HASCAS
Health and Social Care Advisory Service

Executive Summary

Independent Investigation

Into the

Care and Treatment Provided to Mr X

By the

Oxleas NHS Foundation Trust

And the

Gallions Reach Health Centre

Commissioned by NHS England

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1. Investigation Team Preface

1.1. The Independent Investigation into the care and treatment of Mr X was commissioned by NHS England pursuant to *HSG (94)27.*[1] The Investigation was asked to examine a set of circumstances associated with the death of Mr Y who was found dead in his home on 15 June 2013.

1.2. Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of the Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to improve the reporting and investigation of similar serious events in the future.

1.3. Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's Senior Management Team who granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has engaged fully with the root cause analysis ethos of this work.

2. Condolences to the Family and Friends of Mr Y

2.1. The Independent Investigation Team would like to extend its condolences to the family and friends of Mr Y. The Independent Investigation Chair and a Senior Officer from NHS England London Region visited Mr Y's eldest sister on 8 September 2015. We would like to thank her for her valuable insights and the contribution that she was able to make to this investigation.

1. Health Service Guidance (94) 27

3. Incident Description and Consequences

Background for Mr X

3.1. Mr X was born in Somalia where he grew up in Hargsa, capital of Somaliland. Mr X told mental health services that he had experienced a happy childhood. He went to primary and secondary school and left education aged 19. He initially went to work in a factory where he was employed as a buyer; he held this job for five years. At the age of 24 he left Somalia and went to Abu Dhabi where he worked as a medical clerk for over eight years. He returned to Somalia as civil war broke out and he subsequently moved to the United Kingdom in 1997. Mr X did not work from the time of his entry to the United Kingdom due to his emerging mental health problems.

3.2. Mr X was known to Oxleas mental health services from December 1997. Mr X presented with manic and depressive episodes with psychotic elements requiring multiple inpatient admissions. In 2007 he was given the diagnosis of Paranoid Schizophrenia; however in 2008 this was changed to Bipolar Affective Disorder. This diagnosis remained unchanged until after the death of Mr Y whereupon it was altered to that of Schizoaffective Disorder.

3.3. After discharge from his last inpatient admission in 2007 Mr X received care and treatment for his mental illness in the community. He was placed in supported living accommodation and was provided with Care Coordination from the Greenwich Community Mental Health Team (CMHT) where he was placed on an Enhanced Level of the Care programme Approach (CPA).

3.4. Mr X continued stable and well with no signs of his mental illness re-emerging between 2007 and his eventual discharge from Oxleas mental health services in October 2012. Just prior to his discharge Mr X was placed in a private tenancy flat and his ongoing care and treatment was transferred to his GP at the Gallions Reach Health Centre.

Incident Description and Consequences

3.5. Mr X appeared to be coping well following his discharge from Oxleas services. There were no signs of any deterioration of his mental health detected by the GP practice which he visited on a regular basis for his diabetic condition. However on 15 June 2013 Mr Y (who lived in the flat next door to Mr X) was found stabbed to death in his bedroom. After the attack Mr X handed himself in at Belmarsh Prison and confessed to killing his neighbour. He told police *"When I went into his room I was not in my mind"*. On 16 June 2013 Mr X was charged with Mr Y's murder.

3.6. Mr X pleaded guilty to manslaughter on the grounds of diminished responsibility on 7 October 2013. The prosecution accepted his plea on the first day of his trial, 27 January 2014. Psychiatrists agreed he was suffering from a Schizoaffective Disorder at the time of the killing. Mr X was detained indefinitely under sections 37 and 41 of the Mental Health Act (1983 & 2007). Judge Stephen Kramer QC told Mr X *"You killed your neighbour who lived opposite you. You beat him about the head and body and cut his throat with a knife. Both psychiatrists are agreed that at the time of the killing you were mentally ill. You were suffering from a recognised medical condition*

in which symptoms of schizophrenia and a mood disorder co-exist. It is likely you were experiencing delusional ideas. In my judgement the defence of diminished responsibility is made out. I am also satisfied that the nature and degree of your mental disorder makes it appropriate for you to be detained in hospital for medical treatment. It is clear to me that if you stop taking your medication you pose a serious risk to members of the public if still at large".

