider that the current policy removes this possibility and is more clearly in line with the NHS England requirements. The authors of the internal report informed us that, at the time the desk top review was commissioned, the precise nature of the serious incident was not known to them in detail.

6.38 We did consider that the Board level panel inquiry could have focussed more comprehensively on clinical risk assessment, and reviewed the clinical risk assessment policy.

6.39 We agree with the panel that a key weakness in the service provided to Mr EF was the allocation of a student social worker. The panel made relevant and appropriate recommendations about supervision of trainees, training of care coordinators and involvement of qualified professionals within the community team once a patient goes missing from a ward.

6.40 However, we would prefer the Trust ensure that it follows its own clinical risk assessment policy, which clearly states that 'the CPA care coordinator must be a professional qualified staff member and have appropriate training for the role'. This statement appears in the version of the clinical risk assessment policy current in 2014 and in the version reviewed in 2015. The requirement for a qualified professional to be a care coordinator does not however appear in the CPA policy.

6.41 We reviewed the Code of Practice which was in force in April 2014. This confirmed that the medical recommendations for detention made on 12/13 April 2014 would have remained valid for 14 days[59]. In order to activate those recommendations within that period, a new application would have been required. After Mr EF was admitted as an informal patient on 12/13 April 2014 the AMPH uploaded her report onto RiO and left. The Code adds that compulsory detention should be considered if there is a 'strong likelihood' that the person will have a change of mind about informal admission, with 'a resulting risk to their health or safety or to the safety of other people'[60].

6.42 The Code of Practice also states that:

> "Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues where appropriate, e.g. where an application for admission is not

[59] Department of Health (2008) Code of Practice Mental Health Act 1983, paragraph 4.87, replicated in the Code of Practice updated in 2015, paragraph 14.87)
[60] Department of Health (2008) Code of Practice Mental Health Act 1983, paragraph 4.11, repeated in the Code of Practice updated in 2015 paragraph 14.16.

immediately necessary but might be in the future. This information will need to be available at short notice at any time of the day or night"[61].

6.43 In the light of this statement, we consider that medical recommendations should have been uploaded on to RiO when Mr EF agreed to be admitted informally, so that both in-patient wards and the WCSRT would have had immediate access to medical assessments as well as the AMHP's report. This was a recommendation of the Board level panel inquiry report.

6.44 The AMHP's report was added to the electronic record. If it became necessary to review Mr EF's informal status, a new AMHP assessment would be required and could have led to him being detained without the need for further medical assessments (within the 14 day period). Whilst the AMHP told him she would reconsider his informal status should he not conform, the opportunity did not arise as he went missing.

6.45 We were surprised on first reading to see that it was considered necessary to recommend that all professional staff working in psychosis line service should need training in the symptoms of psychosis in order to provide correct management. We recognise that students and trainees might need such training at the beginning of placements, but not for all staff. We understood from interviews that the service felt that the focus should be more on identifying the nuances of complex presentations of psychosis, with other conditions such as substance abuse, rather than being able to identify symptoms. It was also noted that health and social care professionals need to be constantly updating their knowledge, skills and competence.

6.46 We thought that the Board level inquiry report could have commented on the fact that there was no assessment of Mr EF's risk of leaving the ward, given his history of non-engagement with services and two previous instances when he had left a ward without notifying staff (although returning on the same day of his own initiative).

6.47 We felt that the report could have considered whether or not it would have been appropriate to refer Mr EF to substance misuse services.

6.48 Finally, we noted that not all staff who had been involved in Mr EF's care and treatment and who had been interviewed for the inquiry had been provided with a copy of the report. One AMHP and one doctor told us that they had not seen a copy of the report. We were surprised that this had not happened, and would expect the Trust to ensure that all staff involved in an inquiry automatically receive a copy of the report.

[61] Department of Health (2008) Code of Practice Mental Health Act 1983, paragraph 4.85, repeated in the Code of Practice updated in 2015, paragraph 14.107

The action plan and its implementation

6.49 As noted above, the Board level panel inquiry made 13 recommendations. These were all converted into an action plan, with the addition of actions relating to the 'Duty of Candour'[62] and learning from the incident. We considered that the action points appropriately reflected the recommendations.

6.50 We asked the Trust to provide documentary evidence of implementation of action plans. We reviewed this evidence and evaluated implementation of the plans using an adaptation of the NHS Litigation Authority model. This uses three levels of assessment of risk and the principles applied to each level were applied to the implementation of action plans. These are:

- 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 organisation.

6.51 The table below lists the recommendations and actions, describes the evidence provided and our judgement as to the level of implementation achieved. This shows that no evidence of changes in practice was provided/ We would expect that implementation of the action plan would be monitored by relevant Clinical Commissioning Groups

[62] The legal requirement to inform families and carers when things go wrong in the care and treatment of a patient/service user which is provided by or funded by the NHS.

Recommendations	Action taken in response to recommendations	Comments / Evidence of implementation	Level of implementation
Sharing Report with family following incident where possible	Patient Safety to send report to family with an offer of a meeting with service line to discuss report findings	Completed	Level 1
Report and action points to be discussed in team clinical governance meeting	Discussion in clinical governance meeting, evidenced by minutes	Minutes identifying discussion provided	Level 1
The rationale for any non-implementation of medical recommendations must be fully recorded by the AMHP in the form that is provided In addition any disagreement and rationale for the action taken must be fully recorded by the assessing doctor in his summary of the assessment in RiO.	Assurance to be provided that the rationale for non-implementation of medical recommendations	Verbal feedback – medical director has been asked to issue a reminder of this standard to Medical colleagues. AMHP lead and MH lead for Adult Social Care has discussed the standards in the AMHP forum and the form that AMHPs use to record outcomes of assessments has been up-dated.	Level 1
The existence of completed (and reusable) medical recommendations makes the process of making an application for detention easier, should a decision be made by staff that a MHA assessment is necessary. Therefore in future, where Trust staff feel that unused medical recommendations might need to be used in the near future, they must ensure that they are brought to the attention of the MHA Office (and uploaded onto RiO) for ease of access.	MHA Department, medical practitioners informed.	E-mail evidence attached from MHA dept. .	Level 1
When allocating cases to students, the issue of service user non-engagement should be thoroughly considered and dependent on the service user's history, consideration should be given to the allocation of the case to a permanent member of the team so that there is better long term opportunity to address the issue of non-engagement, and thus facilitate the building of stronger therapeutic relationships, with both the service user, and (with their permission), their family members.	In house – Borough or Trust-wide.	Additional document written for Middlesex University BA and MA Social Work Students on placements within statutory Mental Health Settings This has been distributed to all practice assessors and for implementation.	Level 1
A further review should be made by senior staff within the WCSRT regarding the	Barnet Community Service Manger to audit next Student placement –	An audit tool has been created to evaluate the standards of	Level 1

supervision arrangements for social work students to ensure that supervision is taking place as planned, and that it is being recorded in line with the requirements of the Trust's policy on Supervision and the requirements of Middlesex University. Following this review a report based on the findings should be sent to the Director of Nursing Quality and Governance and the Service Director for their attention and once approved, for the Borough Team to take forward.	creating standardised audit tool.	supervision being provided for student social workers. This will be utilised for all student placements and an end of year summary completed for review by the Trust's Assistant Clinical Director, the Community Services Manager and the Social Care Lead for Mental Health.	
When a case is allocated to a student social worker (or student nurse) the supervisor of the student social worker (or nurse) must conduct a direct observation meeting with the service user and the allocated care coordinator in <u>all</u> allocated cases.	University placement book and communication with all team managers. Local addendum	Additional document written for Middlesex University BA and MA Social Work Students on placements within statutory Mental Health Settings This has been distributed to all practice assessors and for implementation.	Level 1
When a student social worker first meets with a member of the service user's family, the student social worker must be accompanied by a professional member of staff from the team, to ensure that correct information sharing parameters are followed.	The need to work to this standard to be agreed, shared and implemented.	Additional document written for Middlesex University BA and MA Social Work Students on placements within statutory Mental Health Settings This has been distributed to all practice assessors and for implementation.	Level 1
If a patient absconds from hospital, in addition to advising the patient's care coordinator (as appears to have happened in this case) the Team Manager must be made fully aware as soon as possible so that opportunity can be provided for a discussion of the case, including discussion of a possible referral to the Crisis and Home Treatment team, prior to any home visit being undertaken. If the service user's care coordinator is a student, part of the discussion will include a review as to who should undertake or accompany the student(s) on the visit, based on a full review of risk.		Standards for supervision have been confirmed and additional focus on the content of supervision – targeting discussions regarding how to best manage service users who are difficult to engage.	Level 1
All visits to service users / clients that are made by student social workers must be fully		Additional document written for Middlesex University BA and MA	Level 1.

documented on RiO. If the visit follows the report of an important issue, such as in this case an absconsion from the ward following a MHA assessment, the record of the visit must include the name of the professional member of staff with whom the visit was discussed, prior to the visit being made. The outcome of that discussion and the outcome of the visit must be documented.		Social Work Students on placements within statutory Mental Health Settings This has been distributed to all practice assessors and for implementation.	
The team should be reminded of the importance of maintaining accurate and up to date documentation. If an action is planned by a member(s) of the team and does not occur, the reason for this should be recorded in the notes, with the next required action or follow up action indicated.		End of year memo completed and issued.	Level 1
The team should review its practice for difficult to engage clients and review their criteria as to when such cases should be escalated and brought to senior management attention. The criteria should include those cases where a service user is admitted into hospital, and then absconds. In these cases senior management should be included in the review and such cases should be allocated to a professional member of staff.		Memo sent to team managers.	Level 1
The Panel has recommended that based on the findings of this case a joint training event in Psychosis is held for all clinicians/ senior managers/ professional staff and trainees within the Barnet CSRT to ensure that all the professional staff (clinicians, community mental health nurses and social workers) can correctly identify possible symptoms and vital signs to make assessments and to provide correct management. The training event to be rolled out to all CSRTs within the Trust. A synopsis of the training to be included as part of the six monthly induction (and pack) for junior doctors.		Opportunities for training of CMHT staff are being considered with the Head of the training department and with colleagues in the forensic services. The training to-date has not been agreed or rolled out. Target date for agreeing methodology of training is as follows.	In progress
The Panel has recommended that the Trust's CPA Policy is provided to all students within the CSRTs on induction and that		Additional document written for Middlesex University BA and MA Social Work Students	Level 1

the requirements of this policy, particularly the role and responsibilities of the care coordinator, is explained to them and carefully monitored in supervision		on placements within statutory Mental Health Settings This has been distributed to all practice assessors and for implementation.	
Senior Managers within the Psychosis Service Line to be reminded that whenever there is an incident the Trust's Serious Incidents Policy must be followed to ensure that all professionals involved in the case are properly supported.		End of year memo circulated.	Level 1

6.52 We have assessed the implementation of all actions at Level 1. This means that advice and guidance has been issued, new standards have been incorporated into documentation. We would recommend that the Trust audits the application of the guidance and these standards and makes any changes indicated by the results of these audits, to ensure that learning and improvement is embedded into practice, standards and procedures.

