HASCAS
Health and Social Care Advisory Service

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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Contents

1. **Investigation Team Preface** **Page 3**
2. **Condolences to the Family and Friends of Mr Y** **Page 3**
3. **Incident Description and Consequences** **Page 3**
4. **Background and Context to the Investigation** **Page 4**
5. **Terms of Reference** **Page 6**
6. **The Independent Investigation Team** **Page 7**
7. **Investigation Method** **Page 7**
8. **Information and Evidence Gathered** **Page 12**
9. **Profile of the Oxleas NHS Foundation Trust and the Gallions Reach Health Centre** **Page 13**
10. **Chronology of Events** **Page 14**
11. **Identification of the Thematic Issues** **Page 25**
12. **Further Exploration and Identification of Contributory Factors and Service Issues** **Page 28**
    - 12.1. Diagnosis **Page 29**
    - 12.2. Medication and Treatment **Page 35**
    - 12.3. Use of the Mental Health Act (1983 & 2007) **Page 43**
    - 12.4. The Care Programme Approach **Page 45**
    - 12.5. Risk Assessment **Page 49**
    - 12.6. Discharge Planning **Page 56**
    - 12.7. Safeguarding, Housing and Vulnerable Adults **Page 60**
    - 12.8. Service User Involvement in Care Planning **Page 64**
    - 12.9. Family Involvement **Page 68**
    - 12.10. Documentation and Professional Communication **Page 70**
    - 12.11. Adherence to Local and National Policy and Procedure **Page 73**
    - 12.12. Clinical Governance **Page 75**
13. **Conclusions** **Page 77**
14. **NHS England, GP Practice and Trust Response to the Incident and the Internal Review** **Page 80**
15. **Notable Practice** **Page 87**
16. **Lessons for Learning** **Page 88**
17. **Recommendations** **Page 89**
18. **Glossary** **Page 96**

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.

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

1. Health Service Guidance (94) 27

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. Background and Context to the Investigation (Purpose of Report)

4.1. The Health and Social Care Advisory Service was commissioned by NHS England to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94) 4*, issued in 1994 to all commissioners and

providers of mental health services. In discussing 'when things go wrong' the guidance states:

"… in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved".

4.2. This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

4.3. The purpose of an Independent Investigation is to review thoroughly the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

4.4. The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

4.5. The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and independent investigation team.

4.6. An HSG (94) 27 investigation is commissioned to produce a report fit for placing in the public domain that sets out the requirements detailed above.

5. Terms of Reference

5.1. *"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.*

5.2. *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".*

6. The Independent Investigation Team

Selection of the Investigation Team

6.1. 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

7. Investigation Method

7.1. On 25 November 2014 NHS England commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section five of this report. The Investigation Methodology is set out below. It was the decision of NHS England that full anonymity be given to Mr X and all witnesses to the Investigation.

Communication with Mr X

7.2. Mr X died on 3 March 2014 and therefore could not be included in this investigation.

Communications with the Families of Mr X and Mr Y

The Family of Mr Y

7.3. Initially no contact was made with Mr Y's family by the Trust or the GP Practice. However it should be noted that on 17 June 2013 the Trust made contact with the police and passed information to the family liaison officer in readiness for when the family wanted contact with the NHS. Contact was eventually made by NHS England in July 2014 via a homicide case worker at Victim Support who was working with the eldest sister of the victim. On 10 October 2014 the NHS England Head of Patient Safety and Patient Safety Lead for Mental Health went to the home of one of Mr Y's sisters where she was joined by two more of his sisters and their Victim Support Worker. The NHS England managers explained all they knew about the incident and said that an independent investigation was going to go ahead.

7.4. On 8 September 2015 the Independent Investigation Chair and a senior officer from NHS England London Region visited Mr Y's sister. On this occasion the process and purpose of the independent investigation was explained to her and the next steps were planned. It was agreed that prior to the publication of the report a further meeting would be held with her and any other family members who would like to be present.

The Family of Mr X

7.5. Initially no contact was made with Mr X's family by the Trust or the GP Practice. Communications were initiated by the Independent Investigation Chair via email and letter. At the time of writing this report no response from the family had been received. However we are mindful that the Inquest into Mr X's death was also running in parallel and renewed efforts will be made in order to communicate the investigation process and findings prior to publication of the report.

Communications with the Oxleas NHS Foundation Trust

7.6. The Independent Investigation Team worked with the designated Trust liaison officer to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished (a Trust briefing workshop was held to facilitate the process);
- those interviews were held on 29 and 30 July 2015 at the Trust Headquarters and that the Investigation Team were afforded the opportunity to interview witnesses and meet with the Senior Managers of the Trust.

7.6. Factual accuracy and headline findings communications were held between the Independent Investigation Team and the Oxleas NHS Foundation Trust in accordance with Investigation best practice.

7.7. The draft report was sent to the Trust for factual accuracy checking on 11 February 2016. Clinical witnesses were also sent copies of the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

Communications with the Gallions Reach Health Centre

7.8. Communications with the health centre were initially delayed until the full GP record was located and sent to the Independent Investigation Team; the records had been archived and were difficult to trace. Subsequently the health centre was contacted, a briefing given and arrangements for interviews made. Interviews were held on 16 October 2015. The draft report was sent to the Health Centre for factual accuracy checking on 22 February 2016.

Witnesses Called by the Independent Investigation Team

7.9. Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with national good practice guidance.

Table One
Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
29 July 2015	Trust Board Chair Trust CEO Trust Medical Director Trust Head of Patient Safety Trust Director of Mental Health and Adult Learning Disability Services ***** Consultant Psychiatrist 2 Associate Specialist	Investigation Chair/Team Nurse Investigation Team Psychiatrists 1 and 2 Investigation Team GP Investigation Team Governance Systems member In attendance: Stenographer
30 July 2015	Occupational Therapist ***** Approved Mental Health Professional Consultant Psychiatrist 1 ***** Care Coordinator 2	Investigation Team Nurse/Chair Investigation Team Psychiatrists 1 and 2 Investigation Team Governance Systems member In attendance: Stenographer
16 October 2015	GP 1 GP2 GP Practice QOF Officer	Investigation Team Nurse/Chair Investigation Team GP In attendance: Stenographer
26	Director of Nursing NHS England	Investigation Team Nurse/Chair

November 2015	London Head of Patient Safety NHS England London Medical Advisor NHS England London	Investigation Team Governance Systems member

Investigation Procedures

7.10. The Independent Investigation Team adopted accepted good practice during the course of its work. This is set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:
   - **(a)** of the terms of reference and the procedure adopted by the Investigation; and
   - **(b)** of the areas and matters to be covered with them; and
   - **(c)** requesting them to provide written statements to form the basis of their evidence to the Investigation; and
   - **(d)** that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and
   - **(e)** that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and
   - **(f)** that it is the witness who will be asked questions and who will be expected to answer; and
   - **(g)** that their evidence will be recorded and a copy sent to them afterwards to sign; and
   - **(h)** that they will be given the opportunity to review clinical records prior to and during the interview.
2. Witnesses of fact will be asked to affirm that their evidence is true.
3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.
4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.
5. All sittings of the Investigation will be held in private.
6. The findings of the Investigation and any recommendations will be made public.
7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.
8. Findings of fact will be made on the basis of evidence received by the Investigation.
9. These findings will be based on the comments within the narrative of the Report.
10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

7.11. The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

7.12. Prior to the first meeting taking place each clinical team member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference (non-clinical team members received a timeline in lieu of the clinical records to preserve patient confidentiality). It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

First Team Meeting 19 May 2015

7.13. The Investigation Team examined and discussed the chronological timeline which had been produced following the receipt of the full clinical records. The Investigation Team decided which staff they wished to interview and agreed questions they would ask. The list of documents required was made; this consisted of various Trust Policies and Operational Policies together with information about the Trust.

Second Set of Team Meetings (between July and end of October 2015)

7.14. There was opportunity during the interview schedule which allowed the Investigation Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the organisation and systems of the teams that had contact with Mr X and also management and governance issues. The team met on several occasions over four months to conduct interviews and hold team discussions.

7.15. Following the witness interviews the Investigation Team received the transcripts and were able to add to the timeline to reflect upon the additional information. There were also additional policies and procedures sent from the Trust and GP Practice which were examined. The Investigation Team was able to work both face-to-face and in a virtual manner in order to complete the Root Cause Analysis methodology and develop the report findings and conclusions. A meeting was held on 28 August 2015 to specifically examine findings and conclusion in relation to the care and treatment provided by the Oxleas NHS Foundation Trust.

Other Meetings and Communications

7.16. The Independent Investigation Chair maintained communications on a regular basis with NHS England throughout the process. Communications were maintained inbetween meetings by email, letter and telephone.

Root Cause Analysis

7.17. The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that, on detailed analysis,

are considered to have contributed to a critical incident occurring. This methodology is the process advocated by NHS England when investigating critical incidents within the National Health Service.

7.18. The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility. RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.
2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

7.19. When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

8. Information and Evidence Gathered (Documents)

8.1. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Trust clinical records for Mr X.
2. GP records for Mr X.
3. GP Practice, NHS England London and Oxleas NHS Foundation Trust internal investigation reports and investigation archive.
4. Trust assurance and governance documentation.
5. Secondary literature review of media documentation reporting the death of Mr Y.
6. Independent Investigation witness transcriptions.
7. Independent Investigation witness statements.
8. Trust Clinical Policies, past and present (relating to the case).

9. GP Practice Clinical Policies, past and present (relating to the case).
10. Trust Care Programme Approach Policies, past and present.
11. Trust Incident Reporting Policies.
12. Trust Being Open Policy.
13. Trust Operational Policies.
14. Care Quality Commission Reports for Oxleas NHS Foundation Trust and Gallions Reach Health Centre.
15. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive (2006).
16. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed* (September 2005).

9. Profile of the Oxleas NHS Foundation Trust and the Gallions Reach Health Centre

Oxleas NHS Foundation Trust

9.1. Oxleas NHS Foundation Trust provides a wide range of health and social care services in south east London, specialising in community health, mental health and learning disability services. The Trust provides care for people of all ages and works closely with a variety of partners to ensure that services are well-integrated and wide-ranging. The Trust has a workforce of around 3,500 people including many highly skilled health and social care professionals. Care and treatment is delivered from 125 sites in a variety of locations across the London Boroughs of Bexley, Bromley and Greenwich and into Kent.

9.2. Trust services include a range of physical health services to adults and children in the community in the boroughs of Bexley and Greenwich. These range from health visitors working with the very young to district nurses and therapists meeting the physical health needs of older people.

9.3. The Trust has been the main provider of specialist mental health care in Bexley, Bromley and Greenwich for more than ten years and has developed a comprehensive portfolio of services in community and hospital settings. The Trust also provides specialist forensic mental health care across south east London and in Kent Prisons.

Gallions Reach Health Centre

9.4. Thamesmead Medical Associates is a partnership of general practitioners. The service was originally practised from premises in Titmus Avenue and moved to the purpose-built Gallions Reach Health Centre in 1986. Gallions Reach Health Centre is one of the largest health centres ever to be built in Great Britain. It not only houses GP practice but also is home to Health Visitors, School Nurses, Speech and Language Therapy, a Sickle Cell Thalassaemia Unit, Physiotherapy/MSK ICAT, Chiropody, Time to Talk, the Marshes Midwifery Team, a Pharmacy and a Dental Practice. It provides full access for disabled patients.

10. Chronology of Events

Root Cause Analyses First Stage

10.1. The chronology of events forms part of the Root Cause Analysis first stage. It provides a history of the care and treatment that Mr X received and also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr X and the care and treatment he received from mental health services.

10.2 This chronology provides a factual summary of events taken from over 2,500 pages of clinical records and other supporting documentation – it does not include every contact. The Independent Investigation Team took the decision to include a significant amount of personal detail, as it is not possible to understand the issues relating to the care and treatment provided without this degree of context.

Background

10.3. 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.

10.4. Mr X was reportedly married in 1987 but was later divorced from his first wife with whom he had no children. There is speculation as to whether or not he married for a second time between 2005 and 2007 when he returned to Somalia for two protracted visits. Mr X had a sister and nephew living in the United Kingdom with whom he had a good and supportive relationship.

History of Care and Treatment

1997

10.5. On **5 December 1997** Mr X was admitted to Greenwich District Hospital under a Section 136 (Mental Health Act 1983 and 2007) for depression and suicidal ideation. He had *"fallen"* in front of a tube train at Green Park Station. He denied trying to kill himself and appeared to be confused. He became tearful when discussing the reasons for his leaving Somalia. He denied feeling depressed or suicidal; he sustained superficial injuries. The GP notes described this as a manic episode with psychotic symptoms.[2] Following his admission it was ascertained that Mr X had been witnessed falling deliberately under a train. He however denied being depressed or suicidal and said something about traumatic events in Somalia which he would not elaborate upon. On this occasion he was diagnosed with diabetes for the first time. He was discharged on **16 December**.

2. Notes pp 1488 and 1724 and GP records p 4

1998

10.6. In **February 1998** Mr X was admitted to Greenwich District Hospital for non-psychotic mania. He was discharged on **1 May** on Haloperidol and Procyclidine (the dosage is not recorded). On **15 May** the GP referred Mr X to secondary care services. He noted that Mr X *"was admitted to G.E. ward on 8th December 1997 and discharged on 16th December 1997 having fallen in front of a tube train. The diagnosis at the time was probably acute confusional state secondary to undiagnosed diabetes. Mr X also admits to being admitted into a hospital in Germany previously, he does not know when, for a similar episode of excitability and agitation".*[3]

2000

10.7. The next admission took place on **17 August**. Mr X was admitted to the Cygnet Wing Blackheath for depression – he had been transferred from Greenwich District Hospital. He was brought to A&E by his sister as he was not eating or drinking and was expressing suicidal ideas. Mr X felt his depression was due to: a) the lack of tangible achievement in life generally b) Divorce from his wife five years previously whom he had loved c) Lack of a family of his own d) Failure to succeed whilst living in Germany.[4]

2002

10.8. In **November** Mr X was reviewed in a Trust outpatient clinic in the presence of his nephew and sister. There were no signs of depression, suicide or psychosis. The assessing doctor concluded that Mr X had never been at threat in Somalia and that some of his story had perhaps been fabricated.[5] The Consultant Psychiatrist wrote to the GP to say that there appeared to be no history of psychological trauma. Mr X lived a socially withdrawn life with his sister and nephew and was thought to be suffering from a chronic adjustment disorder.[6]

2003

10.9. Mr X was given leave to stay in the United Kingdom indefinitely by the Home Office. There are no further details given about this.

2004

10.10. Between **5** and **14 January** Mr X underwent an informal inpatient admission to Oxleas House. He was living with his sister and had been referred by the GP. He had been neglecting himself and was virtually mute. It was noted he had diabetes and hypothyroidism. On admission his mood rapidly stabilised and he was compliant with his medication. The plan was to help him find some accommodation. His insight improved and he was recorded as being no management problem on the ward. He was discharged back to his sister's home and followed up by the Home Treatment Team for a two-week period.[7]

10.11. In **March** the GP wrote to the Consultant Psychiatrist to say that Mr X was refusing to eat or drink and was not speaking. He was thought to be at increased risk due to his diabetic state. An urgent assessment was requested. On **7 April**

3. Old GP notes file 3 pp 9 - 11
4. Old GP notes file 3 pp 1 - 5
5. Old GP notes file 1 p 29
6. Notes p 1306
7. Notes pp 19 – 20 and 1129 - 1139 and 1336

Consultant Psychiatrist 1 wrote to the GP to say that Mr X was *"suffering from an adjustment syndrome, mixed disturbance of emotions and conduct ~ (F43.21)".* It was not thought he was suffering from a severe or enduring mental illness. The plan was for Mr X to continue on Fluoxetine and his anti-diabetic medication and be reviewed in four weeks.

10.12. By **June** Mr X had been admitted once again. Clinical records state that Mr X was placed on Section 5 (2) of the Mental Health Act (some notes are missing for this period and it cannot be determined what exactly happened). Mr X had been aggressive and had stopped eating and drinking; on admission he rapidly became calmer. He was discharged to his sister's home on **22 June**.[8]

10.13. On **5 November** the Consultant Psychiatrist discharged Mr X from the caseload as he had not attended the outpatient clinic. On **27 November** Mr X underwent an informal inpatient admission to Oxleas House via the A&E department. Whilst on the ward he was aggressive and assaulted a female member of staff and ran around the ward naked. He was then detained under Section 5 Subsection 2 of the Mental Health Act by the medical Senior House Officer (SHO). A risk assessment was conducted and all Mr X's risks were deemed to be low with the exception of self neglect and *"suicidal talk".*[9]

2005

10.14. A discharge summary was written on **4 January**. On admission Mr X had rapidly improved. His medication was Fluoxetine 20mg twice daily, he was also on Thyroxine. The plan was to review him at the outpatient clinical in two weeks.[10]

10.15. The Police contacted the Consultant Psychiatrist on **26 May**. The Police were investigating a serious assault and were requesting information about Mr X. The Consultant Psychiatrist faxed Plumstead Police Station to say that he could not disclose Mr X's notes without his consent.[11] It would appear this ended the communication with the Police.