3.7. Mr X died in the place of his detention on 3 March 2014.

4. Terms of Reference

4.1. *"Core Terms of Reference for Independent Investigations under HSG (94) 27.*

- *Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- *Review the progress that the trust has made in implementing the action plan.*
- *Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the 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 brief post investigation evaluation.*

4.2. *Additional Specific Considerations (added on 20 May 2015).*

- *Mr X's ethnic origin and needs as a refugee.*
- *Medication and treatment strategies, to include the decision taken to reduce medication at the point of discharge to primary care.*
- *Ongoing risk formulation in view of Mr X"s previous acts of aggression and violence.*
- *CPA and Care Coordination practice (especially in the light of supported living arrangements).*
- *Carer and family liaison prior to discharge from secondary care services.*
- *The interface between the trust and the GP practice in relation to Mr X's care and management.*

- *Risk, crisis and contingency planning at the point of handover from secondary care to primary care services.*
- *Primary care strategies for managing patents presenting with high levels of risk.*
- *Vulnerable adults and housing issues (relating to both the disabled victim and Mr X himself).*
- *The process for internal investigation following the homicide.*
- *Victim and perpetrator family consultation, liaison and support subsequent to the homicide".*

5. The Independent Investigation Team

Selection of the Investigation Team

5.1. The Investigation Team was comprised of individuals who worked independently of the Oxleas NHS Foundation Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Chair

Dr Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service - Chair, nurse member and report author

Investigation Team Members

Dr Paul Warren	Health and Social Care Advisory Service Associate – Medical member
Professor Abdullahi Fido	Health and Social Care Advisory Service Associate – Medical member and cultural advisor
Dr Emma Nash	Health and Social Care Advisory Service Associate – GP member
Mrs Christine Dent	Health and Social Care Advisory Service Associate – Governance Systems member

Support to the Investigation Team

Mr Greg Britton	Health and Social Care Advisory Service Investigation Manager

Independent Advice to the Investigation Team

Ms Janet Sayers	Solicitor: Kennedys

6. Identification of the Thematic Issues

Thematic Issues

6.1. The Independent Investigation Team identified 12 thematic issues that arose directly from analysing the care and treatment that Mr X received from the Oxleas NHS Foundation Trust and the Gallions Reach Health Centre. These thematic issues are set out below.

1. **Diagnosis.** There was a lack of diagnostic clarity throughout Mr X's contact with Mental Health Services. There is no evidence to suggest a robust diagnostic formulation was developed and in more recent years, Mr X did not seem to have had a proper medical evaluation apart from being seen in the context of CPA reviews when only the most superficial exploration of his mental state would have been possible.

2. **Medication and Treatment. Medication:** Mr X seems to have been treated symptomatically over the years, rather than with specific reference to diagnosis, however the prescription of an antipsychotic drug, Risperidone, was a reasonable choice for treating either a Bipolar Disorder or a Schizophrenic illness. Given the diagnosis of diabetes it would have been good practice to carefully review Mr X's metabolic status and if necessary change his medication to an antipsychotic, such as Aripiprazole, less likely to cause metabolic problems. There is no evidence that this was ever considered or recorded.

   At the point of Mr X's discharge from the Trust in October 2012 he had been symptom free for many years and the long-term plan was for the GP to stop his Risperidone. However, given that it was known that his relapses and admissions to hospital had been precipitated by him stopping his medication, it was somewhat imprudent to suggest that his medication could be stopped at a time when he was no longer being followed up by Mental Health Services.

   Treatment: There is no record of a Wellness and Recovery plan, Relapse Prevention plan, or Crisis and Contingency Plan. This meant there was no structured framework for a comprehensive treatment approach. Whilst robust support was given to Mr X in relation to his social circumstances it would appear he was ambivalent about receiving other kinds of inputs (for example psychotherapy and gambling prevention) and therefore ongoing treatment plans were often put on hold and were minimal in nature.

3. **Use of the Mental Health Act (1983 and 2007).** Mr X remained well and symptom free for a period of six years. In the days and weeks preceding the killing of Mr Y he displayed no symptoms to health professionals suggestive of a decline in his mental state or that an assessment under the Act was indicated.

4. **Care Programme Approach (CPA).** From the summer of 2007 until October 2012 Mr X was on Enhanced or 'Full CPA'. He had a succession of three Care Coordinators who worked with him in the community. The ongoing day-to-day follow up was of an excellent standard ensuring that Mr X received support and that multiagency working was streamlined. However this work often proceeded

outside of a structured framework which meant inputs were mostly task rather than objective driven. The abrupt withdrawal of the service at the point of Mr X's discharge from the CMHT in October 2012 meant that neither Mr X nor the GP practice had an ongoing Wellness and Recovery Plan to follow and that neither had a clearly planned route back into the service should Mr X's mental health relapse.