Recommendation. We recommend that the Trust reviews and monitors the implementation of these actions and, where appropriate, looks to moving the implementation to Level 3.

7. Predictability and Preventability

7.1 We regard 'predictability' as 'the quality of being thought likely to happen, as behaviour or an event'[63]. Our examination of risk assessments acknowledges that these assessments involve someone estimating a probability. If a homicide is thought to have been predictable it means that, at the time of the event, 'the probability was high enough to expect intervention or action by professional practitioners to attempt to avoid it'[64].

7.2 We regard 'prevention' as meaning to stop or hinder something from happening especially by advance planning or action. This involves reviewing the process of care delivery to identify any missed opportunities which, if action had been taken, might have resulted in a different outcome. Therefore, for a homicide to be considered preventable, there would have to have been the knowledge, legal means and the opportunity to stop the event from happening[65].

7.3 Had Mr EF been sectioned on admission to Dorset ward and later when transferred to Sussex ward, we do not consider that it would have prevented him scaling the fence and running away. If this had been the case, he would have been 'Absent without Leave' and could have been returned to the ward

[63] definition of predictability
[64] Munroe E, Rumgay J. (2000) 'Role of risk assessment in reducing homicides by people with mental illness' The British Journal of Psychiatry, 176 pp 116-120,
[65] Munroe E, Rumgay J. (2000) as above.

against his will. The opportunity for him to be assessed by a team of qualified professionals on 15 April 2014 was not taken and had it have been done with particular reference to his risk history, the barriers to further risk within the service would have likely increased. However, we do not conclude, on the basis of the evidence available to us, that this homicide was either predictable or preventable.

7.4 Whilst he did have a history of violence, this was not so serious as that displayed in the homicide. On being sentenced for the offence, the court heard from the judge that the expert medical evidence he had received had commented on the relative rarity of Mr EF's condition to manifest in such serious violence.

7.5 In similar cases, evidence shows that signs in common with the following factors could be recognised in the case of Mr EF:

- cannabis;
- alcohol; and
- propensity to violence.

7.6 But there was no specific single indicator that would have predicted his serious and extreme violence in April 2014. That degree of violence was not comparable to his previous history.

8. Overall analysis and conclusions

8.1 In this section we consider the issues raised and bring together our conclusions as to what we consider to be contributory factors, root causes and examples of good practice.

Contributory factors

8.2 We identified a number of contributory factors – that is, 'Influencing or causal factors that contributed to the incident'[66]. We do not intend to imply that the Trust contributed to the homicide – Mr EF alone committed the crime.

Patient factors

8.3 The broad spectrum of mental health and substance misuse problems that Mr EF experienced, concurrently with his mental illness. The evidence shows that:

"Significantly poor clinical outcomes are expected amongst psychiatric clients who also misuse substances"[67].

8.4 In combination with the above, Mr EF's reluctance to engage with staff, non-compliance with prescribed medication, homelessness/unstable housing and transient lifestyle added to the difficulties facing services trying to meet his complex needs.

[66] Content from NPSA material, definition of contributory factors
[67] Department of Health, 2002, 'Dual diagnosis good practice guide: Mental health policy implementation guidance'

Task factors

8.5 The limited risk information available to the AMHP when assessing Mr EF under the MHA 1983, as amended in 2007, on 13 April 2014, contributing to the decision to admit Mr EF informally. As Mr EF was an informal patient the police were unable to return him to the ward without his agreement.

8.6 We felt that the ease with which Mr EF had been able to go missing from Sussex ward over the fence was a contributory factor, despite the efforts of staff to persuade him to return to the ward. We note that the height of the fence has been raised since this incident.

8.7 Mr EF's departure from the ward so soon after admission precluded an in-depth assessment of his care and treatment needs. It also presented as a missed opportunity for more intensive treatment. This would have included adherence to medication.

8.8 We considered that the inadequate application of the CPA in Mr EF's case contributed to the events that led up to the offences. This framework is designed to provide detailed provision to service users such as Mr EF. The weakness of professional supervision and the deployment of a student who had an inadequate understanding of his role did not address increasing clinical risks and the need for coordinated care and treatment.

8.9 Whilst we fully agree with the principle of 'least restrictive alternative' when assessing a person for detention under the Mental Health Act 1983, as amended in 2007, we would also stress the qualifying clause in the current Code of Practice, where it is clear that the 'least restrictive alternative' should be used where it is 'safe and legal to do so'. Given the limited information about risk and Mr EF's known history of non-engagement, non-compliance with medication and substance misuse, we suggest that in future the issues of 'least restrictive alternative' should be balanced with consideration of safety.

8.10 We considered the opinion expressed that Mr EF's forensic history represented a relatively minor risk in light of the culture of the area where carrying knives was perceived to be a common occurrence. We recognise that there can be a culture of people carrying knives for protection and defence. However, in this case, Mr EF self-reported that he carried knives and had knives and, at one time, a machete in his home. He explicitly linked this to his psychotic symptoms and delusional fears that people in the community were a danger to him.

Root causes

8.11 As expected, we have not concluded that there was a single root cause for these offences. We have concluded that a combination of Mr EF's complex presentation – mental illness, substance misuse, non-engagement, non-compliance with medication, homelessness and movement around North London - weaknesses in risk assessment, deployment of a student as care coordinator, pressures on services, and

lack of input to reduce his substance misuse combined to create a 'root cause'.

Good practice

8.12 We agree with the items identified by the internal report as good practice. In addition we would add:

1. The clear written communication between Barnet mental health services and the GPs in a health centre in the period 2006 to 2007.

2. Advice given to Mr EF by his primary care practice that he was to make an appointment before a prescription was issued and the instructions regarding taking his medication and information who to contact if his symptoms worsened was good practice.

3 Sussex ward invited Mr EF's GP to the CPA/professionals meeting was good practice, although Mr EF had left the ward prior to the date set for the meeting.

4 We note the occupational therapy assessment carried out on 12 May 2005 was detailed and comprehensive, carried out be a student and a senior OT and signed by both.

9. Recommendations

9.1 We are conscious that trusts are responding to recommendations for changes from a number of sources, and that this can become counter-productive. We are aware that regulatory authorities have already made recommendations for the Trust to address, so were open to enter into a dialogue with the Trust. We have not replicated recommendations made by the internal report, but have added a limited number of further recommendations.

Recommendation 1: Although we recognise that the capital implications and future plans for the site must be taken into account, we recommend that, in conjunction with its commissioners the Trust takes urgent steps to ensure that all admission wards are gender specific or, at a minimum, to create gender-specific bedroom and functional areas within mixed-sex wards.

Recommendation 2: The Trust ensures that equipment that is currently free-standing (bench, basketball hoop) in the garden area of the ward from which Mr EF went missing is fixed to the floor. The aim is to put barriers in place, recognising that a recreational area can be high risk

Recommendation 3: The Trust undertakes a detailed and comprehensive audit of the safety and security of the Sussex ward.

Recommendation 4: The Trust should ensure that all service users with psychosis who misuse alcohol and/or illicit substances are considered for referral to substance misuse services. If the decision is to not make a referral, the rationale for the decision should be recorded.

Recommendation 5: Commissioners and the Trust consider working together to devise a more innovative, assertive outreach type of service for those service users who do not organise their lives by diaries and appointments and who move readily and frequently between organisational boundaries. Such services would be more flexible in going to service users where they are and remaining open to service users who move across team or service boundaries within the Trust.

Recommendation 6: The Trust should follow the clinical risk assessment policy and deploy qualified staff to the CPA care coordinator role. If, in exceptional circumstances, a student is considered appropriate for the role, arrangements for role preparation (understanding of the role and appropriate training) should be made with the university programme head and include monitoring by appointed external examiners to the course.

Recommendation 7: The Trust moves towards the development of a more personalised approach to risk assessment, which is individual to each patient, assesses current risk factors and past history and includes a management plan that follows on from the risk assessment. In the meantime, we recommend that the current training on risk assessment and guidance on the use of the existing tool is strengthened.

Recommendation 8: The Trust should revise the CPA policy in order to ensure that the status of care coordinators is consistent with the clinical risk assessment policy.

Recommendation 9: In future instances of homicide by a service user in contact with mental health services, and where practicable, the Trust should offer professional support to meet any mental health needs arising from the incident and should signpost families to help with any other needs arising from the incident, such as financial costs. If the victim is unknown to the Trust, a senior manager should approach the police victim liaison officer to offer assistance to victim's relatives and put them in touch with the Trust if support is requested.

Core Terms of Reference for Independent Investigations under HSG (94) 27

Individual Terms of Reference will be developed in collaboration with the successful Offeror for each individual investigation. However, the following generic terms of reference will apply to each investigation:

Purpose of Investigation

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

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the findings if relevant from any additional report such as Domestic Homicide Review (DHR) and the Trusts progress in implementing any recommendations.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

- Consider if this incident was either predictable or preventable.

- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.

- Assist NHS England in undertaking a post investigation evaluation.