10.16. Between **5** and **16 August** Mr X underwent an informal inpatient admission to Oxleas House. He had initially been seen by the Home Treatment Team. He had not been eating or drinking or taking his medication. Mr X said he had been low in mood since being imprisoned for two months for beating someone. He felt hopeless and in shock about his situation. In the event he had not been convicted and was released from detention. Mr X had beaten his victim because he thought this person was using his sister's home to commit credit card fraud. The plan was to discharge him back to his sister's home.[12] **At this point Mr X left England for two prolonged visits to Somalia.**

2007

10.17. Between **7 April** and **24 May** Mr X underwent an informal admission to Oxleas House. He was admitted from the Surrey Hampshire Borders Trust following his arrival from Somalia at Gatwick airport. He was mute and confused. It was thought

8. Notes 913 – 918 and Notes pp 21 – 22 and 1140 - 1148
9. Notes pp 23 – 24 and Old GP notes file 3 p 47 p 1348
10. Notes pp 1256 - 1260
11. Notes pp 1248 - 1250
12. Notes pp 25 – 26 and 1486

that Mr X may have been experiencing a severe psychotic depression. His blood sugar was found to be extremely high and that he had not been taking his diabetic medication whilst in Somalia. This was seen as being a possible self harming behaviour linked to his depression. On assessment it was noted (by a member of staff who had known him previously) that Mr X had been involved in a previous act of violence at his sister's home when he had hit a man over the head with a baton. The victim had required a week in hospital. No charges were pressed. It was noted that the history of the assault needed to be confirmed with the family. During his admission Mr X said he was hearing voices that were derogatory in nature. However they did not tell him to harm anyone or himself. On occasions Mr X was perplexed and confused. However he stabilised quite quickly and continued to be well. His family was supportive throughout – they mentioned that he had been paranoid, suspicious and withdrawn at home believing people wanted to harm him. The impression was Paranoid Schizophrenia with depression. There were plans for the Housing Team to assess him.[13]

10.18. On **5 June** Mr X was reviewed at a post discharge clinic by an Associate Specialist. Mr X was smartly dressed. He was alert and said he felt well. He was being followed up by the day treatment team at Oxleas House. The ongoing plan was to seek supported accommodation for him.[14]

10.19. On the **8/9 June** Mr X was brought to Oxleas House by the Ambulance Service via A&E as there was a marked motor retardation. Mr X was still living with his sister and he said he was uncomfortable at her home and felt paranoid. He was readmitted to the ward. At this stage the Associate Specialist wrote to the Recovery Team Manager at the Heights (Greenwich CMHT) requesting a Care Coordinator for Mr X.[15] On **27 June** Mr X was assigned a Care Coordinator – he was also discharged (although the exact date for this was not made explicit in the clinical record).

10.20. Mr X was found accommodation via Supported Living. Throughout **July** Mr X attended the ward for day programmes and travelled in a taxi to his new accommodation.

10.21. On **30 July** contact was made with Mr X's new landlord. His medication had run out and he owed £45.00 for food. A cab was arranged to take Mr X to and from the ward as he had no money for a bus. It was noted that Mr X could not go without food because of his diabetes and it was unclear how he would find the money for this.[16] A discharge summary was written; Mr X's diagnosis was given as Paranoid Schizophrenia and Type II Diabetes. It was noted that he was able to function independently and not was considered a risk to either himself or others. Mr X had been admitted with confusion and disorientation. He had probably also discontinued his medication. On admission Mr X had suffered from auditory hallucinations of a derogatory nature. On admission he was considered to be a moderate risk of self harm and a low risk of suicide and harm to others. His medication on discharge was Risperidol Consta 37.5mg fortnightly and Citalopram 40mg once daily; the decision had been made to place Mr X on a depot injection as it appeared the main reason for

13. Notes pp 27 – 29, 293, 322, 327 – 328, 329, 722
14. Notes p 293 & 385 - 387
15. Notes pp 299 - 300
16. Notes p 291 – 292

his relapse was a non compliance with medication. The plan was to follow him up in two weeks at the discharge clinic.[17]

10.22. Throughout **August** Mr X met with Care Coordinator 1 at his home. He had failed to visit the CMHT offices and had missed his depot therefore this was administered at his accommodation. On **10 August** the Landlord telephoned the CMHT to say that Mr X had been aggressive and had demanded his post office card (which he had been asked to hold on Mr X's behalf). Apparently Mr X had run out of money. It was agreed Mr X would have his card and be responsible for buying his own meals. This was to be monitored.[18] Mr X appeared to be stable and well and a bus pass was given to him so he could visit the CMHT.

10.23. Mr X continued to be stable and well. On **15 November** a CPA review was held. Mr X did not attend as he was too sleepy following a prescription of sleeping tablets from his GP. The diagnosis was given as Paranoid Schizophrenia. His medication was a fortnightly depot of Risperidone Contra 37.5mg.

10.24. Mr X was no longer experiencing auditory hallucinations. He said he preferred his family not to be involved in his care. He appeared stable although it was noted that he had no structure to his day. The plan was to:

- continue on Enhanced CPA;
- continue with his medication;
- assess employment issues;
- assess and offer support from the 'Bridge Builder'; and
- arrange another CPA review in three months time.[19]

2008

10.25. Care Coordinator 1 conducted a home visit on **21 January**. She was informed by the Landlord and the Supported Housing Manager that Mr X had been taking money from another resident's room. Mr X was advised that stealing money was a criminal offence and that he should not do it again. The plan was to work with Mr X to help him with his finances.[20]

10.26. On **14 February** a CPA review was held. The diagnosis was given as *"? Paranoid Schizophrenia"*. It was noted that he had previously been given a diagnosis of Bipolar Disorder (no other information was given). His medication was a fortnightly depot of Risperidone Contra 37.5mg. Mr X had been stable since his last admission on **7 August 2007**. Mr X presented as well groomed and calm. He did not appear to be depressed and no psychotic symptoms or cognitive impairment were apparent. Mr X denied any suicidal or violent thoughts and also denied that he was taking Khat or any illegal drug. He did not drink alcohol. The plan was:

- for him to continue on Enhanced CPA;
- to continue with his medication;
- to offer leisure time structure;
- to ask for routine blood tests;

17. Notes pp 392 - 403
18. Notes pp 287 - 290
19. Notes p 284
20. Notes p 282

- to reinforce healthy living initiatives;
- to arrange another CPA review in six months and the 'Caring Landlord' to be invited.[21]

10.27. Mr X continued stable and well; he attended regularly for his depot injection. On **14 August** a **CPA Review** was held. Mr X's diagnosis was now Bipolar Disorder currently in remission. It was noted that he was on a fortnightly depot of Risperidone Contra 25mg. Mr X appeared to be well with no signs of psychosis or cognitive impairment. No risks were identified. The plan was:

- for him to continue on Enhanced CPA;
- to reduce medication from 37.5mg fortnightly to 25mg;
- to arrange an occupational therapy assessment;
- to arrange another CPA review in six months and the 'Caring Landlord' to be invited.[22]

10.28. Throughout the rest of the year Mr X continued stable and well remaining fully engaged with mental health services.

2009

10.29. In **January** Mr X's accommodation placement was reviewed. Mr X was keeping to his license agreement and getting on well with the other residents. No risks were identified. Mr X appeared to be doing well and help with cooking skills was to be offered.[23]

10.30. On **19 February** a CPA review was held. Mr X's diagnosis was given as Bipolar Disorder currently in remission. It was noted that he was on a fortnightly depot of Risperidone Contra 25mg. It was also noted that Mr X had remained stable despite his depot having been reduced. Mr X was appropriately dressed and he appeared friendly, if reserved. No suicidal or violent thoughts were voiced by Mr X. The plan was:

- for him to continue on Enhanced CPA;
- to continue with his medication;
- to continue with OT activities;
- to liaise with the Greenwich Somali Network to identify any cultural issues (there is no record to suggest this was done);
- to arrange another CPA review in six months and the 'Caring Landlord' to be invited.[24]

10.31. Between **March** and **July** Mr X continued stable and well attending regularly for his depot injection at the CMHT base. On **16 July** a CPA review was held. It was noted that he remained stable on the reduced dosage of Risperidone Contra 25mg. The plan stayed the same and he was to be reviewed in six months time.[25]

10.32. Between **July** and **December** Mr X continued to be stable. He received regular inputs from Care Coordinator 1 and also from Occupational Therapy in a bid to

21. Notes pp 280 - 281
22. Notes pp 276 - 277
23. Notes pp 272 - 273
24. Notes pp 269 – 271
25. Notes pp 258 - 261

improve his daily living skills. On **10 December** a CPA review was held. No changes were made to his care and treatment plan and no changes to Mr X's health or wellbeing were noted.[26]

2010

10.33. Mr X made an unplanned visit to the Heights on **28 May**. He wanted to discuss a change of medication at the next CPA. He felt he was well and no longer needed medication. Oral medication was discussed. On **3 June** a CPA review was held. Consultant Psychiatrist 2 decided to change Mr X's medication to oral Risperidone 3mg and to take him off his depot injection. Mr X was deemed to be fully independent and there were no problems identified with his daily living or finances. The plan was:

- for him to continue on Enhanced CPA;
- to change his medication;
- to continue with leisure activities;
- to apply for independent accommodation;
- to arrange another CPA review in six months time.[27]

10.34. During **August, September** and **October** Mr X reported difficulties with managing his money and he also disclosed that he had a gambling problem. In **August** Mr X was transferred to a new Care Coordinator. On **2 November** a CPA review was held. It was noted that Mr X had a diagnosis of Bipolar Disorder and also had a gambling problem. Mr X was prescribed Risperidone 3mg which he was taking. He had experienced no side effects since coming off his depot medication. He remained in supported accommodation but was waiting to be re-housed as a private tenant. Mr X reported no problems with his finances. He was attending drop in centres and was well dressed and groomed. The plan was:

- for him to continue on Enhanced CPA;
- to continue on current medication;
- to continue with leisure activities;
- to arrange another CPA review for as soon as possible.[28]

2011

10.35. In **January** the Greenwich Supported Lodgings Scheme conducted an assessment. It was noted that sometimes Mr X repeated difficult behaviours. Managing money was identified as being a major issue – this led to his borrowing money and this was something he would not stop. However he attended college and the local mosque regularly which he enjoyed. Mr X was generally pleasant but could on occasions be *"moody".* He continued to need support taking his medication. It was reported that he had a significant gambling problem which everyone was *"at a loss"* as to how to address.[29] On **9 February** a meeting was held with Mr X, Care Coordinator 2, his Landlady and the Manager of the Greenwich Supported Lodgings. Mr X was borrowing money from the other residents and this was causing difficulties. He denied he had a gambling problem and refused help. The plan was for the:

26. Notes pp 250 - 25
27. Notes pp 245 - 246
28. Notes pp 240 -241
29. Notes pp 428 – 433

- CCO to work on a budgeting plan;
- for Mr X to avoid borrowing money;
- for him to continue to exercise;
- for Mr X to pay upfront his bill at the Somali restaurant where he ate most of his meals;
- for the Landlady to monitor his medication compliance;
- for the CCO to meeting with Mr X fortnightly;
- to review in one month.

10.36. A housing care plan and risk assessment was completed. The most serious risk identified was his financial exploitation of other residents. Care Coordinator 2 was to remain involved and Mr X was warned this could end his tenancy.[30] During the rest of **February** Care Coordinator 2 continued to work with Mr X on his finances. A contract and support plan was developed. Mr X would lose his tenancy if he continued to financially abuse people. Mr X signed the new contract.

10.37. On **17 March** Mr X was informed that a safeguarding meeting had been held (in relation to the vulnerable adult Mr X had been financially abusing). Mr X was to be allocated a Support Worker to help with his self care and budgeting. He was warned that the police would be involved if he did not stop borrowing from the other residents. A resettlement plan was to be drawn up.[31] On **25 March** a Professionals' Meeting was held regarding an ongoing safeguarding issue at Mr X's accommodation. Mr X was financially exploiting the other residents. It was agreed that a formal warning letter would be sent to Mr X and that Care Coordinator 2 would refer him for an Occupational Therapy assessment to see how best Mr X could be worked with in the future. The plan was to refer Mr X to Gamblers Anonymous.[32] On **20 April** Mr X was escorted to view a new housing project in order to resolve ongoing problems with his behaviour. The landlord showed Mr X around and explained the rules. The plan was to move Mr X after his next CPA review.[33]

10.38. A CPA review was held on **26 April**. At this time Mr X was stable with no psychotic features. He confirmed he had been taking his medication. He was attending college three times a week for English lessons and also attended drop in centres. A review was due in relation to accommodation in order to protect Mr X's vulnerable fellow residents from his constant demands for money. Risks in relation to self harm and harm to others were deemed to be low. The plan was:

- to continue on Enhanced CPA;
- to continue current medication (not mentioned);
- to continue with leisure activities;
- to continue with Occupational Therapy;
- to consider a referral to a gambling clinic;
- to review in six months time.[34]

10.39. A Professionals' Meeting was held on **28 April** so that plans could be put into place to protect a vulnerable adult from whom Mr X continued to demand money.[35]

30. Notes pp 238, 445 – 446, 447 - 450
31. Notes pp 235 - 236
32. Notes pp 234 - 235
33. Notes pp 230 - 231
34. Notes pp 227 - 229
35. Notes p 227

10.40. In **May** Mr X was moved to new accommodation. He was described as being well kept and mentally stable. His tenancy was signed and a support plan agreed. He was still gambling but *"not much".* In **June** a referral to a gambling clinic was made. During this period Mr X remained stable and well. On **11 July** Care Coordinator 2 met with Mr X; he was well kept and compliant with his medication. He had not completed the gambling clinic referral form as he did not think he needed the service. He also said that he was no longer borrowing money. Mr X was informed that he would be allocated a new Care Coordinator who would contact him shortly.[36]

10.41. In **August** the new Care Coordinator took Mr X onto her caseload. Care Coordinator 3 made many attempts to engage with Mr X but was unable to arrange a face-to-face contact. On **2 September** Mr X's former Landlord contacted Care Coordinator 3 to say that Mr X had been laying in wait to take money from a resident at his old address. The resident who was a vulnerable adult felt unable to refuse. Mr X was taking advantage of him.[37] On **9 September** Mr X was discussed at a CMHT team meeting. The situation at his former address was discussed, it was also noted that Mr X was not getting on with his new neighbours. When called Mr X's mobile telephone went straight through to voicemail and he would not answer.

10.42. On **14 September** Mr X made an unannounced visit to the CMHT base. When challenged about taking money from a former housemate Mr X left the building. On 21 September Mr X made another unannounced visit. He wanted help with finding independent private accommodation.[38]

10.43. A CPA review was held on **25 October**. At the review it was thought that Mr X had the ability to live independently. The medication was noted to be Risperidone 3mg at night. He remained stable and had no reoccurrence of his psychotic symptoms. Mr X said he was compliant with his medication and that he experienced no side effects. He continued to attend Trinity and Campus Drop in Centres and denied there were any problems with his gambling and rejected a referral for this. Mr X appeared to be well dressed and groomed and had good insight. No risks were identified and the plan was:

- to continue on Enhanced CPA;
- for Care Coordinator 3 to continue as Care Coordinator;
- to continue on current medication (Risperidone 3mg *nocte*);
- to continue with current daytime structured activities;
- to work on housing issues;
- to meet with Care Coordinator every two weeks;
- to be reviewed in six months time.[39]

10.44. Mr X visited the CMHT base twice in **November** to enquire about how his application for independent living and a private tenancy was progressing. He was told that the Resettlement Team was working on this. On **14 December** it came to Care Coordinator 3's attention that Mr X continued to take money from his former housemate. It was acknowledged that Mr X's gambling habits seemed to be increasing. However Mr X appeared to be making progress even though he needed

36. Notes p 224
37. Notes p 222
38. Notes p 221
39. Notes pp 219 - 220

prompting to wash his clothes, tidy and take a bath. It was noted that Mr X refused to look for either paid or unpaid work and that he had also refused to go to gamblers anonymous.[40]

2012

10.45. On **4 January** Mr X visited the CMHT base to see how his housing application was progressing. He was still financially abusing his former housemate. In **February** Mr X's Landlord expressed his concerns about Mr X's inability to take care of himself and look after his bedroom which was dirty and untidy. The Landlord had only recently been told about Mr X being on Insulin and Risperidone, he was asked to monitor Mr X's compliance. At this stage Care Coordinator 3 found it difficult to engage with Mr X as he was rarely to be found at his home.[41]

10.46. A joint nursing visit was made to Mr X's home on **16 March**. Mr X was well and he had been compliant with his medication. His blood sugar levels were within normal range and he reported having no psychotic symptoms.[42]

10.47. On **25 April** a CPA review was held. Mr X was reported as being stable and well. He was attending college three days a week and also a local drop in centre. He admitted to gambling but said this was minimal as he did not have a lot of money. He was currently living in supported living accommodation and had recently lost an opportunity to be rehoused as he had not maintained contact with Care Coordinator 3; he however remained on the rehousing list. Care Coordinator 3 suggested an urgent meeting to fill in housing forms to which Mr X had agreed. Mr X's risks were all deemed to be low. The plan was:

- to continue on Enhanced CPA;
- for Care Coordinator 3 to continue involvement;
- to continue on current medication (Risperidone 3mg *nocte*);
- to continue with current daytime structured activities;
- to work on housing issues;
- to meet Care Coordinator 3 every two weeks;
- to be reviewed in six months.

10.48. Care Coordinator 3 also wrote that Mr X spent most of the day out of his accommodation and that he continued to gamble. He also continued to harass vulnerable clients for money. However he appeared to be recovering well.[43]

10.49. Mr X began to work with Care Coordinator 3 again. He was told that his gambling and subsequent debts could prevent him being placed in private accommodation. An Appointeeship was discussed with him and he agreed to this (in the event this was not progressed).[44] In **July** Mr X was allocated a flat which made him very happy. He was given a grant to buy furniture and Care Coordinator 3 set up

40. Notes pp 217 - 218
41. Notes p 216
42. Notes p 215
43. Notes pp 212 - 214
44. An appointee is responsible for managing a person's benefits, and also for paying bills and managing a small and limited amount of savings in case of unforeseen circumstances. Appointeeship may be the best course of action if the person has a low level of financial assets, is in receipt of benefits and doesn't have any other sources of income.

the payment process for Mr X's gas and electricity bills. Throughout this period Mr X appeared to be well kept and mentally well.[45]

10.50. Care Coordinator 3 ensured Mr X had a fridge in which to keep his Insulin and took him to the Gallions Reach Health Centre to register. On **8 October** Mr X met with GP 1. It was noted that Mr X had a good history of concordance with medication. It was recorded that *"has 1 week supply of his meds. Thinks he is on metformin 500mg tds, gliclazide 80mg bd, exenatide, risperidone 3mg at night, simvastatin 40mg at night. He will bring in the repeat slip so we can check and put on his repeat for him. Says it's in a weekly dosette box".*[46]

10.51. On **12 October** a CPA review was held with an Associate Specialist and Care Coordinator 3. It was noted that Mr X was happy with the transfer to his GP; no carer view was sought. The plan was for Mr X to continue to receive his medication from his GP practice. It was recorded that Mr X had a Bipolar Disorder which was now in remission and that he was receiving Risperidone 3mg at night. Mr X had been successfully rehoused - there had been fears that he would spend his entire refurbishing grant on gambling, but he had bought a refrigerator, TV and sofa. At this time Mr X was deemed to be stable and was complaint with his medication and was agreeable to discharge from the service. The plan was:

- discharge to GP (and send discharge letter);
- for the GP to continue with medication and to lower it in six months with a view to stopping it altogether if Mr X remained stable;
- for the GP to refer back if there were concerns about Mr X's mental state.[47]

10.52. On **22 October** a medication review was held at the GP surgery. Over the next two months Mr X attended the surgery for diabetes monitoring and minor ailments.