5. **Risk Assessment.** Due to the relative lack of risk assessment documentation it has been difficult to understand how Mr X's risk was managed over time. There appears to have been no formal assessment process and no regular inputs from the multidisciplinary team. There are four main issues:

   - Whilst risk assessment is mentioned in CPA documentation it was based on current presentation only and it would appear the treating team from April 2007 onwards had no understanding of Mr X's previous risk history; this was a significant omission especially in relation to his relapse profile.
   - Conversations about risk were not recorded and no risk formulation was ever developed.
   - Over the years Mr X presented with consistent levels of risk to vulnerable adults in that he stole from them and took money with menace. There was no robust risk management plan put into place to protect those that Mr X exploited.
   - At the point of discharge no risk assessment was conducted which would have detailed Mr X's ongoing issues in order to provide background context for the GP practice that took over his care and treatment. This ran counter to the Trust CPA policy guidelines in operation at the time.

6. **Referral and Discharge Planning.** This process was found to be of a poor general standard. Just before his discharge from the CMHT in October 2012 Mr X moved to a new flat and changed his GP practice. The discharge letter written to the new GP practice did not provide a detailed enough history for Mr X which would have enabled primary care to work with him in an informed manner from the outset.

7. **Safeguarding, Housing and Vulnerable Adults.** Over a period of six years Mr X's gambling and his subsequent debts were an ongoing feature of his presentation. His financial exploitation of the vulnerable adults who were domiciled with him in his supported living accommodation was also an ongoing feature. Safeguarding issues were not managed in either a robust or systematic manner over the years leaving vulnerable adults open to continued financial abuse and exploitation.

   Whilst neither Mr X nor Mr Y were deemed to be vulnerable adults in the legal sense of the definition, both were rendered vulnerable on occasions due to their illnesses and lifestyle choices. However Mr Y was not known to any statutory service and therefore no system failed to operate to protect him.

8. **Service User Involvement in Care Planning and Treatment.** Mr X was always treated with dignity and respect by both primary and secondary care services. His wishes were taken into account and his care and treatment pathway planned

accordingly. However Mr X was not really understood in the context of either his social circumstances or his cultural and ethnic identity. Mr X was adept at getting his needs met – however services may have made assumptions about him which were not correct and served to perpetuate the impression that Mr X was able to function in the community better than he actually was.

9. **Family Involvement.** Mr X had a sister and nephew living in England with whom he lived prior to 2005. Mr X's sister was put in contact with a Somali carer group in 2002 which was good practice. However it would appear that little effort was made by the service to obtain collateral information from Mr X's sister and issues relating to Mr X's past and his psychiatric history were neither ascertained nor understood.

   Following his return from Somalia in 2007 Mr X asked secondary care mental health services to sever links with his sister and nephew as he did not wish for them to be involved in his care and treatment. No further contact with them was made prior to the killing of Mr Y.

10. **Documentation and Professional Communication.** The extant clinical record for Mr X is of a poor general quality. Post 2007 risk assessments and care plans were often under-developed and did not address the ongoing issues described in the day-to-day progress notes. Clinical witnesses to this Investigation described an informal cultural of professional communication where multi-professional discussions were not always recorded on RiO and where unrecorded 'corridor' conversations were the norm.

    A key finding relates to clinical records management. The transfer of hard copy records to the RiO electronic system between 2005 and 2007 meant that a clear dislocation occurred in relation to the continuity of Mr X's clinical information. Risk events of a significant nature pertaining to Mr X were not transferred to the RiO electronic system and this meant that Mr X's treating team post 2007 assessed him without a clear understanding of his psychiatric history.

11. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** The Trust has a fit for purpose set of clinical policies and procedures although it would appear that these were not routinely adhered to by the CMHT. However there is substantial evidence to suggest that the Trust adhered to NICE clinical treatment guidelines.

    The Gallions Reach Health Centre whilst following NICE guidance admits to not having a suite of robust quality standards. The practice is implementing a lessons for learning processes as a result of the death of Mr Y.

12. **Clinical Governance and Performance**. The Trust has in operation mature and robust clinical governance systems although it is a finding of this Investigation that clinical audit processes were not sensitive enough to detect the lack of policy adherence in relation to risk assessment procedures and clinical record maintenance. However no link was made between the homicide of Mr Y and governance failings on the part of the Trust.

7. Conclusions Regarding the Care and Treatment Mr X Received

Overview

7.1. It is a key finding of the Independent Investigation that Mr X was always treated with Compassion and respect by Oxleas NHS Foundation Trust staff and the Gallions Reach Health Centre. Care and treatment was person-centered and Mr X's preferences were always taken into account and his care and treatment regimen adjusted accordingly. Mr X was supported and his recovery maintained for nearly six years. This was good practice.

7.2. Investigations of this kind take a longitudinal view of care and treatment over many years. It is inevitable that there will be findings that show on occasions services did always work as well as policy guidance suggests they should.