Outputs

- A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care

- A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome

- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed)

- Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference

- Independent panel to involve police (including Family Liaison Officers) within the review process

- At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation

- A concise and easy to follow presentation for families

- A final presentation of the investigation to NHS England, Clinical Commissioning Groups, provider Board and to staff involved in the incident as required

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

- We will require monthly updates and where required, these to be shared with families

Timescale

The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter.

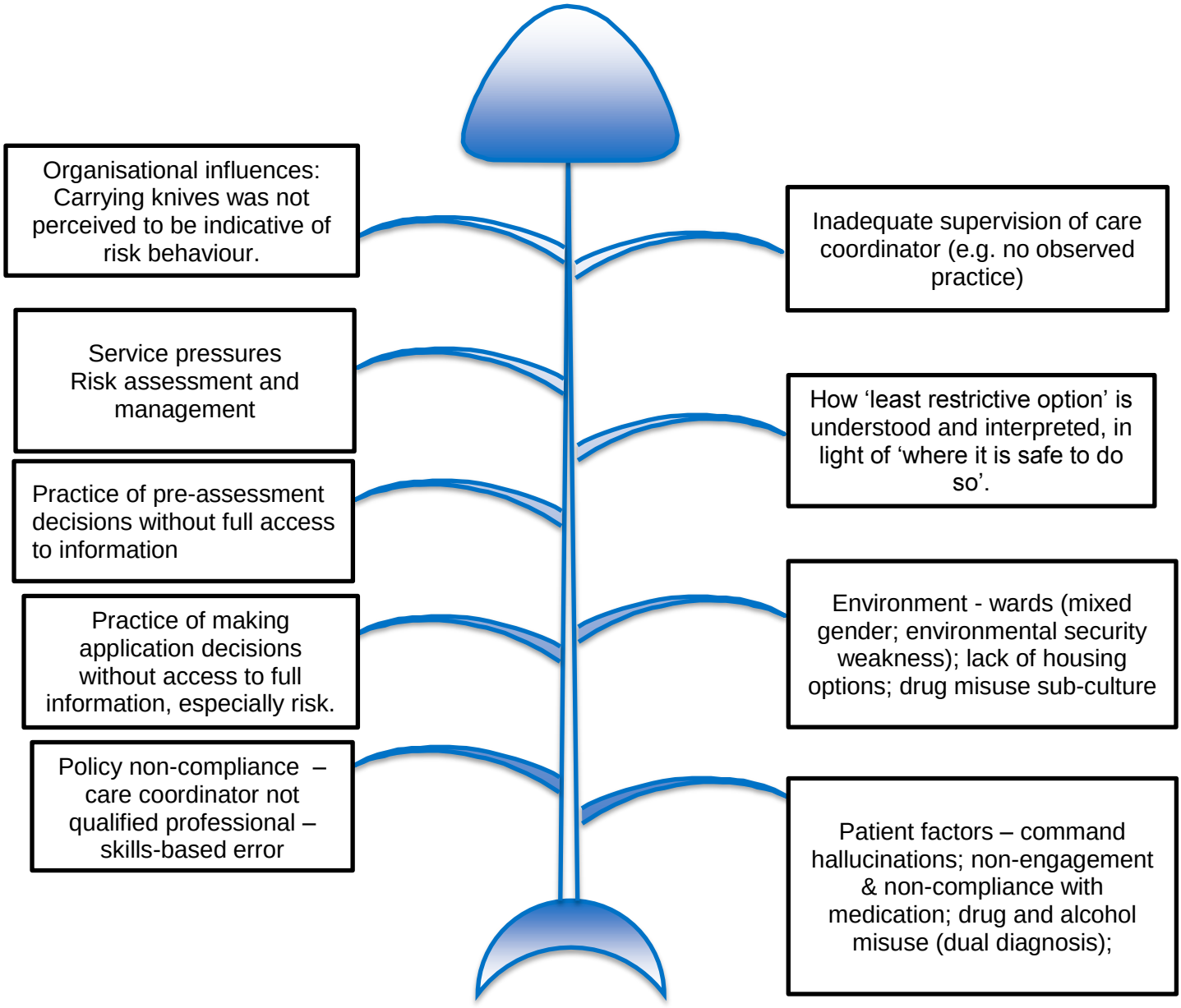
If an extension is required this will need to be submitted to Patient Safety Lead for Mental Health (NHS England, London) and formally endorsed by the Chair of the London Independent Investigations Review Group.

Specific Terms of Reference for Independent Investigation into the Care and Treatment of Mr EF (Ref: 2014/17458) by Barnet, Enfield and Haringey Mental Health NHS Trust

- To explore the clinical decision making and risk assessments specifically relating to risk to others
- To review Mr EF's substance misuse and management plans
- To review the effectiveness of the Trusts management of patients deemed difficult to engage
- To establish how Mr EF managed to abscond from the inpatient facility on the 14 April 2014
- To establish if the egress meets regulatory requirements
- To understand if the instability of Mr EF's living arrangements had an impact on his care planning and understanding of risks

Appendix B – Fishbone

The fishbone diagram shows the contributory factors which we identified in our review of Mr EF's care and treatment.



Appendix C – Members of the Investigation Team

Investigation Chairman and Lead Investigator Mr Anthony R Thompson – Tony offers wide experience to the undertaking of sensitive and high profile SUI investigations. His career spans over 40 years working within public services. This includes H.M. Forces and regulatory /statutory body senior positions held at a national level. A mental health nurse background with subsequent Director posts within mental health services, high secure care, higher education, non-profit organisations and the independent health sector. Tony is an experienced and trained independent investigator he has undertaken numerous sensitive and high profile investigations of SUI within the NHS. He is commissioned as an expert by several legal firms. Post retirement from the NHS he currently holds the following roles:

- Senior Associate of Caring Solutions (UK) Ltd.;
- Director Bridge R&D Ltd;
- Organisational consultant to Roefield and Debdale Specialist Care Ltd;
- Visiting hospital manager (MHA) to P.I.C. Ltd;
- Visiting hospital manager to J. Munroe hospitals group; and
- Independent CAMHS services (NorthWest) R.I (Ofsted and CQC).

Tony is an author, editor and reviewer of standard professional textbooks and journals. He is an international conference speaker within the fields of mental health, learning disabilities and social policy.

Qualifications held include: F. Inst LM.MA.B. Ed (Hons).RMN. RNLD.DN. (Lond). Cert Ed.

His current international work is alongside his Bridge R&D Co Director Dr P. Mathias, on a European project concerning Mental Health and Substance Misuse (dual diagnosis).This is the Erasmus + programme entitled “InTICgration “.This five country programme is assisting agencies to develop the integration of ICT in the educational processes of persons with dual diagnosis. His particular emphasis is on treatment adherence and socialisation in marginalised groups. Two NHS Trusts are assisting with focus group work alongside researchers from J.M. University Liverpool.

Ms Maggie Clifton, MA, MCMI, Investigations Manager. Maggie Clifton has managed and contributed to a number of Independent Investigation Panels and to the review and audit of internal and independent SUI investigation reports. She trained and worked as social scientist, specialising in qualitative research including interviewing, documentary and transcript analysis and report-writing, in health and social policy related areas. She is also a qualified general manager with extensive experience in the voluntary sector of managing services for homeless people and for people with long-term mental health problems. She is currently an independent research and management consultant, specialising in quality assurance, mental health service development, and training and development for managers. As an independent

management consultant she has worked on projects for the Department of Health, Royal College of Nursing, Primary Care Trusts, Universities of Liverpool and Lancaster. She is currently a Senior Associate and Investigations Manager for Caring Solutions (UK) Ltd and Director of Quality Assurance for The Development Partnership and British School of Coaching. She is trained in advanced investigation skills and in the use of the European Foundation for Quality Management Excellence Model.

Dr Michael Rosenberg was previously the Consultant Psychiatrist, Inpatient Triage, South Downs Health NHS Trust (a new post involving the assessment and care of newly admitted patients for the first seven days of their care episode). Between 2003 – 2006 he was the Chief Executive and Honorary Consultant Psychiatrist South Downs Health NHS Trust; a Trust where he had previously been the Medical Director between 1998 – 2003. He was responsible for the Psychiatric Intensive Care Unit at Mill View Hospital from 1999 to 2005 (a modern 10-bedded unit caring for acutely mentally ill patients, requiring short-term intensive treatment). He is approved under Section 12(2) of the Mental Health Act 1983, as amended in 2007. He has extensive experience of the investigation of critical incidents and advised on the management of complaints. He was the lead Director for the Trust Patients' Advisory Forum and responsible for developing the Trust's Strategy for Patient and Public Involvement. He has completed a large number of external reviews into services including independent homicide investigations on behalf of Caring Solutions (UK) Ltd.

Appendix D – Chronology

Date/Time	Event, Event description, action and outcome	Comments	Source
1/09/2004	Seen by a counsellor/therapist at Practice 1, having been referred by his GP. Referred back to GP because of need for drug rehabilitation and social work support to find accommodation.		Trust records
05/10/2004	Letter from youth worker to Mr EF's GP requesting help for mental problems.		Trust records
12/10/2004	GP referral to Barnet CRHTT, assessment process was abandoned when he left the building. Police, GP and a duty Approved Social Worker (ASW)[68] were informed.	Good practice – multi-agency communication	Trust records
14/10/2004	Further assessment by CRHTT. Brief risk assessment completed. Historic and current risk of violence was 'high'; current 'medium' to 'high' risk for substance misuse. Despite these risk elements, Mr EF was not accepted onto the team, he was given self-help advice and referred back to team.	Risk assessment somewhat inadequate. Brief risk assessments are summaries and at as prompts. The assessor should then examine risks in greater depth. For example the context of any prior violence.	Trust records
Intervening period	Mr EF continued to present with recurring bizarre episodes and negative symptoms of psychosis.		Trust records
10/03/2005	GP referral to CRHHT, the GP thought Mr EF might be schizophrenic and requested an assessment as soon as possible. Mr EF assessed by consultant and asked CRHTT to remain involved.		Trust records
22/03/2005	Barnet CRHTT carried out a more detailed assessment of Mr EF identifying a current and historical medium risk of aggression/violence to his family; command hallucinations and paranoia identified as warning signs. Mr EF accepted by CRHTT.		Trust records
23/03/2005	Home visit by CRHTT: Mr EF accepted informal admission to the DSU and was admitted on either 23 or 25 March 2005 and discharged from the CMHT on 25/03/2005.	The records here are inconsistent – hospital discharge letter has him admitted on 23/03/2005; CMHT discharge say he was admitted on 25/03/2005. Either the ward or the CMHT were inaccurate in the discharge letter, it is not known which is correct.	Trust records

[68] The same role as the AMHP, under the Mental Health Act 1983 prior to the revision of 2007.