2013

10.53. Another medication review was held on **14 February** - No problems were noted in relation to his diabetic annual review – his risks were all deemed to be low. A depression questionnaire was negative.[48] On **21 March** Mr X made an unannounced visit to the CMHT base to see Care Coordinator 3. He wanted to talk about reducing his medication – he was advised to discuss this with his GP – he appeared to be mentally stable and well on this occasion.

10.54. On **19 April** Mr X attended the GP practice to ask if his Risperidone could be reduced. Mr X was stable and it was noted that the *"psych"* discharge letter said this could be considered. Consequently the Risperidone was reduced from 3mg to 2mg. The plan was to review in four months, and then reduce to 1mg with a view to stopping altogether.[49] Mr X continued to visit the GP surgery. In **May** he was knocked down by an ambulance and sustained a minor injury to his ankle. During the **10** and **12 June** Mr X came to the GP surgery in order to have his ankle treated. On **12 June** he attended the surgery in order to request a letter in connection with his

45. Notes pp 206 - 209
46. GP Notes pp 8 &14 - 15
47. Notes pp 202 – 204 & pp 46 - 461
48. GP notes p 7
49. GP Notes p 7

ankle and a claim he wished to make. No mention of problems with his mental health were noted or recorded.

10.55. On **15 June** Mr X killed his neighbour Mr Y. A request was made for an Appropriate Adult to go to Plumstead Police Station where Mr X was being held. Background information was also sought. Ultimately Mr X was sent to prison on remand charged with the murder of Mr Y. On **26 September** Mr X was transferred to the Bracton Centre (a mental health forensic medium secure facility) on Section 48 with Section 49 restrictions as his mental state appeared to be relapsing.

2014

10.56. Mr X was sentenced and convicted of manslaughter on the grounds of diminished responsibility on **27 January**. At this stage Mr X was under Sections 37/41 of the Mental Health Act and detained at the Bracton Centre. His diagnosis was given as Schizoaffective Disorder and it was thought that he had killed his neighbour as a result of his mental illness. The likelihood was that he had not been taking his medication and witnesses described his behaviour at the time of the homicide as being *"strange"*. Following his arrest Mr X had also exhibited psychotic symptoms whilst in prison.[50]

10.57. On **3 March** Mr X died. In the days before his death he had been restless and mentally disturbed becoming exhausted and disorientated. Mr X was a diabetic who would not restrict his sugar intake despite constant warnings and advice from staff. On the evening of the **24 February** Mr X was found in a urine soaked bed and he could not be wakened. An ambulance was called and CPR conducted. Mr X was taken to hospital where he later died.

11. Identification of the Thematic Issues

Thematic Issues

11.1. 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

50. Notes pp 34 - 38

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.

12. Further Exploration and Identification of Contributory Factors and Service Issues

12.1. In the simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'Five Whys' could look like this:

- serious incident reported = serious injury to limb;
- immediate cause = wrong limb operated upon (ask why?);
- wrong limb marked (ask why?);
- notes had an error in them (ask why?);
- clinical notes were temporary and incomplete (ask why?);
- original notes had been mislaid (ask why?);
- (because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

12.2. Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. The Court found Mr X guilty of manslaughter and he was sentenced to detention in a secure mental health facility.

RCA Third Stage

12.3. This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. Areas of practice that fell short of both national and local policy expectation.
2. Causal, contributory and service issue factors.

12.4. The terms 'causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

12.5. **Causal Factors:** in the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used to describe any act or omission that had a direct causal bearing upon the failure to manage a mental health service user effectively and a consequent homicide.

12.6. **Contributory Factors:** the term is used to denote a process or a system that failed to operate successfully thereby leading an Independent Investigation Team to conclude that it made a direct contribution to the breakdown of a service user's mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party.

12.7. **Service Issue:** the term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Mr Y need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

12.8. The findings in this chapter analyse the care and treatment given to Mr X. The reader is referred to the narrative chronology for supporting information.

Diagnosis

Context

12.9. Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs and symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, Mental State Examination and observation.

12.10. The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (10th revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

12.11. Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can allow conceptualisation and understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis should never take away from the treatment and management of the service user as an individual, but can provide a platform on which to address some care, treatment and risk management issues. The nature of the individual's personality can also often shape the presentation of the illness.

12.12. A substantial number of service users may well meet the diagnostic criteria for more than one diagnosis at any given time, for example, a person may have a Personality Disorder, a Depressive Disorder and substance misuse problems. For those service users with a number of concurrent diagnoses, or who have very complex presentations, a case formulation can be an invaluable aid to understanding the service user and providing guidance for treating teams in terms of prioritising treatment goals.

Paranoid Schizophrenia

12.13. Schizophrenia is a major mental illness characterised by delusions, hallucinations, abnormality of thought process and form and emotional blunting. It can also be characterised by a lack of insight. The ICD 10 classification for Paranoid Schizophrenia, Schizoaffective Disorder and Bipolar Disorder are set out verbatim below.

Paranoid Schizophrenia

"This is the commonest type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition, and speech, and catatonic symptoms, are not prominent. Examples of the most common paranoid symptoms are:

- *delusions of persecution, reference, exalted birth, special mission, bodily change, or jealousy;*
- *hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form, such as whistling, humming, or laughing;*
- *hallucinations of smell or taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.*

Thought disorder may be obvious in acute states, but if so it does not prevent the typical delusions or hallucinations from being described clearly. Affect is usually less blunted than in other varieties of schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, sudden anger, fearfulness, and suspicion. "Negative" symptoms such as blunting of affect and impaired volition are often present but do not dominate the clinical picture".

Schizoaffective Disorder

"These are episodic disorders in which both affective and schizophrenic symptoms are prominent within the same episode of the illness, preferably simultaneously but at least within a few days of each other. Their relationship to typical mood (affective) disorders and schizophrenic disorders is uncertain. They are given a separate category because they are too common to be ignored…

… Diagnostic Guidelines: A diagnosis of Schizoaffective Disorder should be made only when both definite schizophrenic and definite affective symptoms are prominent simultaneously or within a few days of each other, within the same episode of illness and when, as a consequence of this, the episode of illness does not meet the criteria for either schizophrenia or depressive or manic episode. The term should not be applied to patients who exhibit schizophrenic symptoms and affective symptoms only in different episodes of illness".

Bipolar Disorder

"A major affective disorder marked by severe mood swings (manic or major depressive episodes) and a tendency to remission and recurrence. Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. The causes of bipolar disorder aren't always clear… Bipolar disorder often starts in a person's late teen or early adult years. But children and adults can have bipolar disorder too. The illness usually lasts a lifetime. However, there are effective treatments to control symptoms: medicine and talk therapy. A combination usually works best".

Findings

Findings of the NHS England and Trust Internal Investigation Processes **(NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)**[51]

12.14. The report stated that Mr X had a *"history of manic and depressive episodes, psychotic depression…The working diagnosis until late 2007 was that of paranoid schizophrenia; however this was changed to bipolar affective disorder around this time and remained unchanged thereafter".*

51. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

12.15. The report also made reference to Mr X's attempted suicide in 1998 when he *"fell"* in front of a train and describes in detail his presentation following his return from Somalia in 2007 when he was paranoid and confused with ideas of reference and experiencing command hallucinations.

12.16. It was noted that Mr X's mental health was stable between August 2007 and his discharge from the CMHT in October 2012. No other issues were examined in relation to diagnosis.

12.17. The Independent Investigation found that the information given in the Chronology by the internal investigation to be incorrect in that the working diagnosis of Paranoid Schizophrenia was not given until 2007 (and not in 2004 as stated); prior to this time his diagnosis was not clear. Also the chronology only goes back to 2004 giving an incorrect impression that Mr X was not known to the service before this time.

Findings of the Independent Investigation

Background

12.18. Mr X was given a number of different diagnoses over the period of time he was under the care of Oxleas Mental Health Services. In December 1997 (his first contact with Oxleas Mental Health Services) he was admitted with Depression, having 'fallen' in front of a tube train. He was tearful when discussing his reasons for leaving Somalia and appeared confused. The given diagnosis was an acute confusional state secondary to undiagnosed diabetes.

12.19. In February 1998 Mr X had an admission for Non-Psychotic Mania; this was followed in 2000 by another admission for Depression with suicidal ideation. In 2002, Mr X was assessed in a local outpatient clinic – there was no history of psychological trauma and it was thought he might be fabricating his story (possibly in order to gain United Kingdom residency). He was however thought to be suffering from a Chronic Adjustment Disorder.

12.20. Between the 5 and 14 January 2004 Mr X was admitted informally to Oxleas House. On this occasion he had been neglecting himself and was virtually mute; it was also noted he had Diabetes and Hypothyroidism. On admission his mood rapidly stabilised. When he was followed up at the outpatient clinic on 7 April 2004 by his Consultant Psychiatrist he was not thought to be suffering from a severe or enduring mental illness. Mr X went on to have another two admissions with the same presentation during 2004.

12.21. Between 5 and 16 August 2005 Mr X was admitted informally to hospital once again. He had not been eating, drinking or taking his medication. Mr X said he had been low in mood since being imprisoned for two months for beating someone. He felt hopeless and in shock about his situation but was well enough to be discharged back to his sister's home after 12 days. Mr X then went to Somalia for two prolonged visits extending for a period of some 20 months in total.

12.22. On the return from his second visit to Somalia in April 2007 Mr X was apprehended by the police at Gatwick Airport; he was mute and confused. He was ultimately transferred to Oxleas House where it was thought he was experiencing a

severe psychotic depression. His blood sugar was found to be extremely high and that he had not been taking his diabetic medication whilst in Somalia. During his admission Mr X said he was hearing voices that were derogatory in nature; however they did not tell him to harm anyone or himself. On occasions Mr X was perplexed and confused. However he stabilised quite quickly and continued to be well. His family was supportive throughout – they mentioned that he had been paranoid, suspicious and withdrawn at home believing people wanted to harm him. The impression was Paranoid Schizophrenia with Depression. On the 24 May he was discharged to his sister's house.

12.23. On 8 June 2007 Mr X was brought back to Oxleas House in an ambulance via the local A&E department. Mr X was uncomfortable at his home and paranoid – he also observed to have marked motor retardation. When a discharge summary was prepared on 30 July the diagnosis of Paranoid Schizophrenia was given.

12.24. A CPA review in February 2008 gave the diagnosis as *"? Paranoid Schizophrenia"* it was noted that he had previously been diagnosed as suffering from Bipolar Disorder (no record of this previous diagnosis could be found by the Independent Investigation Team). By 1 April 2008 an entry in the GP notes said Mr X had *"Paranoid Schizophrenia with Bipolar Affective Disorder".* By the 14 August 2008 the given diagnosis was Bipolar Disorder.

12.25. Following the killing of Mr Y a Forensic Report completed in December 2013 gave the diagnosis of Schizoaffective Psychosis and the working diagnosis while Mr X was at the Bracton Centre was of Schizoaffective Disorder. Interestingly (following Mr X's death), the Coroner's office provided information to the Trust on 27 August 2014 to say that the post mortem report stated *"sudden death in antipsychotic medicated Bipolar Disorder in the presence of hypoglycaemia".*

Analysis

12.26. After a detailed examination of the clinical record the Independent Investigation Team could find no rationale for, or formulation of, Mr X's given diagnoses over time. This was particularly evident in relation to the diagnosis of Paranoid Schizophrenia made in 2007 and the subsequent change to Bipolar Disorder in 2008.

12.27. The Independent Investigation Team considered the fact that Mr X had been a high functioning individual until a relatively advanced stage in his life and that he had held down responsible employment until his mid thirties with no apparent signs of mental illness being present. It is difficult to understand how the 2007 diagnosis of Paranoid Schizophrenia was made – especially when the treating team did not appear to have access to his earlier clinical records which detailed the nature of his mental illness between 1997 and 2005 in the context of his known social history. From the evidence available it would appear that no formal diagnostic process was followed, rather a series of impressions were given, possibly exacerbated by a lack of medical continuity and follow up outside of the CPA review forum.

12.28. Mr X came from an East African culture and this may have served to 'distort' the opinion that health care professionals held of him. People from Somalia hold the view that a mental disorder carries stigma and for many people this is associated with weak-mindedness, fear and hopelessness. Mr X disliked talking about his

mental illness and his other problems (such as gambling) preferring to hold fairly superficial conversations with members of his treating team. When well he was kempt and smartly dressed and gave the impression that he was able to cope. It was evident from several of the witness interviews held by this Investigation that some professionals felt uncomfortable pursuing assessments with him as they felt it would be disrespectful to 'push' him further than he allowed. This may have prevented a more detailed knowledge emerging about Mr X's inner world and the exact nature of his mental illness.

12.29. Mr X's diabetes was another complicating factor. This was recognised during his first admission in 1997 and also during his admission following his return from Somalia in 2007. However the fact that his Diabetes could lead to confusion and a worsening of his mental health was not taken into full account in relation to the potential for any future relapse of his mental state, and neither was it taken into account in relation to formulating an understanding of the nature of his mental illness as part of the diagnostic process.

Conclusions

12.30. Mr X's case does not appear to have been subject to a comprehensive clerking process at any stage between his first admission in 1997 and his last admission in 2007. It was not possible to find a detailed history or any robust documented Mental State Examination within his clinical record. It was also evident that significant information from his contact with mental health services prior to August 2005 was not available to his treating team after April 2007. This disrupted continuity and meant that Mr X's previously known psychiatric history was in effect lost.

12.31. It is important to understand that from the summer of 2007 none of the people involved in providing Mr X's care and treatment had any knowledge or experience of him when ill; they only knew him stable and well. In the absence of a detailed diagnostic formulation, and especially since Mr X had requested his family no longer be involved, it is easy to understand how his treating team from this point onwards may not have seen the need for full Mental State Examinations and any ongoing diagnostic formulation process.

12.32. In the event Mr X continued stable and well for a period of six years until the killing of Mr Y. It is not possible to ascertain whether any diagnostic ambiguity contributed to his eventual relapse which was found by the Court to have led to Mr Y's death. However what can be ascertained is that diagnostic formulation was poor and not based upon what was known and what should have been known about Mr X. The interaction between his mental illness, his diabetes and gambling lifestyle was not medically evaluated and consequently was neither understood nor managed. This left open the possibility that at some point in the future Mr X would relapse and these three factors together would combine to create significant difficulties for him (and potentially those around him) in the same manner that had happened on previous occasions.

- ***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.

Medication and Treatment

Context

12.33. The treatment of any mental disorder should have a multi-faceted approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho-education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions - medication. This section concentrates on the issues of medication and psychological treatments in relation to the care and treatment delivered.

12.34. Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments fall into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety) and mood stabilisers. In substance misuse services, medications fall into a number of categories: those used in detoxification and withdrawal (e.g. Benzodiazepines), medication used for substitution and maintenance (e.g. methadone) and medication supporting abstinence (e.g. Acamprosite or Disulfiram / Antabuse).

12.35. Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders. Specific guidance is available from NICE for the treatment of Schizophrenia, Emotionally Unstable Personality Disorder and Drug misuse, amongst other clinical conditions.

12.36. In prescribing medication there are a number of factors that the prescribing clinician must bear in mind. They include consent to treatment, compliance and monitoring, and side effects. The patient's ability to comply with recommended treatments can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time, are they motivated to engage in the process of change, to attend appointments, etc.

National Institute for Health and Clinical Excellence (Nice) Guidance - Schizophrenia

12.37. NICE first published Schizophrenia treatment guidelines in 2002. These guidelines were published in full in 2003, and updated in 2009.[52]

1. *"In primary care, all people with suspected or newly diagnosed schizophrenia should be referred urgently to secondary mental health services for assessment and development of a care plan. If there is a presumed diagnosis of schizophrenia then part of the urgent assessment should include*

52. Nice Guidance (2009) CG82 – replaced with CG178 (2014)

an early assessment by a consultant psychiatrist. Where there are acute symptoms of schizophrenia, the GP should consider starting atypical antipsychotic drugs at the earliest opportunity – before the individual is seen by a psychiatrist, if necessary. Wherever possible, this should be following discussion with a psychiatrist and referral should be a matter of urgency".

2. *"It is recommended that the oral atypical antipsychotic drugs amisulpride, olanzapine, quetiapine, risperidone and zotepine are considered in the choice of first-line treatments for individuals with newly diagnosed schizophrenia".*
3. *"The assessment of needs for health and social care for people with schizophrenia should … be comprehensive and address medical, social, psychological, occupational, economic, physical and cultural issues…Psychological treatments [to include]*

- *Cognitive behavioural therapy (CBT) should be available as a treatment option for people with schizophrenia.*
- *Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user.*
- *Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available*".[53]

National Institute for Health and Clinical Excellence (Nice) Guidance – Bipolar Disorder

12.38. Bipolar Disorder is usually treated with antidepressants to treat depression, antipsychotic drugs to manage the manic phase, and mood stabilising medication to reduce the severity and frequency of the mood changes. NICE provides the following guidance:

- ***"Pharmacological interventions***
  If a person develops mania or hypomania and is not taking an antipsychotic or mood stabiliser, offer haloperidol, olanzapine, quetiapine or risperidone, taking into account any advance statements, the person's preference and clinical context (including physical comorbidity, previous response to treatment and side effects). If the person is already taking lithium, check plasma lithium levels to optimise treatment. Consider adding haloperidol, olanzapine, quetiapine or risperidone, depending on the person's preference and previous response to treatment.

- ***Psychological interventions***
  Offer adults with bipolar depression:
  a psychological intervention that has been developed specifically for bipolar disorder and has a published evidence-based manual describing how it should be delivered or a high-intensity psychological intervention (cognitive behavioural therapy, interpersonal therapy or behavioural couples therapy) in line with recommendations 1.5.3.1–1.5.3.5 in the NICE clinical guideline on depression. Discuss with the person the possible benefits and risks of psychological interventions and their

53.NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 12-13

preference. Monitor mood for signs of mania or hypomania or deterioration of the depressive symptoms".

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[54]

12.39. The report stated that Mr X had ceased to take his medication whilst in Somalia in 2007 and that this had contributed to the breakdown of his mental health leading to his admission to Oxleas House in April 2007. It was also noted that Mr X rapidly stabilised once medication recommenced. Following the second and third admissions in July and August 2007 respectively this pattern re-emerged and it was decided Mr X would be placed on a depot injection to which he agreed.