7.3. Mr X was a complex individual. The clinical information recorded about him fell into two distinct periods a) before his departure to Somalia in 2005 and b) after his return in 2007. It is evident that significant information was in effect 'lost' to the treating teams that provided care and treatment to Mr X after 2007. This had an impact on the way his long-term recovery and wellbeing were viewed and therefore managed. The Independent Investigation Team concludes that over time the CMHT developed a distorted view of Mr X. It has to be understood that none of the health care professionals within the CMHT had known Mr X when unwell and the picture that they developed of him did not take into account the complex interplay of his mental illness, his Diabetes and his lifestyle choices. In effect Mr X was seen through the lens that he preferred to present of himself and no in-depth examination or medical review was undertaken. There was a failure to recognise that Mr X's recovery rested upon the intensive care and support he had received from the Trust and Supported Living accommodation. There was no evidence to suggest he would be able to maintain this independently at the point the decision to discharge him was taken.

7.4. That being said Mr X received an excellent standard of support. He was supported over the years by diligent Care Coordinators who worked hard to help him reach the life goals that he desired. This approach was weakened however by a lack of adherence to formal frameworks and an informal approach to ongoing risk assessment which did not observe Trust policy guidance.

7.5. Whilst there was a great deal of activity it did not always equate to meaningful engagement. There were many ongoing periods of assessment but they failed to reach a true understanding of Mr X's ability to function independently in the community. The assessments and care plans also failed to understand that recovery from severe and enduring mental illness is not linear and that relapse is a common feature that needs to be understood and planned for.

7.6. The Independent Investigation Team concurs with the findings of the Trust internal review in that the decision to discharge Mr X from CPA and the CMHT was not an incorrect decision *per se.* It also concurs with the conclusion that the

discharge should have been staggered allowing Mr X a period of consolidation, monitoring and supervision. This was clearly indicated.

7.7. The handover process between secondary and primary care was not optimal. It is evident that the Trust's CPA policy was not adhered to and the handover failed to provide key information that would have helped the GP practice work with Mr X in a safer and more informed manner. However it is noted that the GP practice worked with Mr X and that he engaged well with the service. It is also recognised that he appeared to remain stable and well both mentally and physically and there were no indications that he was relapsing even in the days before the killing of Mr Y.

Predictability and Preventability

Predictability

7.8. Based upon what was known (and what should have been known) about Mr X there was little information to suggest that a prediction could be made that he would ever kill anyone as a result of his mental illness. The incident where he attacked his sister's friend in 2005 appears to have taken place when Mr X was deemed to be well by the Criminal Justice system. He went to prison and no mental health inputs were required during this period. His mental state was observed to relapse on his release from prison in that he was depressed. However his depression was due to his sense of shame and dishonour – Mr X's own account of the assault did not suggest any psychiatric features were responsible for it.

7.9. It was known that Mr X consistently financially abused vulnerable people. This aspect of Mr X's presentation was never explored in full, however it was understood that his gambling lifestyle (which went unabated) was in part responsible. As Mr X continued to abuse vulnerable adults in this manner it was predictable that this behaviour would continue and that an incident of some kind could take place in the future. It was also predictable that Mr X would encounter financial difficulties and debts which could compromise the continuation of both his recovery and his private accommodation lease.

7.10. It was known, or should have been known, that in the past Mr X relapsed when he stopped staking his medication. This understanding of Mr X's presentation appears to have been lost over time. The Independent Investigation concludes that it could have predicted that a cessation of medication would have impacted negatively upon Mr X's recovery.

Preventability

7.11. In the case of Mr X it would appear that:

- he had stopped taking his medication (even if only a few days before the killing of Mr Y)
- his social conditions had taken a down turn;
- he was no longer coping in the community.

7.12. The Court when sentencing Mr X did not establish the events leading up to the death of Mr Y in manner likely to assist an HSG (94) 27 investigation process examining the quality of the care and treatment Mr X received. Whilst the Court established that Mr X's mental state was a direct causal factor in the killing of Mr Y,

what could not be established were any acts or omissions on the part of NHS services and the contribution, if any, these made to the death of Mr Y.

7.13. The Independent Investigation concludes that the likelihood of a relapse at some point in the future should have been recognised and a plan developed; a staggered discharge should also have been considered. Had this been achieved Mr X's recovery and his ability to live independently would have been tested better prior to discharge from secondary care services. In addition a more robust set of discharge information should have been provided to the Gallions Reach Health Centre. Whilst this approach would not necessarily have prevented a relapse it would have been good practice and would also have created the opportunity to monitor and intervene in a timely manner.