24/03/2005 (date record entered)	3 or 4 unsuccessful visits to Mr EF's B&B accommodation were undertaken by the CRHTT.	Example of 'patient factors'.	Trust records
24/03/2005 (date record entered)	A few days later housing worker took Mr EF to the CRHTT office, Mr EF very guarded and evasive, referred for admission to DSU[69], Edgware. Mr EF assessed as a possible danger to the community, and the command hallucinations might cause Mr EF to fight, hurt or 'even kill' people in the community.	Referral quite clear as to the assessed potential for risk	Trust records
17/05/2005	CPA meeting arranged by his care coordinator. Sections of the record incomplete: • no identified relapse indicators • not signed by Mr EF • no copy given to Mr EF.	Records incomplete	Trust records
20/07/2005	CPA meeting planned, invitation letter sent, no record of any outcome of this meeting.	Records incomplete	Trust records
31/08/2005	CPA health and social care plan designed prior to discharge on that day. Plan included: • accommodation at Nether House (Baytree Care Ltd), staff to monitor medication; • fortnightly visits for care coordinator; • out-patient appointments; Relapse indicators and contingency plans clearly recorded. A review date 'to be arranged'.	Communication with GP – detailed discharge letter.	Trust records
Intervening period	Plan continued in place, to CPA meeting.		Trust records
21/11/2005	CPA meeting. Noted that: • Mr EF had not been taking his medication on occasions; • he had not been attending a gardening project • he was using cannabis intermittently under pressure from friends. (see paragraph 8.3) Plan: to review in three months' time.	Examples of 'patient factors' Example of 'drug subculture' as contributory factor.	Trust records

[69] Dennis Scott Unit.

03/04/2006	CPA meeting held, all key staff attended including his consultant, including staff from Nether House. Mr EF had been advised to attend but did not. Noted that: • alcohol had been removed from his room; • Nether House management had concerns he might be using illicit drugs, but had no concrete evidence; • Mr EF had been absent from the home up to two nights a week; • in previous weeks, Mr EF had been staying with a girlfriend who had a baby; • Mr EF had been attempting to sneak this friend and her baby into Nether House; • Mr EF appeared to be taking his medication. Plan: Mr EF to remain at Nether House (because he was taking his medication); a further review in 3 months' time.		Trust records
30/05/2006	Mr EF's mental state and behaviour had deteriorated; Nether House manager informed Ms LB that an eviction notice was imminent. A serious of incidents broke the house rules, including: • use of illegal substances and alcohol; • lack of engagement in planned activities; • encouraging late night visitors; • an aggressive incident. This altercation was verbal but was felt to be escalating into something more serious. Baytree Care Ltd felt that staff and other residents' safety was being put at risk, and that they could not provide the required support.	Examples of patient factors.	Trust records.
In the next four months.	Mr EF received multiple requests to vacate his room.		Trust records
12/06/2006	Review by consultant, (Dr EH). Mr EF had been served with notice of eviction from Nether House; Mr EF would not take his medication as a depot[70]. Social worker had been unable to find alternative accommodation because of the substance abuse, the option of finding housing with a floating support worker was still being pursued. No further appointments were made, Dr EH would see Mr EF again if the social worker requested this.	Lack of housing options available to Mr EF.	Trust records

[70] Medication given by injection at regular intervals, so that non-compliance is not an issue.

15/12/2006	CPA meeting, Mr EF attended reluctantly, avoiding eye contact. His anxiety was raised as cannabis had been found in his room and he was awaiting news of possible charges. This caused difficulties in assessing mental illness symptoms but Mr EF was hearing voices. The SHO[71] felt that Mr EF's psychotic experience was likely to affect his functioning. Plan: to find alternative accommodation with 'floating support'. Advice was given about the association of psychosis and cannabis use.		Trust records
Early/09/ 2007	Mr EF being supported by the CRHTT and still living in supported accommodation. Mr EF did not engage with the CRHTT despite several attempts to contact him.		RiO[72]
14/09/2007	Mr EF was discharged by the CRHTT; he was referred to the CMHT, GP informed and sent summary of the CRHTT's attempts to engage with him.	Example of good practice – communications with GP	RiO
17/09/2007	Letter from CMHT to GP, service to continue to monitor regularly, so long as he stays at Nether House. Staff at his accommodation advised to contact police if they felt to be at risk. Mr EF described as a vulnerable adult and at risk of harm from others.		RiO
26/10/2007	Care coordinator visited Nether House (Mr EF was still living there), he was not in. Staff informed her Mr EF was doing well and taking medication.		RiO
2/11/2007	Mr EF could not be located, he had failed to attend an appointment with a housing service, despite him knowing about the notice of eviction.		RiO
19/12/2007	Mr EF reported to be experiencing auditory and visual hallucinations and was not taking his medication. He agreed to see the CRHTT and start taking his medication.		RiO
Intervening period	Mr EF missed most of the home visits.		RiO
2/01/2008	Mr EF's medication increased to 10 mg (minimum therapeutic dose).		RiO
08/01/2008	Nether House staff agreed to supervise the medication.		RiO
25/03/2008	CMHT attempted to refer Mr EF to the Homeless Person's Unit, but he did not provide the information required to process the application.		RiO

[71] Senior House Officer, a trainee psychiatrist
[72] The Trust's electronic patient record system

26/03/2008	Temporary housing was offered to Mr EF but he did not like the place and did not accept the offer. Mr EF was still living at Nether House. He was informed the locks would be changed and allow him back only to collect his belongings.	Limited housing options.	RiO
22/04/2008	CRHTT team meeting: decision to discharge Mr EF back to his GP. Rationale included: • lack of engagement with the team; • failure to attend appointments with housing agencies; • not taking his medication; • his mental state had not deteriorated Mr EF would be assessed again if the GP thought their service was necessary.	Patient factors – the non-engagement, non-compliance with medication.	RiO
22/04/2008 to 20/07/2010	No recorded contact by Mr EF with any mental health services.		RiO
20/07/2010	Mr EF telephone call to the EAC at Chase Farm Hospital. A social worker contacted Mr EF's friend, Mr X, who explained that Mr EF was homeless, not taking medication, had had surgery for a broken arm after being beaten up. Mr EF was staying with Mr X at Mr X's flat in Enfield. Mr X was advised that Mr EF should attend Chase Farm Hospital.		RiO
21/07/2010	Mr EF was reluctant to attend hospital but Mr X persuaded him to do so. Social worker informed the EAC that MR EF was on his way to the service.		RiO
21/07/2010 (later in am)	Mr X brought Mr EF to the EAC. Duty doctor recorded comprehensive account of Mr EF's presentation, with a preliminary diagnosis of a relapse of a psychotic illness. Care Plan: refer Mr EF to Enfield CMHT and Enfield EHTT to support him in the meantime.		RiO
27/07/2010	Enfield EHTT home visit, supervised Mr EF taking his medication. A urine sample proved positive for cannabis.		RiO
29/07/2010	Enfield EHTT accepted Mr EF (he received this service until January 2011). Attempts to reengage him with the Barnet CRHTT failed, because of his history of non-engagement.		RiO
During 2010	Mr EF presented to the Enfield EHHT and the Homeless Person's Support Unit with fluctuating mental states.		RiO

23/10/2010	Enfield EHTT visit, Mr EF reporting deterioration in his mental state: • hearing voices; • feeling unsafe around others; • paranoid ideas; • not taking medication for 2 weeks; • isolated in his flat; Plan: a supply of medication; the HTT to ring Mr EF to remind him to see them with paperwork so they could assist him with his benefit claims.		RiO
26/10/2010	Enfield E HTT, Mr EF attended office. Low in mood limited eye contact, voices most of the time, tell him to kill himself, fears harm to self if goes out. Not taking medication, new prescription given. His life 'all messed up'. Not taking substances. To go to office following day for help with housing benefit form.		RiO
27/10/2010	Did not attend office. Visited and came in to office, Has no income at all.		RiO
28/10/2010	Attended office late. Given benefits advice. Applied for a received a crisis loan. Helped to complete benefits forms.		RiO
29/10/2010	Offered council accommodation which Mr EF accepted.		RiO
29/10/2010	Treatment planning meeting held. To continue to support Mr EF in his new accomoodation		RiO
4/11/2010	Tel call reminding Mr EF to come into office as agreed. Did not attend.		RiO
5/11/2010	Treatment planning meeting. If Mr EF remains in Barnet, he will need to be referred to Barnet for allocation of care coordinator and to register with a GP.		RiO
7/11/2010	3 telephone calls to Mr EF, no response, message left.		RiO
9/11/2010	2 tel calls, no answer, message left.		RiO
10/11/2010	Tel call, answered. Mr EF had no credit so could not pick up messages. No utilities at new accommodation, in cold and dark. To come to office following day.		RiO
11/11/2010	Mr EF went into office. Has support worker at his new accommodation, helping with benefits. Medication helping with voices, but still scared to go out, voices telling himto kill himself, walk under a bus. Keen to continue seeing the EHTT. To call Mr EF on 20/21 to arrange visit.		RiO
20/11/2010	Tel call to Mr EF, said he had been unwell, vomiting. Advised to go to A&E if continued.		RiO
21/11/2010	2 telephone calls to Mr EF, no reply, message left.		RiO