12.40. Mr X remained stable and well and in 2010 his medication was changed from depot to oral Risperidone. Mr X had always complied with his depot and appeared to comply with his oral medication with no problems being obvious.

12.41. At the point of discharge from the CMHT in October 2012 the GP was notified that Mr X had been compliant with oral medication and that he had been stable for *"over 3 years".* The advice given to the GP was to consider reducing Mr X's Risperidone in the following six to 12 months with a view to stopping it altogether if he remained stable.

12.42. Following his discharge in October 2012 Mr X met with the GP on 8 October. It was noted that he was on Risperidone for Bipolar Affective Disorder, and Metformin and Gliclazide for Type II Diabetes. The GP arranged for the medication to be made available in blister packs to aide compliance.

12.43. On 14 February 2013 Mr X was reviewed in the Diabetic Clinic and was put on Liraglutide (to stimulate insulin secretion). On 19 April 2013 Mr X visited his GP and requested his Risperidone be reduced from 3mg to 2mg. It was agreed to titrate the dose to 2mg for four months with a consideration to review thereafter.

12.44. The report detailed the summing up from Judge Stephen Kramer at Mr X's trial which said *"it is clear to me that if you stop taking your medication you pose a serious threat to members of the public if at large"* –the assumption being that Mr X had stopped taking his medication prior to the killing of Mr X. The report provided the following analyses:

"Medication Supervision
Was Mr X capable of administering his own medication following his move to independent living?
The trust's review of the case history stated that it was not clear whether or not Mr X was having his medication supervised when he was living in supported accommodation. Furthermore, it was reported to the trust by the

54. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

police that, 'a medication blister pack found in Mr X's flat showed evidence of non-compliance with medication'. This was reported by police on the day of the incident [the death of Mr Y] and is not a proven fact. This led to a question… about whether or not Mr X was capable of self-medication and whether this was an issue when he moved to independent accommodation. In response to this, the trust team stated that Mr X did not have any help to take his medication whilst in supported accommodation (or independent accommodation). He collected his own prescriptions and self-administered the medication. Therefore, they had confidence in Mr X's ability to self-medicate prior to discharge from the trust. They could not explain the police statement regarding evidence of non-compliance as the police would not have known what quantity of this medication Mr X would typically have in his possession at any point.

Reducing the Risperidone Dose (Trust)
Was the plan to reduce Risperidone appropriate?
The Associate Specialist said that different people react to levels of Risperidone in different ways. A normal dose would be around 3mg, but some patients are on a dose of just 1mg. For Mr X to reduce from 3mg to 2mg as he had been stable for so long was entirely appropriate.

Reducing the Risperidone Dose (GP Practice)
What was the nature of the mental health assessment on Mr X prior to reducing his Risperidone in April 2013?
The GPs use a structured assessment for assessing the patient's mental health and that the GP would have done a risk assessment. As the direction to reduce the dose had been given in the discharge letter of 19 October from the trust, no further check with the trust was deemed necessary. The Partner said Mr X had had no violent episodes at the time of registration whether this was reported from police, neighbours, friends or other collateral histories but acknowledged that at the workshop that day she had learned that Mr X did have a history of harm to others. She said that the practice could access the historical records for patients using an on-line system, but only the summarised details were on the system which GPs would be using. In the past, GPs at the practice have identified patients who were floridly psychotic and have called for taxis to take them to the community mental health team if they were deemed to be a risk to self or others. The trust Associate Specialist added that most patients taking anti-psychotic medication wish to come off their medication as they want to be normal. Signs of relapse can be picked up by friends, family, neighbours, A&E, the police and GPs. The Partner said that the practice neighbourhood is a close community and often practice patients will highlight concerns about their neighbours to the GPs – no concerns were raised about Mr X".

12.45. In general the Independent Investigation Team concurs with the findings of the internal investigation report. Additional findings and observations are provided below.

Findings of the Independent Investigation

Antipsychotic Medication Choice

12.46. Over the years Mr X was prescribed Haloperidol, Fluoxetine, Clopixol and Citalopram. In 2007 due to issues with compliance he was prescribed Risperidone Consta (a depot injection) and then in 2010 oral Risperidone 3mg. NICE guidance recommends the use of Risperidone for both Paranoid Schizophrenia and Bipolar Disorder and so this was an appropriate drug to prescribe regardless of what Mr X's diagnosis was finally thought to be. It is a fact that Mr X remained stable and well on Risperidone 3mg over a period of six years and so it was effective in maintaining his recovery. However given the diagnosis of diabetes it would have been good practice to carefully review his 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.

Diabetic Medication

12.47. Mr X was diagnosed with diabetes following his first contact with mental health services in 1997. From this time on he was prescribed medication for this condition by his GP. It is evident from reading through the clinical record that Mr X's mental health treating team was under the impression that he was on Insulin. References to Insulin are made on numerous occasions – particularly when assessing his day-to-day living needs.

12.48. At no time was Mr X ever prescribed Insulin. Instead he was prescribed a series of drugs to stimulate insulin secretion rather than to replace it. This begs the question of how well the mental health team actually understood Mr X and his co-morbidities which might reasonably have had an impact on his mental illness.

Medication Compliance

12.49. From an early stage it was recognised by secondary care mental health services that Mr X experienced a relapse of his mental health when non-compliant with medication. There is also evidence to suggest that when he became non-compliant he not only stopped his antipsychotic medication but also stopped taking his diabetic medication; this contributed further to his confusion and general deterioration.

12.50. From the time of his discharge from inpatient services to Supported Living accommodation in July 2007 there is no evidence to suggest that Mr X was non-compliant with any of his medication. His request to come off his depot in 2010 was reasonable as he found the injection sites uncomfortable. He always collected his medication on a regular basis and, whilst no one supervised him taking it, his continued recovery appears to be evidence enough that he was compliant.

12.51. It remains unclear exactly when (or indeed if) Mr X stopped taking his medication prior to the killing of Mr Y. In the months before the incident he took the trouble to talk to Care Coordinator 3 at the CMHT base to seek advice about a planned medication reduction. He then followed the advice she gave and visited the GP on 19 April 2013 in order to discuss this further. These are not the actions of a man who was planning to randomly stop taking his medication. In the period between the Risperidone being reduced from 3mg to 2mg and the killing of Mr Y Mr

X continued to routinely collect his prescriptions. During this period he appeared to be mentally stable and well when he visited the GP surgery.

12.52. Evidence given to the Court by neighbours suggested that Mr X was acting out of character in the days before the homicide. His lodger made a statement to effect that Mr X had not been taking his medication (however Judge Stephen Kramer found this witness to be unreliable). The Police found medication in a blister pack in Mr X's flat – but it is unclear why they believed this to be evidence of Mr X's non-compliance. The Judge accepted the view that Mr X had not taken his medication and that this was a significant factor in the relapse of his mental health. It is not for this Investigation to argue with a Court finding – however there is no evidence to suggest Mr X did not take his medication outside of a relatively short period of time (probably no more than a couple of days) before the killing of Mr Y. Even with the previous reduction made to the Risperidone in April it is unlikely the cessation of the medication over a relatively short period of time would have led to such a sudden and complete deterioration in his mental state on its own.

12.53. We understand that in the days leading up to the homicide Mr X had been living in the stairwell of his flat and that his lodger had refused him entry back into his home. Evidence supplied to the Court suggests that Mr X had run up gambling debts and that he had sublet his flat out to his lodger. The exact circumstances cannot now be determined. However if this is an accurate account then it is possible that Mr X was in effect living rough and it is possible he no longer had access to either his antipsychotic or diabetic medication. If Mr X was not eating properly then it is possible that these circumstances made a further contribution to the deterioration of his mental health because of the interrelation with his diabetic condition. It is also possible that Mr X did not actively decide to stop taking his medication but that other events intervened which made it impossible for him to continue – something that not even a medication management plan could have either foreseen or monitored.

Medication Reduction

12.54. The Trust Associate Specialist who saw Mr X at the CPA review on 11 October 2012 wrote to the GP at the point of discharge suggesting that the Risperidone could be reduced if Mr X continued stable and well after six months. In itself this appears to have been a reasonable suggestion. However, given that it should have been 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. It would have been better practice for a stepped approach to have been taken. This is because Mr X was faced with several significant changes that occurred all at the same time:

1. He was moved from supported living to private independent accommodation.
2. He was registered with a new GP practice.
3. He was discharged from the CMHT and full Care Coordination after a period of five years.

12.55. It would have been good practice to have commenced a supervised medication reduction programme several months prior to Mr X's discharge so that his mental state could be monitored by a treating team who knew him well. It should also be

noted that no medication review appears to have been held over the preceding five-year period and this was remiss.

Treatment

12.56. Over the years Mr X was offered psychotherapy and gambling addiction inputs in keeping with good practice guidance. Mr X declined these inputs making further therapeutic intervention impossible.

12.57. There is plenty of evidence to show that Mr X was provided with many opportunities whilst living in the community to improve both his quality of life and day-to-day functioning. He attended several drop-in-centres and had assessment and input from Occupational Therapy. Given Mr X's ongoing ambivalence about therapy the service was mindful of Mr X's preferences and sought to intervene in a way that Mr X found acceptable. This was good practice. It should also be noted that over time Mr X had input from three Care Coordinators who all established a good rapport with him and maintained an ongoing therapeutic relationship. This was also good practice.

Somali Culture

12.58. The Independent Investigation Team recruited specialist advisory input from the MIND Hayaan Somali Mental Health Project. Professor Fido from the project had some useful insights about Somali people and medication and treatment compliance. They are as follows.

12.59. **With regards to treatment:** *'Qalbiga caafimad qaba, cagli caafimad qaba ayuu leyahay'*: Somali idiom translated *"If your soul is healthy, your mind is healthy".* Treatment for mental disorders such as depression, anxiety, or PTSD in the general 'sane' population is an unfamiliar concept for many Somalis, not something they have seen back home. Patients and their families need education about the United Kingdom healthcare system and roles of different providers. Individuals will expect that primary doctors (GPs) clarify for patients the roles of the other professionals to whom they are referred. Some patients will not want to see a mental health specialist preferring their GP to consult with a psychiatrist and then administer a recommended treatment. Doctors are usually held in high esteem by Somalis and the primary care doctor would be considered the main person for health delivery, including mental health care.

12.60. **With regards to medication:** Many Somalis are wary of pharmacologic treatments for fear of developing dependence on their prescription medications. There is belief that psychiatric medication is very addictive and there is fear that a person will become addicted and need to take medication for the rest of their life. There is a lack of understanding about how medicines work, especially medication that is not for acute symptoms or that takes time to begin working. The perception is that medication should begin to take effect immediately. Patients typically appreciate medications that help them sleep and take away nightmares, and may be receptive to medications described as 'helping moods to get better'. Unless explicitly told otherwise, patients may expect a cure for the symptoms being treated not realising, for instance, that depression might fluctuate over time and trauma-related symptoms including altered sleep pattern may improve but never completely dissipate. Patients may struggle to understand why prescribed medication is unable to provide a full

cure. Somali culture places value on expressiveness so that reportedly even a violent or an explosive expression is preferable to a subdued affect. Reflecting that notion, there is fear of getting 'worse' with the use of anti-depressants. There is a phrase used in the community to describe the 'dulling' effect of psychiatric medication on a person's expression. It is said that person *"got injected".*

Conclusions

12.61. Mr X was stable for a period of nearly six years following his discharge from inpatient services in 2007. It would appear that Risperidone was an effective medication in that it maintained his recovery. There is evidence to suggest that Mr X was complaint with his medication from 2007 and that despite earlier non - compliance issues he had accepted the role of his medication in maintaining both his physical and mental health. There is plenty of evidence to suggest that Mr X was also offered a comprehensive set of therapeutic interventions in accordance with NICE guidance which unfortunately he did not always wish to pursue.

12.62. The Independent Investigation Team whilst understanding the rationale for reducing Mr X's medication concluded that this was not manged well. This is for two reasons:

1. **Trust Services:** Mr X was on the same medication for nearly six years. It would have been good practice for this to have been reviewed and/or reduced after a period of two to three years whilst under secondary care medical supervision. A review of this kind was most definitely indicated especially in the light of Mr X's Diabetes and any potential Metabolic Syndrome issues.

   Alternatively if it was thought that his mental stability was due to his ongoing medication regimen he should have been advised to continue this in the long term. Any severe and enduring mental illness is unlikely to resolve – recovery is not usually a linear process and no consideration was given to relapse and recovery cycles and the place of an ongoing medication regimen in maintaining wellness. Mr X was last seen by a Consultant Psychiatrist in October 2011 – senior and consistent medical oversight was minimal.

2. **GP Practice:** whilst the internal investigation report suggests that the GP practice would usually conduct a risk assessment prior to the reduction of psychiatric medication – there is no evidence to suggest that this took place in this case. Whilst the record indicates questions about mental state were asked this fell short of a risk assessment process.

12.63. The exact sequence of events leading up to the killing of Mr Y could not be ascertained by the Court. Whilst the Court accepted Mr X was not taking his medication it was never established when the period of non-compliance commenced. It is evident that Mr X's social circumstances appeared to 'unravel' shortly before his fatal encounter with Mr Y. The issue of Mr X's medication non-compliance was not examined fully in this context and it is possible that it was unintentional on his part, forced upon him by social circumstances, and of a short duration only. It would be unreasonable to consider the notion of any intentional non-compliance in isolation as there is no evidence to support this, especially in the light of Mr X's responsible behaviour over a six-year period. It is a fact that his blood

sugar levels remained stable implying a compliance with his diabetic medication (in the past when deliberately non-complaint he would stop taking everything all at once) therefore it is also probable he was still taking his Risperidone as well. The Independent Investigation Team therefore could make no link between any act or omission on the part of NHS services and the cessation of medication compliance which led to the relapse in Mr X's health. Neither could it make any link between the reduced dose of Risperidone and the relapse Mr X experienced.

- ***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.***

Use of the Mental Health Act (1983 and 2007)

Context

12.64. The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

12.65. At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[55]

Section 136

12.66. Section 136 of the Mental Health Act allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours. The place of safety could be a police station or hospital (often a special Section 136 suite).

Section 5 (2)

12.67. Section 5 (2) is temporary holding power which can be put on by the ward doctor or an Approved Clinician and would be due to increased concern about the deterioration in the service user's mental health. This can include a lack of capacity to remain informally or it could be that they have become a risk to themselves or others and are not felt safe to leave the ward. Section 5 (2) can last up to 72 hours, but it is simply a temporary hold for the assessment to be co-ordinated which should be triggered as soon as it is put in place.

55. Mental Health Act Commission 12th Biennial Report 2005-2007

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[56]

12.68. The report states that *"Mr X had history of manic and depressive episodes, psychotic depression and multiple admissions usually under the Mental Health Act".* No other information is given.

Findings of the Independent Investigation

12.69. The reference made by the internal investigation report to multiple admissions usually under the Mental Health Act is misleading and incorrect. Mr X had the following admissions:

1. **5 December 1997:** Mr X was admitted under Section 136 to Oxleas House for depression and suicidal ideation. There is mention that he was later held under Section 2 of the Act but there are no extant records to confirm this.
2. **February 1998:** Mr X was admitted informally to Greenwich District Hospital for non-psychotic mania.
3. **17 August 2000:** Mr X was admitted informally to the Cygnet Wing Blackheath for depression.
4. **5 January 2004:** Mr X was admitted informally to Oxleas House for depression.
5. **13-15 June 2004:** Mr X was placed on a Section 5 (2) but then went on to have an informal admission for a confused state. NB the notes are incomplete and it is difficult to determine exactly what happened.
6. **27 November 2004:** Mr X was admitted informally to Oxleas House; he was temporarily detained under a 5 (2) for a short period of time due to aggression and confusion.
7. **5 August 2005:** Mr X was admitted informally to Oxleas House for depression.
8. **7 April 2007:** Mr X was admitted informally to Oxleas House following intervention from the police at Gatwick airport on his return from Somalia.
9. **8 June 2007:** Mr X was admitted informally to Oxleas House for depression and paranoia.

12.70. From the evidence available there were few admissions that required assessment under the Act. Those requiring intervention were of short duration and a Section 5 (2) was used to maintain Mr X's safety during periods of acute confusion.

Conclusions

12.71. There is no evidence to suggest that Mr X ever required any additional considerations under the Act other than those he received. The events that led to Mr Y's death appear to have been acute in nature and without any forewarning. There were no signs evident to any members of Mr X's primary care and treatment team prior to the killing of Mr Y that Mr X's mental health was relapsing and no opportunity for assessment under the Act arose. In the event no full psychiatric assessment was conducted until September 2013, three months after the homicide, therefore no

56. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

contemporaneous assessment was made about Mr X's mental state and the Independent Investigation concludes that it can provide no further conclusions based on the evidence available.

The Care Programme Approach

Context

12.72. The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.[57] Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach.*[58]

"The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services".[59]

12.73. The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

12.74. The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention. The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is;
    - to keep in close contact with the patient
    - to monitor that the agreed programme of care remains relevant; and
    - to take immediate action if it is not
- ensuring regular review of the patient's progress and of their health and social care needs.

57. The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990
58. Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008
59. Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH; 1995

12.75. The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either 'Standard' or 'Enhanced' CPA according to their level of need.

Local Policy

12.76. The Trust had an evidence-based and fit for purpose policy in place during the time Mr X received his care and treatment. The policy states:

- *"The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.*
- *Core assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self management and self-nurture; with the aim of optimising mental and physical health and well-being.*
- *Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care".*

12.77. *"Characteristics of those clients who **do not** meet criteria for CPA **but still require services** from secondary mental health:*

- *More straightforward needs; e.g. one axis of need being addressed by the Trust;*
- *One agency only involved;*
- *Service user able to easily access support and care needed either alone or with help of family, advocacy, or self help agencies;*
- *Care likely to last the agreed 6-8 sessions or less;*
- *Risks are low;*
- *In stable housing, managing financially;*
- *Employed and not experiencing work related stress".*

12.78. ***"Referring back to primary care***

The point at which outcomes agreed with the service user have been achieved the service user will be referred back to primary care. This should be agreed at the beginning of contact with the service user. On referring back to primary care there should also be a brief summary of the programme of care which Oxleas has delivered and outcomes which have been achieved, a relapse prevention plan to show the user, their support network and GP what things have worked, as well as what has not worked. Detailed advice to the GP surgery about when the service user should be referred back to Secondary services might be appropriate to lessen the number of inappropriate re-referrals".

12.79. The policy also stipulated that core assessments should provide a review of mental and physical health history, a Mental State Examination, and a full holistic assessment of need.