7.14. However, even whilst indicated, the Independent Investigation Team had to consider whether a staggered discharge would have actually prevented the death of Mr Y. The facts are that Mr X appeared to be stable and well until a few days before the killing of Mr Y. The nature of his financial situation has never been determined but it would appear Mr X sublet his accommodation and was living rough in the stairwell of his block of flats. This appeared to have occurred in the days before Mr X killed Mr Y. The change to Mr X's social circumstances appears to have taken place suddenly and it would seem that Mr X's mental health relapsed during this time. It would not be a reasonable to conclude that NHS services could have prevented these circumstances from occurring. The rationale for this is examined below using three tests of reasonability.

1. **Knowledge:** Mr X continued to appear stable and well after his discharge from the CMHT in October 2012. He was last seen at the Gallions Reach Health Centre on 12 June 2013 – three days before the homicide. On this occasion he appeared to be well and there were no indications that he had stopped taking his medication or that his mental health was relapsing. Whilst Mr X's neighbours and lodger described him as behaving strangely in the days before the homicide this information was not made known to NHS services. As the situation was seemingly of a short duration it is likely that Mr X not reached a threshold to raise undue alarm in the minds of those around him.
2. **Opportunity:** NHS services were not aware that Mr X's social circumstances had unravelled and that his recovery was at risk. Therefore there was no opportunity for services to intervene.

3. **Legal Means (use of the Mental Health Act 1983 & 2007):** It would appear that Mr X was not assessed by psychiatric services until three months after his arrest. It will always remain unclear exactly what his mental state was on the day he killed Mr Y. However as NHS services had no knowledge of his relapse and had no opportunity to intervene on the day Mr Y died, the issue of implementing any legal means was not possible, and may not even have been implemented.

Summary

7.15. The care and treatment Mr X received was of a good general standard over the years. This was however weakened by a lack of formal frameworks being applied and Trust policy guidance being adhered to. However the Independent Investigation

concludes that any act or omissions on the part of either Oxleas NHS Foundation Trust or the Gallions Reach Health Centre did not constitute any failings that directly caused the circumstances that led to Mr X's relapse and consequently the death of Mr Y.

8. Notable Practice

Dignity

8.1. Mr X was treated with dignity and respect in a person-centered manner throughout his contact with Oxleas NHS Foundation Trust and the Gallions reach Practice.

Maintenance of Therapeutic Relationship

8.2. The Independent Investigation found that from the summer of 2007 until October 2012 Mr X was on Enhanced or 'Full Care Programme Approach'. He had a succession of three Care Coordinators who worked with him in the community. The ongoing day-to-day follow up was of an excellent standard ensuring that Mr X received support and that multiagency working was streamlined. Each of the three care coordinators maintained a therapeutic relationship with Mr X even when he tried to disengage from service.

COMPPAS

8.3. The Trust has undertaken a significant mental health redesign project with the COMPPAS (Coordinated Operational Move to Primary Plus Services) programme. The Independent Investigation Team was told that this project addressed some of the key problematic issues that related to Mr X's discharge process. It was recognised that primary care services often did not have the confidence to meet the needs of service users with long-term problems and mental health conditions. The project aimed to improve transfer and to also provide time-limited interventions to facilitate transfer processes.

8.4. Between 2013 and 2014 a multidisciplinary group was set up and tasked with transferring 60 percent of service users with relatively low need from secondary o primary care. The objectives were to:

Patient Experience

- provide care closer to home;
- provide a person-centered approach;
- provide continuity of care and expert knowledge;
- ensure responsiveness when service users experience relapse.

Patient Safety

- reduce the potential for under or over prescribing, omissions on prescriptions and medication errors;
- provide rapid response for those defaulting on long-term medication;
- improve communication with primary care staff to improve knowledge and skill.

Clinical Effectiveness

- provide a bespoke set of interventions in the form of care navigation;
- to provide mental state monitoring and annual physical health checks;
- ease access to GPs, psychiatrist and CMHT specialists.

8.5. As at the end of March 2015 a total of 51 per cent of service users had been discharged back to primary care. The learning from the COMPPAS project has been taken and embedded into ongoing major service redesign which has led to Primary Care Plus being established. This process has in effect renegotiated the boundary between primary and secondary health care facilitating supported discharge and transfer.

9. Lessons for Learning

Documentation and Professional Communication

9.1. It is essential for treating teams to ensure that clear, well-documented diagnostic formulations, assessment of needs and risks, and management plans are both recorded and communicated. It should be noted that when clinical continuity issues (particularly those in relation to constant staff changes) are present for patients the written record and levels of professional communication have to work harder. It should also be noted that when 'informal' clinical conversations are held then any decisions made should be entered as part of the clinical record so that clear rationales are recorded and shared widely with all stakeholders in care and treatment.