26/11/2010	Unannounced visit to Mr EF, no reply. Tel. call made, not answered. Treatment planning meeting. To confirm Mr EF's address and discharge/transfer him if in Barnet.		RiO
29/11/2010	Tel call to Mr EF, no reply, message left.		RiO
29/11/2010	Tel call housing support worker to confirm Mr EF's address. Reported that Mr EF seemed well. Plan – to arrange E HTT visit		
30/11/2010	Home visit, Mr EF not at home. Tel. message left.		RiO
1/12/2010	Letter sent to Mr EF, appointment to come to office on 8/12/2010.		
3/12/2010	Team meeting, Mr EF discussed, for imminent discharge.		RiO
8/12/2010	Mr EF did not attend (DNA) for appointment arranged by letter.		RiO
10/12/2010	Treatment planning meeting. Poor engagement; psychosis; medication; risks: Non-engagement; drug use; self-neglect when homeless.		
13/12/2010	Tel call to support worker (from Barnet Outreach) - he had been seeing Mr EF weekly, but this was to be reduced to every two weeks as his benefits and grant had been sorted out. Plan: a joint visit by the support worker and Enfield HTT on 17/12/2010. T/c to Barnet HTT about transfer of Mr EF.		RiO
14/12/2010	Mr EF rejected joint visit with EHTT and support worker – wanted to keep visits separate.		RiO
17/12/2010	Letter sent to Mr EF for meeting on 20/12/2010.		RiO
20/12/2010	Mr EF DNA appointment sent by letter.		RiO
21/12/2010	Unannounced home visit – no response.		RiO
22/12/2010	Support worker called E HTT, Mr EF not at home for his planned visit, out of character. Plan: Support worker has arranged to visit Mr EF on 5/01/2011; E HTT to visit Mr EF on same day.		RiO
24/12/2010	To contact the Barnet Primary Care Mental Health Team (PCMHT) and send discharge summary to them.		RiO
31/12/2010	Treatment planning meeting: stable in mental health, does not need HTT input.		RiO
5/01/2011	PCMHT unable to attend visit for transfer of care; to be rearranged. Staff delayed 10 mins in visit to Mr EF, not in when they arrived.		RiO
6/01/2011	Treatment planning meeting. Arrange to discharge Mr EF that day.		RiO

7/01/2011	Support worker had been unable to see Mr EF at home visit; to arrange further joint visit next week to effect transfer.		RiO
13/01/2011	Enfield West HTT held planning meeting. Mr EF had not engaged with team for several weeks. Attempts to transfer care to Barnet HTT failed as a result. Plan: to discharge Mr EF and refer him to the Barnet CMHT.		RiO
23/01/2011	Enfield HTT referred Mr EF to the Barnet PCMHT, Letter and HTT intervention summary sent to team manager.		RiO
31/01/2011	Barnet PCMHT decided to close Mr EF's case because of his history of non-engagement. The support worker had also reported no current concerns to the Barnet team manager.		RiO
Intervening period	No recorded psychiatric history between decision not to accept him onto the Barnet service on 31/01/2011 and contact from police on 11/06/2013.		RiO
11/06/2013	Mr EF arrested for smashing car windows and he was displaying bizarre behaviour. Police contacted Barnet CMHT to ask if he was known to the service.		RiO
11/06/2013	Mr EF was assessed under the MHA, by two Section 12 doctors and an AMHP. He was detained under Section 2 of the Act and admitted to the DSU. Noted that he last received a service from the Enfield West HTT in January 2011.		RiO
12/06/2013 02:22 11:11	Mr EF refused a physical examination. Ward review: detailed account of his recorded and self-reported psychiatric history. Hearing voices for a long time, possessed by the devil, denies intention to harm self or other. He recognises he is unwell. Accepted medication plan. He had been taking medication intermittently, including from his mother who was prescribed the same medication. Mr EF accepted a physical examination, which recorded no physical abnormalities.		RiO

14/06/2013	Mr EF's mother attended formulation meeting on ward, reported he had been mentally unwell for periods since 12/2012 and she had been giving him medication from his own supply. This was only sporadic. Mrs GG confirmed her son had been taking drugs and alcohol. She confirmed he had been acting on command voices and that this had been getting worse over time. Forensic history – 1 arrest for carrying a knife, 2011; 2012 arrested for carrying a knife, spent a week in prison. Acutely unwell.		RiO
26/06/2013	Mr EF was introduced to a new care coordinator (Ms TU), an agency social worker. There was an altercation with a peer on the ward, which appeared not to be Mr EF's fault. He requested a transfer to another ward.		RiO
30/06/2013	Mr EF was transferred to another ward.		RiO
7/07/2013	Mr EF became paranoid, threatening staff, abusive, accusing them of practising black magic. He was given tranquillising medication, remained disturbed but later settled.		RiO
8/07/2013	CPA meeting held. Attended by Mr EF, his mother and the care coordinator. Mr EF's mother felt that he was better, though not back to normal. Plan: give Mr EF 4 hours unescorted leave, Section 2 allowed to lapse; Mr EF to remain as an informal patient; gradually increase the home leave. Mr EF was advised to register with a GP.		RiO

12/07/2013	CPA Discharge Meeting (Trent Ward): meeting attended by Mr EF; his mother; Dr AS GP trainee; and staff nurse. Care previously discussed with his Consultant Psychiatrist (Trent Ward,) and Dr EH. Concluded that Mr EF was now ready for discharge. Mr EF advised meeting that he was feeling 'slightly down', his voices had gone and he did not feel suspicious of anyone. He felt his medication was working and he was experiencing no side effects. He agreed that he would speak to the HTT if he felt low or if his voices came back. His mother confirmed Mr EF was back to his normal self, his sleeping appeared poor, he was finding it difficult to manage. She was willing for him to return to her home. Plan: for him to be discharged tomorrow to his mother's house, under the care of the HHT.		RiO
13/07/2013	Mr EF discharged from ward and reminded of his court appearance (criminal damages to a car) and the need to attend Police Station. Night medication dispensed as directed.		RiO
14/07/2013	Home Treatment Team (HTT): Attended DSU – medication given. Reports still hears voices but no longer intrusive. Unable to distinguish their content. Plan: HTT to visit daily for next 2 – 3 days to supervise medication and monitor mental state, then to review frequency of visits.		RiO
15/07/2013	Home visit to Mother's house. Advised by Mother that Mr EF was not there, despite her having reminded him of the visit. Medication left with Mother.		RiO

16/07/2013	HTT: Home visit (12 noon): Mr EF reminded to attend Hendon Magistrates Court or a warrant would be issued for his arrest. Telephone contact made with Mr EF's Solicitor to inform her of meeting and of advice given. HTT: Multidisciplinary Team Meeting: Agreed to continue daily supervision of medication for next few days and then review frequency of contact with view to discharge to care coordinator, if all well. HTT: Home visit (evening): Advised by Mother that Mr EF was not at home. It was not known where he was. Mother informed Mr EF did not attend court hearing. Medication left with Mother who agreed to supervise.		RiO
17/ 07/2013	HTT: Telephone call to Mother was advised that Mr EF is registered with a GP. Phoned GP and informed that Mr EF is not on their system. Telephone message left with Mother advising her of this. Request made for Mr EF to go and register as soon as possible.		RiO
18/07/2013	Telephone call from Probation Service requesting written information from service regarding Mr EF's contact with mental health services; current care plan and frequency of visits – to aid recommendations to the court for him. HTT: PM visit: Mr EF seen. Mother upstairs but not seen. Mr EF receptive to visit and medication taken. Reports that he has to attend Court again in 2 weeks. HTT: Evening visit: Home visit. Mr EF seen. Medication given and mental state assessed. Mr EF reported a reduction in voices. Denied suicidal ideation, thoughts of harm to self or others. Reminded of need to register with GP and asked to advise HTT when registered.		RiO
19/07 2013	HTT: Home visit: Mr EF not at home. Medication left with sister. Advised sister of need for Mr EF to register with GP.		RiO

20/07/2013	HTT: Telephone call to Mother to obtain Mr EF's mobile phone number, which was given. Plan: home visit later, to leave 3 nights medication with mother.		RiO
21/07/2013	HTT: Home visit: Mr EF seen. Reported that he was making progress but finding it difficult to go out, worried that he might harm someone. Denied any ideas of harming other or of hearing any voices telling him to harm others. Medication taken. Depot suggested, declined. Reported eating and drinking well, no problems with sleep. Plan: left with 3 night's medication, to be seen as current plan. To liaise with care coordinator for a joint review.		RiO
22/07/2013	Administrative request made to HTT for Mr EF to be seen regarding sick note and Employment Support Allowance (ESA).		RiO
23/07/2013	HHT: Multidisciplinary Team Meeting: Mr EF discussed. HTT to contact Care coordinator tomorrow regarding arrangements for handover.		RiO
23/07/2013	HHT: Telephone call made to Mr EF who said he was not at home. Arrangements made to leave medication with his Mother. Visit to Mother's address. 6 days 'to take away' (TTAs) medication left (12 tablets) sick note and letter for ESA given.		RiO
24/07/2013	HTT: Handover visit with Ms TU (care coordinator) from WCSRT arranged for 29/07/2013 at home address. Home visit to Mother's home. Mother informed of handover meeting.		RiO
25/07/13	HTT: Home visit – no response. Telephone call made to Mr EF on his mobile phone – no response.		RiO
27/07/13	HTT: Home visit to mother's home. Mr EF seen. Advised that voices remain less intense. Mr EF reports that he is unable to hear what the voices are saying. Not reporting any thoughts of self-harm or harm to others. Advised of pending joint appointment on Monday with his care coordinator.		RiO