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[60]

12.80. The report makes little mention of the CPA process provided to Mr X apart from mentioning that Care Coordinators followed Mr X up in the community. That Care Coordinator 3 accompanied Mr X when he registered at the Gallions Reach GP Surgery in August 2012 was cited as good practice. It was also noted that Mr X's engagement with his Care Coordinators was good.

Findings of the Independent Investigation Team

12.81. Between June 2007 and October 2012 Mr X was on full CPA and received care coordination from three consecutive Care Coordinators. In general during this period it was evident that Mr X engaged well with the CMHT and his Supported Living Teams. It was also evident that CPA reviews were held on a regular basis in accordance with the Trust's CPA policy. Mr X was involved in all decisions pertaining to his care and treatment and he appears to have remained stable and well. The role of the Care Coordinator was pivotal to the ongoing quality of care that was provided to Mr X and it can be determined from the day-to-day progress notes that contact was regular, even if it was often reactive in nature, and that the Care Coordinators worked to fulfil Mr X's personal needs and wishes. This was good practice.

12.82. However the good aspects of the CPA process were weakened by a lack of robust documentation and strong multidisciplinary team working. Record keeping was often of a poor standard and it was difficult to determine how care planning was managed. Over a five-year period it would appear that Mr X received only one formal risk assessment and only four care plans were developed. The care plans formulated between July 2007 and October 2012 were as follows:

1. **7 November 2007 (updated 30 March 2011):** a basic plan was written requiring Mr X's mental state to be monitored.
2. **7 November 2007 (updated 9 December 2009 and 10 November 2010):** a basic care plan was prepared requiring Mr X to be educated about his illness and ongoing need for treatment.
3. **24 April 2009:** an Occupational Therapy care plan was developed to improve Mr X's spoken English skills, his IT skills and his day-to-day living skills.
4. **16 November 2010 (ended on 26 October 2011):** a basic plan was developed in relation to Mr X's budgeting skills, taking money with menaces from other residents and his ongoing gambling addiction.

12.83. The care plans in themselves addressed important issues that were legitimately identified as needs for Mr X. However they were basic in nature and there is little evidence provided within the clinical record to demonstrate how they were implemented, monitored and reviewed. It would appear that on many occasions Mr X was ambivalent about the level of input he wanted and that this often served to prevent the care plans from being effective.

60. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

12.84. The short, medium and long-term goals (as stipulated at the CPA reviews) were to maintain Mr X's recovery, to ensure he was linked into his local community and to promote his independence - with a particular focus on an independent living placement. This was commendable even though it remains unclear how this was actually going to be achieved in the face of Mr X's frequent lack of cooperation. It was evident that Mr X would only address issues of relevance to him. He was adept at asking his Care Coordinators to sort things out for him such as benefits, housing and leisure activities. He was usually reluctant to manage his own needs (preferring others to take the lead) and rejected psychological therapy and gambling addictions inputs. This meant that Care Coordination tended to focus on Mr X's social care needs and the monitoring of his recovery. It is a fact that Mr X consistently refused to do his own laundry or cook his own meals. Based upon this it might have been reasonable for the CMHT to determine Mr X was not ready for independent living and that he was best placed to remain in Supported Living accommodation. It was obvious that Mr X was well liked by his Care Coordinators and that this may have served to distort any assessment of him. The prevailing view was that Mr X was high functioning, but in reality there was little evidence to support this notion.

12.85. Whilst the CPA provided to Mr X was of a good general standard and supportive of him over the five years he was with the CMHT, it often failed to make the distinction between good quality care and treatment provision and good quality Care Coordination. This was of particular note on two occasions. The first being in relation to safeguarding issues (please see the relevant chapter section below) and the second being in relation to the discharge process back to primary care in October 2012. The Trust policy for this period made it clear that at the point of discharge a relapse prevention plan should be prepared and a clear process described as to how a service user should be referred back to secondary care services if required. This was not done and demonstrates a weakness in the CPA process.

12.86. Between 2007 and 2012 the CPA review appears to have been the only mechanism used for the clinical evaluation of Mr X. Mr X was not seen by a doctor outside of a CPA review for five years. It should be noted that a CPA review in itself should not replace clinical assessment and evaluation processes. The medical management of Mr X was almost non-existent and it is important to note that no formal medical assessment was conducted up to, and including the point of discharge. This placed a heavy reliance upon the CPA process to deliver more than it was intended to do. The CPA policy stipulated that core assessments should provide a review of mental and physical health history, a Mental State Examination, and a full holistic assessment of need – this was not achieved.

Conclusions

12.87. The Independent Investigation Team found that Mr X received a consistent and supportive level of support from his Care Coordinators even though the documentary evidence in relation to risk assessment and care planning was poor. However it is unclear whether or not Mr X continued to meet the threshold for full CPA during the whole five-year period. It is difficult to see from an examination of the clinical notes what the rationale was for keeping Mr X on full CPA when he was stable and well and consistently refused any formal therapeutic input. However the Independent Investigation team concluded that after such an intensive five-year period of support

the sudden withdrawal of CPA and CMHT service was difficult to understand and that it might have been better practice to have considered a trial period of follow up for Mr X from the CMHT even if full CPA was no longer required. Mr X experienced a significant sequence of change at this time and a period of consolidation was indicated – especially as it was known his daily living skills were restricted and he consistently failed to manage his financial affairs. This aspect will be explored further in the discharge report sub section below.

12.88. The level of medical input and evaluation over time was poor and non-existent outside of the CPA review forum. Even though Mr X had remained stable and well for years he had been diagnosed with a severe and enduring mental illness. Recovery is not usually linear and a proper medical review should have taken place prior to discharge - independent of the CPA review process. The seemingly rapid discharge process did not follow on logically from the high levels of input Mr X had received over the previous five years. A holistic evaluation of how Mr X was likely to function independently was not undertaken and this may have contributed to the eventual unravelling of his social circumstances six months after his discharge from the CMHT.

- ***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.***

Risk Assessment

Context

12.89. Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

12.90. The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

12.91. The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

12.92. It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

12.91. *Best Practice in Managing Risk* (DoH June 2007) states that *"positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed".*[61]

12.93. As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

12.94. Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Local Trust Policy

12.95. The Trust had an evidence-based and fit for purpose policy in place during the time Mr X received his care and treatment from community services. However whilst the risk elements for child safeguarding arrangements were made explicit those in relation to the protection of vulnerable adults were not. This was an omission as clear guidance was not provided.

12.96. The Trust advocated the use of a structured risk assessment method. The policy stated that:

"this approach combines the use of a structured method of assessing risk with the use of actuarial information to assess clearly defined risk factors, risk triggers and ameliorants of risk and makes use of:

- *Clinical experience and knowledge of the client;*
- *The service user's view;*
- *Takes into account views of carers and other professionals".*

"The nature of the clinical risk assessment will depend on the context in which it is made. This includes:

61. Best Practice in Managing Risk; DoH; 2007

- *Routine assessments- e.g. for first contacts with the Trust's services; for ongoing management of severe ongoing difficulties; CPA reviews; and people with severe mental illnesses who are in the early stages of their illness;*
- *Assessment following an incident;*
- *Assessment of risk before deciding about moving a client to, or from, (new) CPA (Department of Health, 2008);*
- *Assessment of risk during discharge planning;*
- *Assessment of risk following re-presentation to the Trust's services;*
- *Any other significant changes".*

12.97. The policy also stipulated the need to align the CPA and risk assessment process to involve all teams involved with the care and treatment of individual service users – especially taking housing partners into consideration. The policy also stated that *"Essential components of clinical risk assessment and clinical risk management include engagement, good history taking, and formulation of risk. Risk formulation is an explanation of how risks arise for a particular service user in the context of conditions that are assumed to be risk factors for a hazardous outcome that is to be prevented (Department of Health, 2007a). The risk formulation should account for both protective factors and risk factors (Department of Health, 2007a). Essentially a risk formulation is a summary of all of the risk and protective factors identified coupled with your (and the client's and carers') impression of what that means and what can be done to minimise risk. Describing the risks and explaining their context in the formulation is a vital step in coming to a decision about the level of risk".*

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[62]

12.98. It was noted that Mr X's Trust RiO risk assessment was last updated in May 2012. It indicated a history of 'harm to self' with reference to suicidal ideation as Mr X had tried to jump in front of a train on more than one occasion in 2007. Harm to others was identified with reference to Mr X exploiting people for money due to his gambling habit and reference was also made regarding Mr X being violent towards others but that no details were known. The investigation report made a criticism in relation to the paucity of the risk information found within the Trust clinical record.

12.99. The report authors were assured by the GP surgery that risk assessment on first contact *"was built into their normal practice and a mental state assessment would have been part of the assessment, although no formal risk assessment was used or documented [in the case of Mr X]. The practice had a low threshold for asking for help and would not have hesitated to call the community mental health team if they had any concerns".*

12.100. The Independent Investigation Team concurs broadly with these findings but notes there are several inaccuracies in the report in relation to risk information. A more detailed examination is provided below.

62. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

Findings of the Independent Investigation Team

12.101. Mr X was known to the same secondary care mental health service for a period of 15 years. This represents a significant amount of time in which to get to know the service user and to build up an understanding of his risk profile. However the Independent Investigation Team found that risk assessment was not conducted in a robust manner over time and that risk assessment information did not travel with the patient between separate episodes of care. This led to distorted and inaccurate information being available in relation to Mr X. The care and treatment that Mr X received can be broadly divided into three distinct periods: a) 1997 – 2005, b) 2007 – October 2012, and c) October 20012 to June 2013.

1997 – 2005

12.102. During this period Mr X was noted to be primarily at risk from acts of self harm and self neglect as a result of his depressive illness. The issue of self neglect was deemed to be of particular importance in relation to Mr X's Diabetes and his increased risk of harm if he failed to eat and drink on a regular basis. It was understood that when depressed Mr X was at increased risk and that his mental state could decline rapidly if he stopped taking his medication – which he frequently did. However in the spring of 2005 an incident occurred which also highlighted Mr X's risk to others. Mr X was involved in an altercation with a man who had been a visitor at his sister's house. On 26 May 2015 the Police wrote to Mr X's Consultant Psychiatrist asking for information as the altercation had led to a serious assault. Mr X had severely beaten his sister's visitor around the head and the victim subsequently required a week in hospital. On this occasion (from the documentation available) it would appear that mental health services declined to provide information to the Police.

12.103. Mr X was detained in prison on remand for two months. Eventually the case was dropped and Mr X was released. On his release from prison Mr X became depressed and mute and was admitted back onto an Oxleas inpatient ward. Mr X said he had been low in mood since being imprisoned. He felt hopeless and in shock about his situation. Mr X had beaten the victim because he thought he was using his sister's home to commit credit card fraud. Mr X recovered quickly and the plan was to discharge him back to his sister's home. On this occasion risk assessment was basic in nature and it was not determined whether the assault might have been exacerbated by Mr X's mental illness. On his discharge from Oxleas Mr X returned to Somalia for two protracted visits lasting a total of 20 months.

2007 – October 2012

12.104. Mr X was admitted back into inpatient services in the spring of 2007 on his return from Somalia. An initial assessment was conducted and it was ascertained that Mr X's blood sugar was extremely high and that he had not been taking his Diabetic medication whilst in Somalia. This was seen as being possible self harming behaviour linked to his depression. It was also noted that Mr X had been involved in a previous act of violence at his sister's home when he had hit a man over the head with a baton; it was recorded that his history needed to be confirmed with the family and that not all of his psychiatric history was available to the team. This information was brought forward from the memory of a member of staff who had treated Mr X previously.

12.105. Following Mr X's placement in Supported Living accommodation in July 2007 risk assessments were conducted in a basic manner. From this time on the RiO record notes that Mr X's risk was determined to be generally low - both to himself and to others – however the process followed is not clear and no formulation was developed in relation to either his diagnosis or social circumstances.

12.106. Of particular concern is the recognition of Mr X's consistent financial abuse of the vulnerable adults with whom he was domiciled. No detailed risk assessment was conducted and no robust management plan was put into place. It is quite clear that Police involvement was indicated but for whatever reason, whilst the problem was noted over many years, nothing was actually done to prevent Mr X from continuing his financial exploitation of other people. Even when Mr X was taking money with menaces his risk to others was usually assessed to be low.

12.107. At the point of Mr X's discharge from the CMHT it would appear that no risk assessment was conducted or historic risk information shared with the GP.

October 20012 to June 2013

12.108. The NHS England and Trust Internal Investigation Report states it would be usual practice for the Gallions Reach Surgery to conduct risk assessments and mental state examinations when psychiatric medication is reviewed. There is no evidence to suggest that this process was followed for Mr X on 19 April when his Risperidone was reduced. When interviewed by the Independent Investigation Team GP witnesses made it clear they had no understanding of what risk assessments were or how they would be used in practice. However witnesses did explain that questions about mental state would be asked prior to medication being changed.

Record Keeping

12.109. The Independent Investigation Team concurs with the findings of the NHS England and Trust Internal Investigation Report regarding the paucity of the risk assessment documentation. This was found to be of an extremely poor standard over time. The clinical risk documentation was so lacking that the Independent Investigation Team asked the Trust to conduct an additional search in case important information had been missed and not passed onto the team. Following this search a single risk assessment form was located. This risk assessment form was commenced on 7 April 2007 and was subject to two updates on 24/25 October 2011 and 24 October 2013. It is impossible to ascertain which entry belongs to which date. It is also impossible to determine how the data on the risk assessment form contributed to any risk management planning. The form contains the following information (a significant amount of which was probably ascertained after the homicide of Mr Y):

1. The MAPPA box was ticked (apparently as part of the entry made in October 2013 after the killing of Mr Y).
2. The risk to vulnerable adults, stalking, and violence to members of the public and staff boxes were ticked (it is unclear when each of the boxes was ticked – however it can be determined that the risk to vulnerable adults box was ticked in 2007 – there is also a footnote that says Mr X had been violent to others – presumably taken from what little was known in relation to the attack on his sister's friend in 2005).

Clinical Records Management

12.110. The Independent Investigation Team was told that the Trust adopted the RiO electronic record system in 2007. At this stage a project was implemented to transfer hard copy data to the new electronic system. The expectation was that important information would be transferred from the old system into the new and that a core assessment would be developed for each open patient record. In the case of Mr X this does not appear to have been achieved. The risk information and psychiatric history held by the Trust for Mr X prior to 2005 was not moved across into the new electronic record which was set up following his return from Somalia in 2007. It is important to note that Mr X's presentation prior to 2007 was significantly different to that after 2007. Had Mr X's psychiatric history travelled with him Mr X might have been understood better in the context of both his mental and physical illness. It is important to understand that Mr X's treating team between July 2007 and October 2011 had only ever seen him when well and had no experience of working with him when relapsed. The importance of the historic record was made greater as Mr X prevented his family from being communicated with once he was placed in Supported Living accommodation in June 2007. This meant that important information was lost.

Process

12.111. The Independent Investigation Team asked witnesses at interview how clinical risk assessment was conducted. No formal or multidisciplinary process was described to us. We were told that the CMHT operated a clinical risk zoning system which was conducted weekly but that the ensuing discussions were not usually recorded on RiO. We were also told that there was lots of discussion within the multidisciplinary team however the recording of these discussions was only deemed necessary if important risks were identified. It would appear that over time Mr X's risks were assessed as being either low or moderate in nature and consequently only an impression, or the most basic summary, was inputted into the record.

12.112. Witnesses explained that the RiO system provides a tick box summary and that no other risk assessment template, apart from the HCR 20, is used in the Trust (in the case of Mr X, prior to June 2013, he was not deemed to meet an HCR 20 threshold and so one was never undertaken). Unfortunately no narrative about Mr X's risk was provided as an alternative way of identifying and communicating risk. It is a key finding of the Independent Investigation Team that risk assessment and management appeared to be discussion-based only which rendered it almost invisible within the clinical record and ensured that successive team members were not privy to Mr X's risk profile over time.

12.113. The Independent Investigation Team also found that medical inputs into Mr X's care and treatment between 2007 and October 2012 were minimal. He was seen periodically by a Consultant Psychiatrist during CPA reviews (which were held six-monthly), but outside of this forum no other medical contact was made or assessment undertaken. Mr X was under four Consultant Psychiatrists over a five year period (one of whom he never met). During this five-year period no medical assessment took place outside of the CPA review forum. Unfortunately no other clinical team member appeared to lead the risk assessment process and it appears to have been an underdeveloped aspect of Mr X's care and treatment.

Conclusions

12.114. It has been difficult to understand the levels of potential risk Mr X presented either to himself or to others over time due to a virtual absence of contemporaneous risk assessment documentation. The Independent Investigation Team concludes that whilst the CMHT operated a risk zoning system this was not documented and that multidisciplinary discussions did not contribute to the risk management of individuals such as Mr X as he seemed to 'slip' under the threshold. At no stage was a diagnostic and risk formulation developed. Instead Mr X's risks were noted but little was practically done with the information to manage the emerging issues over the years.

12.115. It was understood clearly by the CMHT that Mr X was a risk to vulnerable adults as he consistently proceeded to financially abuse them over long periods of time. This was not addressed 'head on' and Mr X continued to exploit people with few sanctions being applied. Whilst he was moved to different accommodation the problem simply travelled with him and did not cease.

12.116. Mr X's perceived risks to himself through either suicide or self neglect became less apparent as the years went by. The CMHT, after 2007, only knew Mr X when well. Team members had never seen Mr X depressed, mute or confused which had been common features of his presentation between 1997 and 2005. This (coupled with the fact that Mr X's old hard copy records had not been entered onto RiO) meant that important information about Mr X's relapse triggers were 'lost' to the CMHT. The tight correlation between Mr X's previous self neglect, poor diet, medication non-compliance and the rapid relapse of his mental health was not understood. All of the time Mr X was under full CPA and in Supported Living accommodation his day-to-day needs were managed for him. Mr X's ability to live independently was never really tested; it would appear that he was able to persuade those around him that 'all was well' but this general notion had no basis in fact. However Mr X's pre-2007 risk assessments had understood he was at significant risk of dying and/or coming to harm should his mental health relapse due to his history of becoming mute, unresponsive and bed bound. For a Diabetic this would always be a dangerous proposition (especially if living alone) and this had not been taken into account.

12.117. Mr X's historic risk of violence to others appears to have been confined to the assault on his sister's friend in 2005 and a few other isolated occasions when he was confused and/or psychotic. On these occasions he became angry and verbally aggressive. These events were never examined and no risk formulation developed.