9.2. When NHS Trusts change clinical record systems this must be managed efficiently so that key information about the patient travels forward in time to successive treating teams. This should be kept under review and full psychiatric histories taken whenever possible.

Care Programme Approach (CPA)

9.3. The Care Programme Approach is more than the provision of community-based monitoring and multi-agency liaison. For patients with severe and enduring mental illness there needs to be recognition that recovery is usually cyclical in nature and not linear. Robust wellness and recovery plans should be developed with clear crisis and contingency plans in place that ensure a long-term view is taken with clear signposting for all involved.

9.4. CPA needs to be managed as a structured framework with inputs being objective rather task driven. Key milestones in the management of a patient should be planned for in advance with clear communication provided.

Policy Adherence

9.5. A standardised and evidence-based approach to treating patients is essential. NHS providers of service both in primary and secondary care settings must ensure that national and local policy guidelines are both identified and adhered to. The delivery of patient care outside of robust evidence-based guidance is remiss and all

clinicians must ensure that practice is delivered in a safe and systematic manner at all times. It should be noted that whilst clinical governance systems can often ascertain compliance to an extent, systems are not always sensitive enough to detect all omissions to policy guidance. This constitutes a sub-audit 'blind spot' which should be acknowledged and steps taken to mitigate against.

10. Recommendations

10.1. The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure patient and public safety in the future.

10.2. The Independent Investigation Team worked with the Oxleas NHS Foundation Trust to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve services and consolidate the learning from this inquiry process.

10.3. A recommendations workshop was held with clinicians and senior staff from the Oxleas Trust. During this workshop the Trust's mental health redesign progress and IPC programme review was discussed. A paper was written by the Trust to support the recommendation development process; key information is incorporated below.

1. Diagnosis

- ***Contributory Factor 1. Poor diagnostic formulation in the context of Mr X's full psychiatric history prevented an in depth assessment of him being made. This meant that successive treating teams over the years could not develop a full clinical picture of his latent risks and ongoing needs with the degree of clarity needed.***

Progress Made To-Date

10.4. During the lessons for learning and recommendation setting workshop held with the Trust it was agreed that more work needed to be undertaken in relation to different ethnic groups and diagnostic formulation; personality disorder was thought to be an issue of particular note. The Mr X report triggered additional questions in the minds of the clinicians involved with his care and it was understood that diagnostic formulation was made more complex when particular social norms were difficult to determine. The clinicians at the workshop decided that it would be helpful to develop a greater understanding of Somali culture and for guidelines to be developed. It was noted that the Trust's previous links with the Somali community had been recently lost.

10.5. The Independent Investigation Team found that there were two main areas for improvement. These were:

1. General issues relating to diagnostic formulation relevant to all service users of the Oxleas NHS Foundation Trust; and
2. Specific issues relating to people from different ethnic groups and people with Somali heritage in particular.

Recommendation 1. Clinicians should make every effort to draw together the psychosocial circumstances and diagnoses of all service users. Whenever possible a full psychiatric history should be taken and used to construct a comprehensive diagnostic formulation. This should be recorded in full in the service user's clinical record and used to inform care and treatment and all risk assessment and management plans. The Trust should:

- **ensure that this expectation is embedded in all policy documentation;**
- **ensure formal mental state examinations are conducted;**
- **make training and supervision available to all clinicians to develop these skills further;**
- **ensure clinical audit builds diagnostic formulation into the annual review cycle.**

Recommendation 2. Guidelines should be developed to assist in the development of diagnostic formulations for Somali service users. The Trust should consider re-establishing links with the local Somali community in general and with the Hayaan MIND mental health Somali project in particular.

2. Medication and Treatment

- ***Service Issue 1. Mr X was not subject to robust medical evaluation over time – processes around medical assessment were weak. Any planned medication reduction should have taken place whilst under the supervision of secondary care services, particularly in the light of Mr X's relapse history.***

Progress Made To-Date

10.6. The lessons for learning and recommendation setting workshop held with the Trust discussed this issue at length. A consensus was reached that medication reductions should always be planned and implemented with the utmost care; especially for service users with severe and enduring mental illness. A sustained and stable medication regimen was seen as being a key factor to the maintenance of recovery and that in future a more structured stance should be taken.

Recommendation 3. The Trust should review its practice in relation to medical assessment and mental state examination. This will require a robust process that can be routinely assured by clinical governance mechanisms within the Trust.