29/07/13:	HTT: Telephone call made to Mr EF to remind him of the hand over meeting today. Mr EF advised that he will be in Court (to submit papers). Meeting to be rearranged.		RiO
30/07/13	HTT: Home visits made am and pm. Mr EF not at home and his mobile telephone switched off. Mother seen and advised regarding handover meeting		RiO
31/07/13	HTT: Home visit – Mr EF seen. Appeared settled in mood and behaviour. Engaged will in conversation and maintained good eye contact. He reported that following court appearance he is not allowed to leave the UK for a couple of months. He reported still hearing voices but they are manageable and getting less. Compliant with his prescribed medication. Reminded of joint handover meeting tomorrow.		RiO
01/08/13	Joint visit: HTT & Ms TU (WCSRT): Seen at home. Mental state assessed. Plan to discharge today to WCSRT. Mr EF has 6 weeks medication, then to collect from his GP. Plan: Ms TU to arrange future medical reviews. Appointment made to see her at the Dennis Scott Unit (DSU) on 08/08/2013. Mr EF to complete forms for registering with GP. Ms TU to assist with application for benefits.		RiO
08/08/2013	DNA out-patient appointment with Ms TU – phone contact established.		RiO
14/08/2013	Mr EF was seen at home by Ms TU. Appeared calm and cooperative. His mood stable. Ms TU informed that he had registered with a GP – details given. Limited Capability for Work form completed. Assessment Summary and Treatment Summary completed by HTT sent to GP. Mr EF reminded to attend Police Station on 15/08/2013.		RiO
14/08/2013	Appointment with health care assistant for routine physical examination. Advice given about weight management and smoking cessation.		GP records

15/08/2013	Ms TU advised that a telephone call had been received from the Police regarding Mr EF's mental capacity at time of alleged offence (smashing car windows). Ms TU attempted to call Police back, but no response to number given. Mobile number left with message.		RiO
16/08/2013	Ms TU advised that a telephone call had been received from GP who advised that the GP practice had received a fax from the service, which was unclear regarding required medication. In a second telephone call GP advised that Mr EF had not been to the surgery to order his prescription and that the telephone number to contact Mr EF is not working. Telephone numbers given to GP by HTT, tested by Ms TU – none working.		RiO
19/08/2013	Telephone call made by Ms TU to Mr EF to remind him to collect his prescription. Telephone call also made to Mother to ask her to remind Mr EF about collecting his prescription.		RiO
20/08/2013	Mr EF attended GP surgery to collect prescription. No psychotic symptoms, no cannabis use. Living with mother.		GP records
21/08/2013	Seen at DSU by Ms TU – evidence of positive care re treatment monitoring; drug use monitoring. Mr EF advised that he had attended the Police Station on 15.08/2013. He was now registered with his GP/		RiO
22/08/2013	Record of 'fit notes' issued. Reports Mr EF agrees with mental health care plan, has seen psychiatrist and has social worker.		GP records
28/08/2013	Mr EF seen at DSU. Mr EF to appear in Court Tuesday 03/09/2013 for the damage to property offence (smashing car windows) . ESA benefit chased. Help requested for the replacement of his Freedom Pass. Mental state assessed, and was deemed to be stable. Mr EF denied use of illicit drugs. Completion of Carers Assessment checked, but Ms TU advised by Mr EF that his mother did not want to complete the form.		RiO

03/09/2013	DNA GP appointment, had not collected prescription. GP tried to call mobile, number not recognised. GP informed Ms TU.	Good practice – multi-agency communications	GP records
04/09/2013	DNA appointment Phone contact established. GP advised that Mr EF had not collected his medication. Letter sent to Mr EF advising him of next appointment when he would meet his new care coordinator, Mr PR, (trainee student social worker).		RiO
23/09/2013	Attempted telephone contact with Mr EF by Ms TU – Phone not answered. Message left for Mr EF to contact Ms TU to make new appointment.		RiO
25/09/2013	Attempted telephone contact with Mr EF by Ms TU – message left for him to contact.		RiO
01/10/2013 & 02/10/2013	GP made two attempts to contact Mr EF by telephone, no reply, messages left.	More examples of 'patient factors'	GP records
03/10/2013	Letter sent to Mr EF informing him of meeting at DSU on 16/10/2013 to review his mental health.		RiO
16/10/2013	Mr EF attended meeting at DSU – meeting observed by two social work students. Mr EF said he no longer had to attend court and that his case had been discharged. He would like to visit his sisters in America but is unable to do so as has criminal record. Referral to 'The Network' discussed with him. Service to be advised of his new mobile telephone number.		
04/11/2013	DNA appointment at DSU with Ms TU. Letter sent by her reminding him of meeting on 11.11/2013 to meet new care coordinator (Mr PR, student social worker) who is being supervised by Mr NO, Principal Practitioner for team.	Allocation of a student as social worker not compliant with clinical risk assessment policy.	RiO
11/11/2013	CPA Review with new coordinator Mr PR (student social worker) Mr EF advised that he is currently living at his mother's house as part of a Court Order until 29/11/13. Plan: Details of new mobile phone number to be provided by Mr EF Replacement of Freedom Pass to be pursued.	Inadequate supervision – no observed practice over 5-month period Mr PR was Mr EF's care coordinator to Mr EF.	RiO

14/10/2013	Mr EF late for GP appointment – prescription issued.		
01/11/2013	GP appointment - prescription issued		GP records
15/11/2013	GP appointment – medical review, 'fit note' issued. Records state that: • compliant with medication; • no psychotic symptoms; • no use of alcohol, cannabis or tobacco • living with his mother • maintaining good eye contact; • to continue with medication • advised who to contact if any problems – voices, mood, side effects – return to GP, contact Ms TU, out of hours service.		GP records
21/11/2013	Home visit by new care coordinator Mr PR. Mr EF advised that he was feeling depressed, said that his medication was helping him and that he did not need to see his doctor or his GP. He was not hearing voices and felt that 'life was unfair'. His reapplication for a Freedom Pass was discussed. Motivational techniques applied by Mr PR in an attempt to help Mr EF come to terms with his situation.		RiO
22/11/2013	Telephone call by Mr PR to Mr EF asking if required information (proof of address) for Freedom Pass could to be brought to DSU before Mr PR leaves the Unit to visit another client. Telephone call made by Mr PR to B&S College regarding details of course relating to 'start your own business' in which Mr EF had expressed some interest. Mr PR advised to call tutor. Message left. Telephone call made by care coordinator to Eclipse regarding possible Life Skills course. Information to be sent out when ready.		RiO
27/11/2013	Telephone call to Mr EF re proof of address. Mr EF stated that he would bring the information required to the DSU between 3pm – 4pm.		RiO

09/12/2013	Mr EF attended DSU for prearranged appointment. Difficult interview meeting as Mr EF very negative to all suggestions made by Mr PR. Angry that Freedom Pass had not yet arrived. Advised Mr PR that he did not wish to see a doctor. Mr PR notes from meeting that Mr EF may not be well, saying he has no friends, and his past friends have betrayed him, that he lacks confidence and self-esteem. He denied hearing voices. Recorded that he did not present as having obvious delusions. Plan: Appointment booked for him to see care coordinator on 15/01/14 at 2pm and will then encourage him again to see a doctor.		RiO
10/12/2013	Provisional appointment with doctor booked for 09/01/14 at 10am with Dr BD.		RiO
02/01/2014	Telephone call to Mr EF by Mr PR – no response.		RiO
09/01/2014	Medical Review by Dr BD. Diagnosis: Paranoid Schizophrenia. Mr EF stated that he was feeling depressed had low self-esteem. Denied having suicidal thoughts. Hearing his own voice in his head advising him not to go outside as somebody may kill him. Feels paranoid, scared of going out as 'somebody may follow me and kill me'. Denied having knife with him or keeping knife behind his bedroom door, as in the past. No thoughts of harming others. Has limited insight but agreed to continue with medication. Denied taking any drugs or alcohol. Plan: ongoing input from Mr PR.		RiO
16/01/2014	GP (telephone) consultation regarding repeat prescription request. Prescription issues, Mr EF given advice on how to take the medication, and to call his care coordinator or out of hours service if his symptoms deteriorated.	Good practice by GP.	GP records
17/01/2014	Mr EF arrived at DSU and asked to be seen – he had a query regarding his Freedom Pass, which was still being processed. Mr PR rebooked appointment Mr EF had missed on Wednesday for later in month.		RiO

04/02/2014	Telephone call by Mr PR to Mr EF re need to arrange appointment – no response to call.		RiO
06/02/2014	GP telephone consultation – repeat prescription requested. Prescription amended to monthly. Asked to make appointment for review as not been seen for some time.		GP records
17/02/2014	Telephone call by Mr PR to Mr EF re need to arrange appointment – no response to call.		RiO
19/02/2014	Telephone call by Mr PR to Mr EF re Freedom Pass – no response to call. Message left advising that Mr EF's proof of address had been lost. An apology was given and a request made for him to send the information again.		RiO
24/02/2014	Telephone call to Mr EF by Mr PR – message left.		RiO
04/03/2014	Telephone call to Mr EF by Mr PR – message left. Telephone call made to Mr EF's Mother to inquire about Mr EF's wellbeing. She informed Mr PR that she had spoken to her son the previous evening. She stated that sometimes he is less well, but believes he is taking his medication and that she see him quite a lot. Mother advised that she was content for Mr PR to visit her or Mr EF at her home or at his home 'should the need arise'. Advised that Mr EF stays at her home a lot, when she is not working.		RiO
05/03/2014	Telephone call to Mr EF's Mother – advised that Mr PR could call at her home at 10.30 as Mr EF maybe there and she will be home from work.		RiO
06/03/2014	Visit to Mother's house. No one in. Mr PR noticed that door had been 'punched in' 3 times – did not know when this had occurred as first time Mr PR had visited property.		RiO
17/03/2014	Telephone call to Mr EF by Mr PR – message left. Telephone call to Mother's home – message left.		RiO