12.118. It is a fact that Mr X appeared to have been stable and well for the six years before he killed Mr Y. The CMHT found him to be polite and well dressed. When Mr X said he was coping well he was believed. The prevailing view was that he was in remission and that this remission would be of long standing. However this impression was based upon an incomplete understanding of Mr X. whilst dependence upon secondary care services should be avoided and independence promoted. It should be recognised that recovery for people with severe and enduring mental illness is seldom linear and that any individual such as Mr X will experience many relapses during a lifetime. This was not factored into Mr X's discharge plan in that no risk, relapse, crisis or contingency plans were developed and this left both Mr

X and the primary care GP practice to which he was discharged, in a potentially vulnerable position.

12.119. The Independent Investigation Team concludes that robust risk assessment and management processes were not followed. Had they been then Mr X and his vulnerabilities might have been understood better. It is reasonable to conclude that had Mr X been understood better a more appropriate discharge planning process would have been developed to support Mr X's recovery.
12.120. It was the finding of the Court that Mr X killed Mr Y as a direct result of his mental illness relapsing. However it would not be reasonable to conclude that had a more robust risk assessment and management process been in place Mr Y's death could have been predicted. It quite clearly could not. Neither would it be reasonable to conclude that a more robust risk assessment and management process, on its own, could have prevented the relapse of Mr X's mental health or allowed for it to have been detected in time to prevent the killing of Mr Y. It is concluded however that the poor risk management process constituted an omission which prevented Mr X from being understood properly. Had a more comprehensive process been followed he might have been offered more support in the community following his discharge from CPA.

- ***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.***

Discharge Planning

Context

12.121. Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[63]

12.122. The report stated that *"Mr X was subsequently discharged back to the care of his GP on 12 October 2012 following an outpatient's review by an Associate Specialist. In making the decision to discharge, the Associate Specialist documented that Mr X had been stable for over 3 years, that he had been adherent to medication*

63. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

throughout this time, that he was demonstrating good insight and was attending to see his GP regularly regarding his diabetic treatment. It was noted at the discharge CPA that Mr X had been successfully rehoused in independent accommodation and this was considered another step towards recovery and independence. Following this review advice was given to the GP to consider reducing Mr X's antipsychotic in the following 6 months to 1 year and to gradually stop medication if he remained stable".

12.123. The investigation processes posed the question as to whether the Trust provided enough information to the GP practice at the point of discharge. The following points were made:

> *"The trust team considered that the transfer systems worked well. The practice Partner said that from their perspective, everything happened that should have happened and they considered that they had all the information they needed in the discharge letter. When asked whether it would have been helpful to include in the letter any signs of relapse to be alert to, the trust Head of Patient Safety said that the trust deliberately did not do this as they had learned from previous experience that being too specific with early warning signs and symptoms meant that GPs would then only look for those particular signs and could miss other ones. The signs of relapse are so variable that it is not possible to predict which ones will be manifest".*

12.124. The Trust felt that transfer and discharge systems had worked well and that Mr X had been supported in his transfer back into primary care. Mr X was said to be *"compliant with the plan and not attending anywhere in crisis. He was planning to return to Somalia as an English teacher. Mr X was a high-functioning man: always smartly dressed. It is not known what happened in the time immediately prior to the murder – but it underlines the fact that the relapse of people with mental health problems can be unpredictable".*

12.125. The GP practice felt that the transfer was of a good standard. The Trust review however made the finding that a key factor to consider was the length of time Mr X had spent in supported accommodation which was exactly five years and that following such a long period in supported accommodation, discharge before a period of monitoring took place could be questioned. The review team thought that a further period of six months for monitoring was indicated.

12.126. The report also stated that *"The trust's discharge summary could include details of past episodes of harm to others so that GP practices can take this into consideration when conducting risk assessments on patients who are mentally ill".*

12.127. The Independent Investigation Team concurs broadly with these findings but notes there are several inaccuracies in the report in relation to discharge planning. A more detailed examination is provided below.

Findings of the Independent Investigation Team

Discharge Decision

12.128. It is evident from an examination of Mr X's clinical records that the CMHT worked to promote Mr X's independent living for a number of years and that he was stable and well for some five years; this was good practice. The decision to discharge Mr X from full CPA was indicated. However the Independent Investigation Team questioned the timing and sequencing of the discharge. Mr X experienced several changes that all occurred at the same time. **First:** He had moved from Supported Living accommodation to a private flat. This meant that he now had to be entirely responsible for his own daily living needs. **Second:** He had also moved to a new GP practice that had yet to build up a working relationship with him. **Third:** Care Coordinators had provided Mr X with a high degree of support over the years and this was withdrawn.

12.129. Within a few weeks three key support mechanisms were removed. It should be remembered that Mr X had always politely refused to manage his own daily living needs and his ability to manage independently in the community had not really been tested; there were no direct inputs from his family so this support mechanism was absent. His well kept appearance and confident statements that he was planning to work in Somalia as an English teacher were taken at face value and as indicators that he was well and could maintain his recovery with no further support. The fact that he was dependent upon those around him to continue his recovery was not taken into account. It might have been more sensible for Mr X to have been retained by the CMHT for a period of time following his discharge from full CPA in order to monitor his progress.

12.130. The Independent Investigation Team considered the fact that Mr X's medication had maintained his recovery for five years. Prior to 2007 Mr X was non-compliant with his medication and his relapses were frequent. At no point between 2007 and 2012 is there any evidence to suggest Mr X's medication regimen was reviewed; this was poor practice. It would have been good practice for the CMHT to have reviewed Mr X's medication on a more regular basis and to have formed an opinion on its role in maintaining Mr X's recovery. Had this been done it is possible that a reduction in Mr X's medication would not have been considered. However if a medication reduction was something that was indicated then it should have been managed by secondary care services prior to discharge so that the effects could be monitored appropriately.

12.131. The Independent Investigation Team found that the decision to discharge Mr X from full CPA was a reasonable decision. However a further period of time with the CMHT was indicated in view of the other changes Mr X was expected to undergo at the same time.

Discharge Process

12.132. The Independent Investigation Team found that Mr X's discharge from the CMHT in October 2012 did not conform to the full expectations of the CPA policy in operation at the time. The CPA policy made it clear that at the point of discharge back to primary care:

1. A brief summary should be provided about the care Oxleas delivered and outcomes achieved.
2. A relapse prevention plan should be developed to support the service user and their network.
3. Detailed advice should be provided to primary care as to how to route the service user back into secondary care and identify what the triggers would be.

12.133. On 19 October 2012 the Associate Specialist (who was present at the 11 October 2012 CPA review) wrote a discharge letter to the Gallions Reach Health Centre. The diagnosis was given as Bipolar Disorder together with a gambling problem. It was also noted that Mr X had Type II Diabetes and was unemployed. The psychiatric medication was given as Risperidone 3mg and the physical medication was given as Metformin 1mg twice daily, Gliclazide 160mg twice daily, Pioglitazone 30mg daily, Simvastatin 40mg daily and Liraglutide injection 18mg once daily. The letter stated that Mr X had been recently rehoused but that there were some concerns about how he would use his housing grant because of his ongoing gambling problems. It was noted that Mr X had remained stable and well and that he was compliant with his medication. Interestingly the letter stated that Mr X self-administered insulin daily which of course was not the case. It is evident that the CMHT had failed to understand Mr X's Diabetes and the medication that he was on even though it had all been listed in the discharge letter.

12.134. The letter advised that Mr X's medication could be reduced after six months with a view to stopping in one year if he remained well. The mental state examination was brief but assessed Mr X as being stable and in recovery. The GP was advised Mr X could be referred back to secondary care service if his mental health deteriorated.

12.135. The letter in itself provided an accurate summing up of Mr X as he presented at the CPA review in October 2012. However important information was lacking. No relapse, crisis or contingency plans were provided in accordance with the Trust's CPA policy. The portrait provided to the GP practice did not make clear Mr X's relapse indicators – probably because the CMHT was no longer aware of them as Mr X had continued stable and well for a long period of time.

Conclusions

12.136. Mr X received a high degree of support over a five-year period from the CMHT. The Independent Investigation Team concludes that by October 2012 too many changes had been put into train without Mr X's recovery being appropriately tested prior to his discharge back into primary care; especially as Mr X had no family support at this time.

12.137. Since the NHS England and Trust internal investigation processes Oxleas NHS Foundation Trust has undertaken a further examination of this case. The organisation is of the view that individuals with severe and enduring mental illness require an ongoing level of support which recognises that recovery is seldom linear. To this end the Trust has developed the COMPPAS project. COMPPAS stands for *"coordinated operational move to primary care plus additional services"*. The aim is to renegotiate the boundary between secondary care and primary care and to improve the liaison in order to enhance the care of the person who is subject to the

transfer. It also aims to provide ongoing support to GPs post transfer. This is good practice and the Independent Investigation Team concurs with the additional conclusions reached by the Trust.

12.138. The Independent Investigation Team concludes that whilst the decision to discharge Mr X from CPA and the CMHT was not an incorrect decision *per se* the timing was poor and the process was not managed in an optimal manner. Due to the complete lack of monitoring that ensued after October 2012 it is not possible to ascertain exactly when Mr X's life began to unravel to the extent where he was living rough and his mental health relapsed. It is reasonable to conclude, based upon what was known and what should have been known about Mr X, that a relapse of some kind was likely at some stage in the future. We conclude that the discharge process undertaken made a significant contribution to the difficulties Mr X encountered in the community remaining unmonitored and unmanaged.

- ***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.***

Safeguarding, Housing and Vulnerable Adults

Context

National Context

12.139. Safeguarding Adults is a responsibility placed on Local Authorities by Section 7 of the Local Authority and Social Services Act (1970). Through this legislation, statutory social care organisations have a duty of partnership to work with other statutory bodies, the NHS and the police, to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice. The Department of Health issued its guidance No Secrets in 2000. This guidance notes:

> *"The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety".*

12.140. Following national consultation in October 2008, the Department of Health published a document which tied existing systems of Clinical Governance into Adult Safeguarding in order to clarify responsibilities and expectations of NHS staff in relation to this issue. By 2010, Local Authorities were expected to have an Adult Safeguarding Board/Committee and a safeguarding framework/procedure in place. Social care staff would be expected to be trained in this area of work and familiar with adult safeguarding policies and procedures.

12.141. There was a clear expectation from the Department of Health that No Secrets would apply to all statutory agencies; however it took sometime before it was fully implemented in the NHS. In the preamble to the Safeguarding Adults: A National Framework of Standards it is noted that:

> *"All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include Article 2: 'the Right to life'; Article 3: 'Freedom from torture' (including humiliating and degrading treatment); and Article 8: 'Right to family life' (one that sustains the individual).*
>
> *Any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse. It follows that all citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services".*

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[64]

12.142. The report does not address safeguarding or housing issues.

Findings of the Independent Investigation Team

Housing

12.143. Mr X was placed in Supported Living accommodation in June 2007. Whilst the documentation is sparse in relation to this decision it would appear that at an early stage it was recognised that Mr X either could not, or would not, take care of himself. Whether this was directly as a result of his mental illness, cultural background or lifestyle choice was never ascertained. Over the years Mr X had substantial inputs from Occupational Therapy. This was good practice. However it became evident that he often would not cooperate.

12.144. On 3 May 2011 a comprehensive Occupational Therapy assessment was conducted. The assessment was requested in order to determine whether or not Mr X would be able to live independently at some point in the future. It was noted that:

1. Mr X had been placed in Supported Living accommodation to support his compliance with medication as he no longer had direct supervision from his family who had previously acted as a protective factor. This had been determined as a low level need. Mr X was able to demonstrate medication compliance and visited his GP unprompted on a regular basis.
2. Mr X was deemed to have the appropriate communication and motor skills to find employment.

64. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

3. Mr X could attend to his personal hygiene needs. He could use the washing machine and kept his clothing clean.
4. Mr X could cook but chose not to, preferring to eat at a local Somali Café. He thought he would cook once he had his own private accommodation. It was noted that Mr X could shop for basic things, like tea and milk and use public transport.
5. Mr X could use a vacuum cleaner and keep his bed space clean.
6. Mr X was positive and said he would be able to cope well in the community.

12.145. On the face of it the assessment was comprehensive and of good quality. However whilst Mr X's ability to care for himself was determined his *actual* day-to-day functioning was not. Over the years it was evident that Mr X had to be chased to maintain both cleanliness and order and that he never cooked for himself. For example, it was recorded on 12 February 2012 that any future housing move might be hampered by the fact his current landlord was frustrated by his inability to keep his space tidy and to wash his clothes. The fact Mr X could look after himself did not always mean he actually would. It is also evident that Care Coordinator 3 was required to actively support Mr X's move into independent living and that he could neither organise nor manage his benefits on his own. It had been known for some time that Mr X could not manage his finances, continued to gamble and ran up debts. This ongoing problem was not adequately addressed and this on its own should have indicated an extended period of monitoring from secondary care services was required for a substantial period of time following Mr X's move to private accommodation.

Safeguarding

Pre-Discharge from the CMHT in 2012

12.146. At no stage between 1997 and 2013 would Mr X have met the criteria for being a 'Vulnerable Adult' in relation to any legislation. At times prior to 2007 he was rendered vulnerable by virtue of his illness but from 2007 Mr X was the perpetrator of abuse rather than the recipient of it. A key finding of this investigation is that safeguarding processes were not managed well by the CMHT in relation to the protection of the vulnerable adults that Mr X financially abused (these individuals are not the focus of our work and their cases could not be examined).

12.147. However the issue remains that Mr X was allowed to be exploitative over a period of several years. Even though he was moved to different accommodation in an attempt to protect his fellow residents, the problem travelled with him and Mr X continued to financially abuse those around him. Whilst he was warned about his behaviour and mention made about police intervention – at no time was a detailed risk management plan put into place. Instead an acknowledgement of the risk was recorded and some possible interventions listed. It was recognised that Mr X frequently ran out of money due to his gambling lifestyle. The suggested interventions (such as Gamblers' Anonymous etc. and attendance at an addictions clinic) were sensible but Mr X refused to cooperate leaving his problems unmanaged. The only course of redress was through the police which was never utilised – leaving the financial abuse of vulnerable adults to continue over several years.

Post Discharge in 2012

12.148. Little is known about Mr Y. He did not appear to have any contact with statutory services. Although Mr Y lived next door to Mr X he was registered with a different GP practice and Gallions Reach had no knowledge or information about him; neither had Mr Y ever received care and treatment from the Oxleas NHS Foundation Trust. The Independent Investigation Team Chair and NHS England Patient Safety Lead for Mental Health met with Mr Y's eldest sister and she explained that Mr Y had lost several toes and parts of his feet which meant he used a wheelchair for travelling any distance. Mr Y's sister also explained that he often kept sums of money in his flat.

12.149. Mr X told the Court that he believed Mr Y begged 'fraudulently' and that he did not need to use a wheelchair. He also said that he frequently gave Mr Y cigarettes, food and money. Based upon what the Independent Investigation Team knows about Mr X's history this account is unlikely to be true. It would appear that Mr X's consistent financial abuse of vulnerable people was not understood by the Court and that the possibility of Mr X exploiting Mr Y was never considered. It cannot be known what the precise course of events was that led up to Mr Y's death. Speculation would not be helpful – however the possibility that Mr X entered Mr Y's flat on the pretext of obtaining money cannot be ruled out – especially as at the time he was in dire straights having been shut out of his flat by his lodger. However neither Mr Y nor Mr X were deemed to be Vulnerable Adults in the legal sense of the definition and no protection system can be said to have failed to have kept either man safe.

Conclusions

12.150. Mr X's Supported Living accommodation provided the environment in which he was able to remain stable and well for over five years. This was good practice. It is regrettable that his financial exploitation of the vulnerable adults with whom he was domiciled could not be stopped by statutory services and that his gambling and lack of financial management ability was not focused upon in more detail. These were crucial factors when determining how successful any private accommodation and independent living placement would turn out to be. The Independent Investigation acknowledges the fact that Mr X was subject to a comprehensive Occupational Therapy assessment as part of his moving on arrangements – however his ability to function did not match his actual approach to the way he chose to manage his life.

12.151. The circumstances that led up to Mr Y's death are not clear. Mr X was not clinically assessed until several months after the homicide of Mr Y. It was evident that he became rapidly unwell once in prison and that he improved equally as rapidly once he had been admitted to the Bracton Centre in the autumn of 2013. The Court found a direct correlation between the relapse of Mr X's mental health and the killing of Mr Y. However the Independent Investigation Team concludes that the lifestyle of both men and the social circumstances Mr X found himself in were underpinning factors of great significance. It remains unclear how each set of circumstances impacted one upon the other and whether Mr X's lifestyle choices, and their consequences, contributed to the relapse of his mental health, or whether his relapsing mental health contributed to the unravelling of his social circumstances. This we will never know. The Independent Investigation concludes that no act or

omission on the part of statutory services in relation to either housing or safegaurding processes *per se* contributed to the death of Mr Y.

- ***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.***

Service User Involvement in Care Planning and Treatment

Context

12.152. The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that: *"… the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*".

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"… people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. It also stated that it would *"… offer choices which promote independence".*

12.153. Good practice also requires care and treatment planning and delivery to be person-centred and sensitive to both cultural and social diversity issues.

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[65]

12.154. The report does not address this issue.

Findings of the Independent Investigation Team

12.155. It was evident to the Independent Investigation Team that Mr X was always treated in a person-centered manner. A great deal of time was given and effort made to ensure Mr X was supported and that he remained engaged with the Trust-based service. However little was ever ascertained about Mr X's cultural background and personal history. The initial assumption made by Service that Mr X was a refugee from Somalia escaping the troubles and that he had been subjected to traumatic experiences. However by 2002 it had been 'established' that Mr X was probably an economic migrant and that he not been resident in Somalia during any of the troubles having lived in both Saudi Arabia and Germany. The circumstances around his 'asylum seeker status' were neither examined nor addressed in any depth and misconceptions about his past continued over the years. NHS services never explored any of this with Mr X as he preferred not to talk about it. Another aspect of his history that was seemingly ignored was his two prolonged visits to Somalia

65. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

between 2005 and 2007. During this time he apparently re-married and had a baby son. He left his wife and son to return to England whereupon his mental health relapsed. It would appear that it was never ascertained what actually happened there and why he returned to England.