Recommendation 4. Clinicians should always conduct medication reductions in a systematic manner and guidelines should be developed to support all such decisions. The following should always be considered prior to medication reduction:

- **the role medication has played in the maintenance of recovery;**
- **the service user's mental health response to previous periods of non-compliance, reductions to, or changes of, medication;**
- **the service user's levels of insight and willingness to seek help/engage when experiencing the first signs of relapse;**
- **the levels of support of from carers/friends who can be relied upon to support the service user if relapse occurs.**

The following should always be conducted prior to medication reduction:

- **psychoeducation (service users and carers);**
- **a mental state examination;**
- **a risk assessment;**
- **discussion/liaison with the rest of the secondary care treating team and/or primary care.**

3. Care Programme Approach

- ***Contributory Factor 2. Whilst Care Coordination provided an excellent level of support for Mr X over the years, CPA was conducted outside of the formal framework stipulated by the Trust policy. This led to a reactive approach being taken which did not assess Mr X in a robust manner and did not provide a structured plan to maintain his discharge and ongoing recovery.***

10.6. As part of the Trust's mental health redesign programme it was noted that *"The implementation of the redesign in the last 8 months has delivered increased throughput with patients supported to access care through a focused – active emphasis on self-management, relapse prevention and re -ablement. This far we have rolled out a comprehensive training programme to support all clinical staff in delivering psychological therapies (problem solving, motivational interviewing, managing intense emotions training rolled out to 80% of our staff teams). In addition training on risk management and care planning is rolled out across all community and inpatients services to ensure that our care plans, crisis and contingency plans reflect our robust plans with patients who present in crisis or require across services input".* The Independent Investigation Team duly notes the work that is ongoing in this area and provides the following recommendation in support of the programme that is already in progress.

<u>Recommendation 5.</u> The Trust has a robust CPA policy. In order to maximise its effectiveness a more sensitive clinical audit tool should be developed to ensure adherence to formal CPA milestones - such as:

- **care planning;**
- **risk assessment;**
- **implementation, monitoring and review of care planning;**
- **relapse prevention;**
- **primary care liaison.**

In addition the Trust should consider making these milestones more explicit during:

- **staff induction;**
- **regular CPA training and development and updating programmes;**
- **clinical supervision.**

4. Risk Assessment

- ***Contributory Factor 3. Risk assessment practice over time was of a poor standard. This meant that Mr X was not understood fully in the context of his mental health and relapse history. Whilst this cannot be cited as a direct causal factor a contribution was made by omission.***

Progress Made To-Date

10.7. At present the Trust is reviewing what risk information should be recorded and how. There is recognition that the RiO electronic record system requires review in relation to clinician access, risk flagging, and alert systems. At the current time clinicians are duplicating information needlessly in order to ensure its accessibility. This is taking time; however the Independent Investigation Team was told that this system is under review.

10.8. The Trust is currently working on risk management improvements. In order to manage risk and crisis planning the Trust has established three x weekly zoning meetings in each locality and has also set up post assessment clinics to ensure teams continue to deliver safe clinical care to all patients and manage risk more proactively for complex and CPA patients. Specifically in relation to discharge planning *"as part of the step down process across the ADAPT and ICMP pathways there is an MDT meeting on a weekly basis that all patients who are on a green level and on CPA are reviewed by the senior team in situ and plans for discharge are discussed and agreed accordingly".* Training is being rolled out across the Trust.

<u>Recommendation 6.</u> The RiO-based risk assessment should always be used by clinical teams who should ensure it is updated and comprehensive; all zoning discussions should be recorded formally. In order to support this the current Trust RiO format review should ensure RiO is fit for purpose. As part of the review the RiO system needs to take into account the requirements of clinicians in relation to accessing significant information and should be able to flag high risk service users and incidents in a simple 'at a glance' format.

<u>Recommendation 7.</u> The Trust is establishing a revised programme for assessing and managing clinical risk. There appears to be a significant improvement. The Trust should audit the revised system six months following the publication of this report to establish:

- **the quality of risk assessment and risk formulation;**
- **the quality of risk management, crisis and contingency plans;**
- **the quality and regulatory monitoring and review processes (in particular the zoning system);**

- **the effectiveness of professional communication and liaison systems (with a particular emphasis on that between primary and secondary care).**

<u>Recommendation 8.</u> The Trust should ensure that clinical risk policies make explicit the assessment and management arrangements required for vulnerable adults.

<u>Recommendation 9.</u> The Gallions Reach Health Centre should adopt a formal risk assessment process when making clinical decisions about patients with severe and enduring mental illness. This should be supported by secondary care (clinical expertise and care pathway support) and CCG input (peformance management).