20/03/2014	Mr EF arrived at DSU unexpectedly wearing large brimmed hat covering face – Mr PR saw him for one hour. Mr EF reported that: • he has not taken his medication since 1st March; • he felt scared to go out of the house, he was afraid he may be violent to somebody. Arranged for him to have a medical review. Discussed his strong negative feelings to others and how to control his feelings. Mr PR went with him to GP practice but they would not give him his medication as he needed to discuss this with the doctor first. Advised to call the doctor's surgery on Thursday before 12 noon to arrange to speak to his GP who will then call him back if he cannot speak to him immediately. Arranged to call him Thursday to see how he gets on. Booked another appointment to see him on 01/04/2014/ Letter sent to GP (Practice 2) dated 09/01/2014 re outcome of assessment. Plan: continued input from his care coordinator.		RiO
20/03/2014	Telephone call by Mr PR to Mr EF Was informed that his GP has asked him to attend surgery today. Booked medical review for Mr EF with Dr JK (GP trainee) for 15/04/2014		RiO
25/03/2014	GP appointment. GP challenged Mr EF regarding medication – he could not be using it correctly, although he says he is. Living alone and visiting mother. Mr PR telephones to remind him about collecting prescriptions and 'fit notes'. No thoughts of harm to self or others. Has been in a fight, does not want ot end up like that again. Having hallucinations, no signs of paranoia.		GP records
01/04/2014	Mr EF did not arrive on time for his appointment with Mr PR. Appointment rebooked for 03/04/2014.		RiO
02/04/2014	Mr EF called in at DSU but Mr PR out on visit. Mr PR spoke to Mr EF on the phone and arranged to be see him on 03/04/2014/		RiO

03/04/2014	Mr EF seen by Mr PR at the DSU. Notes record that: • Mr EF 'presents as well'. • He has issues with food and sleep which is thought may be connected to his medication. • He is keen to stay out of trouble so does not go out. Sees his mother. • He is generally content and takes his medication. • He does not take cannabis or drink or smoke • He does not want to engage in any activities or training or work. • Information provided from GP web site regarding repeat prescriptions. • ESA contacted to see if benefits had been paid. Money had gone out today to his back account. Mr EF to check when he returns home and collects his bank card. • Proof of address given so that application can be remade re Freedom Pass.		RiO
10/04/2014	Telephone call to Mr EF by Mr PR. Mr EF stated that he needs help, but would not elaborate or give reasons. Told by Mr PR that to apply for a Freedom Pass he would need to bring in two passport style photo IDs. Said he would bring them to the DSU for his next appointment.		RiO

12/04/2014 7.14pm 7.51pm	Telephone call from sister to Barnet HTT, she reported concerns with Mr EF's recent behaviour. She was told to contact the Barnet WCSRT. She was given telephone number. If she still had concerns to contact the Police or take her brother to A&E. Mr EF arrested after harassing a women in a shopping centre. Telephone call from AMHP to Barnet HTT. Mr EF has been picked up by the police for following a woman – he is now in Police Station. She requires someone to attend a MHA assessment. Message passed on to CRHTT @ Night. Member of night staff at Police Station was informed that Mr EF had been sexually inappropriate to a woman in the community, drunk and was following the woman who ran into a shop to avoid him. Mr EF was brought to the station and whilst there had attempted to grab a female police officer. Other times he was crying and licking his hands. Rang AMPH and agreed that a MHA assessment should be carried out.		RiO

12/04/2014/ 13/04/2014 (Sunday)	MHA Assessment: Police Station: Present: Dr YZ (Trust doctor); Dr ST (Section 12 approved doctor) and AMHP. Later joined by mental health nurse, Mr LM, CRHT @ night. In early hours on the 13.04/2014, Mr EF was assessed under the Mental Health Act 1983 (amended 2007) by Dr YZ, Dr ST and the AMHP. The assessing team were later joined (as per agreement with the AMPH), by Mr LM from CRHT @ night. When interviewed by the internal inquiry panel the AMHP explained that the referral for a Mental Health Act assessment had been made by police to the Out of Hours AMHP Service for Barnet and Enfield, in the late hours on the 12/04/2014. The AMPH contacted the CRHT@night service for background information as RiO could not be accessed. The MHA assessment to take place and a representative from the team would later join the assessing team at the police station (the CRHT@night team were busy).The assessment should go ahead without the representative present. Dr YZ and Dr ST contacted, to meet outside the police station, as soon as possible, so that they could enter the police station together. Update given by the Desk Sergeant. Mr EF had been identified as the female he had harassed had taken a picture of Mr EF on her mobile phone. When he was brought into the police station he was 'quite aroused' and was under the influence of alcohol, hence the delay in requesting the MHA assessment. Also reported by the Desk Sergeant that at the Police Station Mr EF had attempted to grope a female police officer. Given this information and for the assessment team's safety, it was agreed that Mr EF should be interviewed in his cell, with a police officer present. Mr EF was interviewed in his cell. He could not remember much of what had happened, he had drunk some 'liquor' earlier in the day. He denied other substance use. He said he had been talking to women and at one point said	Limited risk information available prior to decision to offer Mr EF informal admission.	RiO

14/04/2014	Letter from ward staff to GP, inviting the GP to attend a CPA meeting on 16/04/2014. GP replied, was unable to attend.	Good practice to invite GP.	GP records
14/04/2014 12.50pm 7.53pm	Whiteboard Meeting: Present Dr WX, Locum SHO, 2 staff nurses, ward administrator and student nurse. Mr EF discussed. Plan: Mr EF not to leave the ward. If he decides to leave the ward, he needs to be assessed. Mr EF currently on 15 minutes level of observation. Phone call from sister. Reported by staff at handover that at 19:00 Mr EF climbed the fence outside in the garden (smoking area) and went AWOL from the ward. Ground search carried out and Police notified due to his risk and sexually inappropriate behaviour towards women. Mr PR, Mr EF's sister and Bleep Holder notified.	Ease with which Mr EF could get over the fence (height of this now raised).	RiO
15/04/2014 5.56am 11.09am 12.37pm	Telephone call from Police to ward. Police had attended Mr EF's address and Mr EF was at his home, but refused to return with Police to the ward. Police were unable to remove him from this property 'as Mr EF is not on section' Plan: to be handed over to staff this am and discussed at whiteboard meeting. Plan: Refer to AMHP; ask Mr PR to follow up. Mr EF discharged from the ward. Mr PR phoned Mr EF he was at his Mother's house and agreed to see his Mr PR and Dr JK (GP trainee) at 12:30 today, at his Mother's home. Sussex ward staff contacted Barnet AMHP Service with request made for a mental health assessment for Mr EF, as he is not willing to return to hospital following absconding from the ward. Following discussion agreed with ward staff that Mr PR and Dr JK will go and meet him today. The AMPH service will await outcome of this meeting. Discharged from Ward.		RiO

	Diagnosis on discharge: (Discharge Notification to GP) Paranoid schizophrenia; Mental and behavioural disorders due to use of cannabinoids/harmful use; Mental and behavioural disorders due to use of tobacco/harmful use; Home Visit: Mr PR and Dr JK. Mental state assessment undertaken by Dr JK. Impression: • abnormal and inappropriate behaviour may be related to alcohol substance use (Mr EF denies the latter) • currently appeared well, no indication for MHA assessment or admission • risk low at present – Mr EF denies above behaviour, intends to stay at home and recover. Plan: Mr PR to liaise with police; advised Mr EF to comply with police if necessary. Continue to review mental state and behaviour in community. Mr EF advised to avoid alcohol and other substances – Mr EF said he would comply. Mr EF staying with mother, Mr PR will discuss Mr EF's care with her.		
16/04/2014	Telephone call received from Mr EF's sister. Message passed on to Dr WX.		RiO
24/04/2014	Mr PR telephoned Mr EF who said he was at his own home and that he was OK. No longer believes that the Police are bothering him regarding the recent situation and does not believe that they will be pressing any charges and has not received any letters from them. Advised his housing benefit has stopped. Mr PR advised for him to call the number on the letter. He also reminded him to bring two photo IDs to his next appointment on 07/ 05/14 in order that a Freedom Pass can be applied for.		RiO

07/05/2014	Did not attend appointment at DSU. Mr EF contacted by Telephone. Benefits and Freedom Pass discussed. Mr PR reminded him to bring ID photos to next appointment. Next appointment 13/05/14 to be attended by Mr NO and Mr PR's supervisor. Time of appointment may have to be changed for either 11am or 3pm Mr NO to determine).		RiO
23/05/2014	Case discussed with service manager (Mr MN). Team has heard that Mr EF has been arrested for questioning in relation to a murder. Dr JK, Dr KL and Mr NO (Supervisor) advised. Telephone call made by Team Manager to police station. Advised that Mr EF is being questioned and has an appropriate adult with him. A Forensic Medical Examiner has been called who will sort out medication. Police aware of Mr EF's diagnosis and prescription. Contact details left in case further information required. Service Manager updated. Mr MN confirmed Mr EF in police custody will be remanded to prison by magistrates in next day or two. Information from prison - Mr EF to be charged with murder and arson.		RiO
28/05/2014	Telephone call made by Team Manager to Mr EF's mother regarding support. An offer made to meet with Mother, which she said would be helpful. Plan: to call Mother tomorrow.		RiO
29/05/2014	Telephone call made by Team Manager to Mr EF's mother. Agreed to meet 02/06/2014 with team's Consultant Psychiatrist (Dr KL), if possible.		RiO

30/05/2014	Phone contact established with Forensic Consultant Psychiatrist CNWL in-reach team. Mr EF has been seen and reviewed this week in prison, is in the hospital wing as a precautionary measure and is receiving treatment. Currently not presenting as significantly unwell and not wanting to talk about the alleged offence. No clear link currently evident between his mental state and his alleged offending behaviour. Some paranoid ideas disclosed. Current thinking is that it is unlikely Mr EF will be needing diversion into hospital for treatment or assessment.		RiO
02/06/2014	Mr EF's Mother did not come to DSU to see team's Consultant Psychiatrist and Team Manager as arranged. A telephone call was made by Team Manager to Mother and she advised that she had forgotten the appointment. It was left that she would call this week to rearrange.		RiO
03/06/2014	Telephone call from prison (healthcare wing) to WCSRT inviting team to attend a meeting. First available date to include Dr JK doctor and Team Manager is 01/7/2014.		RiO