12.156. This demonstrates a remarkable lack of professional curiosity about Mr X who was known to Oxleas services for fifteen years prior to the death of Mr Y. A deeper understanding or Mr X would have provided a better framework for the delivery of his care and treatment. It would appear that over time several health care professionals felt they understood Mr X because of a shared African heritage – however the African continent is large and the cultural issues pertaining to East African are particular in nature – it is possible that some individuals drew upon their own experiences which may have been very different from those of Mr X.

Somali Culture

12.157. The Independent Investigation Team recruited specialist advisory input from the MIND Hayaan Somali Mental Health Project. Professor Fido from the project had some useful insights about Somali people and their mental health care needs. The following observations and research findings were given.

12.158. According to the United Nations Refugee Agency, Somali refugees and asylum seekers comprise one of the fastest growing populations seeking international amnesty. As of the end of 2006, approximately 460,000 Somali individuals were displaced into the international community. Given the rising prevalence of Somalis within the overall refugee population, health care providers need to become familiar with Somali perceptions and cultural understandings of both physical and mental health conditions. Somalis need to understand the new system of health care and what services are provided in the United Kingdom. Somali culture is comprised of a clan-based social system that places emphasis on family and communal bonds. Almost all Somalis are Sunni Muslims. For those who practice Islam, religion has a much more comprehensive role in life than is typical in Western Europe. It is a belief system, a culture, and a way of life. In Somalia, attitudes, social customs, and gender roles are primarily based on Islamic tradition and a male-dominant society.

12.159. Limited research has been conducted examining the prevalence of mental illness among Somali refugees. Available research has suggested that refugees are at risk for the development of a variety of psychological disturbances including depression, anxiety and post traumatic stress disorder (PTSD). Due to their high prevalence and comorbidity, depression and anxiety have been studied in conjunction in the existing literature looking at Somali mental health. One study examining the prevalence of depression, anxiety and PTSD in 143 Somali refugees residing in the United Kingdom found depression and anxiety to be present in 33.8% of the sample (Bhui, 2006).

12.160. Consistent with overall Somali perceptions of health and illness, psychological well-being is split into two categories of mentally well and mentally ill (or ‘sane’ and ‘insane’). Mild forms of affective disorders are not readily recognised as being a problem requiring professional assistance. Generalised worry and other types of anxiety such as paranoia or obsession/compulsion are not known as mental health

problems, but are considered personality characteristics. Depression or anxiety at the level of disorder were not considered prominent in Somali culture prior to the emergence of civil war in the early 1990s and may not be recognized as a problem until seen as impeding with one's daily functioning. For a period of time before seeking treatment, Somalis may experience many of the symptoms associated with clinical depression such as emotional dyscontrol, problems with sleeping, concentration, attention, or difficulty initiating behaviour. From the patient's perspective, symptoms reflect daily stresses and difficulties of refugee resettlement. Patients often seek treatment to help with sleep or appetite and consider these main symptoms from which other problems stem. A patient may reject a diagnosis of depression, honestly believing that is not their problem, especially when other life stresses remain constant.

12.161. Mental disorder carries stigma and for many people is associated with weak-mindedness, fear and hopelessness. Words like 'mental' and 'depression' may shut communication down and bring to mind Somali institutions where mentally ill ('crazy') patients are kept locked or chained up, often in unsanitary or unsafe conditions, without hope of treatment or recovery, and with few resources to care for basic survival. De-stigmatising mental illness is a central clinical consideration when working with Somali refugees. Efforts to de-stigmatise mental illness might include explaining the prevalence of disorders in the larger population and framing psychiatric illness in general and PTSD or mood disorders in particular as a normal response to atypical biological, psychological and social stressors. Patients may prefer to visit their primary care clinic for mental health care, in order to avoid the stigma of being seen entering a mental health clinic or building specifically designated for mental health care.

12.162. It is helpful if a family member or cultural mediator (if available) attends an appointment to give an indication to the provider whether something unfamiliar or seemingly unusual is within a cultural norm versus bordering on psychotic presentation. Interpreters suggest providers and staff need more awareness to identify patients who are at risk of becoming 'lost in the system' because they appear to function normally but may be expressing subtle signs of memory loss, confusion or bizarre behaviour. Examples given are a patient who demonstrates a lack of engagement or mute acceptance of whatever he/she is told. On the other hand frustration can trigger behaviours like screaming, pressure of speech and the banging of heads on walls. This form of expression does not necessarily mean that a mental illness is present.

12.163. Both men and women may resist discussing traumatic history, expressing a belief that *"The past is in God's hands. Who am I to question?"* Somali men may talk with providers about loss related to previous occupational status as compared to current status which is often lower; frustration with being 'taken care of' and the adjustment issues that go along with that; and in the older males, a sense of loss associated with farmlands, nomadic lifestyle, or connection with their sons. In general, Somalis have strong faith in Allah's will. *"He who brought it is He who relieves it, takes it from you"*. There is belief in a judgment day and that anyone who commits suicide will enter hell in the next life. Being asked directly whether they have had thoughts of suicide is considered by many patients to be *"the worst question".* The trust between a provider and patient can weaken based on this question. The

patient may think the doctor doesn't understand their perspective. Patients may wonder whether their own faith is stronger than their doctor's or whether their doctor believes in God at all. Before asking Somali patients (especially elders) about suicide, health care providers need to first alert them to the question by saying something like, *"As a professional I need to ask you what I know is a sensitive question. I am not meaning to show disrespect*".

12.164. For many Somalis, the first line of healthcare treatment is reading the Quran (particularly for individuals raised in rural Somalia). Many Somali patients believe in beginning treatment this way. Trust can be built around exploring traditional conceptions of illness and treatment. Incorporating readings from the Quran into treatment planning/ case management may be helpful in eliciting the patient's trust in the healthcare process. There are a number of commonalities present amongst the prominent world religions, for instance, the notions of forgiveness and mercy. Focusing on similarities when thinking of patient perspectives can promote dialogue and provide a fundamental place from which the patient-doctor relationship can proceed. Providing care that is consistent with how patients understand the world from a cultural standpoint can minimise psychological tension. Many Somalis believe in religion as their medicine, more than interventions by a doctor or multidisciplinary team. The Quran is believed to be a cure. To assume or imply that the Quran is ineffective is insulting.

12.165. As has already been discussed in the medication and treatment section above psychiatric medication is often viewed with suspicion and a means of taking a person away from themselves. When providing care and treatment consistency is key with Somali people often placing an emphasis on the primary care general practitioner.

Conclusions

12.166. It would appear that many assumptions may have been made by secondary care services about Mr X over the years. It is possible that the guarded history Mr X gave about his past led to services being of the view that he was fabricating a traumatic past in Somalia in order to apply for refugee status. His presentation, mute at times and at others with pressure of speech and bizarre behaviour, may well have been signs of a severe and enduring mental illness – they may also have been the natural expression of a Somalian individual in distress and coming to terms with his new life in England.

12.167. The Independent Investigation Team was advised by the Hayaan Project that Mr X's reluctance to care for himself, or to cook and clean, was probably in part due to the reluctance a Somali man would feel when asked to carry out these tasks. Mr X was probably used to other people meeting his daily living needs, such as his mother, his wife (when he had one) and his sister.

12.168. The fact Mr X thrived when in a Supported Living environment is probably explained by the social nature of the environment – something which Somali people value. Once Mr X lived on his own in private accommodation he may well have found the isolation from family and friends difficult to endure exacerbating his gambling lifestyle.

12.169. Services managed to engage Mr X and also brought him to a realisation of the value of his medication for both his psychiatric and physical conditions. This was good practice and served to maintain his recovery. However it would appear that the lack of professional curiosity about Mr X's life, both past and present, meant that he was not necessarily understood as well as he might have been and an over-reliance was placed upon his own self reports and this led to an overinflated view of how capable he would be in maintaining his recovery alone in community.

- ***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.***

Family Involvement

Context

Carer involvement

12.170. The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared-for person's type and level of service provision required.

12.171. Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they cared for. The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. It also facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[66]

12.172. The report stated that Mr X lived with his sister until 2007 and that he had been previously married (prior to 1971) and had no children.

12.173. The report also stated that *"Following the incident, neither the trust nor the practice had any contact with the families of Mr X or the family of his victim. At the end of July 2014 NHS England, London had contact with a homicide case worker at Victim Support who was supporting the sister of the victim. NHS England, London Head of Patient Safety will give this report to the victim's sister, via the case worker.*

66. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

Any unanswered questions will be passed on to the independent investigation review panel along with this report". No other mention of carers is made and no other analysis is given.

Findings of the Independent Investigation Team

12.174. Mr X lived with his sister between 1997 and 2007 – a period of some ten years. During this time Mr X's sister and her son were key protective factors in keeping Mr X safe and well. Mr X was usually brought to the attention of emergency and mental health services due to the intervention of his family. When he became mute and withdrawn, refusing to eat and drink, they sought help for him. The Trust appears to have had an awareness of the needs of Mr X's family as his sister was referred to the Somali Carers Project by Greenwich Social Services. An interpreter was also sought. This was good practice. This aside – there does not appear to have been any other interaction with Mr X's family. This was a missed opportunity for gaining additional information about Mr X's past, and also a missed opportunity for Services to understand how best to support Mr X's sister in her ongoing carer role.

12.175. Immediately following his release from prison in 2005 Mr X was admitted to hospital feeling confused and depressed. He had a deep sense of shame for the dishonour he had brought to his family. As his time in prison had been due to serious assault a risk assessment was indicated in relation to his sister and nephew's safety – this was not done. Very soon after this he left England to go back to Somalia for a protracted period of time; it seems that he got married and a son was born. The Hayaan Project Adviser to the Independent Investigation Team explained that when a person has a mental health problem marriage is often thought to be a cure and a means of 'straightening' someone out. If this was the reason for Mr X's return to Somalia then it would also have been expected for him to cease taking his medication during this period. This was never explored properly with either Mr X or his family. Therefore nothing is known about this marriage or any children from it, and nothing was learnt about how and why his mental health relapsed – an important aspect when trying to promote his recovery.

12.176. After Mr X's discharge from inpatient services in May 2007 he returned to live at his sister's home. During Mr X's second admission in June 2007 it was ascertained that he no longer wanted his family involved with his ongoing care and treatment. He was discharged into Supported Living accommodation and from this time on all contact between the treating team and his family ceased. Whilst it was known that Mr X continued to visit his family the relationship with them changed and CMHT services never met them.

Conclusions

12.177. Prior to Mr X's return from Somalia Mr X's family acted as full carers. They maintained his recovery and kept him safe. During this period it would appear that services supported the family to a certain extent although there is little recorded in the clinical record. After 2007 the family are not involved with Mr X's care and treatment at all at Mr X's request. There was a missed opportunity to gain collateral information about Mr X both before his return to Somalia and immediately afterwards. Had this been achieved then more would have been understood about his history and mental illness. It is acknowledged that after Mr X went to live in Supported Living accommodation he continued stable and well for a long period of

time. He did not want his family contacted by services. Whilst this was unfortunate Mr X was capacitous and his request had to be adhered to. The Independent Investigation Team understands that the Trust has undertaken significant work in relation to family and carer involvement in recent years. No contributory or service Issues have been identified.

Documentation and Professional Communication

Context

Documentation Trust

12.178. The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance. The GMC states that:

> *"Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off".*[67]

12.179. Pullen and Loudon writing for the Royal College of Psychiatry state that: *"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised".*[68]

Professional Communication

12.180. *"'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion".*[69]

Jenkins *et al* (2002)

12.181. Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

12.182. Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone.[70] The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.[71] The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

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67. http://www.medicalprotection.org/uk/factsheets/records
68. Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) pp 280-286
69. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy,* (2002) p121
70. Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999) p 144
71. Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[72]

12.183. The report makes mention of the poor standard of risk assessment documentation and RiO record maintenance. It was recognised that key information appeared to be missing in relation to Mr X's psychiatric history and that had this been available care and treatment teams might have taken a different approach to Mr X and the way his discharge was managed in 2012.

12.184. The Independent Investigation Team concurs with the findings of the NHS England and Trust Internal Investigation Report.

Findings of the Independent Investigation Team

Trust Documentation and Records Management

12.185. There are three key findings in relation to documentation records management:

1. The general standard of day-to-day documentation was of a poor quality. The extent of this only became evident during interviews with the care and treatment team when it became apparent that an 'informal' communication culture prevailed where discussions were held but not recorded on the RiO system. Witnesses admitted that the clinical record did not represent the work conducted or the level of multidisciplinary input that occurred.

   On the other hand it was found that comprehensive CPA review discussions were recorded and detailed letters sent to primary care on a regular basis (the exception being for the CPA review held on 11 October 2012). This was good practice.

2. Risk assessment and management processes were rendered invisible as they were rarely written into the clinical record. When asked witnesses to this Investigation could not remember how Mr X's risk was managed and no further examination could be undertaken as to the approach applied over the years. This lack of formal recording served to minimise Mr X's risk over the years and prevented important information from being handed over to successive healthcare professionals joining the CMHT.

3. Following the introduction of RiO in 2007 a period of transition ensued. However Mr X's historic hard copy clinical record was not migrated over into the new electronic record that was set up on his return from Somalia. Witnesses told the Independent Investigation that whilst hard copy records would have been available for a period of time during the transition to RiO it was not practical to access the hard copy records on a day-to-day basis. When the electronic record was introduced the expectation was that a core assessment would be inputted onto the RiO system. In the case of Mr X this was not done (probably because

72. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

his case was not open during the transition period). This prevented important information from being made available to Mr X's treating team from 2007 onwards.

The Independent Investigation Team was told that in the fullness of time all hard copy records were scanned and stored in an electronic archive that could be accessed by senior clinicians. However we were told that a) Mr X's presentation after his transfer to the CMHT did not warrant accessing the old archived records and b) many health professionals did not know how to access the archive and therefore did not use it.

GP Documentation and Records Management

12.186. Mr X registered with the Gallions Reach Surgery on 25 September 2012. At this point a request was made for his former GP records to be sent to the new practice. It would appear that the records were delivered within the usual four week timeframe. By the 23 November 2012 Mr X's case notes had been coded and summarised by a practice administrator. Significant factors, like his diabetes management, were entered onto the system so he could be followed up and monitored in an appropriate manner. Subsequently he was placed on both the diabetic and enhanced mental health register. The Independent Investigation Team was told that a GP would only request to see the old notes if there was an anomaly detected between the given diagnoses and the medication regimen, or concerns raised in a discharge summary.

12.187. Mr X's new GP at the Gallions Reach Surgery met with him on 8 October 2012 prior to any discharge letter being sent from the CMHT or his full GP record being sent from his previous practice. Due to the content of the discharge letter sent by the CMHT on 19 October 2012 no further in depth examination of Mr X's old GP record was thought to be needed.

Trust Professional Communication and Interagency/Service Liaison

12.188. During the years that Mr X received care and treatment from the CMHT professional communication between primary and secondary care appeared to be of a good general standard. Detailed communications took place following each CPA review and housing partners were kept both involved and supported by Mr X's Care Coordinators. This was good practice. At the point of Mr X's discharge in October 2012 professional communication was more limited in nature and did not provide the necessary information as indicated by extant Trust policy guidance.

GP Professional Communication and Interagency/Service Liaison

12.189. As has already been detailed in the report sections above, the discharge process for Mr X was not optimal. When interviewed by the Independent Investigation the GP practice was of the view that a more detailed history for Mr X, his past acts of violence and relapse information, was warranted and that additional consideration would have been taken when reducing his medication in April 2013 had his full history been known. The information provided by the CMHT gave no indication of any potential risk, had this been provided the practice would have undertaken a more detailed examination of Mr X's former GP records once they arrived at the surgery.

Conclusions

12.190. The Independent Investigation Team concludes that there was a clear division regarding the information known about Mr X before and after 2007. It is evident that significant facts about Mr X's risk and relapse profile were lost and that this meant he was not understood in the context of his full psychiatric history. This was exacerbated by the ongoing poor standard of risk documentation once Mr X was discharged from inpatient services in July 2007. Over time this served to present Mr X and his needs in a particular light which might not always have been either accurate or helpful. Mr X retained latent risks in relation to recovery and relapse due to the intricate interaction between his mental illness, diabetes and lifestyle choices, but these were not truly understood.

12.191. This lack of robust knowledge and risk formulation meant that when Mr X was discharged from the CMHT in October 2012 his current treating team passed on what they thought they knew about him; however this information did not provide the full picture of this complex man and did not safeguard his recovery as well as it might have done.

- ***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.***

Adherence to Local and National Policy and Procedure

Context

12.192. Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients".*[73] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

12.193. **Corporate Responsibility:** policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 12.13 below.

12.194. **Team Responsibility:** clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team

73. Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p 328

leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

12.195. **Individual Responsibility:** all registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

Findings

Findings of the NHS England and Trust Internal Investigation Processes (NB: The findings below are taken from the August 2014 NHS England report where the findings of both processes were brought together in one document)[74]

12.196. This aspect was not examined by the NHS England and Trust internal investigation.

Findings of the Independent Investigation Team

Oxleas NHS Foundation Trust

12.197. There are two key policies that Trust-based services were required to follow in relation to the care and treatment provided to Mr X. These are the CPA and risk management policies respectively. Both the CPA and risk policies in operation at the time were evidence-based and fit for purpose. It is evident that the policies were developed by senior clinicians and sponsored through the Trust's clinical governance systems. This was good practice. It would appear that most aspects of the CPA policy were followed in a consistent manner over time. Omissions were mostly evident in the area of formal care plans which were not well documented, monitored or evaluated.

12.198. In the case of risk assessment and management there appears to have been an almost total departure from policy guidelines. As has already been identified (in the report sections above) risk management documentation was of such poor quality that it has not been impossible to provide any examination of the process followed. It would appear that a culture of formal and informal discussion prevailed in the CMHT over a period of many years in which risk was discussed but not recorded. Witnesses to this investigation acknowledged that most of the discussions held were not entered onto RiO if a service user was deemed to be at low risk. At interview it was evident that witnesses found it difficult to describe what process was actually followed although individuals were at pains to state that risk was considered to be paramount importance. The Trust policy does not advocate any formal risk assessment template to be used apart from what is available in RiO. Clinicians are however encouraged to write a full narrative account of assessments undertaken. Instead the Independent investigation Team found that abbreviated impressions only were recorded and risk assessments were not conducted as part of an ongoing clinical or medical review.