5. Referral and Discharge Planning

- ***Contributory Factor 4. The discharge process for Mr X did not allow for a trial period to test his ability to live independently (especially in the light of his poor management of money and continued gambling). Neither did it provide the GP Practice with a full set of information to support Mr X's recovery.***

Progress Made To-Date

10.9. The Trust has undertaken significant work in with the COMPPAS project and the establishment of Primary Care Plus (please see paragraphs 15.3. – 15.5.).

<u>Recommendation 10.</u> The Trust has established a new model of service delivery via Primary Care Plus. This appears to be working well. The Trust should audit the revised system six months following the publication of this report; this to be achieved in conjunction with the relevant CCGs. The audit should also ascertain GP and service satisfaction with the new arrangements.

6. Safeguarding, Housing and Vulnerable Adults

- ***Service Issue 2. Mr X's financial abuse of his fellow residents whilst in Supported Living accommodation was managed poorly leaving vulnerable adults open to continued exploitation.***

<u>Recommendation 11.</u> The Trust has fit for purpose policies and processes in relation to protecting vulnerable adults from abuse. However it is recommended that more explicit guidance is developed in relation to:

- **service user on service user abuse;**
- **risk assessment and risk management of vulnerable adults which support detailed protection plans;**
- **explicit information about which agency leads for each service user (perpetrator and victim of abuse);**
- **criteria for police referral and intervention;**
- **the Trust risk assessment policy makes more explicit the actions required in relation to Vulnerable Adults.**

7. Service User Involvement in Care Planning and Treatment

- ***Contributory Factor 5. Mr X was not understood in the full context of his cultural identity. This may have weakened the approach taken to support him over the years and prevented a full assessment of his needs from being developed.***

Progress Made To-Date

10.10. The Trust has commenced talks with members from the Hayaan MIND Somali mental health project in order to develop practice guidelines for Somali service users and their families. This recommendation should be addressed in conjunction with recommendation 1 above (see diagnoses).

Recommendation 12. The Trust should consider re-establishing links with the local Somali community in general and with the Hayaan MIND mental health Somali project in particular. Guidelines should be developed in relation to the culture and identity of Somali people with reference also made to the additional impact of asylum seeker and refugee status on mental health and general wellbeing.

8. Documentation and Professional Communication

- ***Contributory Factor 6. Record keeping and records management processes were of a poor general standard over the years in relation to Mr X. This meant that important information about him was 'lost' over time and this impacted upon the way in which the CMHT managed his case.***

Recommendation 13. The Trust should ensure that its current audit processes are reviewed so that they are sensitive enough to detect non-compliance in relation to recording clinical information to an appropriate professional standard.

Recommendation 14. All known patients re-presenting to the Trust will have their archived files checked; if archived between 2005 - 2007, the records will be reviewed to determine whether:

- **a core assessment was conducted at the point of record transition;**
- **the psychiatric history was transitioned from one system to the other;**
- **key risk information transitioned in an easily accessible format;**
- **current care and treatment is appropriate in the light of any identified historic context.**

9. Adherence to Local and National Policy and Procedure

- ***Service Issue 3. The CMHT did not follow Trust policy guidance and operated a less structured and informal approach to CPA and risk assessment processes.***

Progress Made To-Date

10.11. As part of the mental health redesign process the Trust has rolled out a training programme for care planning and clinical risk assessment to ensure all service users have crisis and contingency plans. It is hoped this will improve compliance.

Recommendation 15. In keeping with Recommendation 13 the Trust should revise its clinical audit tools to ensure they are sensitive enough to detect policy non-compliance. The Trust also utilise training and clinical supervision to reinforce the importance of policy adherence.

10. Family Communication Following Incidents

Progress Made To-Date

10.12. NHS England London has been working closely with providers and Mental Health leads, the Metropolitan Police and NHSLA. Guidance on family contact has now been developed and this is due to be rolled out at the end of 2016. Training is being designed by NHS England with the support of the Metropolitan Police and legal teams which will be delivered across London to both NHS providers and Metropolitan Police Family Liaison Officers with a target date of spring 2017. NHS England now also has a direct liaison officer link with Metropolitan Police who is a member of the Independent Investigation review Group. This individual supports all investigations and contacts with families thus facilitating ongoing family communication processes.

Recommendation 16. Following serious incidents involving homicide or suicide the Trust must make every effort to contact families with immediate effect. The Trust and NHS England should discuss how best this can be facilitated (in light of the new arrangements set out directly above) with the Metropolitan Police Service and ensure that dedicated senior officers are deployed within the organisation to maintain support and communication throughout the investigation process.