01/07/2014	Dr JK and Team Manager attended prison for meeting with Clinical Psychologist; Prison Psychiatrist and a another member of staff. Mr EF attended latter part of meeting. Mr EF advised that he felt confused and said he was not coping. Mr EF did not engage with the meeting. Mother has not visited. Mr EF did not consent for W CSRT to inform his Mother about their visit. Dr JK reported on Brief Mental State Examination. Dr JK could not determine any formal thought disorder, or whether Mr EF was refusing to engage or was too depressed to do so. Prison team advised that Mr EF has not presented as a risk to himself or others since his admission. W CSRT asked if they thought Mr EF's mental state had contributed to the alleged crime. Responded that it was not possible to comment on this; no-one in the team knew Mr EF very well; they were aware of his previous behaviours over many years; they were not aware of any acute deterioration in his mental health around the time of the incident. Plan: Team to keep informed regarding Mr EF's progress due to the implications upon his social and housing arrangements. Care transferred to the prison mental health team until his release or discharge. Dr JK suggested and offered to contact previous MH Team to see if they have anything to add to above, will contact the prison if so.		RiO
August 2014	Mr EF pleaded guilty to manslaughter by reason of diminished responsibility and also pleaded guilty to arson and being reckless as to whether life was endangered, (when setting fire to Mr BC's flat in a block where neighbours were at home).		Judge's sentencing remarks

05/02/2015	The judge accepted the recommendation of the doctor reporting to the CPS on Mr EF's mental condition and sentenced him to be detained under Section 37 of the MHA. The judge also imposed an indefinite restriction order under Section 41. (Mr EF can only be discharged with the permission of the Home Secretary.)		Judge's sentencing remarks
29/04/2015	Letter to GP from Pathology Laboratory, reporting Mr EF's raised blood glucose levels. The secure unit was identified as the source of referring the blood sample.	Possible that the undiagnosed diabetes could have affected on his mental state	GP records
18/08/2015	Mr EF confirmed he is receiving ongoing treatment for type 2 diabetes.		Interview with Mr EF/

Appendix E Abbreviations and definitions

Abbreviation	Definition
AMHP	Approved Mental Health Practitioner
ASW	Approved Social Worker
AWOL	Absent without leave
CDW	Community Development Worker
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CSRT	Community Support and Recovery Team
CSRT@Night	Community Support and Recovery Team at Night
CRHHT	Crisis Resolution and Home Treatment Team
DH	Department of Health
DNA	Did not attend
Enfield EHTT	Enfield East Home Treatment Team
ECHR	European Commission on Human Rights
MHA	Mental Health Act 1983, as amended in 2007
NICE	National Institute for Health and Social Care Excellence
NPSA	National Patient Safety Agency
PCMHT	Primary Care Mental Health Team
QoF	Quality and Outcome framework
RiO	The Trust's electronic patient record
RCA	Root Cause Analysis
WCSRT	Barnet West Community Support and Recovery Team

Appendix F Anonymisation index

Mr BC	Victim
Mr CC	Mr BC's brother
Mr EF	Perpetrator
Mrs GG	Mr EF's mother
Ms HJ	Approved Mental Health Practitioner
Dr KL	Consultant Psychiatrist, W-CRST
Mr MN	Psychosis Service Line Manager at the time of the offences; currently Assistant Clinical Director
Prof OP	Executive Director of Nursing, Governance and Quality and author of the Board Level Panel Inquiry
Dr QR	Consultant Psychiatrist, Complex Care Team and member of the Board Level Panel Inquiry
Dr ST	Consultant Psychiatrist and Section 12 doctor
Dr UV	Consultant Psychiatrist and Clinical Director
Dr WX	Consultant Psychiatrist, Sussex Ward at the time of Mr EF's admission)
Dr YZ	Consultant Psychiatrist, ST45 doctor
Dr BD	Associate specialist psychiatrist, Section 12 doctor
Mr FG	Approved Mental Health Practitioner
Dr EH	Consultant Psychiatrist, CRHTT
Dr JK	GP trainee, on placement with WCSRT
Mr LM	Nurse, WCSRT
Mr NO	Social Worker, Principal Practitioner and Supervisor of Mr PR
Mr PR	Student social worker and care coordinator of Mr EF at the time of the incident
Ms TU	Agency social worker, previous care coordinator for Mr EF, WCSRT

Appendix G – Roles and responsibilities of a care co-ordinator

The following list of roles and responsibilities for a care coordinator under the CPA is taken from the Trust's CPA policy, 2013.

11.15. Role and Responsibilities of Care Coordinator:

1). To engage with and establish a partnership relationship with service users with reference to their care and treatment that will enable them to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

2). To ensure that the service user understands, has all the required information on diagnosis, medication and other relevant aspects of their care and treatment, and has the opportunity to make decisions and participate fully in the CPA process and their recovery, through self-assessment, and advocacy if required.

3). To encourage service users to assess their strengths, risk and needs, identify what 'recovery' means to them and take a lead in making decisions about their own care and treatment.

4). Support service users to find strength in their resilience in the face of adversity.

5). Discuss with service users their views on prescribed medication including progress, concerns, side effects, and general thoughts about compliance, document and represent these views at meetings as required.

6). Encourage the service user to initiate and maintain their 'Service User Information and Recovery file'. The file is solely for service user's personal use. (Based on the adapted 'Moving Forward' Toolkit).

7). Contribute to the formulation of the care plan based on the service users self-assessment, a health and social care needs assessment by the most appropriate multi-disciplinary team in collaboration with the user, and where appropriate and agreed by the service user, his/her Carer.

8). Document unmet needs and discuss with supervisor who must collate them for the service, and present on a regular basis in Local and Trust Clinical Governance Meetings for review and/or possible future action.

9). Maintain contact with the service user in the community, monitoring the package of care.

10). Meet with service users to ensure they have time to prepare for their CPA meetings and reviews, Use the CPA Preparation Checklist.

11). Work towards a collaborative strategy with service users, their carers and other professionals in preventing relapse and promoting well-being, and recovery, continually assessing needs, strengths, aspirations and level of risk and developing a care plan with the service user.

12). Ensure the service user and their carers, where appropriate, are able to contribute to and understand the care plan and are given a copy. It must be written in an accessible format in terms that the service user understands, using pictures if required. They must be encouraged to keep the copy in their Information and Recovery file.

13). Ensure contact with the service user wherever they are, for example, whilst in hospital, adolescent unit etc. Contributing to assessment, liaison and care planning while in these settings (including if placed in a private hospital).

14). Ensure that they continue to meet with service users while they are in hospital, at least in line with any already planned appointments, and once a week where practical.

15). To oversee transfer of care and discharge processes (discharge from hospital and discharge to primary care).

16). Prior to any presentation at the Mental Health Funding Panel to attend the MDT discharge Planning Meeting and go through the Mental Health Panel Checklist clarifying if all key assessments and documentation are in place.

17). Relevant documentation must be authorized by their Community, Support and Recovery Team manager and where available the Delayed Transfer of Care Coordinator prior to attendance at a funding panel.

18). Following discharge from hospital contact within seven days must be made with the service user by either phone call, exchange of text contact, or interview.

19). Liaise with and keep in contact with carers and all other services involved in the service user's care, including primary care services, accommodation placement teams, day care services etc.

20). To ensure an assessment of carer's needs is carried out, and where appropriate agree a care plan for the carer.

21). The assessment can be delegated to specialist workers for whom the specialist role has been designated. Where needs are identified, outcomes must be recorded, monitored, and reviewed on an annual basis. Carers must always be informed of their right to request a carer's assessment.

22). Where appropriate, provide or source carers with education/advice and information about the care they give to the service user, including working with strengths, signs and symptoms of mental illness, medication and side effects, dealing with difficult behaviour, de-escalation, risk recognition, recovery.

23). To be familiar with the responsibilities of section 117 aftercare as detailed in the MHA code of practice.

24). Where appropriate to use specialist skills to provide particular types of therapy

25). Provide information about local resources and opportunities in the community that may be useful to assist the service user with social inclusion and their recovery.

26). Facilitate access to community groups and networks that enable the service user to participate in community activities.

27). When on leave to ensure, a named contact is nominated and that this information is conveyed to the service user and the carer if appropriate.

28). When the care coordinator is off sick it is the managers responsibility to allocate a replacement and inform the service user and carer and ensure that they who they might contact must the need arise.

29). Convene multidisciplinary CPA review meetings, and based on an assessment of mental capacity, offering the service user the opportunity to lead the discussions and determine the agenda, time, venue and attendance, and ensure that the frequency of the CPA meetings conform to the standards specified in this policy.

30). Ensure that in CPA meetings service users are supported by relatives, friends, carers or by an advocate, and have access to an interpreter, if they so wish.

31). When a service user does not or is unable to specify the attendance for the CPA meeting, this must be documented as well as ensuring that they are asked well in advance whether they mind the presence of a student or other professionals not directly involved in their care.

32). Ensure that the service user is informed of all those invited to attend.

33). Ensure that the service user has had the opportunity to use advance agreement statements.

34). Ensure that the service user has opportunity to be assessed for access to direct payments and or individual budgets and where appropriate, involving enablement services prior to allocation of individual budget.

35). With the service user, bring together a list of strengths and aspirations, as well as issues for discussion at the CPA review meeting, and that any advance agreement statements, made by the service user, are available for consideration.

36). Ensure that service user has been consulted and had the opportunity to set the agenda prior to the meeting and that all relevant attendees receive a copy.

37). Ensure all communication, outcomes of reviews and advanced agreements are documented with care plans adjusted as necessary.

38). Service Users must receive a copy of their care plan within 7 working days of the plan being drawn up and agreed. It must be written in terms that they understand that avoids the use of jargon, abbreviations and complicated technical terms. They must be encouraged to keep the copy in their Information and Recovery File.

39). If a service user is subject to a Guardianship Order made to the Local Authority, a social work professional is likely to be the most suitable Care Coordinator.

40). Any change of care coordinator (which may be at the request of the service user as well as for other reasons) must be discussed with the service user, the multi-disciplinary team and clinical team leader, and the decision to change recorded in the patient's clinical record.

Appendix H – References

Trust policies

Barnet early intervention service operational policy (2008)

Clinical Risk Assessment and Management policy (2011)

Clinical Risk Assessment and Management (2014)

CPA policy (2013)

CRHT operating policy (2015)

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