74. Oxleas NHS Foundation Trust: Steis 2013/22386: Review of Case History: (September 2013). NHS England: Review of NHS Care Given to … [Mr X] (1 August 2014)

Gallions Reach GP Practice

12.199. It was evident when meeting with GPs at the practice that patients were coded and placed on special registers in accordance with the current GP contract. However the GP witnesses mentioned that they did not use any guidance other than that provided by NICE and that they had no working knowledge of formal risk assessment processes. It was noted that the practice worked hard to maintain high quality care and treatment but that it often had to put in place what it thought best with little support or guidance from NHS commissioners and provider partners.

Conclusions

12.200. The Trust had robust, fit for purpose policies in place. However there appeared to be a lack of ownership within the CMHT that it was everyone's business to adhere to the guidance in relation to Mr X. This appeared to be because his risks were deemed to be low not requiring any in depth assessment or management processes to be deployed. There is however sufficient evidence to support the conclusion that the Trust adhered fully to NICE guidelines. The GP practice appeared to work to required contractual specifications and NICE guidance. However the practice recognises that more formal quality processes need to be put into place as a result of taking part in the Independent Investigation process.

- ***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.***

Clinical Governance and Performance (to include clinical supervision, professional leadership and organisational change)

Context

12.201. "*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish".*[75]

12.202. NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

12.203. During the time that Mr X was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

75 Department of Health http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

12.204. It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr Y. The issues that have been set out below are those which have relevance to the care and treatment that Mr X received.

Findings

Oxleas NHS Foundation NHS Trust

12.205. Oxleas NHS Foundation Trust sees clinical audit and other quality improvement initiatives as a cornerstone of its arrangements for developing and maintaining high quality patient-centred services. When carried out in accordance with best practice standards, clinical audit can lead to improvements in the quality of care and patient outcomes, as well as providing assurance of compliance with clinical standards. Each year, Oxleas agrees an annual programme of quality improvement and clinical audit activity that is implemented across the financial year. This will be made up of a compilation of projects that meet's the Trust corporate requirements for assurance which include the following key areas:

- National Audits/HQIP/Quality Accounts;
- Trust-wide Priorities e.g. care planning, NICE guidance implementation, areas of concern linked to serious incidents, complaints, CQC assurance, Safeguarding etc.;
- NHSLA Priorities;
- Identified directorate priorities that have been ratified for a Trust-wide approach;
- CQUINs/Commissioner priorities.

12.206. The ratification and implementation of the annual programme of quality and clinical audit activity is overseen by the Medical Director and the Trust Clinical Effectiveness Group (CEG). The CEG is also responsible for reviewing the findings and agreed actions resulting from all trust wide clinical audits.

12.207. At the time the Independent Investigation was in train the Trust was rated 'green' by Monitor for finance and five-year strategic planning (2014 – 2019). The CQC has rated the Trust's risks to be in the lowest category and there are no regulatory issues or enforcement actions in place at the present time. The Trust has consistently excelled in the area of staff engagement being rated in the top 20 per cent of Trusts in the country.

Gallions Reach Health Centre

12.208. The GP practice was inspected by CQC in 2013. The practice failed to meet two standards:

1. **People should be given the medicines they need when they need them, and in a safe way**: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. This was considered to have a minor impact on the people using the service. It would not have impacted upon the care and treatment Mr X received.
2. **People should be cared for by staff who are properly qualified and able to do their job**: People were not always cared for, or supported by, suitably qualified, skilled and experienced staff. This was in relation to the taking up of

employment references. This was considered to have a minor impact on the people using the service. It would not have impacted upon the care and treatment Mr X received.

12.209. The Practice was found to be implementing sound clinical guidelines. However the Independent Investigation Team found that this could perhaps be better supported by the commissioners of service.

Conclusions

12.210. The Independent Investigation Team concludes that the Trust governance systems are robust and fit for purpose even though systems were not sensitive enough to detect non-adherence to the CPA and Risk policies by the Greenwich CMHT. It is evident that the organisation makes governance its core business and that it has been independently monitored over the years by both Monitor and CQC who have been able to confirm its high level of functioning. No connection was made in relation to any governance failures and the death of Mr Y.

12.211. The Independent investigation also concluded that whilst improvements could be made regarding the Gallions Reach Health Centre clinical policy guidelines no connection was made in relation to any governance failures and the death of Mr Y

13. Conclusions Regarding the Care and Treatment Mr X Received

Overview

13.1. 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.

13.2. 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 not always work as well as policy guidance suggests they should.

13.3. 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.

13.4. 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.

13.5. 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.

13.6. 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.

13.7. 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

13.8. 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.

13.9. 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.

13.10. 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

13.11. 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.

13.12. 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.

13.13. 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.

13.14. 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 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 had 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

13.15. 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.

14. Oxleas NHS Foundation Trust's Response to the Incident and Internal Review

The NHS England and Trust Internal Review

14.1. On 17 June 2013 a StEIS (Strategic Executive Information System) report was raised four days after the death of Mr Y. Oxleas NHS Foundation Trust confirmed that Mr Y was not known to the Trust. On 18 June 2013 a decision was taken between the Trust, Greenwich CCG and NHS England that the case might not be eligible for an HSG (94) 27 process – however in the interests of transparency a decision was taken to upload the case onto StEIS.

14.2. In the weeks that followed a decision was taken for Primary Care services to lead the homicide investigation. The rationale for this was that Mr X had been discharged from the Oxleas NHS Foundation Trust nine months previously and that the case should be managed by the Gallions Reach Health Centre. It was agreed that NHS England London Region would oversee the process (this was completed on 26 February 2014).

14.3. In August 2013 it was also agreed that Oxleas NHS Foundation Trust would conduct a desk top review of the case. This was completed on 9 September 2013.

14.4. On 19 June 2014 a case review workshop was held by NHS England with representatives from the Gallions Reach Health Centre and Oxleas NHS Foundation Trust in attendance to verify findings and to establish recommendations and remedial actions. A final report that brought all of the learning to-date together was prepared on 1 August 2014 by NHS England. The decision to proceed to HSG (94) 27 independent investigation was confirmed.

The Internal Investigation Process comprised the following Personnel at the Case Review Workshop

- Care Co-Ordinator for Mr X, Oxleas NHS Foundation NHS Trust
- Associate Specialist for Mr X, Oxleas NHS Foundation NHS Trust
- Director of Nursing and Governance, Oxleas NHS Foundation NHS Trust
- Head of Patient Safety, Oxleas NHS Foundation NHS Trust
- Partner, Gallions Reach Health Centre
- Head of Patient Safety, NHS England, London
- Patient Safety Manager, NHS England, London (Facilitator)

Key Findings, Analysis and Conclusions

14.5. Key findings comprised the following for Trust:

"Discharge Planning:
Was there an appropriate discharge plan formulated and implemented?
In the trust's review of the case history (Appendix 2), the authors of the review Concluded that discharge from services at the time it happened was appropriate, however, it suggests that the discharge process could have been more staggered, spanning over a six month period to ensure that sufficient time had passed following Mr X's move to independent accommodation prior to discharge from the trust.
At the workshop, the trust team said that preparation for discharge commenced well in advance of the event and included weekly discussions about discharge arrangements. Their reflection is that nothing further could have been done within an extended period – thus, they did not accept the internal report finding that the process should have been more staggered.

Medication Supervision:
Was Mr X capable of administering his own medication following his move to independent living?
The trust's review of the case history stated that it was not clear whether or not Mr X was having his medication supervised when he was living in supported accommodation. Furthermore, it was reported to the trust by the police that, 'a medication blister pack found in Mr X's flat showed evidence of non-compliance with medication'. This was reported by police on the day of the incident and is not a proven fact. This led to a question at the workshop about whether or not Mr X was capable of self-medication and whether this was an issue when he moved to independent accommodation.

In response to this, the trust team stated that Mr X did not have any help to take his medication whilst in supported accommodation (or independent accommodation). He collected his own prescriptions and self-administered the medication. Therefore, they had confidence in Mr X's ability to self-medicate prior to discharge from the trust. They could not explain the police statement regarding evidence of non-compliance as the police would not have known what quantity of this medication Mr X would typically have in his possession at any point, as above.

Consultant Contact:
Was it appropriate that Mr X was not seen by a consultant when he was discharged?
Mr X's last contact with a Consultant Psychiatrist at the trust was in October 2011 and he was discharged from the trust in October 2012 – one year later. The trust Associate Specialist (who was the last trust doctor to see Mr X before he was discharged) and the Director of Nursing and Governance both stated that this was standard practice and that the Consultant would normally only have direct contact prior to in-patient discharges.

Reducing the Risperidone Dose:
Was the plan to reduce Risperidone appropriate?
The Associate Specialist said that different people react to levels of Risperidone in different ways. A normal dose would be around 3mg, but some patients are on a dose of just 1mg. For Mr X to reduce from 3mg to 2mg as he had been stable for so long was entirely appropriate.

Discharge Information for the Practice:
Did the trust provide sufficient information about Mr X to the practice when he was discharged?
The trust team considered that the transfer systems worked well.
The practice Partner said that from their perspective, everything happened that should have happened and they considered that they had all the information they needed in the discharge letter. When asked whether it would have been helpful to include in the letter any signs of relapse to be alert to, the trust Head of Patient Safety said that the trust deliberately did not do this as they had learned from previous experience that being too specific with early warning signs and symptoms meant that GPs would then only look for those particular signs and could miss other ones. The signs of relapse are so variable that it is not possible to predict which ones will be manifest.

Key Learning Points for the Trust:
What are the learning points from Mr X's care?
The trust considered that the transfer systems worked and Mr X was well supported in transition to primary care. He was compliant with the plan and not attending anywhere in crisis. He was planning to return to Somalia as an English teacher. Mr X was a high-functioning man: always smartly dressed. It is not known what happened in the time immediately prior to the murder – but it underlines the fact that the relapse of people with mental health problems can be unpredictable. The Associate Specialist said that he had worked as a locum in many health trusts across the country and Oxleas is the one of the best that he has ever worked in. He said that

after much reflection, he cannot think of anything that could have been done differently – and there were many features of excellent care for Mr X.

14.5. Key findings comprised the following for Gallions Reach Health Centre:

Discharge Information from the Trust:
Did the practice have sufficient information about Mr X when he was discharged?
The GPs considered that they had received all the information they required from the trust in relation to Mr X when he was discharged to their care.

Assessment of Mr X on Registering with Practice:
Was there a suitable practice Mental Health Risk Assessment for Mr X?
When asked if the GP whom Mr X saw on his first appointment would have undertaken any form of mental health risk assessment given that he had just been discharged from the care of mental health services, the Partner said that it was built into their normal practice and a mental state assessment would have been part of the assessment, although no formal risk assessment was used or documented. The practice had a low threshold for asking for help and would not have hesitated to call the community mental health team if they had any concerns. There were no alarm signals relating to Mr X's registration, such as when a patient moves practice but does not move accommodation or has a delay in registering. It was clear from his records that he had engaged with physical health checks previously, such as having a flu jab and diabetic review. The trust Care Co-ordinator accompanied Mr X for his new patient health check at the practice – which was highlighted as an example of excellent care.

Reducing the Risperidone Dose:
What was the nature of the mental health assessment on Mr X prior to reducing his Risperidone in April 2013?
The GPs use a structured assessment for assessing the patient's mental health and that Dr A would have done a risk assessment. As the direction to reduce the dose had been given in the discharge letter of 19 October from the trust, no further check with the trust was deemed necessary. The Partner said Mr X had had no violent episodes at the time of registration whether this was reported from police, neighbours, friends or other collateral histories but acknowledged that at the workshop that day she had learned that Mr X did have a history of harm to others. She said that the practice could access the historical records for patients using an on-line system, but only the summarised details were on the system which GPs would be using. In the past, GPs at the practice have identified patients who were floridly psychotic and have called for taxis to take them to the community mental health team if they were deemed to be a risk to self or others. The trust Associate Specialist added that most patients taking anti-psychotic medication wish to come off their mediation as they want to be normal. Signs of relapse can be picked up by friends, family, neighbours, A&E, the police and GPs.

The Partner said that the practice neighbourhood is a close community and often practice patients will highlight concerns about their neighbours to the GPs – no concerns were raised about Mr X.

Mental Health Expertise within the Practice:
Would there have been a different approach if the practice had a GP with a Special Interest (GPwSI) in Mental Health?
The Partner said that all GPs would have completed psychiatric placements and are skilled at risk assessment. Since August 2013 they have had a GP with an interest in Mental Health – but not a formal GPwSI.

Mr X's Contact with the Practice on 10 June:
The police psychiatrists determined that Mr X was suffering from a schizo-affective disorder at the time of the killing: could this have been recognised by Dr B when Mr X saw Dr B a few days before the murder?
The trust view was that a Forensic Medical Examiner would have undertaken a mental health assessment when he was detained after the killing, and at that point Mr X was not referred to a mental health trust but to a prison, therefore, he must have been considered mentally well at that point. The time spent in prison would have led to the deterioration in Mr X's mental health which was diagnosed by the psychiatrists. The Partner said the Gallions Reach practice provides GP services to Belmarsh, and users there known to be mentally ill are passed on to Gallions Reach – this had not happened in relation to Mr X – so she deduced that he must have been mentally well.

Key Learning Points for the Practice:
What are the learning points from Mr X's care?
The Partner said that it is reassuring how much good practice occurred in relation to Mr X's care, for example the Care Co-ordinator accompanying Mr X for this initial registration and subsequent appointments at Gallions Reach. She said that every practice should have a Care Co-ordinator like Mr X's one. Mr X engaged well and had continuity of care from Dr A. There were no signs of deterioration in his mental state. His next yearly review would have been in September or October 2013.
She went on to say that she did not know until February 2014 that this incident had occurred – so it would be worth considering some form of notification system from the trust for partners.

14.6. Key conclusions were:

"During the case review these examples of good practice were identified:

1. *The trust Care Co-ordinator accompanied Mr X to his initial appointments when he registered with Gallions Reach Health Centre*
2. *The trust view was that the transfer systems worked and Mr X was well supported in transition to Primary Care.*

Neither the trust team nor the practice Partner identified any aspects of the care provided by the trust which they consider should have been done differently. The lessons learned that were highlighted were:

- *The relapse of people with mental health problems can be unpredictable*
- *To consider informing partner agencies when acute incidents occur*

Neither the practice Partner nor trust team identified any aspects of the care provided by the practice which they consider should have been done differently and no lessons learned were highlighted. Potential learning points are:

- *To consider the use of a formal risk assessment by the practice for patients with mental illness, especially when reduction in anti-psychotic medication is to be implemented*
- *The trust's discharge summary could include details of past episodes of harm to others so that GP practices can take this into consideration when conducting risk assessments on patients who are mentally ill*

Recommendations

14.7. The recommendations for the review were as follows:

1. Oxleas NHS Foundation Trust to inform partner agencies when acute incidents occur.
2. This case to be considered in relation to the Article 2, HSG (94) 27 to determine if it fits the criteria for an independent investigation according to the criteria. It is recommended that this report is used by the independent investigation review panel to inform their view on the adequacy of the investigations thus far.

Independent Investigation Team Feedback on the Internal Investigation Report Findings and Process

14.8. The commissioning of the internal investigation process followed an atypical route. The issue appeared to be whether an incident involving a patient who had been discharged for nine months from secondary care services met the guidance for independent investigation. It is the experience of the Independent Investigation Team that the six-month timeframe set out in HSG (94) 27 is a guideline only and that if any potential lessons for learning are indicated following a homicide then an Independent Investigation should always follow – even if more than six months have elapsed since discharge. In addition all NHS services should be prepared to undertake a full internal investigation process in relation to the care and treatment pathway provided regardless of organisational boundary issues.

14.9. In the immediate aftermath of the homicide the parties agreed that the GP practice would lead an investigation, but due to various factors the GP practice did not undertake the investigation and this was not identified by NHS England until many months later.

14.10. In the event it took over a year for local services to conduct a review which was robust enough in nature to yield any findings and conclusions. The NHS England Chair of the Independent Investigation Review Group made a decision in March 2014 that an independent investigation should be commissioned; however at this stage the CEO of the Oxleas Trust challenged the decision stating that a local investigation should take place first. This was duly completed.

14.11. On reflection the process followed was not robust enough to examine in full all of the significant care and treatment issues. At the time of the incident some of the processes within the newly created NHS organisations (following the demise of the strategic health authorities) were not fully-formed which inhibited decision-making and inter-organisational transactions which would have led to a more effective approach to establishing an investigation into this incident. That being said the Trust desk top review and NHS England review provided valuable insights and the

Independent Investigation Team acknowledges they made a significant contribution to remedial actions being taken in relation to service improvement.

Being Open

14.12. The National Patient Safety Agency issued the original Being Open guidance in September 2005; the guidance was then updated in 2009. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and expected to have their action plans implemented and a local Being Open policy in place by June 2006. The Being Open safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The Being Open guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.

14.13. Although the Being Open guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

14.14. Unfortunately following the incident neither the Trust nor the GP practice made any contact with either the family of the victim or the perpetrator. In July 2014 the sister of Mr Y was traced by NHS England. The family of Mr X was not contacted until the Inquest of Mr X was underway. The lack of timely communication with the families was poor practice.

Staff Support

14.15. Witnesses told the Independent Investigation Team that they felt well supported throughout the internal investigation processes. However lessons for learning were not shared widely and this is something that both the Trust and the GP practice need to address when managing any future incidents.

Progress against the Trust Internal Review Action Plan

14.16. The Trust reports that the success of the COMPPAS project which ran within the Greenwich Recovery Teams between 2013 and 2015 has informed the

operational policy of the Primary Care Plus function within the reconfigured community mental health services in Greenwich. These reconfigured services have been in operation since September 2015.

15. Notable Practice

Dignity

15.1. 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

15.2. 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

15.3. 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.

15.4. 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.

15.5. 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.

16. Lessons for Learning

Documentation and Professional Communication

16.1. 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.

16.2. 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)

16.3. 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.

16.4. 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

16.5. 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.

17. Recommendations

17.1. 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.

17.2. 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.

17.3. 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

17.4. 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.

17.5. 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.

<u>Recommendation 1.</u> 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.**

<u>Recommendation 2</u>. 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

17.6. 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.

<u>Recommendation 3.</u> 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.

<u>Recommendation 4.</u> 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.***

17.6. 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

17.7. 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.

17.8. 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

17.9. 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

17.10. 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

17.11. 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

17.12. 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.

18. Glossary

Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach	National systematic process to ensure assessment

(CPA)	and care planning occurs in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people own homes.
Care Coordination	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Mental Health Act (1983 and 2007)	The Mental Health Act 1983/2007 covers the assessment, treatment and rights of people with a mental health condition.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
Service User	The term of choice of individuals who receive mental health services when describing themselves.